DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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ID: UWU3 Facility ID: 00947

MEDICARE/MEDICAID PROVIDER NO. (L1) 245342 2.STATE VENDOR OR MEDICAID NO. (L2) 395463300		3. NAME AND AD (L3) THE ESTAT (L4) 313 SOUTH (L5) STILLWATE	ES AT GREE GREELEY S	LEY LLC	(L6) 55082	4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERS (L9) 03/01/2017	SHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other er Complaint
6. DATE OF SURVEY 01/16/2018 8. ACCREDITATION STATUS: 0 Unaccredited	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	DING DATE: (L35)
•	(L18) (L17)	Compliance	nce With equirements e Based On: cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of 3 7. Medical I	Services Limit Director om Size
		Requirements	and/or Applied	Waivers:	* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 74	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARKS (II	F APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Susanne Reuss, Unit Supe	ervisor	0	1/25/2018	(L19)	Kamala Fiske-Downing	, Enforcement Spe	ecialist 01/25/2018 (L20)
PART II -	TO BE	COMPLETED E	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible	(L21)		IPLIANCE WITI ITS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Control3. Both of the Above	ol Interest Disclosure Stn	
22. ORIGINAL DATE 23. LT	C AGREEN	MENT 24	I. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION BI 08/01/1986	EGINNING	DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		UNTARY o Meet Health/Safety
(L24)	<i>A</i> 1)		(L25)		02-Dissatisfaction W/ Reimburs	00 1 411 1	Meet Agreement
		VE SANCTIONS n of Admissions:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	07-Provi	der Status Change
(L27) B.	Rescind Su	spension Date:	(L44) (L45)			00-Activ	e
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS		
		01111					
(L28	3)	VIII		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	L DATE			
(L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245342

January 24, 2018

Ms. Yaneque Walker, Administrator The Estates At Greeley LLC 313 South Greeley Street Stillwater, MN 55082

Dear Ms. Walker:

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 January 10, 2018 the above facility is certified for:

74 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 74 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,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 24, 2018

Ms. Yaneque Walker, Administrator The Estates At Greeley LLC 313 South Greeley Street Stillwater, MN 55082

RE: Project Number S5342027

Dear Ms. Walker:

On December 15, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 16, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 8, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2017, effective January 10, 2018 and therefore remedies outlined in our letter to you dated December 15, 2017, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICALD CERTIFICATION AND TRANSMITTAL	L
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Facility ID: 00947

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MEDICARE/MEDICAID PROVIDE (L1) 245342 2.STATE VENDOR OR MEDICAID N		3. NAME AND AI (L3) THE ESTAT (L4) 313 SOUTH	TES AT GREE	ELEY LLC		4. TYPE OF ACTIOn Initial	2. Recertification
(L2) 395463300	Ю.	(L5) STILLWAT		TKELI	(L6) 55082	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF 0	OW/NED CHID	7. PROVIDER/SU		CORV	<u>02</u> (L7)	7. On-Site Visit	9. Other
(L9) 03/01/2017	OWNERSHIP	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey Afte	er Complaint
	/2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		FISCAL YEAR END	ING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATION	1	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requiren	nents:
To (b):			equirements e Based On:		2. Technical Personnel		
		•			3. 24 Hour RN	7. Medical D	
12.Total Facility Beds	74 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	8. Patient Roo9. Beds/Room	
13.Total Certified Beds	74 (L17)	X B. Not in Con Requirements	npliance with Pro and/or Applied	~	* Code: B *	9. Beds/Room (L12)	1
14. LTC CERTIFIED BED BREAKDO	WN	•			15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
74							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Robyn Woolley, HFE	NE II		01/04/2018	(L19)	Kamala Fiske-Downing.	Enforcement Spe	cialist 01/24/2018 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBIL	ITY		IPLIANCE WIT	H CIVIL	21. 1. Statement of Finar	ncial Solvency (HCFA-25 ol Interest Disclosure Stm	
1. Facility is Eligible to P	articipate	KIGI	III3 ACT.		3. Both of the Above		(HC174-1515)
2. Facility is not Eligible	(L21)						
	(E21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	INVOLU	NTARY
08/01/1986					01-Merger, Closure		Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER	
	A. Suspension	n of Admissions:	T 40		04-Other Reason for Withdrawar	07-Provid 00-Active	ler Status Change
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29). INTERMEDIARY			30. REMARKS		
		01111					
	(L28)	VIIII		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	L DATE			
	(L32)			(L33)	DETERMINATION APPR	ROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 15, 2017

Ms. Yaneque Walker, Administrator The Estates At Greeley LLC 313 South Greeley Street Stillwater, MN 55082

RE: Project Number S5342027

Dear Ms. Walker:

On December 1, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

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 **Metro A Survey Team 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: susanne.reuss@state.mn.us

Phone: (651) 201-3793 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 10, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 10, 2018 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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

The Estates At Greeley LLC December 15, 2017 Page 4

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your 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 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 March 1, 2018 (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

The Estates At Greeley LLC December 15, 2017 Page 5

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 June 1, 2018 (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

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 The Estates At Greeley LLC December 15, 2017 Page 6

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,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

PRINTED: 01/04/2018 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED
		245342	B. WING		12/01/2017
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments		E 00		
E 007 SS=F	Emergency Prepare conducted Novemb 2017 during a received The facility's plan or as your allegation of Department's acceptottom of the first poesused as verificated Upon receipt of an revisit of your facilities validate that substate regulations has been your verification.	f correction (POC) will serve of compliance upon the otance. Your signature at the page of the CMS-2567 form will tion of compliance. acceptable POC an on-site y may be conducted to untial compliance with the en attained in accordance with	E 00'	7	1/10/18
	and maintain an em that must be review annually. The plan (3) Address patient but not limited to, poservices the [facility an emergency; and including delegation plans.**	n. The [facility] must develop nergency preparedness plan yed, and updated at least must do the following:] /client population, including, ersons at-risk; the type of y has the ability to provide in continuity of operations, as of authority and succession			
	hospice, PACE, HH FQHC, or ESRD fa This REQUIREMEN by:	risk" does not apply to: ASC, IA, CORF, CMCH, RHC, cilities.] NT is not met as evidenced and document review, the		The facility s Emergency Preparedne	ess
AROBATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

12/25/2017

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.

NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY LLC STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET	1/2017
THE ESTATES AT GREELEY LLC	
STILLWATER, MN 55082	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 007 Continued From page 1 facility failed to develop an emergency preparedness plan (EPP) which identified the at risk population of the facility, as well as the types of services the facility could provide in an emergency. This had the potential to affect 59 of 59 residents currently residing in the facility, as well as staff and visitors. Findings include: During a review of the facility's EPP, the plan did not identify the facility's at risk population or the type of services the facility could offer in an emergency. On 12/1/17 at 2:50 p.m. the administrator verified these items were missing from the EPP.	1/10/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245342	B. WING		12/0	1/2017
	PROVIDER OR SUPPLIER TATES AT GREELEY L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
E 015	safety and for the s provisions. (B) Emergency li (C) Fire detection systems. (D) Sewage and *[For Inpatient Hosp Policies and proced (6) The following ar hospice-operated in The policies and problems following: (iii) The provision on hospice employees evacuate or shelter limited to the follow (A) Food, water, supplies. (B) Alternate sout following: (1) Temperature and safety and for the following: (1) Temperature and safety and for the following: (2) Emergency (3) Fire detect systems. (C) Sewage and This REQUIREMENT by: Based on interview facility failed to inclusive facility failed fai	afe and sanitary storage of ghting. n, extinguishing, and alarm waste disposal. Dice at §418.113(b)(6)(iii):] dures. e additional requirements for apatient care facilities only. occdures must address the f subsistence needs for and patients, whether they in place, include, but are not ing: medical, and pharmaceutical arces of energy to maintain the res to protect patient health he safe and sanitary storage of lighting.	E 015	The facility s Emergency Prepare Plan (EPP) will be updated to add how the facility will provide medical pharmaceutical supplies in the every emergency Administrator or Design be responsible.	ress al and ent of an	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245342	B. WING			12/0	01/2017
	PROVIDER OR SUPPLIER	LC		3	TREET ADDRESS, CITY, STATE, ZIP CODE 13 SOUTH GREELEY STREET TILLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	revealed the EPP far facility was going to pharmaceutical supervacuation or a she administrator verification and proposition of medical supplies. Procedures for Trace	P policy and procedures ailed to address how the provide medical and oplies in the event of a facility elter in place emergency. The ed on 12/2/17 at 2:57 p.m. the cedures did not address the all and pharmaceutical ocking of Staff and Patients	E				1/10/18
SS=F	[(b) Policies and prodevelop and implementation policies and proceed plan set forth in parassessment at para and the communication this section. The poreviewed and update	pocedures. The [facilities] must ment emergency preparedness dures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of blicies and procedures must be ted at least annually.] At a es and procedures must					
	and sheltered patie an emergency. If o patients are relocat [facility] must docur	k the location of on-duty staff nts in the [facility's] care during n-duty staff and sheltered ed during the emergency, the nent the specific name and iving facility or other location.					
	ICF/IIDs at §483.47 Policies and proced location of on-duty the [PRTF's, LTC, I	1.184(b), LTC at §483.73(b), (5(b), PACE at §460.84(b):] dures. (2) A system to track the staff and sheltered residents in CF/IID or PACE] care during ency. If on-duty staff and					

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E 018	sheltered residents emergency, the [PF must document the the receiving facility *[For Inpatient Hosp Policies and proced (ii) Safe evacuation includes considerat needs of evacuees; transportation; iden location(s) and prim communication with assistance. (v) A system to trace employees' on-duty hospice's care durin on-duty employees relocated during the must document the the receiving facility *[For CMHCs at §44 procedures. (2) Saf which includes constreatment needs of responsibilities; trarevacuation location means of communication assistance. *[For OPOs at § 48 procedures. (2) A sydocumentation that donor information, potential and actual	are relocated during the RTF's, LTC, ICF/IID or PACE] specific name and location of or or other location. Dice at §418.113(b)(6):] dures. from the hospice, which ion of care and treatment is staff responsibilities; tification of evacuation hary and alternate means of an external sources of the kind the location of hospice and sheltered patients in the ang an emergency. If the or sheltered patients are an emergency, the hospice specific name and location of or or other location. 85.920(b):] Policies and evacuees; staff insportation; identification of (s); and primary and alternate cation with external sources of 6.360(b):] Policies and	EC	118			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 018	procedures. (2) Saf facility, which included needs of the patient This REQUIREMENT by: Based on interview facility failed to develope and implement of the procedures revealed system for tracking emergency. However, on 12/1/17, at 3:00 developed a staff to Policies/Procedures CFR(s): 483.73(b) (a) [(b) Policies and procedures and the communication section. The poreviewed and updating and the policies and procedures and the communication and the policies and procedures and the communication and the policies and updating the policies and updating the policies and the communication and the policies and updating the policies and the communication and the policies and updating the policies and updating the policies and the communication and the policies and updating the policies and the communication and the policies and updating the policies and up	4.62(b):] Policies and re evacuation from the dialysis responsibilities, and responsibility, as resident in the event of an responsibility residing in the facility, as resident in the event of an responsibility had developed a resident in the event of an responsibility had not acking system. responsibility had not acking system. responsibility had not acking system. responsibilities in Place responsibilities in	E 01	The facility s Emergency Prepare Plan (EPP) will be updated to address tracking of staff in the event of an emergency. Administrator or Desig be responsible.	ess the	1/10/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	(. ,	SURVEY
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		I SHOULD E		(X5) COMPLETION DATE
E 022	patients, staff, and [facility]. *[For Inpatient Hosp and procedures. (6) The following ar hospice-operated in The policies and procedures and procedures are policies and procedures. (i) A means to shoospice employees This REQUIREMED by: Based on interview facility failed to dev preparedness plan and procedures for staff and/or resident not able to evacuat to remain at the fact be arranged. This has to remain at the fact be arranged. This has to residents current well as staff, volunted as staff, volunted as staff and procedures revealed procedure to address revealed procedure to address residents, staff and persons were not a evacuated or if the sheltering in place of the administrator staff.	ans to shelter in place for volunteers who remain in the poices at §418.113(b):] Policies at §418.113(b):] Policies at additional requirements for apatient care facilities only. Occedures must address the pelter in place for patients, who remain in the hospice. The is not met as evidenced and document review, the elop an emergency (EPP) which included policy sheltering in place residents, its in the event the facility was a e and some persons needed and the potential to affect 59 of atly residing in the facility, as teers and visitors. It is EPP policy and the date was no policy or so how to shelter in place for visitors in the event some ble to be immediately facility had determined	EO	The facility s Emergency F Plan (EPP) will be updated sheltering in place, resident visitors. Administrator or De responsible.	to address, staff, a	ss and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082		
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E 022 E 024 SS=F	need to evacuate.	s could be sent in case of the s-Volunteers and Staffing	E 0			1/10/18
	[(b) Policies and prodevelop and implementation policies and proceed plan set forth in parassessment at para and the communication this section. The poreviewed and updaminimum, the polici address the following (6) [or (4), (5), or (7) volunteers in an emstaffing strategies, for integration of St	pocedures. The [facilities] must ment emergency preparedness lures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of policies and procedures must be ted at least annually. At a less and procedures must mg:] as noted above] The use of the process and role at and Federally designated				
	*[For RNHCIs at §4 procedures. (6) The emergency and oth strategies to address emergency. This REQUIREMEN by: Based on interview facility failed to developreparedness plan and procedure to a staffing strategies in This had the potent	03.748(b):] Policies and e use of volunteers in an er emergency staffing as surge needs during an NT is not met as evidenced and document review, the		The facility s Emergency Prepa Plan (EPP) will be updated to adduse of volunteers during the even emergency. Administrator or Deswill be responsible.	lress the t of an	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE COMF	SURVEY PLETED
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	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082		
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E 024	the facility had volu	ge 8 o.m. the administrator stated nteers at the facility. A review nd procedures revealed there	E 02	24		
E 029 SS=F	were policy and pro strategies, but there volunteers. The lac	cedures to address staffing was not staffing strategy for k of a policy and procedure staffing was verified at this trator.	E 02	29		12/31/17
	emergency prepare that complies with F and must be review annually. This REQUIREMEN by: Based on interview facility failed to development of the for each resident's and contact informat facilities in the area.	st develop and maintain an edness communication plan Federal, State and local laws red and updated at least of and document review, the elop a communication plan names and phone numbers physician, as well as the name ation for other long term care s. This had the potential to dents residing at the facility.		The facility s Emergency Prepare Plan (EPP) will be updated to includ names and contact information for residents physician, as well as the names of long-term care facilities in immediate area. Administrator or Designee will be responsible.	de the each e	
	able to provide a co- included each staff' However, there was which included the information, such a	p.m. the administrator was ontact list for staff, which is name and phone number. Is no contact list developed names and contact is phone numbers or email residents physician. In				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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E 029	and associated pho	listed by name local hospitals one numbers, but the list did m care facilities in the	EC)29			
E 031 SS=F	list did not include in physician's or for ot	erified at this time the contact information for resident her long term care facilities. Sontact Information	ΕC)31			12/18/17
	emergency prepare that complies with F and must be review	ist develop and maintain an indress communication plan Federal, State and local laws red and updated at least munication plan must include					
	information for the f (i) Federal, State, tr emergency prepare (ii) The State Licens	ibal, regional, or local edness staff. sing and Certification Agency. e State Long-Term Care					
	information for the f (i) Federal, State, tr emergency prepare (ii) Other sources o	ibal, regional, and local denotes staff.					

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	This REQUIREMENT by: Based on interview facility failed to deven which included the the Office of the State Ombudsman. This of 59 residents residents residents include: The facility's comminformation for the Care Ombudsman. 12/1/17, at 3:12 p.n. contact information facility's communication facility's communication of the Care Ombudsman. 12/1/17, at 3:12 p.n. contact information facility's communication facility's communication plans (a): [(c) The [LTC facility and maintain an emcommunication plans State and local laws updated at least an plan must include a (8) A method for shemergency plan, this appropriate, with families or represer This REQUIREMENT by: Based on interview facility failed to imposite which included a method for include	ection and Advocacy Agency. NT is not met as evidenced and document review, the elop a communication plan names contact information for ate Long-Term Care had the potential to affect 59 ding at the facility. unication plan lacked contact Office of the State Long-Term The administrator verified on a. that "No" the ombudsman's was not present in the ation plan. haring Plan with Patients by and ICF/IID] must develop nergency preparedness and must be reviewed and nually.] The communication all of the following: aring information from the at the facility has determined residents [or clients] and their	EO		The facility s Emergency Prepare Plan (EPP) has been updated to inthe name and contact information foffice of State of Long-Term Care Ombudsman. Administrator or Deswill be responsible. The facility s admission packets wupdated to include letter informing patients of the Emergency Prepare Plan (EPP) and available for review	clude or the signee vill be dness	1/10/18

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E 035	59 of 59 residents of as well as staff and Findings include:	idents, families or is had the potential to affect currently residing in the facility, visitors.	E 0	Location of the Emergency Prep Plan (EPP) binder will be shared resident council and family meet Administrator or Designee will be responsible.	at ng.	
	information on how the EPP was provio representative via to administrator stated admission packet in found by the survey	p.m. the administrator stated the facility planned on sharing led to residents, families and he admission packet. The dithere was a letter in the indicating the EPP could be results book. A review of the provided to the survey team the a letter.				
E 037 SS=F	be presented in res and during family m provided in this man administrator also s		E 0	37		1/10/18
	ASCs, PACE organ and dialysis facilitie (i) Initial training in a policies and proced staff, individuals pro arrangement, and v expected role.	m. The [facility, except CAHs, izations, PRTFs, Hospices, s] must do all of the following: emergency preparedness lures to all new and existing oviding services under volunteers, consistent with their ncy preparedness training at				

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 037	(iv) Demonstrate st procedures. *[For Hospitals at § at §491.12:] (1) Tra or RHC/FQHC] mu: (i) Initial training in opolicies and proced staff, individuals proarrangement, and vexpected roles. (ii) Provide emerge least annually. (iii) Maintain docum (iv) Demonstrate st procedures. This is what's in SC *[For Hospices at § hospice must do all (i) Initial training in opolicies and proced hospice employees services under arrae expected roles. (ii) Demonstrate staprocedures. (iii) Provide emerge least annually. (iv) Periodically reviemergency prepare employees (includir special emphasis p procedures necess others. *[For PRTFs at §44]	dentation of the training. aff knowledge of emergency 482.15(d) and RHCs/FQHCs ining program. The [Hospital st do all of the following: emergency preparedness lures to all new and existing oviding on-site services under volunteers, consistent with their incy preparedness training at mentation of the training. aff knowledge of emergency M but is missing here. 418.113(d):] (1) Training. The lof the following: emergency preparedness lures to all new and existing and individuals providing angement, consistent with their aff knowledge of emergency ency preparedness training at itew and rehearse its edness plan with hospice ang nonemployee staff), with laced on carrying out the ary to protect patients and	E 0	37		
	program. The PRTI	F must do all of the following:				

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E 037	policies and proced staff, individuals prarrangement, and expected roles. (ii) After initial train preparedness train (iii) Demonstrate start procedures. (iv) Maintain documpreparedness train *[For PACE at §460 organization must of the companization	emergency preparedness dures to all new and existing oviding services under volunteers, consistent with their ing, provide emergency ing at least annually. Eaff knowledge of emergency mentation of all emergency ing. D.84(d):] (1) The PACE do all of the following: emergency preparedness dures to all new and existing oviding on-site services under ractors, participants, and ent with their expected roles. Ency preparedness training at eaff knowledge of emergency ing informing participants of to go, and whom to contact in incy. Inentation of all training. 85.68(d):](1) Training. The of the following: atining in emergency ites and procedures to all new individuals providing services to and volunteers, consistent	EO	37		

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E 037	and assigned speci	personnel must be oriented fic responsibilities regarding	E 03	7		
	their first workday. include instruction i	ency plan within 2 weeks of The training program must n the location and use of signals and firefighting				
	The CAH must do a (i) Initial training in a policies and proced reporting and exting and where necessal personnel, and gue cooperation with fire	5.625(d):] (1) Training program. all of the following: emergency preparedness lures, including prompt guishing of fires, protection, ary, evacuation of patients, sts, fire prevention, and efighting and disaster ew and existing staff,				
	individuals providin and volunteers, cor roles. (ii) Provide emerge least annually. (iii) Maintain docum	g services under arrangement, asistent with their expected entry preparedness training at mentation of the training. aff knowledge of emergency				
	CMHC must provid preparedness polic and existing staff, in under arrangement with their expected documentation of the demonstrate staff k procedures. Therea emergency prepare annually.	85.920(d):] (1) Training. The e initial training in emergency ies and procedures to all new ndividuals providing services and volunteers, consistent roles, and maintain he training. The CMHC must nowledge of emergency after, the CMHC must provide edness training at least				

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E 037	facility failed to train regarding policy and emergency prepare the potential to affer residing in the facility. Findings include: During an interview 12/1/17, at 3:26 p.n. "No" when asked if been trained on the facility's EPP. The aplanned on doing the provide an exact dascheduled for. INITIAL COMMENTAL A recertification sur November 28 through Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. The facility's plan of as your allegation of Department's accept enrolled in ePOC, yat the bottom of the form. Your electron	and document review, the hing new and current staff of procedures in the facility's edness plan (EPP. This had ct 59 of 59 residents currently ty, as well as staff and visitors. With the administrator on the administrator stated new and current staff had a policy and procedures in the administrator stated they ne training, but was unable to atte the training had been are training had been acceptable electronic POC, and are facility may be conducted to antial compliance with the en attained in accordance with a correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will	E 03	The facility will develop a plan to to current and new staff on Emergence Preparedness Plan (EPP). Administration or Designee will be responsible.	СУ	
F 565 SS=E	· · · ·	oup and Response	F 56	5		1/5/18

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F 565	and participate in re (i) The facility must group, if one exists reasonable steps, v to make residents a upcoming meetings (ii) Staff, visitors, or resident group or fa the respective grou (iii) The facility mus person who is appr group and the facility providing assistanc requests that result (iv) The facility mus resident or family g the grievances and groups concerning in the facility. (A) The facility mus response and ration (B) This should not facility must implem request of the resid §483.10(f)(6) The r participate in family §483.10(f)(7) The r family member(s) or representative(s) m families or resident residents in the fac This REQUIREMEN by: Based on document	esident has a right to organize esident groups in the facility. provide a resident or family, with private space; and take with the approval of the group, and family members aware of a in a timely manner. To other guests may attend amily group meetings only at p's invitation. It provide a designated staff oved by the resident or family ty and who is responsible for e and responding to written from group meetings. It consider the views of a roup and act promptly upon recommendations of such issues of resident care and life at be able to demonstrate their hale for such response. The beconstrued to mean that the nent as recommended every tent or family group. The esident has a right to be groups. The esident has a right to have the or other resident the representative(s) of other sility. The interview and interview, the	F 565	Residents R4, R10, R13, R24, R3	
		w up on resident council passing of snacks and		R45, R47 & R58 have been provid public broadcast station (PBS) tele	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
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F 565	television channel r (R4, R10, R13, R24 who voiced complated by the voiced by	padcast station (PBS) reception for 9 of 9 residents 4, R33, R39, R45. R47, R58) ints. If the resident council meeting riber, October and November riber 6. Old Business: (A re brought up as NEW rest meeting. Red [sic] the rest that was submitted to show resisue.) A. PBS- different riack cart. Was the issue risfaction? Both boxes were rere was no further explanation relevision channel or the rick cart by facility staff. There rms filled out to address follow resident council requests. In reeting was scheduled on rea.m. and 9 residents R4, R10, 9, R45. R47, R58 participated reverse to R58's room and the rest too high for R58 to reach in rest, R4 who was assessed rely intact, expressed staff reck to R4's roommate but they	F 565	channels and snacks passed to the routinely. All residents that receive nutrition will continue to be offered snacks. Those needing copies of television channels will also be provided with these copies. All staff will be re-educated on the process of discresident snack passes as well as residents needing copies of televichannels have those copies. Audist snack passes to be completed we weeks; then as needed. Administry Director of Nurse Services (DNS) Designee will be responsible particular will provide redirection or change necessary to ensure completion a continuation of monitoring process on compliance date of 1/05/18.	e oral d ovided tributing ensuring sion ts of eekly x 4 rator and or y. QAPI when und/or	

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		245342	B. WING		12	/01/2017
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CO 313 SOUTH GREELEY STREET STILLWATER, MN 55082		701/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 565	10/26/17 as cognitis snack cart which sadesk was usually e During the interview 8/17/17 as cognitive been no resolution PBS television statishave but has not rewere not always off routine basis. All 9 residents R4, R45. R47, R58 valisestoring the PBS there was an ongoin snack. All 9 resides resolution to the resident council. Document review of titled Resident Couread, "Concerns presented meeting will be docured, "Concerns proconcerns presented meeting will be docured, "The Adminissummary to the councing on the grievance not after receipt of the When interviewed administrator verification of the PBS television snacks	vely intact, expressed the at in the hallway by the nurses mpty by 6:00 p.m. v, R45 who was assessed ely intact, expressed there had to the request to resume the ion that the facility used to estored. R45 verified snacks fered by the facility staff on a start of the request to resume the ion that the facility used to estored. R45 verified snacks fered by the facility staff on a start of the facility staff on a start of the facility policy of the facility policy, dated 7/17, noil Policy, under number 6. occess/resolution- Any during a resident council rumented and resolved per the pocument review of the evance Procedure, dated 9/01, trator shall issue a written mplainant of proposed action of later than seven (7) days	F 5	65		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245342	B. WING			12/0	01/2017
	PROVIDER OR SUPPLIER	LC		313	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH GREELEY STREET LLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 565	the October minutes November minutes initiate a concern fo	s council minutes on 9/20/17, s on 10/23/17 and the on 11/21/17, but did not r the resident council television and snack passing	F 5	65			
F 585 SS=D	Grievances CFR(s): 483.10(j)(1 §483.10(j) Grievano)-(4)	F 5	85			1/5/18
	§483.10(j)(1) The regrievances to the fathat hears grievance reprisal and without reprisal. Such griev respect to care and furnished as well as furnished, the beha	esident has the right to voice cility or other agency or entity es without discrimination or fear of discrimination or ances include those with treatment which has been that which has not been vior of staff and of other reconcerns regarding their LTC					
	facility must make p	esident has the right to and the brompt efforts by the facility to the resident may have, in a paragraph.					
		acility must make information vance or complaint available					
	grievance policy to of all grievances recontained in this pa provider must give a to the resident. The include:	acility must establish a ensure the prompt resolution garding the residents' rights ragraph. Upon request, the a copy of the grievance policy grievance policy must t individually or through					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245342	B. WING			12/0	01/2017
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY LLC			3	TREET ADDRESS, CITY, STATE, ZIP CODE 13 SOUTH GREELEY STREET TILLWATER, MN 55082			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	facility of the right to (meaning spoken) of grievances anonym of the grievance anonym of the grievance anonym of the grievance anonym of the grievance off can be filed, that is, address (mailing ar number; a reasonal completing the reviet to obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvement Agency and State Lagrogram or protecti (ii) Identifying a Grieresponsible for overeceiving and trackic conclusions; leading by the facility; main information associate example, the identification grievance submitted written grievance decoordinating with stancessary in light of (iii) As necessary, to prevent further poteright while the alleg investigated; (iv) Consistent with reporting all alleged abuse, including injand/or misappropria anyone furnishing significant in the grievance of the protection of the grievance of th	ent locations throughout the offile grievances orally or in writing; the right to file rously; the contact information icial with whom a grievance his or her name, business and email) and business phone ole expected time frame for ew of the grievance; the right decision regarding his or her contact information of swith whom grievances may pertinent State agency, and Organization, State Survey cong-Term Care Ombudsman on and advocacy system; evance Official who is reseeing the grievance process, and grievances through to their grany necessary investigations taining the confidentiality of all atted with grievances, for the resident for those end anonymously, issuing ecisions to the resident; and ate and federal agencies as a specific allegations; aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately I violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ininistrator of the provider; and	F	585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 585	(v) Ensuring that all include the date the summary statementhe steps taken to isummary of the per regarding the residual to whether the groofirmed, any contaken by the facility and the date the wrough (vi) Taking appropriace ordance with Stof the residents' rigor if an outside entithe State Survey Agorganization, or loc confirms a violation rights within its area (vii) Maintaining eviresult of all grievand 3 years from the issued decision. This REQUIREMED by: Based on interview facility failed to add grievance for 1 of 1 complained about of the facility for t	I written grievance decisions a grievance was received, a at of the resident's grievance, nvestigate the grievance, a rtinent findings or conclusions ent's concerns(s), a statement prievance was confirmed or not rective action taken or to be as a result of the grievance, ritten decision was issued; iate corrective action in rate law if the alleged violation this is confirmed by the facility the ty having jurisdiction, such as gency, Quality Improvement cal law enforcement agency of for any of these residents' as of responsibility; and idence demonstrating the ces for a period of no less than suance of the grievance NT is not met as evidenced of and document review, the press in a timely manner a food resident (R30) who had	F 5	585	A grievance form was completed for R31 s complaint of cold food. A fol was done on 12/01/17 by Social Se and resident reported that food was now. Dietary will continue to monito temperatures in the facility per curre practice. All resident concerns will be addressed per current Grievance procedure and also reviewed at Recouncil meetings. Food Temperature audits to be completed weekly x 4 withen as needed. Director of Culinary Services or designee will be responsarty. QAPI will provide redirection change when necessary to ensure	llow-up ervices s hotter or food ent be sident re weeks; y	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245342	B. WING _		12/	01/2017
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY LLC (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 585 Continued From page 22 started coming to the facility approximately thre weeks ago. A review of the complaint revealed that on 11/7/17, R31 had told licensed social worker (SW)-A "The food is always cold." On 12/1/17, at 1:05 p.m. the resident was interviewed and stated no one had gotten back her regarding her complaint, but the food was hotter now. On 12/1/17, at 1:16 p.m. SW-A stated she had interviewed the resident regarding the resolutio of the complaint. SW-A stated she had provided the complaint to the previous FSM, who abrupticed the complaint to the previous FSM.				STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082		
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 585 F 625 SS=D	started coming to the weeks ago. A review of the community of the complaint. So the complaint to the quit and the complaint to the quit and the complaint of the complaint to the quit and the complaint of the complaint of the exact data and given to the FS before Thanksgiving of complaints of complaint was receis no information reresolution of the complaint. SW-up done regarding to the person rethe complaint. SW-up done regarding to the CFR(s): 483.15(d) Notice of Sed Hold CFR(s): 483.15(d) Notice of Sed Hold	applaint revealed that on old licensed social worker is always cold." p.m. the resident was ted no one had gotten back to omplaint, but the food was p.m. SW-A stated she had dent regarding the resolution W-A stated she had provided in previous FSM, who abruptly aint was lost. SW-A stated they int the week of 11/20/17, and FSM . SW-A stated they did not in the complaint was rewritten in the week of 11/20/17, and FSM . SW-A stated they did not in the complaint was rewritten in the week of 11/20/17, and FSM . SW-A stated they did not in the complaint was rewritten in the complaint was rewritten in the week it was right in the complaint was rewritten in the complaint was rewr	F 5	completion and/or continuation monitoring process based on c date of 1/05/18.		1/10/18
	nursing facility trans the resident goes o	te before transfer. Before a sfers a resident to a hospital or n therapeutic leave, the t provide written information to				

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 625	specifies- (i) The duration of tany, during which the return and resume facility; (ii) The reserve been plan, under § 447.4 (iii) The nursing face bed-hold periods, was paragraph (e)(1) of resident to return; a (iv) The information of this section. §483.15(d)(2) Bed-the time of transfer hospitalization or the facility must provide resident represental specifies the duration described in paragrathis REQUIREMENT by: Based on interview facility failed to provide facility failed	dent representative that the state bed-hold policy, if the resident is permitted to tresidence in the nursing I payment policy in the state 0 of this chapter, if any; ility's policies regarding which must be consistent with this section, permitting a and a specified in paragraph (e)(1) thold notice upon transfer. At of a resident for terapeutic leave, a nursing to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section. IT is not met as evidenced I and document review, the wide a Notice of Bed Hold and of 3 residents (R7, R45 and asferred to a hospital. In failed to ensure a system was ntly provide bed hold notices aled no written documentation tion was provided to the I representative at the time of	F 6	R7, R45, and R61 were trans hospital without proper bed hopolicy was reviewed with R7 a R61 discharged from facility. residents that have been trans the hospital in past 30 days consure proper bed hold policy given. Bed hold policy will be resident council meetings and new admission. Policy and proper bed hold Policy for Hospital Therapeutic Leave policy reviewer mains current. All licensed will be educated on the Bed-For Hospital Transfer and Therapeutic Transfer and Trans	old. Bed hold and R45. Audit of all aferred to ampleted to has been reviewed at with every ocedure of transfer and awed and nursing staff hold Policy	

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	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP COI 313 SOUTH GREELEY STREET STILLWATER, MN 55082		
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F 625	tract symptoms. On 11/30/17 at 8:15 spouse indicated thany information on member (R7) was to 10/8/17, 10/18/17 a stated, she was not appeared to be surbed hold policy. R7 signed written docut transferred to the hand 10/27/17. Progress note date "Noted increase in meal. Resident una recliner chair Inc Called on-call Dr. [of to send to ER [eme Resident sent to ER Lakeview ER. Called Lakeview stated her of gross hematuria Progress note date indicated, "Call reconsurgery went well, the night at the hos Progress notes dat reads, "Spouse retuing that hos for more information Progress notes dat reads, "Called Lakeregarding resident's [resident] is being a surgical) floor for so	perplasia with lower urinary of a.m., family member (F)-A he facility had not given him a bed hold, when his family transferred to a hospital on and 10/27/17. In addition, F-A transferred hold policy and prised when informed about its medical record lacked mentation of bed hold when ospital on 10/8/17, 10/18/17 at 10:15 p.m., read, weakness prior to evening able to transfer self out of treased confusion noted doctor] He gave order for OK orgency room] for evaluation. It is ambulance at 1830 to the doctor and the was admitted with primary dx"	F 62	Leave. Social Services or Descomplete weekly audit of all retransferred to the hospital to exproper bed hold has been give will occur weekly x 4, monthly audit results will be reported to committee for further review a recommendations.	esidents ensure en. Audits x 2 and o QAPI	

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	PROVIDER OR SUPPLIER TATES AT GREELEY L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082	, .=/	- · · - · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETION DATE
F 625	(LPN)-B verified that signed written document and the stated, "I am unable paper works." On 12/1/17 at 11:35 confirmed that the written documentated transferred to the hand 10/27/17. SS-Ethat she had discust regarding bed hold documentation of it On 12/1/17 at 11:45 nursing (IDON) subtrecord lacked signed bed hold when R7 on 10/8/17, 10/18/1 addition, when R45 hospital on 5/29/17 resident's wife about we did not have conhold." R45's admission readmitted to the facithat included major hypertension, Raying gangrene and multion 11/28/17 at 12:35 transferred to the hacquiring pneumon record lacked signed bed hold when the hospital on 5/29/17	a.m., licensed practical nurse at the medical record lacked imentation of bed hold when to the hospital on 10/8/17, 1/17. Also, when R45 was ospital on 5/29/17, LPN-B at to locate the signed bed hold a.m., social service (SS)-B medical record lacked signed ion of bed hold when R7 was ospital on 10/8/17, 10/18/17 indicated, she can speculate sed with R45 verbally but did not have any written a.m., interim director of ostantiated that the medical ed written documentation of was transferred to the hospital 7 and 10/27/17, and in was transferred to the . IDON mentioned, "I spoke to at it and basically verified that inversation regarding bed cord revealed R45 was lity on 8/16/16 with diagnoses depressive disorder, anxiety, aud's syndrome without the sclerosis. 35 p.m., R45 stated, was ospital on 5/29/17 due to ia. However, R45's medical and written documentation of resident was sent to the	F 625			

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F 625	"Resident c/o coug Saturday evening. provider, Dr. (doctogiven sxs (symptor (emergency depart 8:20pm. Resident pransported to LVH paramedics. Resid Progress note date revealed, "Residenthis writer. She stat (intensive care unit to the facility on The Friday" On 12/1/17 at 12:3 with her today about the first time staff he with her. The facility policy a signed written documentated to the facil 10/7/17 at 3:30 p.m. chronic hypoxia. A 1:42 p.m., revealed saturation levels are ordered R61 be sedepartment for evarevealed no bed her the resident/family/of the hospital trans. On 12/1/17, at 2:24 nurses stated they information. At 3:2 (LPN) -B verified be	h & fatigue since Late This writer called on-call or) returned call and was ns), and provider advised ED ment) tonight. 911 called at o/u (pick up) @ 8:30pm & (Lakeview Hospital) via ents husband informed." id 5/30/17 at 1:14 p.m., t just called facility to speak to les she is currently in the ICU) Possibly will be returning ursday, but states it could also of p.m., F-A stated IDON spoke at the bed hold policy and was lave discuss bed hold policy and procedure did not address aments regarding bed hold. notes revealed R61 was allity, from the hospital, on a. with diagnoses that included nursing note dated 10/7/17 at at R61 had low oxygen and the nurse practitioner and the nurse practitioner and to the emergency luation. Record review old information was provided to legal representative at the time	F 62	5		

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	PROVIDER OR SUPPLIER	LC	3	STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082		
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F 657 SS=D	§483.21 (b)(2) A corbe- (i) Developed withir the comprehensive (ii) Prepared by an includes but is not I (A) The attending p (B) A registered nurresident. (C) A nurse aide wiresident. (D) A member of fo (E) To the extent properties of the explanation must medical record if the and their resident resident resident's care plan (F) Other appropriate disciplines as deteror as requested by (iii) Reviewed and reteam after each assessments. This REQUIREMED by: Based on observation document review, to care plan for 1 of 1 is resident had been a risks of consuming	chensive Care Plans imprehensive care plan must in 7 days after completion of assessment. interdisciplinary team, that imited to hysician. It is with responsibility for the th responsibility for the od and nutrition services staff. acticable, the participation of the resident's representative(s). It is included in a resident's the participation of the resident the presentative is determined the development of the the staff or professionals in mined by the resident's needs the resident. The system of the resident in the resident in the resident in the resident in the resident. The system of the resident in the res	F 657	Resident R30 s dietary orders we reviewed and care plan and assign sheets have been updated and refleof resident s specific dietary order and benefit education completed w resident and POA regarding risk of comfort feedings. New admissions/re-admits will continue	ment ective s. Risk ith	1/5/18

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER TATES AT GREELEY L	rc	,	3	STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082	,	.,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)) BE	(X5) COMPLETION DATE
F 657	lying in bed, with the and nutrition was be feeding. Also at this pathologist (SLP) in out of a specific mil juice and if so, what orange juice. When was thickened, R30 stated he was work SLP-D stated R30's Con 12/1/17, at 1:35 stated she knew R30 only family or friend staff could not. On 12/1/17, at 1:35 could have pop when she was not aware A physician's order physician had author R30's request and the R30's re	6 p.m. R30 was observed to head of the bed elevated eing provided via a tube at time a speech language of formed R30 the kitchen was and asked R30 if he wanted to kind. R30 replied he wanted asked at this time if the juice of replied he did not know, and ing with a SLP. When asked, a fluids were thickened. 9 p.m. registered nurse could have regular fluids and the scould give R30 the pop, and p.m. RN-A again stated R30 and he requested. NA-D stated of this information. dated 11/18/17, revealed the prized comfort feedings at that R30 was aware of the	Fe	657	assessed for dietary preferences a appropriate interventions initiated. residents will continue to be assest quarterly, annually, with significant in condition, and as needed, with individual care plans being update accordingly. Dietary audits to be completed we weeks; then as needed. DNS or dwill be responsible party. QAPI will redirection or change when neces ensure completion and/or continual monitoring process based on complete of 1/05/18.	Other sed change d ekly x 4 esignee provide sary to ation of	

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F 657	physician's order of feedings. Pain Management	al of comfort feedings, with the f 11/18/17 for comfort	F 657			1/5/18
SS=D	provided to resider consistent with protection the comprehensive and the residents'. This REQUIREME by: Based on observative, the facility care and services resident (R39) in the pain. Findings include: During an observation R39 was sitting up bedroom and complete includes and burning. When interviewed expressed the pair and burning sense had been a 6 since licensed practical in medication and to the matter with the LPN-A encouraged room until breakfast the room and be later than the complete in the co	nsure that pain management is nts who require such services, fessional standards of practice, e person-centered care plan, goals and preferences. NT is not met as evidenced ation, interview, and document failed to provide the necessary to minimize pain for 1 of 1 ne sample identified as having tion on 12/1/17, at 11:06 a.m. in the wheel chair in the plained of buttock pain, an		Resident R39 has been assessed pain management to ensure reside individual pain Care plan is update reflective of her needs and other non-pharmacological interventions Other residents will continue to be assessed quarterly, annually, with significant change in condition, and needed with individual care plans bupdated accordingly. New admissions/re-admits will continue assessed for pain management and appropriate interventions are initiat Staff have been educated on offeri non-pharmacological interventions pain management and follow up procedures. Pain Management car audits to be completed weekly x 4 then as needed. DNS or designee responsible party. QAPI will provide redirection or change when necessensure completion and/or continual monitoring process based on complete of 1/05/18.	ent s d and d and d as being to be d ed. ng for e weeks; will be e sary to tion of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245342	B. WING _		12	/01/2017
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL A. BUILDING B. WING STREET ADDRESS, 313 SOUTH GREE STILLWATER, M PREFIX (EACH CO	STREET ADDRESS, CITY, STATE, ZIP CO 313 SOUTH GREELEY STREET STILLWATER, MN 55082		-			
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
labSa Dassona sima hi hi Dinim ca a Wisicilisi pre le re a rebi	uid in bed after bre uttocks/rectum rer utvocks/rectum rer urveyor turned on ssistance. locument review of dministration recomposition and the continued dose of the process of the proce	akfast and the main a pain level of 6. the resident call light for for the resident call light for for fixed at the resident call light for for dated 12/1/17, revealed at ived a scheduled dose of let 5 mg by mouth three times at 500 a.m. R39 received a Tylenol (acetaminophen) 1000 times a day for pain. At 8:15 a prn (as needed) dose of ablet 5 mg by mouth every 4 ar pain rated 6-10. The fixed for pain to the bed. R39 ain of pain to the rectum area A came to the room to assist complaints of buttock pain. The fixed for pain to the was a well movement which was weal the skin had a moist, proximately two inch area at tum/anus. R39 complained of a burning associated with the land referred to the pain as a fied there was a moist, flame	F 6	97		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	` /	E SURVEY PLETED
		245342	B. WING			12/	01/2017
	PROVIDER OR SUPPLIER	LC		313	REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH GREELEY STREET ILLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	would have realized after breakfast to depain. During an interview 11:30 a.m. NA-F ved dressed R39 and the day shift uses a meinto the wheel chaird did not provide any at 8:00 a.m R39 we movement and doe movement was cau. When interviewed despressed being up down after breakfast happen at 8:15 a.m. like you are not mup pay attention to you about the diabetic recontinues to work of interventions to dive choosing positive in validated because the burning and itching the bowel movement staff "forgot about realized because the burning and itching the bowel movement staff "forgot about realized because the burning and itching the bowel movement staff "forgot about realized because the burning and itching the bowel movement staff "forgot about realized burning and itching the bowel movement staff "forgot about realized because the burning and itching the bowel movement staff "forgot about realized because the burning and itching the bowel movement staff "forgot about realized because the burning and itching the burning feeling was expressed appreciated appreci	check on the pain level then It R39 was not laid into bed etermine the cause of the with NA-F on 12/1/17, at rified that the night shift then leaves R39 in bed until the chanical lift to transfer R39 for breakfast. NA-F verified cares for R39 since getting up ras not able to feel the bowel as not know if the bowel as not able to feel the bowel as the nurse said would. R39 stated, "Makes you feel the of a person that they don't as the nurse R39 talked herve pain on the left side and an non pharmacological ert attention with reading and nagery. Now R39 feels here was a reason for the buttock pain associated with the R39 expressed feeling the ne" and the request to be lain	F 6	97			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245342	B. WING		12	/01/2017	
-	ROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODI 313 SOUTH GREELEY STREET STILLWATER, MN 55082			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 880 SS=F	(related to) arthritis, neuropathy. Reside of comfort as evide (signs/symptoms) or verbalizing satisf R39 was assessed 9/21/17, according Mental Status. When interviewed or registered nurse (Rexpectation would hain in bed when the administered to evaluand to follow up on medication administed Infection Prevention CFR(s): 483.80(a)(1) §483.80 Infection CThe facility must es infection prevention designed to provide comfortable environdevelopment and tradiseases and infection program. The facility must es and control program a minimum, the follow §483.80(a)(1) A systeporting, investigations.	dent is at risk for pain r/t , left side paralysis, ent will maintain adequate level nced by no s/s of unrelieved pain or distress, action with level of comfort." as cognitively intact on to the Brief Interview for on 12/1/17, at 1:00 p.m. N)-B verified the facility have been to ensure R39 was e pain medication was aluate possible causes of pain the effectiveness of the pain tration. a & Control 1)(2)(4)(e)(f) control tablish and maintain an and control program a a safe, sanitary and ment and to help prevent the ansmission of communicable ions. a prevention and control tablish an infection prevention on (IPCP) that must include, at		380		1/5/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245342	B. WING		12	/01/2017
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP 313 SOUTH GREELEY STREET STILLWATER, MN 55082	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 880	providing services arrangement based conducted accordinaccepted national signs is \$483.80(a)(2) Writt procedures for the but are not limited (i) A system of survice possible communicities in the facilies (ii) When and to whose when the facilies of the persons in the facilies (iii) When and to whose followed to provide (iii) Standard and the facilies of the facilie	sitors, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards; ten standards, policies, and program, which must include, to: reillance designed to identify cable diseases or rey can spread to other received assessible incidents of ease or infections should be ransmission-based precautions revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, the infectious agent or organism that the isolation should be the esible for the resident under the ces under which the facility by ese with a communicable askin lesions from direct ents or their food, if direct	F 8	80		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245342	B. WING		12/0	01/2017
	PROVIDER OR SUPPLIER	LC	3	TREET ADDRESS, CITY, STATE, ZIP CODE 13 SOUTH GREELEY STREET STILLWATER, MN 55082	12/	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	transport linens so infection. §483.80(f) Annual rather facility will condidered and update the This REQUIREMED by: Based on interview facility failed to ensprogram included of resident infections. This defipotential to affect a the facility. In additing a manner as to program included to of resident in a deficient of the facility. In additing a manner as to program include: The facility in fection of the facility's infection of the facility infection. The facility is infection of the facility analysis and or investigations in the facility utilized. Resident Infections identified by each infections, pneumovaginitis, etc. The facility, etc.	ndle, store, process, and as to prevent the spread of	F 880	The Facility s Infection Control Lowere reviewed and updated on 11/3 at the time MDH s Annual survey. procedure and forms to indicate trained trending was also put in place immediately. Handwashing education been reviewed with all staff, especiafter providing peri-care for resident soiled briefs or after toilet use, as wafter treatments. Staff will continue trained and audited for glove donning handwashing before, during, and aperi-care and treatments. Handwas will continue being provided upon hwith annual reviews, skills fairs, and needed with routine audits. Handwas audits to be completed weekly x 4 then as needed. DNS or designeed responsible party. QAPI will provide redirection or change when necessed ensure completion and/or continual monitoring process based on complete of 1/05/18.	on has ally on has being ng and fter shing hire, d as ashing weeks; will be exary to tion of	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245342	B. WING		12	/01/2017
	PROVIDER OR SUPPLIER TATES AT GREELEY L	rc		STREET ADDRESS, CITY, STATE, ZIP COE 313 SOUTH GREELEY STREET STILLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	information was pronurses. The forms analysis and or inverses. The forms analysis and or inverses. The forms analysis and or inverses. The forms analysis and or inverses analysis and or inverse for example, the formal form did not identify infections or if they. On 11/30/17 at 10:5 she was responsibly program for the facilists of infections by January 2017 throu IDON reported that the facility morning trends would be ided QA. However, the I documentation of a reported the infection quality assurance in On 11/30/17 at 12:2 facility was not trenstaff infections. Policy and procedu PREVENTION AND dated 8/17, reveale Program is compredetection, preventical among residents are elements of the procoordination/Overse Surveillance Data	gistered nurse (RN)-B] after ovided monthly by the unit lacked any documentation of estigation of patterns identified. In the infections was urinary ere was no documentation of alysis of these infections. The vifresidents had symptoms of were treated with antibiotics. 55 a.m., the IDON indicated a for the infection control ility. The IDON provided the vunit for the months of agh November 2017. The each infection mentioned at stand up meetings and any entified at the meeting and in DON verified there was no ny discussion. The IDON on control logs are taken to the meetings. 27 p.m., the IDON verified the ding/analyzing all resident and ore titled INFECTION CONTROL PROGRAM, d, "the Infection Control hensive in that it addressed on and control of infections and personal. The major	F 8	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245342	B. WING		12/	/01/2017
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, 2 313 SOUTH GREELEY STREET STILLWATER, MN 55082	ZIP CODE	• ., = •
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 36	F 8	80		
	the bathroom and we Nursing assistant (I wheelchair to the to walker, where R41 asked about the coworn by R41, NA-O without washing the incontinent brief where the soiled pad in a scleansing hands or provided pericare to pericare, NA-C remwashing hands place pulled R41's pants while touching the touching the touching the touching the touching the touching the call then removed the sthe bag to the soile NA-C then left the scleansing her hand mechanical lift, and so NA-C could get hands. The lift was On 11/28/17, at 1:1 be incontinent of st nursing assistant (Ner hands and don incontinent care with the sistence of the soile nursing assistant (Ner hands and don incontinent care with the sistence of the sistence	43 p.m. R41 requested to use was taken back to her room. NA)-C walked R41 from the bilet using a transfer belt and voided on the toilet. When ndition of the incontinent brief stated it was a "little" wet and bir hands, NA-C removed the bile wearing gloves and placed garbage can. Without removing gloves NA-C on R41. After providing the providing the placed and removed the gloves and without bed a new incontinent pad, up and walked R41 to the bed transfer belt and R41's walker. Cleansed her hands NA-C down, covered the resident up light within R41's reach. NA-C soiled garbage bag and took dutility room for disposal. Soiled utility room without so to the sink and wash her not cleansed. 6 p.m. R30 was observed to ool. Before beginning cares, NA)-B was observed to wash a pair of gloves and provide the disposable wipes and a tring the cleansing NA-B				
	without cleansing h	ves and donned new gloves er hands. When incontinent d, NA-B placed all soiled items which was at the side of the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245342	B. WING		12	2/01/2017	
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP COE 313 SOUTH GREELEY STREET STILLWATER, MN 55082			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	bed. Without washiclean incontinent propad up between RS cleansed her handspants. The soiled it garbage can and ta Without cleansing I mechanical lift, whito a bathroom, and NA-B could get to to 1:29 p.m. The lift wown on 12/1/17, at 2:03 stated R30 was col considered contaginated Considered contaginates (RN)-A came with R109, as NA-C staff to assist with to the with R109, as NA-C staff to assist with the without cleansing I protective boots an NA-G donned a pawashing her hands R109 onto his right be incontinent of st cleanse R109 using cream cleanser and plastic bag in a gar gloves or washing lincontinent brief be soiled gloves and washing her hands R109's legs. The glwithout cleansing her without cleansing her washing the soiled gloves and wash	ing her hands, NA-B placed a ad beneath R30 and pulled the 80's legs. Still not having s, NA-B then pulled up R30's ems were removed from the aken to a soiled utility room. Her hands NA-B touched a ch was blocking the entrance move the lift out of the way so he sink and wash her hands at as not cleansed. 8 p.m. registered nurse (RN)-B onized for C-diff and no longer	F 8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		E SURVEY IPLETED
	245342	B. WING _		12/	01/2017
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY					
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
RN-A removed rencleanse hands bef mechanical lift. Sti hands, NA-G remogarbage can, put in and without hand of wheelchair. RN-A and did not cleans mechanical lift and positioned so R100 wheelchair at 4:35 make R109's bed until the bed had but the bed had but the bed had but the soiled dressing removed a dressing removing the soiled package of gauze pads, while still we the gauze pads with proceed to cleans soiled gloves RN-C soiled gauze bag of wash her hands.	n the resident. At 4:32 p.m. noved her gloves, but did not ore leaving the room to get the II without having cleansed her oved the soiled items from the n a new garbage bag in the can cleansing grabbed R109's returned with the mechanical lift e hands. Both staff touched the I the sling to get the resident 9 could be transferred into the p.m. NA-G then proceeded to and did not wash her hands	F 88			
incontinent product provided after a re F 923 Ventilation SS=E CFR(s): 483.90(i)(ts or when pericare was sident used the toilet.	F 92	23		1/5/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		SURVEY PLETED
		245342	B. WING		12/0	01/2017
	PROVIDER OR SUPPLIER TATES AT GREELEY L	LC	3	STREET ADDRESS, CITY, STATE, ZIP CODE 813 SOUTH GREELEY STREET STILLWATER, MN 55082	,	., = •
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 923	Continued From pa	ige 39	F 923			
	by means of window or a combination of This REQUIREMEI by: Based on observative review, the facility of ventilation for one of north unit, affecting facility. Findings include: On all days of the sunpleasant odor lin	ws, or mechanical ventilation,		The facility will install lockable swi covers to ensure ventilation switch not easily accessible to staff or suffalling and bumping the switches. So be educated on the importance of switches in the on position. Audits ventilation system will be complete weekly x 4 weeks, and monthly on Maintenance Director or designee responsible party.	es are oplies Staff will leaving of the ed going.	
	stated that she did lingering in that par several days. Whe room was the origin all the rooms and rechecked and were odor was only in the room. She thought mentioned at a Nov On 12/1/17 at 11:50 housekeeping direct north unit and aske unpleasant odor on that they were not a maintenance direct ventilation system a maintenance direct have been an odor room in that area o	In nursing assistant (NA)-G notice that this odor had been to f the north hallway for a sked if she knew which of the odor, she replied that esidents on that unit had been clean and she thought that the e hallway and not in a resident at that this odor had been wember staff meeting. Of the maintenance director and ctor were asked to observe the ed if they were aware of an a the unit. They both replied aware of an odor and the cor stated that he audited the eard it was working fine. The cor suggested that there may emanating from the dirty utility and the odor did not seem				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245342	B. WING			12/0	01/2017
	PROVIDER OR SUPPLIER	LC		31	TREET ADDRESS, CITY, STATE, ZIP CODE 13 SOUTH GREELEY STREET TILLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 923	strong in that room. checking the ventilar resident's room near ceiling vent in the b 221 was tested with and the tissue woul bathroom. The ma went to check the vothe facility and returned the ventilation turned the ventilation turned the ventilation. The maintenance of monthly audits of the not find a problem in the work of the ventilation of the work of the ventilation. When the administre 12/1/17 at 12:10 p. r. not sure how the ventilation of the ventilation. On 12/01/17 at 12:10 p. r. not sure how the ventilation of	ge 40 The surveyor suggested ation in the bathroom of a ar the center of the odor. The athroom shared by 220 and a small piece of bath tissue d not cling to the vent in that intenance director immediately entilation system controls of med shortly, explaining that he in controls switched off. He on controls on at that time. irector stated that he did ne ventilation system and did in the month of November. The ator was interviewed on interviewed on interviewed on interviewed are in the janitor's closet and are in the janitor's closet and are in the janitor's closet and umped when supplies were 15 p.m. the maintenance is audit log showing that an interviewed	F9	923			

F5342026

PRINTED: 12/27/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245342 B. WING 12/01/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET THE ESTATES AT GREELEY LLC STILLWATER, MN 55082 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID 1D COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (The Estates of Greeley) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/25/2017

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.

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
		245342	B. WING		12	/01/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (313 SOUTH GREELEY STREET STILLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUSE FOLLOWING INFO	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST MS-2567 WILL BE USED AS F COMPLIANCE.	KO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245342	B. WING			12/0	01/2017
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 13 SOUTH GREELEY STREET TILLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCIES (K-TAGS) TO: Health Care Fire Ir State Fire Marshal 445 Minnesota St., St Paul, MN 55101 By email to: Marian.Whitney@s Angela.Kappenma THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or proposed to the defice 3. The name and/or responsible for correvent a reoccurred at 3 directly determined to be of the building was constructed at 3 directly determined to be of the building Type II(111) constructly was constructed to the building that was	THE PLAN OF OR THE FIRE SAFETY Inspections Division Suite 145 -5145, or State.mn.us and n@state.mn.us PRRECTION FOR EACH OT INCLUDE ALL OF THE DRMATION: what has been, or will be, done	K	0000			

	OF DEFICIENCIES OF CORRECTION			IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245342	B. WING	· · · ·	12/	01/2017
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082	-in-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	allowed for existing surveyed as one buconstruction. The building is prot	age 3 neet the construction type buildings, the facility was uilding as Type V(111) ected by a full fire sprinkler has a fire alarm system with	K 00	00		
	full corridor smoke	detection and spaces open to monitored for automatic fire				
	The facility has a cacensus of 57 at the	apacity of 70 beds and had a time of the survey.				
	The requirement at NOT MET as evide	42 CFR, Subpart 483.70(a) is need by:				
	system. The facility full corridor smoke	ected by a full fire sprinkler has a fire alarm system with detection and spaces open to monitored for automatic fire tion.				
		apacity of XX beds and had a time of the survey.		*		
	The requirement at NOT MET as evide Fire Drills CFR(s): NFPA 101	42 CFR, Subpart 483.70(a) is need by:	K 7	12		12/31/17
	signal and simulation conditions. Fire drill times under varying on each shift. The s	te transmission of a fire alarm on of emergency fire is are held at unexpected g conditions, at least quarterly staff is familiar with procedures rills are part of established		2		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245342	B. WING			12/0	01/2017
	PROVIDER OR SUPPLIER	LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082		3 SOUTH GREELEY STREET	A11	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 712	conducting drills is persons who are q Where drills are co 6:00 AM, a coded a instead of audible a 18.7.1.4 through 18.7.1.7 This REQUIREME by: Fire Drills Fire drills include the signal and simulatic conditions. Fire drill times under varying on each shift. The and is aware that conducting drills is persons who are q Where drills are co 6:00 AM, a coded a instead of audible a 18.7.1.4 through 18.7.1.7 Findings Include: On facility tour betwon 12/1/2017, bas and interview that the Facility is miss 3rd shaft. This deficient practite the residents, staff	illity for planning and assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and announcement may be used alarms. 8.7.1.7, 19.7.1.4 through NT is not met as evidenced The transmission of a fire alarm on of emergency fire alarm on on of emergency fire alarm		712	A December fire drill for all shifts of conducted by Maintenance Directed designee by 12/31/17. Ongoing mire drills for all shift will be conducted by Maintenance Directed designee. All fire drills documentated be turned in to Administrator montensure timeliness and compliance	or or onthly eted and etor or tion will thly to	

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245342	B. WING			12/	01/2017
	PROVIDER OR SUPPLIER	LC		313 SOUTH G	ESS, CITY, STATE, ZIP CODE GREELEY STREET R, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE	
					9		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 15, 2017

Ms. Yaneque Walker, Administrator The Estates At Greeley LLC 313 South Greeley Street Stillwater, MN 55082

Re: State Nursing Home Licensing Orders - Project Number S5342027

Dear Ms. Walker:

The above facility was surveyed on November 28, 2017 through December 1, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> 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 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.

The Estates At Greeley LLC December 15, 2017 Page 2

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

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 contact Susanne Reuss, Unit Supervisor at (561) 201-3793 or at 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,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

PRINTED: 01/02/2018 FORM APPROVED

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00947	B. WING		12/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	1 (:	'H GREELE\ 'ER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the deficient herein are not corrected shall with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the management of the schedule of the minnesota Department of the schedule of the minnesota Department of the schedule of	nether a violation has been				
	When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ns several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/infelicensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12/25/17 **Electronically Signed**

STATE FORM 6899 UWU311 If continuation sheet 1 of 29

TITLE

(X6) DATE

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00947	B. WING		12/0	1/2017
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THE EST	TATES AT GREELEY L	I C	H GREELEY			
040.15	CLIMMA DV CTA		TER, MN 550	PROVIDER'S PLAN OF CORRECTION	ONI	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure proc completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				
	On November 28, 29, 30, 2017 and December 1, 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. 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.					
	column entitled " II statute/rule out of co "Summary Stateme and replaces the "Tocorrection order. The findings which are in after the statement evidence by." Follow	umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute at the ent of This Rule is not met as wing the surveyors findings Method of Correction and prection.				
	FOURTH COLUMN "PROVIDER'S PLA	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

Minnesota Department of Health

STATE FORM 6899 UWU311 If continuation sheet 2 of 29

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (2	X3) DATE S COMPL	
		00947	b. WING		12/0	1/2017
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THE EQT	ATES AT GREELEY L	313 SOUT	H GREELE	STREET		
IIIL LOI	AILS AI GILLLEI L	STILLWAT	TER, MN 55	082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEAR ON EACH PAGE.					
	THIS WILL AFFEA	N ON EACH FAGE.				
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision		2 570			1/5/18
	Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.					
	by: Based on observati document review, the care plan for 1 of 18 resident had been a risks of consuming beverages while regastrostomy tube. Findings include: On 11/28/17, at 1:1 lying in bed, with the and nutrition was be	ent is not met as evidenced on, record review, and ne facility failed to revise the 5 residents (R30) after the assessed and informed of the regular food and unthickened ceiving nutrition via a 6 p.m. R30 was observed head of the bed elevated eing provided via a tube time a speech language		Resident R30 s dietary orders were reviewed and care plan and assignments sheets have been updated and reflet of resident sepecific dietary orders and benefit education completed with resident and POA regarding risk of comfort feedings. New admissions/re-admits will continue that assessed for dietary preferences an appropriate interventions initiated. Or residents will continue to be assessed quarterly, annually, with significant of in condition, and as needed, with individual care plans being updated.	ment ective s. Risk th to be nd Other ed change	

Minnesota Department of Health

STATE FORM 6899 UWU311 If continuation sheet 3 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00947	B. WING		12/0	1/2017
	PROVIDER OR SUPPLIER	I C 313 SOUT	DRESS, CITY, F TH GREELE' TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	pathologist (SLP) in out of a specific mil juice and if so, what orange juice. When was thickened, R30 stated he was work SLP-D stated R30's On 12/1/17, at 12:4 (RN)-A stated R30 had pop in his room On 12/1/17, at 1:35 stated she knew R3 only family or friend staff could not. On 12/1/17, at 1:35 could have pop whe she was not aware A physician's order physician had author R30's request and trisks of such feedin A review of the initial revealed the care pafter the 11/18/17, pcomfort feedings. On 12/1/17, at 1:38 care plan had not be physician's order of feedings. SUGGESTED MET	Informed R30 the kitchen was k and asked R30 if he wanted to kind. R30 replied he wanted asked at this time if the juice of replied he did not know, and ing with a SLP. When asked, is fluids were thickened. 9 p.m. registered nurse could have regular fluids and in. p.m. nursing assistant (NA)-D R30 had pop in his room, but the scould give R30 the pop, and in he requested. NA-D stated of this information. dated 11/18/17, revealed the prized comfort feedings at that R30 was aware of the	2 570	accordingly. Dietary audits to be completed weekly x 4 weeks; the needed. DNS or designee will be responsible party. QAPI will provi redirection or change when nece ensure completion and/or continumonitoring process based on condate of 1/05/18.	de ssary to uation of	

Minnesota Department of Health

STATE FORM 6899 UWU311 If continuation sheet 4 of 29

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00947	B. WING		12/0	1/2017
	PROVIDER OR SUPPLIER	I C 313 SOUT	ORESS, CITY, S TH GREELEN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROPROFICIENCY)) BE	(X5) COMPLETE DATE
2 570	designee, could desand procedures related should be correction. The adnould ensure staff a related to care plan an amount of time cassessment and per (QAPI) committee cadministrator, DON that information bac further improvement	velop and implement policies ated to the updating and care plans. The resident(s) and others who may also be assessed in the plan of ninistrator, DON, or designee are educated and trained revisions. Random audits for determined by the quality enformance improvement could ensure compliance. The , or designee could then take ok to QAPI to assess need for	2 570			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the resident must rema prefers to remain in	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ang home resident must be out possible unless there is a the attending physician that the in in bed or the resident	2 830			1/5/18
		on, interview, and document		Resident R39 has been assessed	for pain	

Minnesota Department of Health

STATE FORM 6899 UWU311 If continuation sheet 5 of 29

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00947	B. WING		12/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	1 (:	H GREELE\ ER, MN 550			
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2 830	Continued From pa	ge 5	2 830			
	review, the facility for care and services to resident (R39) in the pain. Findings include: During an observate R39 was sitting up bedroom and compitching and burning. When interviewed dexpressed the pain and burning sensate had been a 6 since licensed practical nedication and to be the matter with the LPN-A encouraged room until breakfaste the room and be laid R39 expressed frustlaid in bed after brebuttocks/rectum rerication.	ailed to provide the necessary or minimize pain for 1 of 1 er sample identified as having for on on 12/1/17, at 11:06 a.m. In the wheel chair in the plained of buttock pain, an sensation. In 12/1/17, at 11:06 a.m. R39 level to the buttocks itching ion was a 6, and the pain level 8:00 a.m. when R39 asked urse (LPN)-A for pain be laid in bed to see what was buttocks. According to R39, R39 to remain in the dining the was finished and then go to down in bed after breakfast.		management to ensure resident individual pain Care plan is update reflective of her needs and other non-pharmacological interventions residents will continue to be assest quarterly, annually, with significant in condition, and as needed with it care plans being updated accordin New admissions/re-admits will corbe assessed for pain management appropriate interventions are initial Staff have been educated on offer non-pharmacological interventions management and follow up proced Pain Management care audits to be completed weekly x 4 weeks; then needed. DNS or designee will be responsible party. QAPI will provide redirection or che when necessary to ensure complete and/or continuation of monitoring plased on compliance date of 1/05	ed and s. Other sed c change dividual agly. attinue to t and ted. ing s for pain dures. be as ange ange stion process	
	5:00 a.m. R39 rece oxycodone HCI tab a day for pain. At 8: scheduled dose of mg by mouth three a.m. R39 received a hydrocodone HCI ta hours as needed fo	rd dated 12/1/17, revealed at ived a scheduled dose of let 5 mg by mouth three times 00 a.m. R39 received a Tylenol (acetaminophen) 1000 times a day for pain. At 8:15 a prn (as needed) dose of ablet 5 mg by mouth every 4				

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FORM 6899 UWU311 If continuation sheet 6 of 29

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00947	B. WING		12/0	1/2017
	PROVIDER OR SUPPLIER	313 SOU	DRESS, CITY, S TH GREELEY TER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	nursing assistants (mechanical lift to tracontinued to compland buttocks. LPN-and evaluate the complex when staff turned in small amount of bocleaned away to reflame red area, apsurrounding the rectum/anus area a level 6. LPN-A verification for a sore area to the approximate two increctum/anus area with the bowel mover. When interviewed the complex of the complex	(NA)-E and NA-F used the ansfer R39 into the bed. R39 ain of pain to the rectum area A came to the room to assist amplaints of buttock pain. R39 to the side, there was a wel movement which was weal the skin had a moist, proximately two inch area stum/anus. R39 complained of burning" associated with the and referred to the pain as a ied there was a moist, flame at tissue that was an ch area surrounding the which could have been caused ment irritating the skin. In 12/1/17, at 11:20 a.m. cain level should have been at 8:15 a.m. and if LPN-A had check on the pain level then at R39 was not laid into bed etermine the cause of the	2 830			
	11:30 a.m. NA-F ved ressed R39 and the day shift uses a medinto the wheel chair did not provide any at 8:00 a.m R39 we movement and does movement was caused.	prified that the night shift then leaves R39 in bed until the echanical lift to transfer R39 for breakfast. NA-F verified cares for R39 since getting up was not able to feel the bowel as not know if the bowel asing the pain at 8:15 a.m				
	expressed being up	on 12/1/17, at 12:14 p.m. R39 oset that R39 did not get laid of as the nurse said would				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00947	B. WING		12/0	1/2017
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREEL EY LLC 313 SOU		DRESS, CITY, S TH GREELEY TER, MN 550			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
like you are not repay attention to about the diabeted continues to work interventions to condition the bowel mover staff "forgot about in bed after bread when interviewed was sitting up in expressed feeling wexpressed apprecausing the burn Document review 3/8/17, read, "Referelated to) arthreneuropathy. Resof comfort as evice (signs/symptoms or verbalizing satting wexpressed apprecausing the burn burn burn burn burn burn burn burn	.m. R39 stated, "Makes you feel nuch of a person that they don't ou." Furthermore R39 talked concrete pain on the left side and con non pharmacological livert attention with reading and imagery. Now R39 feels ethere was a reason for the ng buttock pain associated with nent. R39 expressed feeling the tome" and the request to be lain cfast. In the chair in the bedroom and gobetter and the itching and as gone. R39 smiled and ciation for finding out what was ing and itching feeling. In of R39's plan of care, revised sident is at risk for pain r/t tis, left side paralysis, dent will maintain adequate level denced by no s/s In of of norelieved pain or distress, isfaction with level of comfort." In deal as cognitively intact on the growth of the Brief Interview for the Brief Interview for the pain medication was evaluate possible causes of pain on the effectiveness of the pain on the effectiveness of the pain on the effectiveness of the pain the effectiveness of the pain on the effectiveness of the pain on the effectiveness of the pain on the effectiveness of the pain the effectivenes of the pain the effectiveness of the pain the effectivenes o	2 830			

Minnesota Department of Health STATE FORM

6899 UWU311 If continuation sheet 8 of 29

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION ()	X3) DATE S COMPL	
		00947	B. WING		12/0 ⁻	1/2017
	PROVIDER OR SUPPLIER	313 SOUT	DRESS, CITY, S TH GREELEN			
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2 830	The director of nurs all residents at risk receiving the neces director of nursing of random audits of the appropriate care and TIME PERIOD FOR (21) days.	HOD OF CORRECTION: ing or designee, could review for pain to assure they are sary treatment/services. The or designee, could conduct ne delivery of care; to ensure d services are implemented. R CORRECTION: Twenty-one	2 830			4/5/40
213/3	Program Subpart 1. Infection home must establist control program destantiary environmental This MN Requiremental subparts of the subpart of	n control program. A nursing h and maintain an infection signed to provide a safe and nt.	21375			1/5/18
	facility failed to provand care and service the spread of infect R41, R109) observed. Findings include: On 11/28/17, at 12: the bathroom and we Nursing assistant (Nursing assistant (Nursing assistant et al.) wheelchair to the towalker, where R41 asked about the control of the service of th	and document review the ride appropriate hand hygiene, res in a manner as to prevent ion for 3 of 8 residents (R30, red for cares. 43 p.m. R41 requested to use was taken back to her room. NA)-C walked R41 from the ilet using a transfer belt and woided on the toilet. When andition of the incontinent brief stated it was a "little" wet and		The Facility s Infection Control Log reviewed and updated on 11/30/17, time MDH s Annual survey. A proceand forms to indicate tracking and trending was also put in place immediately. Handwashing education been reviewed with all staff, especial after providing peri-care for resident soiled briefs or after toilet use, as we after treatments. Staff will continue be trained and audited for glove donning handwashing before, during, and aft peri-care and treatments. Handwash will continue being provided upon his with annual reviews, skills fairs, and needed with routine audits. Handwash	at the edure on has ally ts with ell as being and ter hing ire, I as	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE : COMPI	
		00947	B. WING		12/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	313 SOUT	H GREELE	Y STREET		
THE EST	AILS AI GILLLLI L	STILLWAT	TER, MN 55	082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 9	21375			
	without washing the incontinent brief wh the soiled pad in a g cleansing hands or provided pericare to pericare, NA-C rem washing hands place pulled R41's pants while touching the t Still without having assisted R41 to lay and placed the call then removed the s the bag to the soiled NA-C then left the s cleansing her hands mechanical lift, and	eir hands, NA-C removed the ile wearing gloves and placed garbage can. Without removing gloves NA-C of R41. After providing oved the gloves and without ed a new incontinent pad, up and walked R41 to the bed ransfer belt and R41's walker. cleansed her hands NA-C down, covered the resident up light within R41's reach. NA-C oiled garbage bag and took dutility room for disposal. soiled utility room without s, touched and moved a dimove the lift out of the way to the sink and wash her		audits to be completed weekly x 4 then as needed. DNS or designed responsible party. QAPI will provid redirection or change when necess ensure completion and/or continuamonitoring process based on complete of 1/05/18	will be de sary to ation of	
	be incontinent of stonursing assistant (Ner hands and don incontinent care with cream cleanser. Duremoved soiled glowithout cleansing hecare was completed into a garbage can, bed. Without washind clean incontinent papad up between R3 cleansed her hands pants. The soiled its garbage can and ta Without cleansing hechanical lift, which to a bathroom, and	6 p.m. R30 was observed to col. Before beginning cares, IA)-B was observed to wash a pair of gloves and provide h disposable wipes and a uring the cleansing NA-B wes and donned new gloves er hands. When incontinent d, NA-B placed all soiled items which was at the side of the ng her hands, NA-B placed a ad beneath R30 and pulled the 0's legs. Still not having s, NA-B then pulled up R30's ems were removed from the ken to a soiled utility room. Her hands NA-B touched a ch was blocking the entrance move the lift out of the way so he sink and wash her hands at				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00047	B WING		40/0	1 /0017
		00947	B. WING		12/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	I C	H GREELEY			
			ER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 10	21375			
	1:29 p.m. The lift w	as not cleansed.				
	On 12/1/17, at 2:03 p.m. registered nurse (RN)-B stated R30 was colonized for C-diff and no longer considered contagious.					
	lying in bed and NA check and change nurse (RN)-A came with R109, as NA-G staff to assist with t Without cleansing hypotective boots and NA-G donned a pai washing her hands. R109 onto his right be incontinent of stocleanse R109 using cream cleanser and plastic bag in a garl gloves or washing hincontinent brief be soiled gloves and w	5 p.m. R109 was observed -G stated they were about to R109. At 4:27 p.m. registered into the room to assist NA-G a stated R109 required two urning side to side in bed. hands RN-A removed R109's d socks. Also at this time r of gloves without first RN-A and NA-G then turned side and R109 was noted to pool. NA-G then proceeded to g disposable wipes and a d threw the soiled items into a bage can. Without removing hands, NA-G placed a clean heath R109, then removed the vithout hand cleansing, donned s. With the new gloves on				
	NA-G pulled the inc R109's legs. The gl without cleansing h pants up and a med positioned beneath RN-A removed rem	continent pad up between oves were removed and ands NA-G pulled R109's chanical lift sling was the resident. At 4:32 p.m. oved her gloves, but did not				
	mechanical lift. Still hands, NA-G remove garbage can, put in and without hand cleans and did not cleans and did not cleans and mechanical lift and	ore leaving the room to get the without having cleansed her wed the soiled items from the a new garbage bag in the can leansing grabbed R109's eturned with the mechanical lift is hands. Both staff touched the the sling to get the resident could be transferred into the				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		'				
		00947	B. WING		12/0	1/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY (STATE, ZIP CODE		
NAME OF I	TIOVIDEIT OIT SOLT EIEIT		ΓH GREELE\			
THE EST	TATES AT GREELEY L	I C:	TER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ıge 11	21375			
		p.m. NA-G then proceeded to and did not wash her hands een made.				
	observed for R109. observed to cleans move a garbage caremoved a dressing the soiled dressing removing the soiled package of gauze pads, while still weathe gauze pads with proceed to cleanse soiled gloves RN-G soiled gauze bag of wash her hands.	23 a.m. a dressing change was . At this time RN-G was be hands, don a pair of gloves, an closer to the bed and g to R109's left heel and place in the garbage can. Without d gloves, RN-G opened a new pads, remove several gauze aring the soiled gloves, spray h a wound cleanser and the wound. Still wearing the a was observed to place the in the night stand and then				
	hands were to be wincontinent product	Hand Washing policy indicated vashed after changing is or when pericare was sident used the toilet.				
	The director of nurs develop policies an control program in nursing or designed	THOD OF CORRECTION: sing or designee, could and procedures for an infection the facility. The director of e, could conduct random at this infection control implemented.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21390	MN Rule 4658.080	0 Subp. 4 A-I Infection Control	21390			1/5/18
	Subn 4 Policies	and procedures. The infection				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SUF COMPLET	
		00947	B. WING		12/01/2	017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
THE EST	TATES AT GREELEY L	I C	TH GREELEY TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE C	(X5) OMPLETE DATE
21390	procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service ed prevention and con E. a resident he immunization progredefined in part 465 procedures of resident the prevention and F. the development employee health popractices, including defined in part 4656 G. a system for products which affeed disinfectants, antise incontinence produ I. methods for current standards of This MN Requirements by: Based on interview facility failed to ens program included of of resident infection infections. This defined	ust include policies and provide for the following: based on systematic data or nosocomial infections in a detection, investigation, and is of infectious diseases; disprecautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of lect infection control, such as eptics, gloves, and	21390	The Facility s Infection Control Loreviewed and updated on 11/30/12 time MDH s Annual survey. A program of trending was also put in place immediately. Audits to be complet weekly x 4 weeks; then as needed or designee will be responsible part QAPI will provide redirection or che	7, at the ocedure I ed b. DNS urty.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00947	B. WING		12/0	1/2017
	PROVIDER OR SUPPLIER	I C 313 SOUT	DRESS, CITY, S H GREELEN ER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	The facility's infection January 2017 logs identified track infections, symptom However, the facility analysis and or investigation of the facility utilized and Resident Infections identified by each manager Infections that have the past 11 months infections, pneumor vaginitis, etc. The facility analysis, etc. The facility manager Information was promurses. The forms in analysis and or investigation of the facility infections or if they On 11/30/17 at 10:5 she was responsibly program for the facility morning trends would be ide QA. However, the lidocumentation of a	on control logs were reviewed through November 2017. The ing records of residents with as cultures and treatment. It laked documentation of estigation of patterns identified. In a form titled Line Listing of a form titled Line Listing of the forms were filled out, nonth and separated by unit. It been noted in the facility in included urinary tract in included in the facility in included urinary for the unit gistered nurse (RN)-B] after ovided monthly by the unit acked any documentation of lysis of these infections. The infections was urinary trace was no documentation of lysis of these infections. The infection infection infection control in infection control in infection mentioned at stand up meetings and any intified at the meeting and in DON verified there was no in in included in incontrol logs are taken to the infection control logs are taken to the infection in control logs are taken to the infection in th	21390	when necessary to ensure complete and/or continuation of monitoring based on compliance date of 1/05	process	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00947	B. WING		12/0	01/2017
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
THE EST	TATES AT GREELEY L	I.C.	TH GREELEY TER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	On 11/30/17 at 12:2 facility was not tren staff infections. Policy and procedu PREVENTION AND dated 8/17, reveale Program is compredetection, prevention among residents are elements of the procedure of the pro	27 p.m., the IDON verified the ding/analyzing all resident and re titled INFECTION D CONTROL PROGRAM, d, "the Infection Control hensive in that it addressed on and control of infections and personal. The major gram are: eight Policies and procedures analysis Antibiotic Stewardship tent Prevention of Infection THOD OF CORRECTION: sing or designee, could d procedures for an infection the facility. The director of e, could conduct random at this infection control	21390			
21426	(a) A nursing home maintain a comprel infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimir Morbidity and Morta	A.04 Subd. 3 Tuberculosis ntrol e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease ution (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis	21426			1/5/18

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winneso	ita Department of He	ailli				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00947	B. WING		12/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	1 (H GREELEY ER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	infection control pla unpaid employees, residents, and volui Health shall provide regarding implemen	n that covers all paid and contractors, students, nteers. The Department of technical assistance ntation of the guidelines.	21426			
	by: Based on interview facility failed to impl Disease Control (C the transmission of employees (E-A, E- State Tuberculosis potential to affect al facility. Findings include: Tuberculin Skin Tes E-A's record indicat E-A's medical recor TST-First step resu of indication and int file nor provided wh	ted E-A was hired on 9/25/17. I'd lacked evidence of lts; number of millimeter (mm) erpretation of reading in the		The identified employees will be reassessed for TB-Screening. TB-Screening will be administered hire and assessed, per company pDNS or designee will be responsib QAPI will provide redirection or characteristic complete and/or continuation of monitoring pbased on compliance date of 1/05.	oolicy. ble party. ange tion process	
	E-B's medical recor	red E-B was hired on 10/3/17. I'd lacked evidence of the file nor provided when				

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E-C's record indicated E-C was hired on 7/25/17.

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00947	B. WING		12/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	-
THE EST	TATES AT GREELEY L	I C	TH GREELE\ TER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 16	21426			
	E-C's medical record lacked evidence of TST- Second step in the file nor provided when requested.					
	nursing (IDON) veri evidence of TST-Fi millimeter (mm) of i reading and TST-S IDON stated they a staff files and are si	55 a.m., the interim director of ified employees' files lacked rst step results; number of indication and interpretation of Second step not completed. re trying to work through the till in the process of updating sure every employees TB ct.				
	Regulation for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, Screening Health Care Workers (HCWs) directed " Serial TB screening Serial TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a one-step TST or single IGRA (Interferon Gamma Release Assay)					
	any related chest X should be maintained. TST documentation the test (i.e., month millimeters of indurence in the state of	es of TST or IGRA results and ray and medical evaluations ed in the employee's record. In should include the date of aday, year), the number of ation (if no induration, and interpretation (i.e.,				
	SUGGESTED MET	HOD OF CORRECTION:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	·	(X3) DATE SURVEY COMPLETED	
	00047			12/01/2017	
NOVIDED OD SLIDDLIED				12/0	1/2017
	313 SOUT				
TES AT GREELEY L	LC STILLWAT	TER, MN 55	082		
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI	D BE	(X5) COMPLETE DATE
Continued From pa	ge 17	21426			
develop policies and suberculosis screen The director of nurs conduct random auduberculosis screen mplemented. TIME PERIOD FOF (21) days.	d procedures for a hing program in the facility. Sing or designee, could hid to ensure that this hing program has been				
Residents of HC Fa Subd. 18. Respon residents shall have	ac.Bill of Rights nsive service. Patients and the the right to a prompt and	21870		ì	1/5/18
Based on document acility failed to follow concerns regarding obtaining public browlelevision channel receivision complainte facility failed to food grievance for 1 complained about complained about complained receivision complained compl	at review and interview, the law up on resident council passing of snacks and padcast station (PBS) eception for 9 of 9 residents 1, R33, R39, R45. R47, R58) ints. In addition, address in a timely manner a 1 of 1 resident (R30) who had cold food.		R45, R47 & R58 have been provid public broadcast station (PBS) tele channels and snacks passed to the routinely. All residents that receive nutrition will continue to be offered Those needing copies of television channels will also be provided with copies. All staff will be re-educated process of distributing resident snapasses as well as ensuring resident needing copies of television channels have those copies. Audits of snack to be completed weekly x 4 weeks as needed.	ed with evision em oral snacks. In these don the ack nts els c passes ; then	
TO THE TOP SECOND TOPS OF THE TOP SECOND TOPS OF THE TOP SECOND TOPS OF THE TO	SUMMARY STA' (EACH DEFICIENCY REGULATORY OR LS) Continued From page in the director of nurs levelop policies and aberculosis screen in the director of nurs onduct random audiberculosis screen implemented. TIME PERIOD FOF 21) days. MN St. Statute 144. Residents of HC Faculosis shall have easonable response equests. This MN Requirements as a sequest of the following in the faculity failed to follow oncerns regarding in the facility failed to be delevision channel response elevision channel response el	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 The director of nursing or designee, could levelop policies and procedures for a suberculosis screening program in the facility. The director of nursing or designee, could onduct random audits to ensure that this suberculosis screening program has been implemented. TIME PERIOD FOR CORRECTION: Twenty-one 21) days. AN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and easonable response to their questions and equests. This MN Requirement is not met as evidenced by: Based on document review and interview, the acility failed to follow up on resident council oncerns regarding passing of snacks and obtaining public broadcast station (PBS) elevision channel reception for 9 of 9 residents R4, R10, R13, R24, R33, R39, R45. R47, R58) who voiced complaints. In addition, the facility failed to address in a timely manner a cood grievance for 1 of 1 resident (R30) who had omplained about cold food.	TES AT GREELEY LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 The director of nursing or designee, could levelop policies and procedures for a uberculosis screening program in the facility. The director of nursing or designee, could conduct random audits to ensure that this uberculosis screening program has been implemented. TIME PERIOD FOR CORRECTION: Twenty-one 21) days. MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and esidents shall have the right to a prompt and easonable response to their questions and equests. This MN Requirement is not met as evidenced by: lassed on document review and interview, the acility failed to follow up on resident council oncerns regarding passing of snacks and bitaining public broadcast station (PBS) elevision channel reception for 9 of 9 residents R4, R10, R13, R24, R33, R39, R45. R47, R58) who voiced complaints. In addition, the facility failed to address in a timely manner a bod grievance for 1 of 1 resident (R30) who had omplained about cold food. Findings include: Document review of the resident council meeting initutes for September, October and November	STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MM 55082 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 The director of nursing or designee, could evelop policies and procedures for a buserculosis screening program in the facility, the director of nursing or designee, could onduct random audits to ensure that this uberculosis screening program has been mplemented. IME PERIOD FOR CORRECTION: Twenty-one 21) days. AN St. Statute 144.651 Subd. 18 Patients & tesidents of HC Fac. Bill of Rights Subd. 18. Responsive service. Patients and esidents shall have the right to a prompt and easonable response to their questions and equests. This MN Requirement is not met as evidenced yes lasted on document review and interview, the acility failed to follow up on resident council oncerns regarding passing of snacks and bitaining public broadcast station (PBS) tele channels and snacks passed to the routinely. All residents that receive nutrition will continue to be offered Those needing copies of television channels will also be provided with copies. All staff will be re-educated process of distributing residen needing copies of television chann have those copies. Audits of snack to be completed weekly x 4 weeks as needed. Administrator and Director of Nurs.	STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Continued From p

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE S		
	00947	B. WING		12/0	12/01/2017	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE ESTATES AT GREELEY LLC	1	H GREELE\ ER, MN 550				
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
department response the resolution of the is channels and B. Snac resolved to your satisf checked No and there regarding the PBS telepassing of the snack owere no concern form through with the reside. A resident council mee 11/30/17, at 10:40 a.m R13, R24, R33, R39, I with two MDH surveyor. During the interview, F 11/15/17 as cognitively seeing snacks delivered cart with snacks was torder to help self. During the interview, F 8/31/17 as cognitively would bring in a snack have never offered R4. During the interview, F 10/26/17 as cognitively snack cart which sat in desk was usually emporated by the interview, F 10/26/17 as cognitively snack cart which sat in desk was usually emporated by the interview, F 10/26/17 as cognitively snack cart which sat in desk was usually emporated by the interview, F 10/26/17 as cognitively snack cart which sat in desk was usually emporated by the interview, F 10/26/17 as cognitively snack cart which sat in desk was usually emporated by the interview, F 10/26/17 as cognitively snack cart which sat in desk was usually emporated by the interview, F 10/26/17 as cognitively snack cart which sat in desk was usually emporated by the interview, F 10/26/17 as cognitively snack cart which sat in desk was usually emporated by the interview, F 10/26/17 as cognitively snack cart which sat in desk was usually emporated by the interview, F 10/26/17 as cognitively snack cart which sat in desk was usually emporated by the interview, F 10/26/17 as cognitively snack cart which sat in desk was usually emporated by the interview of the interview o	brought up as NEW It meeting. Red [sic] the Ithat was submitted to show Ithat was no further explanation Ithat evision channel or the Ithat was no further explanation Ithat evision channel or the Ithat was no further explanation Ithat evision channel or the Ithat was no further explanation Ithat evision channel or the Ithat was scheduled on Ithat evision was assessed Ithat who was assessed Ithat was a	21870	responsible party. QAPI will provide redirection or change when necessensure completion and/or continual monitoring process based on complete of 1/05/18. A grievance form was completed for R31 s complaint of cold food. A forwas done on 12/01/17 by Social S and resident reported that food warnow. Dietary will continue to monit temperatures in the facility per curpractice. All resident concerns will addressed per current Grievance procedure and also reviewed at Recouncil meetings. Food Temperature audits to be completed weekly x 4 then as needed. Director of Culina Services or designee will be responsarty. QAPI will provide redirection change when necessary to ensure completion and/or continuation of monitoring process based on complate of 1/05/18.	sary to ation of pliance or ollow-up ervices as hotter or food rent be esident ure weeks; ary ensible a or estate o		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING:		SURVEY LETED
		00947	B. WING		12/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
THE EST	TATES AT GREELEY L	I C	H GREELEY			
040.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	ER, MN 550		ON!	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21870	Continued From pa	ge 19	21870			
	R45. R47, R58 valid restoring the PBS to there was an ongoing snack. All 9 reside resolution to the restresident council. Document review of titled Resident Councerd, "Concerns presented meeting will be doctoried will be doctoried," I complaint and Gried read, "The Administ summary to the correstories of the PBS to t	R10, R13, R24, R33, R39, dated concerns about elevision channel and that ng issue with being offered a nts verified there was no sident concerns expressed at f the facility policy, dated 7/17, ncil Policy, under number 6. ocess/resolution- Any d during a resident council umented and resolved per the Document review of the evance Procedure, dated 9/01, trator shall issue a written inplainant of proposed action o later than seven (7) days grievance."				
	administrator verific complaints regarding the PBS television of snacks was a continued profit The administrator of September resident the October minutes November minutes initiate a concern for complaints of PBS so the issues could					
	service manager (Fone food complaint	oximately 12:45 p.m. the food SM) stated there had been she had been aware of since y. At 1:00 p.m. the FSM stated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		00947	B. WING		12/0	01/2017
	PROVIDER OR SUPPLIER	313 SOU	DRESS, CITY, S TH GREELEY TER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21870	the original complair rewritten and she hon the complaint. To dividing their time be started coming to the weeks ago. A review of the community of the complaint of the complaint. So the complaint to the quit and the complaint to the quit and the complaint of the complaint was received in the complaint was received in the complaint of the complaint of the complaint was received in the person received in the person received in the complaint of t	int had been lost, was ad not had time to follow up he FSM stated they were between two facilities and he facility approximately three held licensed social worker is always cold." p.m. the resident was sted no one had gotten back to complaint, but the food was helden regarding the resolution W-A stated she had provided a previous FSM, who abruptly aint was lost. SW-A stated they int the week of 11/20/17, and FSM. SW-A stated they did not be the complaint was rewritten is M, but knew it was right g. SW-A stated they or she knew when the original sived. SW-A stated that if there ceived in a week regarding mplaint she will send an email esponsible for following up on A stated there was no follow				
	The Adminstrator a the facility polices in individual grievance	THOD OF CORRECTION: nd/or designee could review n regards to transmission of es, and educate staff on how to to the appropriate department				

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STATE FORM 6899 UWU311 If continuation sheet 21 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00947	B. WING		12/0	1/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	THE ESTATES AT GREELEY LLC STILLW			' STREET 082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21870	in a timely manner. monitor grievances grievances were ac	ge 21 The administrator could on a routine basis to ensure ted upon in a timely manner. R CORRECTION: Twenty-one	21870			
21880	Subd. 20. Grievar shall be encouraged their stay in a facility to understand and epatients, residents, residents may voice changes in policies and others of their cinterference, coerci including threat of cogrievance procedur well as addresses at Office of Health Fanursing home ombut Americans Act, sec posted in a conspice. Every acute care residential program 253C.01, every non facility employing merovides outpatient have a written inter at a minimum, sets followed; specifies to limits for facility resor resident to have advocate; requires	nces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, on, discrimination, or reprisal, lischarge. Notice of the e of the facility or program, as and telephone numbers for the cility Complaints and the area adsman pursuant to the Older tion 307(a)(12) shall be				1/5/18

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILDING.			
		00947	B. WING		12/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	I C:	H GREELEY ER, MN 550			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETE DATE
21880	an impartial decision otherwise resolved residential programs 253C.01 which are treatment programs centers with section health maintenance 62D.11 is deemed requirement for a way procedure. This MN Requirement for a way procedure.	on maker if the grievance is not Compliance by hospitals, as as defined in section hospital-based primary and outpatient surgery and 144.691 and compliance by corganizations with section to be compliance with the written internal grievance. The review and interview, the passing of snacks and padcast station (PBS) reception for 9 of 9 residents 14, R33, R39, R45. R47, R58) ints. In addition, address in a timely manner a 1 of 1 resident (R30) who had	21880	Residents R4, R10, R13, R24, R3 R45, R47 & R58 have been provide public broadcast station (PBS) teleschannels and snacks passed to the routinely. All residents that receive nutrition will continue to be offered. Those needing copies of television channels will also be provided with copies. All staff will be re-educated process of distributing resident snapasses as well as ensuring resident eeding copies of television channels will also be completed weekly x 4 weeks as needed. Administrator and Director of Nurs Services (DNS) or designee will be responsible party. QAPI will provide redirection or change when neces ensure completion and/or continuations.	ded with evision lem e oral I snacks. In these d on the ack ints nels k passes s; then se e le sary to	
	channels and B. Sr resolved to your sa	e issue.) A. PBS- different nack cart. Was the issue tisfaction? Both boxes were ere was no further explanation		monitoring process based on com date of 1/05/18.	pliance	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
			7. BOILDING.			
		00947	B. WING	·····	12/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	1.0	H GREELE\ ER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21880	regarding the PBS passing of the snac were no concern for through with the rest of the rest of the rest of the self. A resident council of through the rest of the rest	television channel or the ek cart by facility staff. There rms filled out to address follow sident council requests. neeting was scheduled on a.m. and 9 residents R4, R10, 9, R45. R47, R58 participated eyors present. V, R58, who was assessed vely intact, expressed never vered to R58's room and the as too high for R58 to reach in experimental expressed staff ack to R4's roommate but they R4 a snack. V, R33 who was assessed vely intact, expressed the at in the hallway by the nurses	21880	A grievance form was completed in R31 is complaint of cold food. A find was done on 12/01/17 by Social Sand resident reported that food was now. Dietary will continue to monit temperatures in the facility per curpractice. All resident concerns will addressed per current Grievance procedure and also reviewed at R council meetings. Food Temperature audits to be completed weekly x 4 then as needed. Director of Culina Services or designee will be responsively. QAPI will provide redirection change when necessary to ensure completion and/or continuation of monitoring process based on complate of 1/05/18.	ollow-up dervices as hotter for food frent be esident ure weeks; ary onsible n or	
	During the interview 8/17/17 as cognitive been no resolution PBS television stati have but has not re	w, R45 who was assessed ely intact, expressed there had to the request to resume the on that the facility used to stored. R45 verified snacks ered by the facility staff on a				
	R45. R47, R58 valid restoring the PBS to there was an ongoi snack. All 9 reside	R10, R13, R24, R33, R39, dated concerns about elevision channel and that ng issue with being offered a nts verified there was no sident concerns expressed at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00947	B. WING		12/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	THE ESTATES AT GREEL BY LLC		H GREELEY ER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	resident council. Document review of titled Resident Courread, "Concerns preconcerns presented meeting will be doc grievance policy." I Complaint and Grieread, "The Administrator on the grievance not after receipt of the grievance not such a complaints regarding the PBS television of snacks was a continued professional professional treatment of the grievance not grievance initiate a concern for complaints of PBS so the issues could on 12/1/17, at appropriate manager (Fone food complaint coming to the facility the original complaint. To dividing their time by the grievance in the grievance of the grie	of the facility policy, dated 7/17, noil Policy, under number 6. Docess/resolution- Any during a resident council umented and resolved per the Document review of the vance Procedure, dated 9/01, trator shall issue a written inplainant of proposed action of later than seven (7) days grievance." On 11/30/17, at 1:47 p.m. the ed being aware of the resident ing the residents wanting back channel and the passing of oblem for the resident council. igned off as reviewing the treouncil minutes on 9/20/17, son 10/23/17 and the on 11/21/17, but did not or the resident council television and snack passing	21880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00947	B. WING		12/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	I C	TH GREELEY TER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From page 25		21880			
	A review of the complaint revealed that on 11/7/17, R31 had told licensed social worker (SW)-A "The food is always cold." On 12/1/17, at 1:05 p.m. the resident was interviewed and stated no one had gotten back to her regarding her complaint, but the food was hotter now. On 12/1/17, at 1:16 p.m. SW-A stated she had interviewed the resident regarding the resolution of the complaint. SW-A stated she had provided the complaint to the previous FSM, who abruptly quit and the complaint was lost. SW-A stated they rewrote the complaint the week of 11/20/17, and gave it to the new FSM. SW-A stated they did not recall the exact date the complaint was rewritten and given to the FSM, but knew it was right before Thanksgiving. SW-A stated she keeps a log of complaints so she knew when the original complaint was received. SW-A stated that if there is no information received in a week regarding resolution of the complaint she will send an email out to the person responsible for following up on the complaint. SW-A stated there was no follow up done regarding R31's complaint.					
	The Adminstrator a the facility polices in individual grievance communicate them in a timely manner. monitor grievances	HOD OF CORRECTION: nd/or designee could review n regards to transmission of es, and educate staff on how to to the appropriate department The administrator could on a routine basis to ensure sted upon in a timely manner.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00947	B. WING		12/0	1/2017
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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
23240	Continued From pa	ge 26	23240			
23240	MN Rule 4658.5409 Existing Constructor	5 Ventilation Requirements;	23240			1/5/18
	ventilation in the kit collection room, soi areas, except if the semiprivate, and is ventilation. Ventilat according to part 46 This MN Requirement by: Based on observation review, the facility of ventilation for one conorth unit, affecting facility. Findings include: On all days of the sunpleasant odor line	ent is not met as evidenced on, interview, and document lid not provide adequate of three units in the facility, the 23 of 59 residents in the		The facility will install lockable swit covers to ensure ventilation switch not easily accessible to staff or sufalling and bumping the switches be educated on the importance of switches in the on position. Audits ventilation system will be complete weekly x 4 weeks, and monthly on Maintenance Director or designee responsible party.	nes are pplies Staff will leaving of the ed going.	
	stated that she did lingering in that par several days. Whe room was the origin all the rooms and re checked and were odor was only in the room. She thought mentioned at a Nov On 12/1/17 at 11:50	B nursing assistant (NA)-G notice that this odor had been tof the north hallway for nasked if she knew which of the odor, she replied that esidents on that unit had been clean and she thought that the hallway and not in a resident that this odor had been tember staff meeting. Of the maintenance director and stor were asked to observe the				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00947	B. WING		12/0	1/2017	
	PROVIDER OR SUPPLIER	313 SOUT	DDRESS, CITY, STATE, ZIP CODE TH GREELEY STREET ATER, MN 55082				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
23240	north unit and aske unpleasant odor on that they were not a maintenance direct ventilation system a maintenance direct have been an odor room in that area or room was checked strong in that room, checking the ventilar resident's room neadeiling vent in the best of the ventilation. The maintenance direct whe facility and returned the ventilation turned the ventilation turned the ventilation. The maintenance do monthly audits of the not find a problem in the ventilation of the ventilation of the ventilation of the ventilation of the ventilation. The maintenance do monthly audits of the not find a problem in the ventilation of the vent	d if they were aware of an the unit. They both replied aware of an odor and the or stated that he audited the and it was working fine. The or suggested that there may emanating from the dirty utility and the odor did not seem. The surveyor suggested ation in the bathroom of a ar the center of the odor. The athroom shared by 220 and a small piece of bath tissue d not cling to the vent in that intenance director immediately entilation system controls of med shortly, explaining that he in controls on at that time. If interest interest in the controls on at that time. If it is the was entilation system and did in the month of November. The surveyor suggested at the time of the controls of the vent in that intenance director immediately entilation system controls of the controls of the ventilation system and did in the month of November. The surveyor suggested at the time of the vent in that intenance director immediately entilation system controls of the ventilation system and did in the month of November. The surveyor suggested that time. It is that the did in the ventilation system and did in the month of November. The surveyor suggested that the did in the month of November. The surveyor suggested that time. It is that the was entilation system and did in the month of November. The surveyor suggested that the did in the month of November and that time. It is that the did in the possibility that the nursing eventilation system off at thought it made the building the ventilation system off at thought it made the building the ventilation system off at thought it made the building the ventilation system off at thought it made the building the ventilation system off at thought it made the building the ventilation system off at thought it made the building the ventilation system off at thought it made the building the ventilation system off at thought it made the building the ventilation system of at the ventilation system of	23240				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00947	B. WING		12/0	1/2017	
	NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY LLC STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
23240	colder. On 12/1/17 at 1:24 hall was gone. SUGGESTED MET The administrator, redesignee could ensemaintenance progra accurately reflect or maintenance schedon a routine basis. policies and proced changes and perfor rounds/audits perior maintenance is adefacility could report assurance performacommittee for furthed ongoing compliance.	p.m. the odor on the north unit THOD OF CORRECTION: maintenance supervisor, or ture a preventative am was developed to ngoing preventative fulled or needed in the facility The facility could create fures, educate staff on these am environmental dically to ensure preventative equately completed. The those findings to the quality ance improvement (QAPI) er recommendations to ensure	23240				

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