DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 26, 2021

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

RE: CCN: 245337
Cycle Start Date: March 18, 2021

Dear Administrator:

On April 26, 2021, we notified you a remedy was imposed. On May 24, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 19, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 18, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 8, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 8, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 19, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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April 26, 2021

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

RE: CCN: 245337
Cycle Start Date: March 18, 2021

Dear Administrator:

On April 8, 2021, we informed you that we may impose enforcement remedies.

On April 8, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 18, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 18, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 18, 2021.

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

payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 18, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Linden Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 18, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Jamie Perell, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 18, 2021 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. BUILDING _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/7/21, to 4/8/21, an abbreviated survey was completed at your facility by a surveyor from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5337050C (MN00071604) with a deficiencies cited at F558 and F656. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide equipment necessary to	F 558	A.) R1 discharged from the facility 4/6/2021.	5/19/21

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

Electronically Signed | 05/03/2021

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F 558	Continued From page 1 accommodate a resident's individualized needs for 1 of 1 resident (R1) reviewed for bariatric needs. Findings include: R1's admission Minimum Data Set (MDS) dated 3/10/21, indicated R1 was cognitively intact, with diagnoses which included dorsalgia (severe back pain), severe morbid obesity, spinal stenosis, neuromuscular dysfunction of bladder and paraplegia. R1 required extensive to total assistance with activities of daily living. Further, the MDS identified R1 had a functional limitation in range of motion to both sides of his upper and lower extremities. R1 used a wheelchair. R1's care plan dated 3/10/21, identified R1 had an alteration in mobility related to paraplegia. Interventions included transfer R1 via a Maxi-Lift (fulf-body mechanical lift) with assistance of two staff. During an interview on 4/7/21, at 2:19 p.m. family member (FM)-A stated there was not proper equipment for nursing or therapy staff to assist R1 because he "was a big man." FM-A stated the facility had not informed her they did not have the proper equipment to care for R1 and family would had transferred R1 out of the facility had they known. FM-A stated R1 was perfectly capable of using the toilet and R1 struggled because he had to lay in bed to have a bowel movement, in a pad, and staff did not come right away to clean him. FM-A stated prior to admission to the facility R1 was able to get to the toilet, was continent of bowel and used a condom catheter. FM-A stated as R1 was unable to sit on the toilet at the facility due to lack of equipment and R1 had started to	F 558	B.) Facility will complete a full house inventory of lift equipment availability, and function, in addition to a full house audit of current resident equipment needs, and that the current equipment is appropriate and/or available. C.) The facility utilizes the Facility Risk Assessment to determine what resources are necessary to care for residents needs, and what types of resident medical complexities we are capable of meeting at this facility. The facility reviews all new admission referrals for equipment needs prior to admission. The facility has owned equipment, and vendor relationships to rent additional equipment on short notice, which can be ordered and delivered same day or following day. The IDT / management team will be educated on the process for review of resident equipment needs, and how to procure needed equipment prior to new admission arrival, or upon resident condition changes. The nursing staff, therapy staff, and maintenance will be educated on a process for documenting necessary equipment repairs in TELS, and taking equipment out of service as needed until a replacement, or rental can be obtained. D.)The facility will complete a weekly audit of all new admissions in addition to a sample of 3 current residents weekly for 3 weeks, monthly x3, and quarterly thereafter, to review for current resident equipment needs are being met.	

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F 558	Continued From page 2 have problems with his bowels. FM-A stated facility's lack of proper equipment was a concern and lead to R1 not getting the walking and tolerance she had expected him to achieve during the short-stay. Review of R1's medical record revealed: --A Physical Therapy Treatment Encounter Note dated 3/11/21, at 3:23 p.m. indicated the maintenance director was to find a Sara lift (sit-to-stand mechanical lift) with appropriate weight support from another facility so R1 may "begin standing with assist." -A Physical Therapy Treatment Encounter Note dated 3/16/21, at 2:00 p.m. indicated staff attempted to get R1 into a power wheelchair with a Hoyer lift, however, they were "unable to locate appropriate sling for safety." -A Physical Therapy Treatment Encounter Note dated 3/17/21, at 2:38 p.m. indicated a physical therapy assistant (PTA) and certified occupational therapy assistant (COTA) provided "co treatment" and the bariatric Sara lift was not holding a charge, per maintenance notes. -A late entry nursing note dated 4/3/21, at 11:30 a.m. indicated R1 had requested to get up into his wheelchair using a Hoyer lift (mechanical lift) so he could have lunch with FM-A. R1 was updated he had not been up in a wheelchair throughout his stay. R1 was made aware it was a safety issue and the writer would speak with therapy regarding getting R1 up in his chair in the morning. During interview, on 4/7/21, at 11:21 a.m. licensed practical nurse (LPN)-A stated R1	F 558	The inventory of facility lift equipment, and records of preventative maintenance, and/or rental equipment will be audited weekly for three weeks and then monthly x3 and quarterly thereafter. Findings will be reported monthly to the QAPI team. DON responsible to report findings during QAPI meeting. The QAPI committee will determine the frequency and the duration of the audits.	

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F 558	Continued From page 3	F 558		

required total staff assistance with all activities of daily living.

During interview on 4/7/21, at 11:34 a.m. NA-B stated she worked with R1 a few times, and R1 required total assistance with all the cares and was incontinent of bowel. NA-B stated she never saw R1 out of the bed, even with a Hoyer lift. NA-B stated R1 did not like how the Hoyer lift made him feel. NA-B stated R1 verbalized he was angry as he wanted to get out of bed on 4/4/21, when FM-A came to the facility. NA-B confirmed R1 was told by staff they were unable get him out of bed because therapy had not approved due to safety.

During interview on 4/8/21, at 8:27 a.m. when asked how R1's toileting was completed, RN-A stated nursing depended on therapy to set the pace on how to transfer R1. RN-A stated after therapy assessed R1 they would let nursing know how to transfer him to the commode. RN-A stated R1 would let staff know when he needed to be changed after he had a bowel movement. RN-A stated the facility had a Hoyer lift, however, R1 experienced spasms which was a safety issue. RN-A stated therapy was not comfortable using a Hoyer lift and did not want to put nursing or therapy in danger. When asked if proper equipment had been obtained to accommodate R1's condition, RN-A stated the last communication she had with maintenance staff they were unable to get a Sara lift.

During interview on 4/7/21, at 3:08 p.m. the director of therapy (DOT) stated initially when R1 was admitted to the facility an available Sara lift did not match R1's weight safely. The DOT stated he thought the facility rented a bariatric

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F 558	Continued From page 4	F 558		

Sara lift which supported R1's weight. The DOT stated there was also a Hoyer lift which supported R1's weight and safe for R1 to use. The DOT stated R1 believed all facility lifts were not supportive of his weight and it was "demoralizing." The DOT stated R1 refused getting out of bed on many occasions because he did not want to use a Hoyer lift. The DOT stated challenges of working with R1 included not having parallel bars in the therapy room which supported R1. The DOT stated therapy had a conversation with the social service director that R1 was getting to a point they needed to do a referral to another facility with state-of-the-art equipment. The DOT acknowledged he was not aware the Sara lift had battery issues as documented by a therapy staff.

During interview on 4/7/21, at 1:45 p.m. PT stated R1 used a Hoyer lift to get up but did not like it because he was "scrunched up." PT stated when a Hoyer lift was not used to assist R1 sitting up, four staff were required for safety. PT stated there was a Hoyer lift available which accommodated R1's weight, but R1 refused to use it.

During a follow up interview on 4/8/21, at 9:14 a.m. PT stated they never used the Sara Lift to transfer R1 out of the bed, but instead used a walker. PT stated prior to admission, R1 was not using a lift for transfers which was probably a good thing. PT stated the biggest problem with R1 was getting him to sit on the edge of his bed, hence, they requested R1 to use the Hoyer. PT stated R1 did not like the Hoyer lift as it made him feel uncomfortable. PT confirmed, "If there would have been a Sara lift, it would have been used to practice standing longer with two people instead

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F 558	Continued From page 5	F 558		

of us pulling extra people to do the sit to stand with walker."

During interview on 4/8/21, at 8:06 a.m. the director of social services (DSS) stated a referral to another facility who had proper equipment did not occur because R1 and FM-A did not request it. The DSS stated "My understanding was we had the equipment [Sara lift]. I was not aware the battery was dying, and this would not be something they would have discussed with me."

During interview on 4/8/21, at 8:48 a.m. the DON stated she thought facility maintenance staff rented a Sara lift as the facility's Sara lift needed battery replaced. The DON stated she was not aware there was not proper equipment at the facility to provide care for R1. The DON stated a Sara lift was available at the facility, but she was not able to respond when asked why the lift was not being used for therapy and while toileting R1.

During interview on 4/8/21, at 10:30 a.m. a former maintenance employee, stated on 3/12/21, he went to work for a sister facility. He stated he brought a Sara lift from a sister facility to the facility R1 resided in. He stated he checked the Sara lift battery function when he brought it to the facility and verbalized it was working at that time. He stated no one from therapy or nursing communicated there was a concern with the Sara lift he had delivered. He stated assumed the equipment was properly functioning.

Facility policy titled Activities of Daily Living (ADLs), Supporting revised 3/18, directed, "Residents will provided with care, treatment and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).

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F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer and/or provide bathing, as preferred, for 1 of 1 resident (R1), who was dependent upon staff for bathing assistance, reviewed for choices. Findings include:	F 561	A.) R1 discharged from the facility 4/6/2021. B.) All current residents will be provided with opportunities for expressing resident choice, in regards to bathing preferences.	5/19/21

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F 561	Continued From page 7 R1's admission Minimum Data Set (MDS) dated 3/10/21, indicated R1 was cognitively intact and had diagnoses which included dorsalgia (severe back pain), severe morbid obesity, spinal stenosis and paraplegia. The MDS identified it was "somewhat important" for R1 to choose between a tub bath, shower, bed bath or sponge bath. R1 required extensive to total assistance with bathing. R1's care plan dated 4/5/21, identified R1 had a self-care deficit related to incomplete paraplegia and nerve damage. Interventions included providing extensive assistance with bathing. Review of R1's medical record revealed: -An undated facility bath schedule revealed R1 was scheduled baths on Tuesday mornings. -Review of the interdisciplinary notes and Weekly Skin Inspections indicated R1 had not received, or been offered, a tub bath, shower, bed bath or sponge bath on 3/9/21, and 3/23/21. R1 received bed baths on 3/16/21, and 3/30/21. R1 recieved a shower on 4/6/21. During an interview on 4/7/21, at 2:19 p.m. family member (FM)-A stated throughout R1's stay at the facility from 3/4/21, through 4/6/21, he only received a shower on 4/6/21, which was a few hours before he discharged from the facility. FM-A stated R1 told her staff gave him bed baths because he was exposed to COVID-19 and was quarantined. FM-A stated R1 told her he did not feel clean, and smelled like himself. FM-A stated she visited the facility and R1 smelled. FM-A stated she brought forward concerns to staff related to R1's skin, ears and nails not being kept clean. FM-A stated she assisted R1 trim his nails	F 561	The facility will complete full house bathing preference audit. The policy for COVID-19 quarantine was reviewed and does indicate process for providing bathing to residents who are in quarantine status at the facility, should be provided with bathing per their preferences. C.) All IDT/management and nursing staff will be educated to the procedure of interviewing resident for bathing preference, and also providing bathing to residents according to their preferences within the guidelines of the isolation/precaution status for COVID-19 or other infections, if applicable. D.) All new admissions, and sample of 3 current residents will be audited/interviewed weekly x 3 weeks on their shower/bath preference satisfaction, then monthly for 3 months, and quarterly thereafter. DON or designee will report findings to QAPI. The scope and frequency of audits will be revised according to recommendations from QAPI.	

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	245337	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 561	Continued From page 8	F 561		

During interview on 4/7/21, at 11:05 a.m. nursing assistant (NA)-A stated she assisted R1 with cares during his short-stay. NA-A stated R1 required assistance with all activities of daily living.

During interview, on 4/7/21, at 11:21 a.m. licensed practical nurse (LPN)-A stated R1 required total assistance with all activities of daily living.

During interview on 4/7/21, at 11:34 a.m. NA-B stated she worked with R1 a few times and R1 required total assistance with all cares and was incontinent of bowel.

During interview on 4/7/21, at 12:14 p.m. RN-A stated R1 was given bed baths because he was on back-to-back quarantines due to COVID-19 exposure. RN-A stated R1's quarentine ended on 3/23/21, and R1's scheduled bath day were on Tuesday mornings. RN-A verified R1 was not offered, nor received, a tub bath, shower, or bed bath on 3/9/21 and 3/23/21. RN-A stated R1 received bed baths on 3/16/21 and 3/30/21. RN-A confirmed R1 should had received a showers on 3/23/21 and 3/30/21.

During interview on 4/8/21, at 8:48 a.m. the DON stated she had started educating staff on making sure they provided residents with showers once they were done with COVID-19 quarantine the next day.

Facility policy title Activities of Daily Living (ADLs), dated 3/18, directed "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain

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F 561	Continued From page 9 good nutrition, grooming, and personal and oral hygiene.	F 561		

Electronically delivered
April 26, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: SNH911

Dear Administrator:

The above facility was surveyed on April 7, 2021 through April 8, 2021 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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 immediately contact:

Jamie Perell, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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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: On 4/5/21, to 4/6/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be	2 000		

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2 000	Continued From page 1 completed. The following complaints were found to be SUBSTANTIATED: H5337050C (MN00071604), with licensing orders issued at 0560 and 1810. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents. 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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. 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	2 000		

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2 000	Continued From page 2 MINNESOTA STATE STATUTES/RULES.	2 000		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide equipment necessary to accommodate a resident's individualized needs for 1 of 1 resident (R1) reviewed for choices. Findings include: R1's admission Minimum Data Set (MDS) dated 3/10/21, indicated R1 was cognitively intact, with diagnoses which included dorsalgia (severe back pain), severe morbid obesity, spinal stenosis, neuromuscular dysfunction of bladder and paraplegia. R1 required extensive to total assistance with activities of daily living. Further, the MDS identified R1 had a functional limitation in range of motion to both sides of his upper and lower extremities. R1 used a wheelchair. R1's care plan dated 3/10/21, identified R1 had an alteration in mobility related to paraplegia. Interventions included transfer R1 via a Maxi-Lift	21810	corrected	5/19/21

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21810	Continued From page 3 (fulf-body mechanical lift) with assistance of two staff. During an interview on 4/7/21, at 2:19 p.m. family member (FM)-A stated there was not proper equipment for nursing or therapy staff to assist R1 because he "was a big man." FM-A stated the facility had not informed her they did not have the proper equipment to care for R1 and family would had transferred R1 out of the facility had they known. FM-A stated R1 was perfectly capable of using the toilet and R1 struggled because he had to lay in bed to have a bowel movement, in a pad, and staff did not come right away to clean him. FM-A stated prior to admission to the facility R1 was able to get to the toilet, was continent of bowel and used a condom catheter. FM-A stated as R1 was unable to sit on the toilet at the facility due to lack of equipment and R1 had started to have problems with his bowels. FM-A stated facility's lack of proper equipment was a concern and lead to R1 not getting the walking and tolerance she had expected him to achieve during the short-stay. Review of R1's medical record revealed: --A Physical Therapy Treatment Encounter Note dated 3/11/21, at 3:23 p.m. indicated the maintenance director was to find a Sara lift (sit-to-stand mechanical lift) with appropriate weight support from another facility so R1 may "begin standing with assist." -A Physical Therapy Treatment Encounter Note dated 3/16/21, at 2:00 p.m. indicated staff attempted to get R1 into a power wheelchair with a Hoyer lift, however, they were "unable to locate appropriate sling for safety." -A Physical Therapy Treatment Encounter Note	21810		

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21810	Continued From page 4 dated 3/17/21, at 2:38 p.m. indicated a physical therapy assistant (PTA) and certified occupational therapy assistant (COTA) provided "co treatment" and the bariatric Sara lift was not holding a charge, per maintenance notes. -A late entry nursing note dated 4/3/21, at 11:30 a.m. indicated R1 had requested to get up into his wheelchair using a Hoyer lift (mechanical lift) so he could have lunch with FM-A. R1 was updated he had not been up in a wheelchair throughout his stay. R1 was made aware it was a safety issue and the writer would speak with therapy regarding getting R1 up in his chair in the morning. During interview, on 4/7/21, at 11:21 a.m. licensed practical nurse (LPN)-A stated R1 required total staff assistance with all activities of daily living. During interview on 4/7/21, at 11:34 a.m. NA-B stated she worked with R1 a few times, and R1 required total assistance with all the cares and was incontinent of bowel. NA-B stated she never saw R1 out of the bed, even with a Hoyer lift. NA-B stated R1 did not like how the Hoyer lift made him feel. NA-B stated R1 verbalized he was angry as he wanted to get out of bed on 4/4/21, when FM-A came to the facility. NA-B confirmed R1 was told by staff they were unable get him out of bed because therapy had not approved due to safety. During interview on 4/8/21, at 8:27 a.m. when asked how R1's toileting was completed, RN-A stated nursing depended on therapy to set the pace on how to transfer R1. RN-A stated after therapy assessed R1 they would let nursing know how to transfer him to the commode. RN-A	21810		

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21810	Continued From page 5	21810		

stated R1 would let staff know when he needed to be changed after he had a bowel movement. RN-A stated the facility had a Hoyer lift, however, R1 experienced spasms which was a safety issue. RN-A stated therapy was not comfortable using a Hoyer lift and did not want to put nursing or therapy in danger. When asked if proper equipment had been obtained to accommodate R1's condition, RN-A stated the last communication she had with maintenance staff they were unable to get a Sara lift.

During interview on 4/7/21, at 3:08 p.m. the director of therapy (DOT) stated initially when R1 was admitted to the facility an available Sara lift did not match R1's weight safely. The DOT stated he thought the facility rented a bariatric Sara lift which supported R1's weight. The DOT stated there was also a Hoyer lift which supported R1's weight and safe for R1 to use. The DOT stated R1 believed all facility lifts were not supportive of his weight and it was "demoralizing." The DOT stated R1 refused getting out of bed on many occasions because he did not want to use a Hoyer lift. The DOT stated challenges of working with R1 included not having parallel bars in the therapy room which supported R1. The DOT stated therapy had a conversation with the social service director that R1 was getting to a point they needed to do a referral to another facility with state-of-the-art equipment. The DOT acknowledged he was not aware the Sara lift had battery issues as documented by a therapy staff.

During interview on 4/7/21, at 1:45 p.m. PT stated R1 used a Hoyer lift to get up but did not like it because he was "scrunched up." PT stated when a Hoyer lift was not used to assist R1 sitting up, four staff were required for safety. PT stated

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21810	Continued From page 6	21810		

there was a Hoyer lift available which accommodated R1's weight, but R1 refused to use it.

During a follow up interview on 4/8/21, at 9:14 a.m. PT stated they never used the Sara Lift to transfer R1 out of the bed, but instead used a walker. PT stated prior to admission, R1 was not using a lift for transfers which was probably a good thing. PT stated the biggest problem with R1 was getting him to sit on the edge of his bed, hence, they requested R1 to use the Hoyer. PT stated R1 did not like the Hoyer lift as it made him feel uncomfortable. PT confirmed, "If there would have been a Sara lift, it would have been used to practice standing longer with two people instead of us pulling extra people to do the sit to stand with walker."

During interview on 4/8/21, at 8:06 a.m. the director of social services (DSS) stated a referral to another facility who had proper equipment did not occur because R1 and FM-A did not request it. The DSS stated "My understanding was we had the equipment [Sara lift]. I was not aware the battery was dying, and this would not be something they would have discussed with me."

During interview on 4/8/21, at 8:48 a.m. the DON stated she thought facility maintenance staff rented a Sara lift as the facility's Sara lift needed battery replaced. The DON stated she was not aware there was not proper equipment at the facility to provide care for R1. The DON stated a Sara lift was available at the facility, but she was not able to respond when asked why the lift was not being used for therapy and while toileting R1.

During interview on 4/8/21, at 10:30 a.m. a former maintenance employee, stated on 3/12/21, he

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21810	Continued From page 7 went to work for a sister facility. He stated he brought a Sara lift from a sister facility to the facility R1 resided in. He stated he checked the Sara lift battery function when he brought it to the facility and verbalized it was working at that time. He stated no one from therapy or nursing communicated there was a concern with the Sara lift he had delivered. He stated assumed the equipment was properly functioning. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON), or designee, could develop, review, and /or revise policies and procedures to ensure all residents have personal care based on individual needs. The DON, or designee, could educate all appropriate staff. The DON, or designee, could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative	21830		5/19/21

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21830	Continued From page 8	21830		

chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family

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	00948	A. BUILDING: _____ B. WING _____	C 04/08/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 9 member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to offer and/or provide bathing, as preferred, for 1 of 1 resident (R1), who was	21830	corrected	

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21830	Continued From page 10 dependent upon staff for bathing assistance, reviewed for choices. Findings include: R1's admission Minimum Data Set (MDS) dated 3/10/21, indicated R1 was cognitively intact and had diagnoses which included dorsalgia (severe back pain), severe morbid obesity, spinal stenosis and paraplegia. The MDS identified it was "somewhat important" for R1 to choose between a tub bath, shower, bed bath or sponge bath. R1 required extensive to total assistance with bathing. R1's care plan dated 4/5/21, identified R1 had a self-care deficit related to incomplete paraplegia and nerve damage. Interventions included providing extensive assistance with bathing. Review of R1's medical record revealed: -An undated facility bath schedule revealed R1 was scheduled baths on Tuesday mornings. -Review of the interdisciplinary notes and Weekly Skin Inspections indicated R1 had not received, or been offered, a tub bath, shower, bed bath or sponge bath on 3/9/21, and 3/23/21. R1 received bed baths on 3/16/21, and 3/30/21. R1 recieved a shower on 4/6/21. During an interview on 4/7/21, at 2:19 p.m. family member (FM)-A stated throughout R1's stay at the facility from 3/4/21, through 4/6/21, he only received a shower on 4/6/21, which was a few hours before he discharged from the facility. FM-A stated R1 told her staff gave him bed baths because he was exposed to COVID-19 and was quarantined. FM-A stated R1 told her he did not feel clean, and smelled like himself. FM-A stated she visited the facility and R1 smelled. FM-A	21830		

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21830	Continued From page 11	21830		

stated she brought forward concerns to staff related to R1's skin, ears and nails not being kept clean. FM-A stated she assisted R1 trim his nails

During interview on 4/7/21, at 11:05 a.m. nursing assistant (NA)-A stated she assisted R1 with cares during his short-stay. NA-A stated R1 required assistance with all activities of daily living.

During interview, on 4/7/21, at 11:21 a.m. licensed practical nurse (LPN)-A stated R1 required total assistance with all activities of daily living.

During interview on 4/7/21, at 11:34 a.m. NA-B stated she worked with R1 a few times and R1 required total assistance with all cares and was incontinent of bowel.

During interview on 4/7/21, at 12:14 p.m. RN-A stated R1 was given bed baths because he was on back-to-back quarantines due to COVID-19 exposure. RN-A stated R1's quarentine ended on 3/23/21, and R1's scheduled bath day were on Tuesday mornings. RN-A verified R1 was not offered, nor received, a tub bath, shower, or bed bath on 3/9/21 and 3/23/21. RN-A stated R1 received bed baths on 3/16/21 and 3/30/21. RN-A confirmed R1 should had received a showers on 3/23/21 and 3/30/21.

During interview on 4/8/21, at 8:48 a.m. the DON stated she had started educating staff on making sure they provided residents with showers once they were done with COVID-19 quarantine the next day.

Facility policy title Activities of Daily Living (ADLs), dated 3/18, directed "Residents who are unable

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21830	Continued From page 12 to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. SUGGESTED METHOD OF CORRECTION: The DON, or designee, could develop policies and procedures regarding resident choices, educate staff, and conduct audits to ensure identified family preferences for cares and routines are followed by staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		