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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UWU3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00947

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245342**

2.STATE VENDOR OR MEDICAID NO.
(L2) **395463300**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT GREELEY LLC**
(L4) **313 SOUTH GREELEY STREET**
(L5) **STILLWATER, MN** (L6) **55082**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2017**

6. DATE OF SURVEY **01/16/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **74** (L18)

13.Total Certified Beds **74** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 01/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/25/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
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

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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
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/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UWU3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00947

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245342**
2.STATE VENDOR OR MEDICAID NO.
(L2) **395463300**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT GREELEY LLC**
(L4) **313 SOUTH GREELEY STREET**
(L5) **STILLWATER, MN** (L6) **55082**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2017**

6. DATE OF SURVEY **12/01/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **74** (L18)
13.Total Certified Beds **74** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Robyn Woolley, HFE NE II 01/04/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/24/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

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

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

Remedies - 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;

Potential Consequences - 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

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

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

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
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted November 28 through December 1, 2017 during a recertification survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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.	E 000		
E 007 SS=F	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	E 007	The facility□s Emergency Preparedness	1/10/18

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

Electronically Signed | 12/25/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 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.	E 007	Plan (EPP) will be updated to include the risk population, as well as the services the facility could provide in an emergency. Administrator or Designee will be responsible.	
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and	E 015		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 015	Continued From page 2 safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include in the emergency preparedness plan (EPP) how the facility was to provide for medical and pharmaceutical supplies in the event of a facility evacuation or if residents were going to be sheltered in place. This had the potential to affect 59 of 59 residents currently residing in the facility, as well as staff and visitors.	E 015	The facility□s Emergency Preparedness Plan (EPP) will be updated to address how the facility will provide medical and pharmaceutical supplies in the event of an emergency Administrator or Designee will be responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 015	Continued From page 3 Findings include: A review of the EPP policy and procedures revealed the EPP failed to address how the facility was going to provide medical and pharmaceutical supplies in the event of a facility evacuation or a shelter in place emergency. The administrator verified on 12/2/17 at 2:57 p.m. the EPP policy and procedures did not address the provision of medical and pharmaceutical supplies.	E 015		
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and	E 018		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 018	Continued From page 4 sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.	E 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 018	Continued From page 5 *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an emergency preparedness plan (EPP) which identified how staff were to be tracked in the event of 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: A review of the facility's EPP policy and procedures revealed the facility had developed a system for tracking resident in the event of an emergency. However, the administrator verified on 12/1/17, at 3:00 p.m. the facility had not developed a staff tracking system.	E 018	The facility□s Emergency Preparedness Plan (EPP) will be updated to address the tracking of staff in the event of an emergency. Administrator or Designee will be responsible.	
E 022 SS=F	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or	E 022		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 022	Continued From page 6 (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an emergency preparedness plan (EPP) which included policy and procedures for sheltering in place residents, staff and/or residents in the event the facility was not able to evacuate and some persons needed to remain at the facility until an evacuation could be arranged. This had the potential to affect 59 of 59 residents currently residing in the facility, as well as staff , volunteers and visitors. Findings include: A review of the facility's EPP policy and procedures revealed there was no policy or procedure to address how to shelter in place residents, staff and/or visitors in the event some persons were not able to be immediately evacuated or if the facility had determined sheltering in place was appropriate. On 12/1/17, at 3:04 p.m. the administrator was not able to find a policy for sheltering in place. The administrator stated the facility had an agreement with a sister facility where residents,	E 022	The facility□s Emergency Preparedness Plan (EPP) will be updated to address sheltering in place, residents, staff, and visitors. Administrator or Designee will be responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 022	Continued From page 7 staff and volunteers could be sent in case of the need to evacuate.	E 022		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an emergency preparedness plan (EPP) which included a policy and procedure to addressed the use of volunteer staffing strategies in the event of an emergency. This had the potential to affect 59 of 59 residents currently residing in the facility, as well as staff and visitors.	E 024	The facility□s Emergency Preparedness Plan (EPP) will be updated to address the use of volunteers during the event of an emergency. Administrator or Designee will be responsible.	1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 024	Continued From page 8 Findings include: In 12/2/17, at 3:18 p.m. the administrator stated the facility had volunteers at the facility. A review of the EPP policy and procedures revealed there were policy and procedures to address staffing strategies, but there was not staffing strategy for volunteers. The lack of a policy and procedure related to volunteer staffing was verified at this time by the administrator.	E 024		
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a communication plan which included the names and phone numbers for each resident's physician, as well as the name and contact information for other long term care facilities in the areas. This had the potential to affect 59 of 59 residents residing at the facility. Findings include: On 12/1/18, at 1:20 p.m. the administrator was able to provide a contact list for staff, which included each staff's name and phone number. However, there was no contact list developed which included the names and contact information, such as phone numbers or email addresses for each residents physician. In	E 029	The facility□s Emergency Preparedness Plan (EPP) will be updated to include the names and contact information for each residents□ physician, as well as the names of long-term care facilities in the immediate area. Administrator or Designee will be responsible.	12/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 029	Continued From page 9 addition, the facility listed by name local hospitals and associated phone numbers, but the list did not include long term care facilities in the immediate vicinity of the facility. The administrator verified at this time the contact list did not include information for resident physician's or for other long term care facilities.	E 029		
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency.	E 031		12/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 031	Continued From page 10 (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a communication plan which included the names contact information for the Office of the State Long-Term Care Ombudsman. This had the potential to affect 59 of 59 residents residing at the facility. Findings include: The facility's communication plan lacked contact information for the Office of the State Long-Term Care Ombudsman. The administrator verified on 12/1/17, at 3:12 p.m. that "No" the ombudsman's contact information was not present in the facility's communication plan.	E 031	The facility□s Emergency Preparedness Plan (EPP) has been updated to include the name and contact information for the Office of State of Long-Term Care Ombudsman. Administrator or Designee will be responsible.	
E 035 SS=F	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a communication plan, which included a method for sharing appropriate information from the emergency preparedness	E 035	The facility□s admission packets will be updated to include letter informing patients of the Emergency Preparedness Plan (EPP) and available for review.	1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 035	Continued From page 11 plan (EPP) with residents, families or representatives. This had the potential to affect 59 of 59 residents currently residing in the facility, as well as staff and visitors. Findings include: On 12/2/17, at 3:09 p.m. the administrator stated information on how the facility planned on sharing the EPP was provided to residents, families and representative via the admission packet. The administrator stated there was a letter in the admission packet indicating the EPP could be found by the survey results book. A review of the admission packet provided to the survey team failed to include such a letter. The administrator also stated information would be presented in resident/family council meetings and during family meetings, but had not been provided in this manner at this point in time. The administrator also stated the EPP had not been placed near the survey results book as of this date and time.	E 035	Location of the Emergency Preparedness Plan (EPP) binder will be shared at resident council and family meeting. Administrator or Designee will be responsible.	
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually.	E 037		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 12 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. This is what's in SOM but is missing here. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 13 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 14 procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by:	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 15 Based on interview and document review, the facility failed to training new and current staff regarding policy and procedures in the facility's emergency preparedness plan (EPP. This had the potential to affect 59 of 59 residents currently residing in the facility, as well as staff and visitors. Findings include: During an interview with the administrator on 12/1/17, at 3:26 p.m. the administrator stated "No" when asked if new and current staff had been trained on the policy and procedures in the facility's EPP. The administrator stated they planned on doing the training, but was unable to provide an exact date the training had been scheduled for.	E 037	The facility will develop a plan to train current and new staff on Emergency Preparedness Plan (EPP). Administrator or Designee will be responsible.	
F 000	INITIAL COMMENTS A recertification survey was conducted November 28 through December 1, 2017. Upon receipt of an acceptable electronic 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. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)	F 565		1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 16 §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to follow up on resident council concerns regarding passing of snacks and	F 565	Residents R4, R10, R13, R24, R33, R39, R45, R47 & R58 have been provided with public broadcast station (PBS) television	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 17 obtaining public broadcast station (PBS) television channel reception for 9 of 9 residents (R4, R10, R13, R24, R33, R39, R45. R47, R58) who voiced complaints. Findings include: Document review of the resident council meeting minutes for September, October and November 2017, revealed number 6. Old Business: (A review of each issue brought up as NEW BUSINESS at the last meeting. Red [sic] the department response that was submitted to show the resolution of the issue.) A. PBS- different channels and B. Snack cart. Was the issue resolved to your satisfaction? Both boxes were checked No and there was no further explanation regarding the PBS television channel or the passing of the snack cart by facility staff. There were no concern forms filled out to address follow through with the resident council requests. A resident council meeting was scheduled on 11/30/17, at 10:40 a.m. and 9 residents R4, R10, R13, R24, R33, R39, R45. R47, R58 participated with two MDH surveyors present. During the interview, R58, who was assessed 11/15/17 as cognitively intact, expressed never seeing snacks delivered to R58's room and the cart with snacks was too high for R58 to reach in order to help self. During the interview, R4 who was assessed 8/31/17 as cognitively intact, expressed staff would bring in a snack to R4's roommate but they have never offered R4 a snack. During the interview, R33 who was assessed	F 565	channels and snacks passed to them routinely. All residents that receive oral 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 distributing resident snack passes as well as ensuring residents needing copies of television channels have those copies. Audits of snack passes to be completed weekly x 4 weeks; then as needed. Administrator and Director of Nurse Services (DNS) or Designee will be responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 18	F 565		

10/26/17 as cognitively intact, expressed the snack cart which sat in the hallway by the nurses desk was usually empty by 6:00 p.m.

During the interview, R45 who was assessed 8/17/17 as cognitively intact, expressed there had been no resolution to the request to resume the PBS television station that the facility used to have but has not restored. R45 verified snacks were not always offered by the facility staff on a routine basis.

All 9 residents R4, R10, R13, R24, R33, R39, R45. R47, R58 validated concerns about restoring the PBS television channel and that there was an ongoing issue with being offered a snack. All 9 residents verified there was no resolution to the resident concerns expressed at resident council.

Document review of the facility policy, dated 7/17, titled Resident Council Policy, under number 6. read, "Concerns process/resolution- Any concerns presented during a resident council meeting will be documented and resolved per the grievance policy." Document review of the Complaint and Grievance Procedure, dated 9/01, read, "The Administrator shall issue a written summary to the complainant of proposed action on the grievance no later than seven (7) days after receipt of the grievance."

When interviewed on 11/30/17, at 1:47 p.m. the administrator verified being aware of the resident complaints regarding the residents wanting back the PBS television channel and the passing of snacks
was a continued problem for the resident council. The administrator signed off as reviewing the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 19 September resident council minutes on 9/20/17, the October minutes on 10/23/17 and the November minutes on 11/21/17, but did not initiate a concern for the resident council complaints of PBS television and snack passing so the issues could be resolved.	F 565		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585		1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 20 postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 21 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address in a timely manner a food grievance for 1 of 1 resident (R30) who had complained about cold food. Findings include: On 12/1/17, at approximately 12:45 p.m. the food service manager (FSM) stated there had been one food complaint she had been aware of since coming to the facility. At 1:00 p.m. the FSM stated the original complaint had been lost, was rewritten and she had not had time to follow up on the complaint. The FSM stated they were dividing their time between two facilities and	F 585	A grievance form was completed for R31□s complaint of cold food. A follow-up was done on 12/01/17 by Social Services and resident reported that food was hotter now. Dietary will continue to monitor food temperatures in the facility per current practice. All resident concerns will be addressed per current Grievance procedure and also reviewed at Resident council meetings. Food Temperature audits to be completed weekly x 4 weeks; then as needed. Director of Culinary Services or designee will be responsible party. QAPI will provide redirection or change when necessary to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 22 started coming to the facility approximately three 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 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.	F 585	completion and/or continuation of monitoring process based on compliance date of 1/05/18.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		1/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 23 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a Notice of Bed Hold and Readmission for 3 of 3 residents (R7, R45 and R61) who were transferred to a hospital. In addition, the facility failed to ensure a system was in place to consistently provide bed hold notices in a timely fashion. Findings include: Record review revealed no written documentation of bed hold information was provided to the resident/family/legal representative at the time of the hospital transfers. R7's admission record revealed R7 was admitted to the facility on 4/20/17 with diagnoses that included major depression, hypertension and	F 625	R7, R45, and R61 were transferred to the hospital without proper bed hold. Bed hold policy was reviewed with R7 and R45. R61 discharged from facility. Audit of all residents that have been transferred to the hospital in past 30 days completed to ensure proper bed hold policy has been given. Bed hold policy will be reviewed at resident council meetings and with every new admission. Policy and procedure of Bed-Hold Policy for Hospital Transfer and Therapeutic Leave policy reviewed and remains current. All licensed nursing staff will be educated on the Bed-Hold Policy for Hospital Transfer and Therapeutic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 24 benign prostatic hyperplasia with lower urinary tract symptoms. On 11/30/17 at 8:15 a.m., family member (F)-A spouse indicated the facility had not given him any information on a bed hold, when his family member (R7) was transferred to a hospital on 10/8/17, 10/18/17 and 10/27/17. In addition, F-A stated, she was not aware of bed hold policy and appeared to be surprised when informed about bed hold policy. R7's medical record lacked signed written documentation of bed hold when transferred to the hospital on 10/8/17, 10/18/17 and 10/27/17. Progress note dated 10/8/17 at 10:15 p.m., read, "Noted increase in weakness prior to evening meal. Resident unable to transfer self out of recliner chair ... Increased confusion noted ... Called on-call Dr. [doctor]... He gave order for OK to send to ER [emergency room] for evaluation. Resident sent to ER via ambulance at 1830 to Lakeview ER. Called for update at 2130. Nurse at Lakeview stated he was admitted with primary dx of gross hematuria ..." Progress note dated 10/18/17 at 6:53 p.m., indicated, "Call received from Lakeview hospital. Surgery went well, but resident will be spending the night at the hospital." Progress notes dated 10/27/17 at 12:26 p.m., reads, "Spouse returned from appointment and told writer that husband has been admitted to hospital due to concerns for infection in testicle. She stated that hospital would be calling facility for more information on Resident medications." Progress notes dated 10/27/17 at 1:03 p.m., reads, "Called Lakeview hospital to inquire regarding resident's status. RN ... notified that res [resident] is being admitted to med-surg (medical surgical) floor for scrotal cellulitis and will be treated with IV (intravenous) Vancomycin today."	F 625	Leave. Social Services or Designee to complete weekly audit of all residents transferred to the hospital to ensure proper bed hold has been given. Audits will occur weekly x 4, monthly x 2 and audit results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 25 On 12/1/17 at 11:35 a.m., licensed practical nurse (LPN)-B verified that the medical record lacked signed written documentation of bed hold when R7 was transferred to the hospital on 10/8/17, 10/18/17 and 10/27/17. Also, when R45 was transferred to the hospital on 5/29/17, LPN-B stated, "I am unable to locate the signed bed hold paper works." On 12/1/17 at 11:39 a.m., social service (SS)-B confirmed that the medical record lacked signed written documentation of bed hold when R7 was transferred to the hospital on 10/8/17, 10/18/17 and 10/27/17. SS-B indicated, she can speculate that she had discussed with R45 verbally regarding bed hold but did not have any written documentation of it. On 12/1/17 at 11:45 a.m., interim director of nursing (IDON) substantiated that the medical record lacked signed written documentation of bed hold when R7 was transferred to the hospital on 10/8/17, 10/18/17 and 10/27/17, and in addition, when R45 was transferred to the hospital on 5/29/17. IDON mentioned, "I spoke to resident's wife about it and basically verified that we did not have conversation regarding bed hold." R45's admission record revealed R45 was admitted to the facility on 8/16/16 with diagnoses that included major depressive disorder, anxiety, hypertension, Raynaud's syndrome without gangrene and multiple sclerosis. On 11/28/17 at 12:35 p.m., R45 stated, was transferred to the hospital on 5/29/17 due to acquiring pneumonia. However, R45's medical record lacked signed written documentation of bed hold when the resident was sent to the hospital on 5/29/17. A progress note dated 5/29/17 at 9:14 p.m., read,	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 26	F 625		

"Resident c/o cough & fatigue since Late Saturday evening ... This writer called on-call provider, Dr. (doctor) ... returned call and was given sxs (symptoms), and provider advised ED (emergency department) tonight. 911 called at 8:20pm. Resident p/u (pick up) @ 8:30pm & transported to LVH (Lakeview Hospital) via paramedics. Residents husband ... informed."
Progress note dated 5/30/17 at 1:14 p.m., revealed, "Resident just called facility to speak to this writer. She states she is currently in the ICU (intensive care unit) ... Possibly will be returning to the facility on Thursday, but states it could also be Friday ..."
On 12/1/17 at 12:39 p.m., F-A stated IDON spoke with her today about the bed hold policy and was the first time staff have discuss bed hold policy with her.
The facility policy and procedure did not address signed written documents regarding bed hold.

A review of nurses notes revealed R61 was admitted to the facility, from the hospital, on 10/7/17 at 3:30 p.m. with diagnoses that included chronic hypoxia. A nursing note dated 10/7/17 at 1:42 p.m., revealed R61 had low oxygen saturation levels and the nurse practitioner ordered R61 be sent to the emergency department for evaluation. Record review revealed no bed hold information was provided to the resident/family/legal representative at the time of the hospital transfer.

On 12/1/17, at 2:24 p.m. the assistant director of nurses stated they would look for the bed hold information. At 3:29 p.m. licensed practical nurse (LPN) -B verified bed hold information had not been provided to R61 at the time of the hospital transfer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and document review, the facility failed to revise the care plan for 1 of 15 residents (R30) after the resident had been assessed and informed of the risks of consuming regular food and unthickened beverages while receiving nutrition via a gastrostomy tube.	F 657	Resident R30 □s dietary orders were reviewed and care plan and assignment sheets have been updated and reflective of resident□s specific dietary orders. Risk and benefit education completed with resident and POA regarding risk of comfort feedings. New admissions/re-admits will continue to be	1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 28 Findings include: On 11/28/17, at 1:16 p.m. R30 was observed lying in bed, with the head of the bed elevated and nutrition was being provided via a tube feeding. Also at this time a speech language pathologist (SLP) informed R30 the kitchen was out of a specific milk and asked R30 if he wanted juice and if so, what kind. R30 replied he wanted orange juice. When asked at this time if the juice was thickened, R30 replied he did not know, and stated he was working with a SLP. When asked, SLP-D stated R30's fluids were thickened. On 12/1/17, at 12:49 p.m. registered nurse (RN)-A stated R30 could have regular fluids and had pop in his room. On 12/1/17, at 1:35 p.m. nursing assistant (NA)-D stated she knew R30 had pop in his room, but only family or friends could give R30 the pop, and staff could not. On 12/1/17, at 1:35 p.m. RN-A again stated R30 could have pop when he requested. NA-D stated she was not aware of this information. A physician's order dated 11/18/17, revealed the physician had authorized comfort feedings at R30's request and that R30 was aware of the risks of such feedings. A review of the initial care plan dated 9/2/17, revealed the care plan had not been updated after the 11/18/17, physician's order authorizing comfort feedings. On 12/1/17, at 1:38 p.m. RN-C verified the initial care plan had not been updated regarding the	F 657	assessed for dietary preferences and appropriate interventions initiated. Other residents will continue to be assessed quarterly, annually, with significant change in condition, and as needed, with individual care plans being updated accordingly. Dietary audits to be completed weekly x 4 weeks; then as needed. DNS or designee will be responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 29 physician's approval of comfort feedings, with the physician's order of 11/18/17 for comfort feedings.	F 657		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services to minimize pain for 1 of 1 resident (R39) in the sample identified as having pain. Findings include: During an observation on 12/1/17, at 11:06 a.m. R39 was sitting up in the wheel chair in the bedroom and complained of buttock pain, an itching and burning sensation. When interviewed on 12/1/17, at 11:06 a.m. R39 expressed the pain level to the buttocks itching and burning sensation was a 6, and the pain level had been a 6 since 8:00 a.m. when R39 asked licensed practical nurse (LPN)-A for pain medication and to be laid in bed to see what was the matter with the buttocks. According to R39, LPN-A encouraged R39 to remain in the dining room until breakfast was finished and then go to the room and be laid down in bed after breakfast. R39 expressed frustration because R39 was not	F 697	Resident R39 has been assessed for pain management to ensure resident□s individual pain Care plan is updated and reflective of her needs and other non-pharmacological interventions. Other residents will continue to be assessed quarterly, annually, with significant change in condition, and as needed with individual care plans being updated accordingly. New admissions/re-admits will continue to be assessed for pain management and appropriate interventions are initiated. Staff have been educated on offering non-pharmacological interventions for pain management and follow up procedures. Pain Management care audits to be completed weekly x 4 weeks; then as needed. DNS or designee will be responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18.	1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 30	F 697		

laid in bed after breakfast and the buttocks/rectum remain a pain level of 6. Surveyor turned on the resident call light for assistance.

Document review of the medication administration record dated 12/1/17, revealed at 5:00 a.m. R39 received a scheduled dose of oxycodone HCl tablet 5 mg by mouth three times a day for pain. At 8:00 a.m. R39 received a scheduled dose of Tylenol (acetaminophen) 1000 mg by mouth three times a day for pain. At 8:15 a.m. R39 received a prn (as needed) dose of hydrocodone HCl tablet 5 mg by mouth every 4 hours as needed for pain rated 6-10.

During an observation on 12/1/17, at 11:12 a.m. nursing assistants (NA)-E and NA-F used the mechanical lift to transfer R39 into the bed. R39 continued to complain of pain to the rectum area and buttocks. LPN-A came to the room to assist and evaluate the complaints of buttock pain. When staff turned R39 to the side, there was a small amount of bowel movement which was cleaned away to reveal the skin had a moist, flame red area, approximately two inch area surrounding the rectum/anus. R39 complained of pain as "itching and burning" associated with the rectum/anus area and referred to the pain as a level 6. LPN-A verified there was a moist, flame red sore area to the tissue that was an approximate two inch area surrounding the rectum/anus area which could have been caused by the bowel movement irritating the skin.

When interviewed on 12/1/17, at 11:20 a.m. LPN-A verified the pain level should have been assessed again after R39 received the prn dose of Oxycodone HCl at 8:15 a.m. and if LPN-A had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 31	F 697		

followed through to check on the pain level then would have realized R39 was not laid into bed after breakfast to determine the cause of the pain.

During an interview with NA-F on 12/1/17, at 11:30 a.m. NA-F verified that the night shift dressed R39 and then leaves R39 in bed until the day shift uses a mechanical lift to transfer R39 into the wheel chair for breakfast. NA-F verified did not provide any cares for R39 since getting up at 8:00 a.m.. R39 was not able to feel the bowel movement and does not know if the bowel movement was causing the pain at 8:15 a.m..

When interviewed on 12/1/17, at 12:14 p.m. R39 expressed being upset that R39 did not get laid down after breakfast as the nurse said would happen at 8:15 a.m. R39 stated, "Makes you feel like you are not much of a person that they don't pay attention to you." Furthermore R39 talked about the diabetic nerve pain on the left side and continues to work on non pharmacological interventions to divert attention with reading and choosing positive imagery. Now R39 feels validated because there was a reason for the burning and itching buttock pain associated with the bowel movement. R39 expressed feeling the staff "forgot about me" and the request to be lain in bed after breakfast.

When interviewed on 12/1/17, at 1:13 p.m. R39 was sitting up in the chair in the bedroom and expressed feeling better and the itching and burning feeling was gone. R39 smiled and expressed appreciation for finding out what was causing the burning and itching feeling.

Document review of R39's plan of care, revised

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 32 3/8/17, read, "Resident is at risk for pain r/t (related to) arthritis, left side paralysis, neuropathy. Resident will maintain adequate level of comfort as evidenced by no s/s (signs/symptoms) of unrelieved pain or distress, or verbalizing satisfaction with level of comfort." R39 was assessed as cognitively intact on 9/21/17, according to the Brief Interview for Mental Status. When interviewed on 12/1/17, at 1:00 p.m. registered nurse (RN)-B verified the facility expectation would have been to ensure R39 was lain in bed when the pain medication was administered to evaluate possible causes of pain and to follow up on the effectiveness of the pain medication administration.	F 697		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the infection control program included ongoing trending and analysis of resident infections to prevent the spread of infections. This deficient practice had the potential to affect all 59 residents who resided in the facility. In addition, the facility did not provide appropriate hand hygiene, and care and services in a manner as to prevent the spread of infection for 3 of 8 residents (R30, R41, R109) observed for cares. Findings include: The facility's infection control logs were reviewed from January 2017 through November 2017. The logs identified tracking records of residents with infections, symptoms cultures and treatment. However, the facility lacked documentation of analysis and or investigation of patterns identified. The facility utilized a form titled Line Listing of Resident Infections. The forms were filled out, identified by each month and separated by unit. Infections that have been noted in the facility in the past 11 months included urinary tract infections, pneumonia, bacteria conjunctivitis, vaginitis, etc. The forms were completed by the interim director of nursing (IDON) and/or the unit	F 880	The Facility□s Infection Control Logs were reviewed and updated on 11/30/17, at the time MDH□s Annual survey. A procedure and forms to indicate tracking and trending was also put in place immediately. Handwashing education has been reviewed with all staff, especially after providing peri-care for residents with soiled briefs or after toilet use, as well as after treatments. Staff will continue being trained and audited for glove donning and handwashing before, during, and after peri-care and treatments. Handwashing will continue being provided upon hire, with annual reviews, skills fairs, and as needed with routine audits. Handwashing audits to be completed weekly x 4 weeks; then as needed. DNS or designee will be responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35 nurse manager [registered nurse (RN)-B] after information was provided monthly by the unit nurses. The forms lacked any documentation of analysis and or investigation of patterns identified. For example, the form for the month of March 2017, indicated 1 of the infections was urinary tract infections. There was no documentation of any trending or analysis of these infections. The form did not identify if residents had symptoms of infections or if they were treated with antibiotics. On 11/30/17 at 10:55 a.m., the IDON indicated she was responsible for the infection control program for the facility. The IDON provided the lists of infections by unit for the months of January 2017 through November 2017. The IDON reported that each infection mentioned at the facility morning stand up meetings and any trends would be identified at the meeting and in QA. However, the IDON verified there was no documentation of any discussion. The IDON reported the infection control logs are taken to the quality assurance meetings. On 11/30/17 at 12:27 p.m., the IDON verified the facility was not trending/analyzing all resident and staff infections. Policy and procedure titled INFECTION PREVENTION AND CONTROL PROGRAM, dated 8/17, revealed, "the Infection Control Program is comprehensive in that it addressed detection, prevention and control of infections among residents and personal. The major elements of the program are: Coordination/Oversight Policies and procedures Surveillance Data analysis Antibiotic Stewardship outbreak Management Prevention of Infection Employee Health".	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 36	F 880		

On 11/28/17, at 12:43 p.m. R41 requested to use the bathroom and was taken back to her room. Nursing assistant (NA)-C walked R41 from the wheelchair to the toilet using a transfer belt and walker, where R41 voided on the toilet. When asked about the condition of the incontinent brief worn by R41, NA-C stated it was a "little" wet and without washing their hands, NA-C removed the incontinent brief while wearing gloves and placed the soiled pad in a garbage can. Without cleansing hands or removing gloves NA-C provided pericare to R41. After providing pericare, NA-C removed the gloves and without washing hands placed a new incontinent pad, pulled R41's pants up and walked R41 to the bed while touching the transfer belt and R41's walker. Still without having cleansed her hands NA-C assisted R41 to lay down, covered the resident up and placed the call light within R41's reach. NA-C then removed the soiled garbage bag and took the bag to the soiled utility room for disposal. NA-C then left the soiled utility room without cleansing her hands, touched and moved a mechanical lift, and move the lift out of the way so NA-C could get to the sink and wash her hands. The lift was not cleansed.

On 11/28/17, at 1:16 p.m. R30 was observed to be incontinent of stool. Before beginning cares, nursing assistant (NA)-B was observed to wash her hands and don a pair of gloves and provide incontinent care with disposable wipes and a cream cleanser. During the cleansing NA-B removed soiled gloves and donned new gloves without cleansing her hands. When incontinent care was completed, NA-B placed all soiled items into a garbage can, which was at the side of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37	F 880		

bed. Without washing her hands, NA-B placed a clean incontinent pad beneath R30 and pulled the pad up between R30's legs. Still not having cleansed her hands, NA-B then pulled up R30's pants. The soiled items were removed from the garbage can and taken to a soiled utility room. Without cleansing her hands NA-B touched a mechanical lift, which was blocking the entrance to a bathroom, and move the lift out of the way so NA-B could get to the sink and wash her hands at 1:29 p.m. The lift was 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.

On 11/28/17, at 4:25 p.m. R109 was observed lying in bed and NA-G stated they were about to check and change R109. At 4:27 p.m. registered nurse (RN)-A came into the room to assist NA-G with R109, as NA-G stated R109 required two staff to assist with turning side to side in bed. Without cleansing hands RN-A removed R109's protective boots and socks. Also at this time NA-G donned a pair of gloves without first washing her hands. RN-A and NA-G then turned R109 onto his right side and R109 was noted to be incontinent of stool. NA-G then proceeded to cleanse R109 using disposable wipes and a cream cleanser and threw the soiled items into a plastic bag in a garbage can. Without removing gloves or washing hands, NA-G placed a clean incontinent brief beneath R109, then removed the soiled gloves and without hand cleansing, donned a new pair of gloves. With the new gloves on NA-G pulled the incontinent pad up between R109's legs. The gloves were removed and without cleansing hands NA-G pulled R109's pants up and a mechanical lift sling was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 positioned beneath the resident. At 4:32 p.m. RN-A removed removed her gloves, but did not cleanse hands before leaving the room to get the mechanical lift. Still without having cleansed her hands, NA-G removed the soiled items from the garbage can, put in a new garbage bag in the can and without hand cleansing grabbed R109's wheelchair. RN-A returned with the mechanical lift and did not cleanse hands. Both staff touched the mechanical lift and the sling to get the resident positioned so R109 could be transferred into the wheelchair at 4:35 p.m. NA-G then proceeded to make R109's bed and did not wash her hands until the bed had been made. On 11/29/17, at 9:23 a.m. a dressing change was observed for R109. At this time RN-G was observed to cleanse hands, don a pair of gloves, move a garbage can closer to the bed and removed a dressing to R109's left heel and place the soiled dressing in the garbage can. Without removing the soiled gloves, RN-G opened a new package of gauze pads, remove several gauze pads, while still wearing the soiled gloves, spray the gauze pads with a wound cleanser and proceed to cleanse the wound. Still wearing the soiled gloves RN-G was observed to place the soiled gauze bag on the night stand and then wash her hands. The facility's 2/16, Hand Washing policy indicated hands were to be washed after changing incontinent products or when pericare was provided after a resident used the toilet.	F 880		
F 923 SS=E	Ventilation CFR(s): 483.90(i)(2) §483.90(i)(2) Have adequate outside ventilation	F 923		1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 923	Continued From page 39 by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not provide adequate ventilation for one of three units in the facility, the north unit, affecting 23 of 59 residents in the facility. Findings include: On all days of the survey there was an unpleasant odor lingering in the north hallway between the shower room and the nursing station. On 12/1/17 at 11:38 nursing assistant (NA)-G stated that she did notice that this odor had been lingering in that part of the north hallway for several days. When asked if she knew which room was the origin of the odor, she replied that all the rooms and residents on that unit had been checked and were clean and she thought that the odor was only in the hallway and not in a resident room. She thought that this odor had been mentioned at a November staff meeting. On 12/1/17 at 11:50 the maintenance director and housekeeping director were asked to observe the north unit and asked if they were aware of an unpleasant odor on the unit. They both replied that they were not aware of an odor and the maintenance director stated that he audited the ventilation system and it was working fine. The maintenance director suggested that there may have been an odor emanating from the dirty utility room in that area of the unit. That dirty utility room was checked and the odor did not seem	F 923	The facility will install lockable switch covers to ensure ventilation switches are not easily accessible to staff or supplies falling and bumping the switches. Staff will be educated on the importance of leaving switches in the on position. Audits of the ventilation system will be completed weekly x 4 weeks, and monthly ongoing. Maintenance Director or designee will be responsible party.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 923	Continued From page 40	F 923		

strong in that room. The surveyor suggested checking the ventilation in the bathroom of a resident's room near the center of the odor. The ceiling vent in the bathroom shared by 220 and 221 was tested with a small piece of bath tissue and the tissue would not cling to the vent in that bathroom. The maintenance director immediately went to check the ventilation system controls of the facility and returned shortly, explaining that he found the ventilation controls switched off. He turned the ventilation controls on at that time. The maintenance director stated that he did monthly audits of the ventilation system and did not find a problem in the month of November.

When the administrator was interviewed on 12/1/17 at 12:10 p.m., she stated that she was not sure how the ventilation system was turned off, but the controls are in the janitor's closet and maybe they were bumped when supplies were moved around.

On 12/01/17 at 12:15 p.m. the maintenance director provided his audit log showing that an audit was done on 11/6/17 and it read, "Exhaust Fans: Inspect exhaust fans for proper operation and clean if necessary done." When the maintenance director provided the audit log, he stated that it was a possibility that the nursing staff was turning the ventilation system off at night because they thought it made the building colder.

On 12/1/17 at 1:24 p.m. the odor on the north unit hall was gone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/01/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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	K 000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/01/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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, (Name of facility) 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.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/01/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 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 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Greeley Healthcare Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type 2(111) construction. In 1988, an addition was constructed to the west side of the building that was determined to be of Type II(111)construction. In 1997, an addition was constructed to the north and south sides of the building that was determined to be of Type V(111)construction. Because the original building	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/01/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 3 and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building as Type V(111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of XX beds and had a census of XX at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established	K 712		12/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/01/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 4 routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Findings Include: On facility tour between 01:00 PM and 05:00 PM on 12/1/2017, based on documentation review and interview that the following include: The Facility is missing December fire drill for the 3rd shaft. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	A December fire drill for all shifts will be conducted by Maintenance Director or designee by 12/31/17. Ongoing monthly fire drills for all shift will be conducted and documented by Maintenance Director or designee. All fire drills documentation will be turned in to Administrator monthly to ensure timeliness and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/01/2017**

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision 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. This MN Requirement is not met as evidenced by: Based on observation, record review, and document review, the facility failed to revise the care plan for 1 of 15 residents (R30) after the resident had been assessed and informed of the risks of consuming regular food and unthickened beverages while receiving nutrition via a gastrostomy tube. Findings include: On 11/28/17, at 1:16 p.m. R30 was observed lying in bed, with the head of the bed elevated and nutrition was being provided via a tube feeding. Also at this time a speech language	2 570	Resident R30□s dietary orders were reviewed and care plan and assignment sheets have been updated and reflective of resident□s specific dietary orders. Risk and benefit education completed with resident and POA regarding risk of comfort feedings. New admissions/re-admits will continue to be assessed for dietary preferences and appropriate interventions initiated. Other residents will continue to be assessed quarterly, annually, with significant change in condition, and as needed, with individual care plans being updated	1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 3 pathologist (SLP) informed R30 the kitchen was out of a specific milk and asked R30 if he wanted juice and if so, what kind. R30 replied he wanted orange juice. When asked at this time if the juice was thickened, R30 replied he did not know, and stated he was working with a SLP. When asked, SLP-D stated R30's fluids were thickened. On 12/1/17, at 12:49 p.m. registered nurse (RN)-A stated R30 could have regular fluids and had pop in his room. On 12/1/17, at 1:35 p.m. nursing assistant (NA)-D stated she knew R30 had pop in his room, but only family or friends could give R30 the pop, and staff could not. On 12/1/17, at 1:35 p.m. RN-A again stated R30 could have pop when he requested. NA-D stated she was not aware of this information. A physician's order dated 11/18/17, revealed the physician had authorized comfort feedings at R30's request and that R30 was aware of the risks of such feedings. A review of the initial care plan dated 9/2/17, revealed the care plan had not been updated after the 11/18/17, physician's order authorizing comfort feedings. On 12/1/17, at 1:38 p.m. RN-C verified the initial care plan had not been updated regarding the physician's approval of comfort feedings, with the physician's order of 11/18/17 for comfort feedings. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or	2 570	accordingly. Dietary audits to be completed weekly x 4 weeks; then as needed. DNS or designee will be responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 4 designee, could develop and implement policies and procedures related to the updating and revision of resident care plans. The resident(s) mentioned above, and others who may also be affected should be assessed in the plan of correction. The administrator, DON, or designee could ensure staff are educated and trained related to care plan revisions. Random audits for an amount of time determined by the quality assessment and performance improvement (QAPI) committee could ensure compliance. The administrator, DON, or designee could then take that information back to QAPI to assess need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	2 830	Resident R39 has been assessed for pain	1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 review, the facility failed to provide the necessary care and services to minimize pain for 1 of 1 resident (R39) in the sample identified as having pain. Findings include: During an observation on 12/1/17, at 11:06 a.m. R39 was sitting up in the wheel chair in the bedroom and complained of buttock pain, an itching and burning sensation. When interviewed on 12/1/17, at 11:06 a.m. R39 expressed the pain level to the buttocks itching and burning sensation was a 6, and the pain level had been a 6 since 8:00 a.m. when R39 asked licensed practical nurse (LPN)-A for pain medication and to be laid in bed to see what was the matter with the buttocks. According to R39, LPN-A encouraged R39 to remain in the dining room until breakfast was finished and then go to the room and be laid down in bed after breakfast. R39 expressed frustration because R39 was not laid in bed after breakfast and the buttocks/rectum remain a pain level of 6. Surveyor turned on the resident call light for assistance. Document review of the medication administration record dated 12/1/17, revealed at 5:00 a.m. R39 received a scheduled dose of oxycodone HCl tablet 5 mg by mouth three times a day for pain. At 8:00 a.m. R39 received a scheduled dose of Tylenol (acetaminophen) 1000 mg by mouth three times a day for pain. At 8:15 a.m. R39 received a prn (as needed) dose of hydrocodone HCl tablet 5 mg by mouth every 4 hours as needed for pain rated 6-10. During an observation on 12/1/17, at 11:12 a.m.	2 830	management to ensure resident□s individual pain Care plan is updated and reflective of her needs and other non-pharmacological interventions. Other residents will continue to be assessed quarterly, annually, with significant change in condition, and as needed with individual care plans being updated accordingly. New admissions/re-admits will continue to be assessed for pain management and appropriate interventions are initiated. Staff have been educated on offering non-pharmacological interventions for pain management and follow up procedures. Pain Management care audits to be completed weekly x 4 weeks; then as needed. DNS or designee will be responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 nursing assistants (NA)-E and NA-F used the mechanical lift to transfer R39 into the bed. R39 continued to complain of pain to the rectum area and buttocks. LPN-A came to the room to assist and evaluate the complaints of buttock pain. When staff turned R39 to the side, there was a small amount of bowel movement which was cleaned away to reveal the skin had a moist, flame red area, approximately two inch area surrounding the rectum/anus. R39 complained of pain as "itching and burning" associated with the rectum/anus area and referred to the pain as a level 6. LPN-A verified there was a moist, flame red sore area to the tissue that was an approximate two inch area surrounding the rectum/anus area which could have been caused by the bowel movement irritating the skin. When interviewed on 12/1/17, at 11:20 a.m. LPN-A verified the pain level should have been assessed again after R39 received the prn dose of Oxycodone HCl at 8:15 a.m. and if LPN-A had followed through to check on the pain level then would have realized R39 was not laid into bed after breakfast to determine the cause of the pain. During an interview with NA-F on 12/1/17, at 11:30 a.m. NA-F verified that the night shift dressed R39 and then leaves R39 in bed until the day shift uses a mechanical lift to transfer R39 into the wheel chair for breakfast. NA-F verified did not provide any cares for R39 since getting up at 8:00 a.m.. R39 was not able to feel the bowel movement and does not know if the bowel movement was causing the pain at 8:15 a.m.. When interviewed on 12/1/17, at 12:14 p.m. R39 expressed being upset that R39 did not get laid down after breakfast as the nurse said would	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 happen at 8:15 a.m. R39 stated, "Makes you feel like you are not much of a person that they don't pay attention to you." Furthermore R39 talked about the diabetic nerve pain on the left side and continues to work on non pharmacological interventions to divert attention with reading and choosing positive imagery. Now R39 feels validated because there was a reason for the burning and itching buttock pain associated with the bowel movement. R39 expressed feeling the staff "forgot about me" and the request to be lain in bed after breakfast. When interviewed on 12/1/17, at 1:13 p.m. R39 was sitting up in the chair in the bedroom and expressed feeling better and the itching and burning feeling was gone. R39 smiled and expressed appreciation for finding out what was causing the burning and itching feeling. Document review of R39's plan of care, revised 3/8/17, read, "Resident is at risk for pain r/t (related to) arthritis, left side paralysis, neuropathy. Resident will maintain adequate level of comfort as evidenced by no s/s (signs/symptoms) of unrelieved pain or distress, or verbalizing satisfaction with level of comfort." R39 was assessed as cognitively intact on 9/21/17, according to the Brief Interview for Mental Status. When interviewed on 12/1/17, at 1:00 p.m. registered nurse (RN)-B verified the facility expectation would have been to ensure R39 was lain in bed when the pain medication was administered to evaluate possible causes of pain and to follow up on the effectiveness of the pain medication administration.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pain to assure they are receiving the necessary treatment/services. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide appropriate hand hygiene, and care and services in a manner as to prevent the spread of infection for 3 of 8 residents (R30, R41, R109) observed for cares. Findings include: On 11/28/17, at 12:43 p.m. R41 requested to use the bathroom and was taken back to her room. Nursing assistant (NA)-C walked R41 from the wheelchair to the toilet using a transfer belt and walker, where R41 voided on the toilet. When asked about the condition of the incontinent brief worn by R41, NA-C stated it was a "little" wet and	21375	The Facility□s Infection Control Logs were reviewed and updated on 11/30/17, at the time MDH□s Annual survey. A procedure and forms to indicate tracking and trending was also put in place immediately. Handwashing education has been reviewed with all staff, especially after providing peri-care for residents with soiled briefs or after toilet use, as well as after treatments. Staff will continue being trained and audited for glove donning and handwashing before, during, and after peri-care and treatments. Handwashing will continue being provided upon hire, with annual reviews, skills fairs, and as needed with routine audits. Handwashing	1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 9 without washing their hands, NA-C removed the incontinent brief while wearing gloves and placed the soiled pad in a garbage can. Without cleansing hands or removing gloves NA-C provided pericare to R41. After providing pericare, NA-C removed the gloves and without washing hands placed a new incontinent pad, pulled R41's pants up and walked R41 to the bed while touching the transfer belt and R41's walker. Still without having cleansed her hands NA-C assisted R41 to lay down, covered the resident up and placed the call light within R41's reach. NA-C then removed the soiled garbage bag and took the bag to the soiled utility room for disposal. NA-C then left the soiled utility room without cleansing her hands, touched and moved a mechanical lift, and move the lift out of the way so NA-C could get to the sink and wash her hands. The lift was not cleansed. On 11/28/17, at 1:16 p.m. R30 was observed to be incontinent of stool. Before beginning cares, nursing assistant (NA)-B was observed to wash her hands and don a pair of gloves and provide incontinent care with disposable wipes and a cream cleanser. During the cleansing NA-B removed soiled gloves and donned new gloves without cleansing her hands. When incontinent care was completed, NA-B placed all soiled items into a garbage can, which was at the side of the bed. Without washing her hands, NA-B placed a clean incontinent pad beneath R30 and pulled the pad up between R30's legs. Still not having cleansed her hands, NA-B then pulled up R30's pants. The soiled items were removed from the garbage can and taken to a soiled utility room. Without cleansing her hands NA-B touched a mechanical lift, which was blocking the entrance to a bathroom, and move the lift out of the way so NA-B could get to the sink and wash her hands at	21375	audits to be completed weekly x 4 weeks; then as needed. DNS or designee will be responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 10 1:29 p.m. The lift was 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. On 11/28/17, at 4:25 p.m. R109 was observed lying in bed and NA-G stated they were about to check and change R109. At 4:27 p.m. registered nurse (RN)-A came into the room to assist NA-G with R109, as NA-G stated R109 required two staff to assist with turning side to side in bed. Without cleansing hands RN-A removed R109's protective boots and socks. Also at this time NA-G donned a pair of gloves without first washing her hands. RN-A and NA-G then turned R109 onto his right side and R109 was noted to be incontinent of stool. NA-G then proceeded to cleanse R109 using disposable wipes and a cream cleanser and threw the soiled items into a plastic bag in a garbage can. Without removing gloves or washing hands, NA-G placed a clean incontinent brief beneath R109, then removed the soiled gloves and without hand cleansing, donned a new pair of gloves. With the new gloves on NA-G pulled the incontinent pad up between R109's legs. The gloves were removed and without cleansing hands NA-G pulled R109's pants up and a mechanical lift sling was positioned beneath the resident. At 4:32 p.m. RN-A removed removed her gloves, but did not cleanse hands before leaving the room to get the mechanical lift. Still without having cleansed her hands, NA-G removed the soiled items from the garbage can, put in a new garbage bag in the can and without hand cleansing grabbed R109's wheelchair. RN-A returned with the mechanical lift and did not cleanse hands. Both staff touched the mechanical lift and the sling to get the resident positioned so R109 could be transferred into the	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 11 wheelchair at 4:35 p.m. NA-G then proceeded to make R109's bed and did not wash her hands until the bed had been made. On 11/29/17, at 9:23 a.m. a dressing change was observed for R109. At this time RN-G was observed to cleanse hands, don a pair of gloves, move a garbage can closer to the bed and removed a dressing to R109's left heel and place the soiled dressing in the garbage can. Without removing the soiled gloves, RN-G opened a new package of gauze pads, remove several gauze pads, while still wearing the soiled gloves, spray the gauze pads with a wound cleanser and proceed to cleanse the wound. Still wearing the soiled gloves RN-G was observed to place the soiled gauze bag on the night stand and then wash her hands. The facility's 2/16, Hand Washing policy indicated hands were to be washed after changing incontinent products or when pericare was provided after a resident used the toilet. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could develop policies and procedures for an infection control program in the facility. The director of nursing or designee, could conduct random audits to ensure that this infection control program has been implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection	21390		1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 12 control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the infection control program included ongoing trending and analysis of resident infections to prevent the spread of infections. This deficient practice had the potential to affect all 59 residents who resided in the facility. Findings include:	21390	The Facility□s Infection Control Logs were reviewed and updated on 11/30/17, at the time MDH□s Annual survey. A procedure and forms to indicate tracking and trending was also put in place immediately. Audits to be completed weekly x 4 weeks; then as needed. DNS or designee will be responsible party. QAPI will provide redirection or change	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 13 The facility's infection control logs were reviewed from January 2017 through November 2017. The logs identified tracking records of residents with infections, symptoms cultures and treatment. However, the facility lacked documentation of analysis and or investigation of patterns identified. The facility utilized a form titled Line Listing of Resident Infections. The forms were filled out, identified by each month and separated by unit. Infections that have been noted in the facility in the past 11 months included urinary tract infections, pneumonia, bacteria conjunctivitis, vaginitis, etc. The forms were completed by the interim director of nursing (IDON) and/or the unit nurse manager [registered nurse (RN)-B] after information was provided monthly by the unit nurses. The forms lacked any documentation of analysis and or investigation of patterns identified. For example, the form for the month of March 2017, indicated 1 of the infections was urinary tract infections. There was no documentation of any trending or analysis of these infections. The form did not identify if residents had symptoms of infections or if they were treated with antibiotics. On 11/30/17 at 10:55 a.m., the IDON indicated she was responsible for the infection control program for the facility. The IDON provided the lists of infections by unit for the months of January 2017 through November 2017. The IDON reported that each infection mentioned at the facility morning stand up meetings and any trends would be identified at the meeting and in QA. However, the IDON verified there was no documentation of any discussion. The IDON reported the infection control logs are taken to the quality assurance meetings.	21390	when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 14 On 11/30/17 at 12:27 p.m., the IDON verified the facility was not trending/analyzing all resident and staff infections. Policy and procedure titled INFECTION PREVENTION AND CONTROL PROGRAM, dated 8/17, revealed, "the Infection Control Program is comprehensive in that it addressed detection, prevention and control of infections among residents and personal. The major elements of the program are: Coordination/Oversight Policies and procedures Surveillance Data analysis Antibiotic Stewardship outbreak Management Prevention of Infection Employee Health". SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could develop policies and procedures for an infection control program in the facility. The director of nursing or designee, could conduct random audits to ensure that this infection control program has been implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis	21426		1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 15 infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement current Centers for Disease Control (CDC) guidelines for preventing the transmission of Tuberculosis (TB) for 3 of 5 employees (E-A, E-B and E-C) as directed by State Tuberculosis Guidelines. This had the potential to affect all residents reside in the facility. Findings include: Tuberculin Skin Test (TST). E-A's record indicated E-A was hired on 9/25/17. E-A's medical record lacked evidence of TST-First step results; number of millimeter (mm) of indication and interpretation of reading in the file nor provided when requested. E-B's record indicated E-B was hired on 10/3/17. E-B's medical record lacked evidence of TST-Second step in the file nor provided when requested. E-C's record indicated E-C was hired on 7/25/17.	21426	The identified employees will be reassessed for TB-Screening. TB-Screening will be administered upon hire and assessed, per company policy. DNS or designee will be responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 16 E-C's medical record lacked evidence of TST-Second step in the file nor provided when requested. On 11/30/17, at 10:55 a.m., the interim director of nursing (IDON) verified employees' files lacked evidence of TST-First step results; number of millimeter (mm) of indication and interpretation of reading and TST- Second step not completed. IDON stated they are trying to work through the staff files and are still in the process of updating everyone to make sure every employees TB information is correct. 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)... General principles ·All reports or copies of TST or IGRA results and any related chest X-ray and medical evaluations should be maintained in the employee's record. ·TST documentation should include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative) ..." SUGGESTED METHOD OF CORRECTION:	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 17 The director of nursing or designee, could develop policies and procedures for a tuberculosis screening program in the facility. The director of nursing or designee, could conduct random audits to ensure that this tuberculosis screening program has been implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to follow up on resident council concerns regarding passing of snacks and obtaining public broadcast station (PBS) television 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 food grievance for 1 of 1 resident (R30) who had complained about cold food. Findings include: Document review of the resident council meeting minutes for September, October and November 2017, revealed number 6. Old Business: (A	21870	Residents R4, R10, R13, R24, R33, R39, R45, R47 & R58 have been provided with public broadcast station (PBS) television channels and snacks passed to them routinely. All residents that receive oral 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 distributing resident snack passes as well as ensuring residents needing copies of television channels have those copies. Audits of snack passes to be completed weekly x 4 weeks; then as needed. Administrator and Director of Nurse Services (DNS) or designee will be	1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 18 review of each issue brought up as NEW BUSINESS at the last meeting. Red [sic] the department response that was submitted to show the resolution of the issue.) A. PBS- different channels and B. Snack cart. Was the issue resolved to your satisfaction? Both boxes were checked No and there was no further explanation regarding the PBS television channel or the passing of the snack cart by facility staff. There were no concern forms filled out to address follow through with the resident council requests. A resident council meeting was scheduled on 11/30/17, at 10:40 a.m. and 9 residents R4, R10, R13, R24, R33, R39, R45. R47, R58 participated with two MDH surveyors present. During the interview, R58, who was assessed 11/15/17 as cognitively intact, expressed never seeing snacks delivered to R58's room and the cart with snacks was too high for R58 to reach in order to help self. During the interview, R4 who was assessed 8/31/17 as cognitively intact, expressed staff would bring in a snack to R4's roommate but they have never offered R4 a snack. During the interview, R33 who was assessed 10/26/17 as cognitively intact, expressed the snack cart which sat in the hallway by the nurses desk was usually empty by 6:00 p.m. During the interview, R45 who was assessed 8/17/17 as cognitively intact, expressed there had been no resolution to the request to resume the PBS television station that the facility used to have but has not restored. R45 verified snacks were not always offered by the facility staff on a routine basis.	21870	responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18. A grievance form was completed for R31□s complaint of cold food. A follow-up was done on 12/01/17 by Social Services and resident reported that food was hotter now. Dietary will continue to monitor food temperatures in the facility per current practice. All resident concerns will be addressed per current Grievance procedure and also reviewed at Resident council meetings. Food Temperature audits to be completed weekly x 4 weeks; then as needed. Director of Culinary Services or designee will be responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 19 All 9 residents R4, R10, R13, R24, R33, R39, R45. R47, R58 validated concerns about restoring the PBS television channel and that there was an ongoing issue with being offered a snack. All 9 residents verified there was no resolution to the resident concerns expressed at resident council. Document review of the facility policy, dated 7/17, titled Resident Council Policy, under number 6. read, "Concerns process/resolution- Any concerns presented during a resident council meeting will be documented and resolved per the grievance policy." Document review of the Complaint and Grievance Procedure, dated 9/01, read, "The Administrator shall issue a written summary to the complainant of proposed action on the grievance no later than seven (7) days after receipt of the grievance." When interviewed on 11/30/17, at 1:47 p.m. the administrator verified being aware of the resident complaints regarding the residents wanting back the PBS television channel and the passing of snacks was a continued problem for the resident council. The administrator signed off as reviewing the September resident council minutes on 9/20/17, the October minutes on 10/23/17 and the November minutes on 11/21/17, but did not initiate a concern for the resident council complaints of PBS television and snack passing so the issues could be resolved. On 12/1/17, at approximately 12:45 p.m. the food service manager (FSM) stated there had been one food complaint she had been aware of since coming to the facility. At 1:00 p.m. the FSM stated	21870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 20	21870		

the original complaint had been lost, was rewritten and she had not had time to follow up on the complaint. The FSM stated they were dividing their time between two facilities and started coming to the facility approximately three 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 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.

SUGGESTED METHOD OF CORRECTION:
The Adminstrator and/or designee could review the facility polices in regards to transmission of individual grievances, and educate staff on how to communicate them to the appropriate department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 21 in a timely manner. The administrator could monitor grievances on a routine basis to ensure grievances were acted upon in a timely manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21870		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by	21880		1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 22 an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to follow up on resident council concerns regarding passing of snacks and obtaining public broadcast station (PBS) television 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 food grievance for 1 of 1 resident (R30) who had complained about cold food. Findings include: Document review of the resident council meeting minutes for September, October and November 2017, revealed number 6. Old Business: (A review of each issue brought up as NEW BUSINESS at the last meeting. Red [sic] the department response that was submitted to show the resolution of the issue.) A. PBS- different channels and B. Snack cart. Was the issue resolved to your satisfaction? Both boxes were checked No and there was no further explanation	21880	Residents R4, R10, R13, R24, R33, R39, R45, R47 & R58 have been provided with public broadcast station (PBS) television channels and snacks passed to them routinely. All residents that receive oral 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 distributing resident snack passes as well as ensuring residents needing copies of television channels have those copies. Audits of snack passes to be completed weekly x 4 weeks; then as needed. Administrator and Director of Nurse Services (DNS) or designee will be responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 23 regarding the PBS television channel or the passing of the snack cart by facility staff. There were no concern forms filled out to address follow through with the resident council requests. A resident council meeting was scheduled on 11/30/17, at 10:40 a.m. and 9 residents R4, R10, R13, R24, R33, R39, R45. R47, R58 participated with two MDH surveyors present. During the interview, R58, who was assessed 11/15/17 as cognitively intact, expressed never seeing snacks delivered to R58's room and the cart with snacks was too high for R58 to reach in order to help self. During the interview, R4 who was assessed 8/31/17 as cognitively intact, expressed staff would bring in a snack to R4's roommate but they have never offered R4 a snack. During the interview, R33 who was assessed 10/26/17 as cognitively intact, expressed the snack cart which sat in the hallway by the nurses desk was usually empty by 6:00 p.m. During the interview, R45 who was assessed 8/17/17 as cognitively intact, expressed there had been no resolution to the request to resume the PBS television station that the facility used to have but has not restored. R45 verified snacks were not always offered by the facility staff on a routine basis. All 9 residents R4, R10, R13, R24, R33, R39, R45. R47, R58 validated concerns about restoring the PBS television channel and that there was an ongoing issue with being offered a snack. All 9 residents verified there was no resolution to the resident concerns expressed at	21880	A grievance form was completed for R31□s complaint of cold food. A follow-up was done on 12/01/17 by Social Services and resident reported that food was hotter now. Dietary will continue to monitor food temperatures in the facility per current practice. All resident concerns will be addressed per current Grievance procedure and also reviewed at Resident council meetings. Food Temperature audits to be completed weekly x 4 weeks; then as needed. Director of Culinary Services or designee will be responsible party. QAPI will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process based on compliance date of 1/05/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 24 resident council. Document review of the facility policy, dated 7/17, titled Resident Council Policy, under number 6. read, "Concerns process/resolution- Any concerns presented during a resident council meeting will be documented and resolved per the grievance policy." Document review of the Complaint and Grievance Procedure, dated 9/01, read, "The Administrator shall issue a written summary to the complainant of proposed action on the grievance no later than seven (7) days after receipt of the grievance." When interviewed on 11/30/17, at 1:47 p.m. the administrator verified being aware of the resident complaints regarding the residents wanting back the PBS television channel and the passing of snacks was a continued problem for the resident council. The administrator signed off as reviewing the September resident council minutes on 9/20/17, the October minutes on 10/23/17 and the November minutes on 11/21/17, but did not initiate a concern for the resident council complaints of PBS television and snack passing so the issues could be resolved. On 12/1/17, at approximately 12:45 p.m. the food service manager (FSM) stated there had been one food complaint she had been aware of since coming to the facility. At 1:00 p.m. the FSM stated the original complaint had been lost, was rewritten and she had not had time to follow up on the complaint. The FSM stated they were dividing their time between two facilities and started coming to the facility approximately three weeks ago.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 25 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. SUGGESTED METHOD OF CORRECTION: The Adminstrator and/or designee could review the facility polices in regards to transmission of individual grievances, and educate staff on how to communicate them to the appropriate department in a timely manner. The administrator could monitor grievances on a routine basis to ensure grievances were acted upon in a timely manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
23240	Continued From page 26	23240		
23240	MN Rule 4658.5405 Ventilation Requirements; Existing Constructn Existing facilities must have mechanical exhaust ventilation in the kitchen, laundry, soiled linen collection room, soiled utility rooms, and toilet areas, except if the toilet area is private or semiprivate, and is provided with window ventilation. Ventilation must be provided according to part 4658.4520. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility did not provide adequate ventilation for one of three units in the facility, the north unit, affecting 23 of 59 residents in the facility. Findings include: On all days of the survey there was an unpleasant odor lingering in the north hallway between the shower room and the nursing station. On 12/1/17 at 11:38 nursing assistant (NA)-G stated that she did notice that this odor had been lingering in that part of the north hallway for several days. When asked if she knew which room was the origin of the odor, she replied that all the rooms and residents on that unit had been checked and were clean and she thought that the odor was only in the hallway and not in a resident room. She thought that this odor had been mentioned at a November staff meeting. On 12/1/17 at 11:50 the maintenance director and housekeeping director were asked to observe the	23240	The facility will install lockable switch covers to ensure ventilation switches are not easily accessible to staff or supplies falling and bumping the switches. Staff will be educated on the importance of leaving switches in the on position. Audits of the ventilation system will be completed weekly x 4 weeks, and monthly ongoing. Maintenance Director or designee will be responsible party.	1/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
23240	Continued From page 27	23240		

north unit and asked if they were aware of an unpleasant odor on the unit. They both replied that they were not aware of an odor and the maintenance director stated that he audited the ventilation system and it was working fine. The maintenance director suggested that there may have been an odor emanating from the dirty utility room in that area of the unit. That dirty utility room was checked and the odor did not seem strong in that room. The surveyor suggested checking the ventilation in the bathroom of a resident's room near the center of the odor. The ceiling vent in the bathroom shared by 220 and 221 was tested with a small piece of bath tissue and the tissue would not cling to the vent in that bathroom. The maintenance director immediately went to check the ventilation system controls of the facility and returned shortly, explaining that he found the ventilation controls switched off. He turned the ventilation controls on at that time. The maintenance director stated that he did monthly audits of the ventilation system and did not find a problem in the month of November.

When the administrator was interviewed on 12/1/17 at 12:10 p.m., she stated that she was not sure how the ventilation system was turned off, but the controls are in the janitor's closet and maybe they were bumped when supplies were moved around.

On 12/01/17 at 12:15 p.m. the maintenance director provided his audit log showing that an audit was done on 11/6/17 and it read, "Exhaust Fans: Inspect exhaust fans for proper operation and clean if necessary done." When the maintenance director provided the audit log, he stated that it was a possibility that the nursing staff was turning the ventilation system off at night because they thought it made the building

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	12/01/2017

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
23240	Continued From page 28 colder. On 12/1/17 at 1:24 p.m. the odor on the north unit hall was gone. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	23240		