

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 14, 2020

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

RE: CCN: 245342

Cycle Start Date: September 29, 2020

Dear Administrator:

On September 29, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant 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:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 28, 2020.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 28, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 28, 2020.

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:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 November 28, 2020, 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 Greeley Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 28, 2020. 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), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, 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: susanne.reuss@state.mn.us

Office: (651) 201-3793

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 March 29, 2021 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

PRINTED: 10/28/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245342	B. WING	B. WING		C 09/29/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082	03/.	29/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 00	00			
F 000	was conducted on a your facility by the Mealth to determine Preparedness regulacility is IN compliance of the CMS-28 Although no plan of required the facility electronic document INITIAL COMMENT On September 28, survey was comple complaint investigation NOT to be in comple complaint investigation NOT to be in complete at your facility by the Health to determine Infection Control. The compliance. Because you are ensignature is not required of the CMS-28. The facility's plan of the CMS-28.	arrolled in ePOC, your uired at the bottom of the first 567 form. If correction is required, it is acknowledge receipt of the ack	F 00	00			
ADODATO:	as your allegation o Department's accep	f compliance upon the otance. Upon receipt of an		TITLE		(X6) DATE	

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

(X6) DATE

Electronically Signed

10/23/2020

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.

			l ` ′		E SURVEY IPLETED	
		245342	B. WING			C 29/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082	1 03/	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 000	acceptable electron facility will be condu	ic POC, a revisit of your locted to validate that loce with the regulations has	FC	000		
	Notify of Changes (CFR(s): 483.10(g)(F 5	580		10/20/20
	(i) A facility must im consult with the resconsistent with his or representative(s) w (A) An accident involves and physician intervention (B) A significant characteristic and physician intervention (B) A significant characteristic and physician intervention (B) A significant characteristic and physician in either lifectinical complication (C) A need to alter the aneed to discontinut treatment due to adcommence a new for (D) A decision to transistent from the fall \$483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatic available and prophysician. (iii) The facility must resident and the results when there is-	olving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lith, mental, or psychosocial chreatening conditions or as); reatment significantly (that is, are an existing form of verse consequences, or to orm of treatment); or ansfer or discharge the cility as specified in otification under paragraph (g) and, the facility must ensure that ation specified in §483.15(c)(2) wided upon request to the sident representative, if any, and or roommate assignment				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER.		IPLE CONSTRUCTION NG	COMI	(X3) DATE SURVEY COMPLETED	
		245342	B. WING _			29/2020	
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CO 313 SOUTH GREELEY STREET STILLWATER, MN 55082			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	(B) A change in res State law or regular (e)(10) of this sectic (iv) The facility musupdate the address phone number of the representative(s). §483.10(g)(15) Admission to a conthat is a composite §483.5) must disclosite physical configurations that compart, and must spectroom changes betworder §483.15(c)(9). This REQUIREMED by: Based on document facility failed to report in condition for 1 of condition change of weakness and new the facility to inform decline resulted in limit with a critical low he blood cells that carrithe rest of the body transfusions. Findings include: R1's initial admission dated 8/24/20, indicated many condition in the condition conditions.	ident rights under Federal or cions as specified in paragraph on. It record and periodically (mailing and email) and he resident Inposite distinct part. A facility distinct part (as defined in ose in its admission agreement ration, including the various orise the composite distinct cify the policies that apply to oveen its different locations). In it is not met as evidenced in treview and interview, the cort a significance of a change in a significance of a change in a significance. The failure of in the physician of a three day that has a significance of a change in a significance. The failure of in the physician of a three day that has a significance of a change in a significance of	F 58	Resident (R1) was discharge hospital and did not return to As a result, we were not able the resident sadmitting diag a family member that diagnos a CVA. Staff sdocumented did not support that diagnosis Nursing staff were re-educate importance of: -monitoring for changes in recondition -Notification of MD/NP with a information -Improving assessment and documentation skills -Assess, validate and docum information reported to them staff member with reporting telestening to and sharing with	the facility. to validate gnosis. It was sed him with information s. ed on the sident Il pertinent ent by any other ools		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	` ´COM	(X3) DATE SURVEY COMPLETED	
	245342	B. WING		1	C 29/2020	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY LL	С		STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082	1 0011		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
indicated a lab value deciliter (normal value physician ordered Ratevaluation and blood admitted to the hospin on 8/17/20 with a Hg transfusions. R1's IPN dated 9/14/and bladder for the mindependently." R1's IPN dated 9/20/nurse (RN-A) docum assistant registered] resident is feeling we up assessment or vital R1's IPN's dated 9/20/documented, "Pt info to visit at the window stroke earlier in the coweakness. Stroke as [F-A's] request, no Sistroke noted. Pt had temporal artery, tempauxiliary. Ice pack apcontinue to monitor. 20 68, 93 RA [room at the stool color. R1's IPN's dated 9/2 Writer [RN-B] called a change in conditior chest X-ray and lab were as the stool color.	w of interdisciplinary dated 8/13/20, at 11:22 a.m. for a Hgb of 6.1 grams per e 13.8 to 17.2 g/dL) and the to be sent to the hospital for transfusion. R1 was ital and returned to the facility	F 580	families wishes for hospitalization Facility Policy, Change in Condit reviewed and remains current. The DON or designee will reviewed and assessment forms 3x for complete and accurate docut The DON or designee will random interview NAR so obtain infort they have communicated to nurthen review the chart for appropt documentation. The DON or dewill audit all hospital discharge cappropriate assessment, MD/NI notification documentation. Audits will be conducted weekly weeks, every other week for 2 mand then QAPI will determine fur auditing schedule thereafter and provide redirection/recommendated based on existing audits. LNHA/designee is responsible from plance	v progress v progress substitutions, was weekly mentation. wally mation ses and riate esignee tharts for p, family for 6 months ture l will ations		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED C	
		245342	B. WING _		09	/ 29/2020	
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP COI 313 SOUTH GREELEY STREET STILLWATER, MN 55082			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	PRN [whenever ne syrup administered restlessness noted cup of water for ora had urinal on mouth removed it from monot address dark si with new incontiner. R1's IPN dated 9/2 writer received a cawas 4.7 g/dL which who order R1 to be via EMS (emergent admitted to the host critically low hemogotransfusions. When interviewed stated on 9/20/20, 39:00 p.m. through to closed window visit [RN-B] and told [RN a stroke, why was to needed to send [Ranurse to do a stroke [R1] was so weak a condition. The nurse be concerned about told that nurse to so and they did not do facility because of the big change [R1] was to the hospital. I lef nurse wouldn't liste	cessary] Tylenol and cough. Pt increased anxiety and asking for ice chips and using all swabs for drinking. Pt also h, writer intervened and buth," The documentation did tools or a three day decline nce. 1/20, at 9:14 a.m. indicated the all from the lab that R1's Hgb was reported to the physician esent to the emergency room by medical services). R1 was epital on 9/21/20, with dx of globin and required blood on 9/25/20, at 2:17 p.m. F-A at sometime between 8:30 - he window during an outside to the physician and required blood on 9/25/20, at 2:17 p.m. F-A at sometime between 8:30 - he window during an outside to the window during an outside to the left eye drooping and they are left eye drooping and they are told me there was nothing to the told me	F 58	30			
	[R1] was so weak a condition. The nurse be concerned about told that nurse to so and they did not do facility because of big change [R1] was the nurse did not list to the hospital. I left nurse wouldn't liste something was verme [R1] had another	and this is a big change in the told me there was nothing to at and everything was fine. I send [R1] 911 to the hospital it. We aren't allowed in the Covid but I knew there was a as too weak to even talk and sten when I said send [R1] 911 to crying I was so upset that the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245342	B. WING			C / 29/2020	
NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY LLC			,	STREET ADDRESS, CITY, STATE, ZIP C 313 SOUTH GREELEY STREET STILLWATER, MN 55082			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	listen to me that so so upset" When interviewed on ursing assistant (Nencouragement to the last three days went down hill, [R1] the urinal, [R1's] stodark, I reported it to iron deficiency, I rewere aware of his stor [R1]." When interviewed ocertified nurse practice and on the color of the physician the fact the past three days esplethargy, incontiner color. Furthermore, the information from pertaining to the charsistant of the color of the pertaining to the charge assistant of the color of the pertaining to the charge assistant of the charge and the color of the pertaining to the charge assistant of the charge assistant	s and the nurse would not mething was very wrong. I was on 9/28/20, at 10:55 a.m. NA-A) stated, "[R1] needed get up and get motivated, [R1] wasn't walking, the strength was incontinent, would spill bols were dark, usually not that [RN-A] but was told that was ported the dark stools, nurses stools, they said it was normal on 9/28/20, at 1:15 p.m. titioner (CNP) indicated [R1] a severe stroke in July, seen by nultiple anticoagulation at that cated iron supplements could the stool but it would have the nursing assistant the nursing assistant seen a deterioration for the pecially weakness, increased and stool darkening in the CNP stated, "In light of in the nursing assistant ange in bowel movement color	F 5	,			
	evaluation, it would the NP of those fact sent [R1] to the ER When interviewed of verified [NA-A] report not feeling good, and	he family insisting on an have been prudent to inform ts and I probably would have for evaluation right away." on 9/28/20, at 1:24 p.m. RN-A orted that [R1] was weak and had being incontinent but did not orted the stool was darker than					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245342	B. WING _		1	C / 29/2020
	NAME OF PROVIDER OR SUPPLIER THE ESTATES AT GREELEY LLC			STREET ADDRESS, CITY, STATE, ZIP CO 313 SOUTH GREELEY STREET STILLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	when interviewed of that the NA-A report change in [R1's] conhave prompted the diagnosis of anemia. August which requitransfusions would physician should have been reported. When interviewed of the family concerns information the nursimportant for the ormade aware of to hin condition of a paid. When interviewed overified speaking with ewindow and indiassessment and everified speaking with the onot telling the physibe evaluated immethe vital signs were better to find out whit were before sending on call physician was	on 9/28/20, at 1:32 p.m. the (DON) verified now knowing ted 9/20/20, at 1:08 p.m. the ndition to the nurse should nurse to evaluate the a and the Hgb of 6.1 g/dL in red hospitalization for blood be information the on call ave been made aware of. ON verified the family wishes ue to stroke concerns should I to the physician. on 9/28/20, at 1:57 p.m. rified importance to listen to a and as a team the sing assistant shared was a call physician to have been elp in determining the change	F 58			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING		COM	E SURVEY PLETED
		245342	B. WING			C 09/29/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 313 SOUTH GREELEY STREET STILLWATER, MN 55082	ODE	031.	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD E	BE	(X5) COMPLETION DATE
	Document review or Resident Condition. facility shall notify the physician health caresident condition and Nurse will notify the physician/healthcare been: A significant or physical, emotional alter the resident's significantly; A need hospital/treatment or physician/healthcare make detailed obse and pertinent inform Baseline Care Plan CFR(s): 483.21(a)(1) The fill implement a baseline S483.21(a) (1) The fill implement a baseline that includes the inseffective and person that meet profession The baseline care profession The baseline care profession. (ii) Include the minimal necessary to prope including, but not lirus (A) Initial goals base (B) Physician order. (C) Dietary orders. (D) Therapy services. (E) Social services.	of the policy titled, Change in a dated 6/2019, read, The seresident/representative and reprovider of changes in the and/or status. 1. The licensed resident's reprovider when there has change in the resident's remedical treatment of the transfer the resident to a center. 2. Prior to notifying the reprovider, the nurse will revations and gather relevant anation for the provider. 1)-(3) Insive Person-Centered Care reached are plan for each resident structions needed to provide not each resident and standards of quality care. Dan mustathin 48 hours of a resident mustath of the provider of the resident mustath of the provider of the resident of the provide of the provide of the resident of the provide of t	F 5				10/20/20
	(i) i AOART IECOIII	ппопаціон, п аррпоавіс.					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245342	B. WING			09/2	29/2020
	PROVIDER OR SUPPLIER	LC		3	TREET ADDRESS, CITY, STATE, ZIP CODE 13 SOUTH GREELEY STREET TILLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	comprehensive car care plan if the com (i) Is developed with admission. (ii) Meets the require (b) of this section (c) this section). §483.21(a)(3) The resident and their resident and	facility may develop a e plan in place of the baseline aprehensive care planthin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the epresentative with a summary e plan that includes but is not of the resident. The resident's medications and and treatments to be a facility and personnel acting ility. Formation based on the details we care plan, as necessary. Note is not met as evidenced and review and interview, the elop a baseline individualized as a known diagnosis of esidents (R1) reviewed for	F6	555	Resident (R1) was discharged to the hospital and did not return to the farmation of the far	cility. nt e been oblem	
	included anemia, c (CVA) and malnutri	erebral vascular accident			We will continue to develop a basic plan within 48 hours of admission. provide additional training to license nurses regarding appropriate care	We ed	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		245342	B. WING			29/2020
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP COD 313 SOUTH GREELEY STREET STILLWATER, MN 55082		20,2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 655	progress notes (IPN indicated a lab valu oxygen-transport models) of 6.1 grams 13.8 to 17.2 g/dL) at to be sent to the hot transfusion. R1 was hospital 8/13/20, ar 8/17/20 with a Hgb transfusions. R1's care plan review with interventions or recent blood transfusion would care for R1 to watch and the second progress of the last three days went down hill, [R1] the urinal, [R1's] sto dark, I reported it to iron deficiency, I rewere aware of his second for [R1]." When interviewed of the urinal of the last three days went down hill, [R1] the urinal, [R1's] sto dark, I reported it to iron deficiency, I rewere aware of his second for [R1]."	N) dated 8/13/20, at 11:22 a.m. e for a Hgb (iron-containing letalloprotein in the red blood per deciliter (normal value and the physician ordered R1 spital for evaluation and blood is re-admitted back to the ad returned to the facility on of 8.2 g/dL post blood ew failed to address anemia r to address the low Hgb and	F 65	development, including necess updates after readmission. An audit tool was developed to hour care plans to ensure they current problems, goals and in Audits will be completed within of admission by the DON or do Audits will be conducted week weeks, every other week for 2 and then QAPI will determine auditing schedule thereafter as provide redirection/recommen based on existing audits. LNHA/designee is responsible.	o review 48 contain terventions. o 72 hours esignee ly for 6 months future nd will dations	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245342	B. WING		1	C 29/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082	1 09/	29/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 880 SS=E	6/2019, addressed developed within 48 The interdisciplinary healthcare practition baseline care needs initial goals of the renursing orders, dieta and social services policy read, The goal individualized care pareas and their cauthat are targeted and Infection Prevention CFR(s): 483.80(a)(f) The facility must estinfection prevention designed to provide comfortable environd development and tradiseases and infection program. The facility must estand control program a minimum, the follows 483.80(a)(1) A systematical provided in the follows 483.80(a)(1) A systematical providing investigation and communicable staff, volunteers, visiproviding services that are targement based in the follows are providing services that are targement based in the follows are providing services that are targement based in the follows are provided to provided t	re Planning, dated, revision a baseline care plan would be a hours of admission and read, a team will review the ner's orders and implement is, including such things as; esident, physician orders, ary orders, therapy services, as needed." Furthermore the all of the person centered, plan is to identify problem is ses, and develop interventions and meaningful to the resident. In & Control 1)(2)(4)(e)(f) control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention in (IPCP) that must include, at powing elements: Item for preventing, identifying, and controlling infections diseases for all residents, sitors, and other individuals	F 6	55		11/4/20

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			COM	E SURVEY IPLETED
	245342	B. WING			1	29/2020
	rc		3	13 SOUTH GREELEY STREET	,	
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
scepted national signature accepted national signature and limited to (i) A system of surversible communical infections before the persons in the facili (ii) When and to who communicable disereported; (iii) Standard and trous to be followed to proving the facili (iii) When and how it resident; including the facili (iii) A system of the facili (iii) Standard and trous to be followed to proving the facility of th	en standards, policies, and program, which must include, oceillance designed to identify able diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a put not limited to: curation of the isolation, infectious agent or organism that the isolation should be the sible for the resident under the coes under which the facility by ess with a communicable skin lesions from direct into their food, if direct it the disease; and ine procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the aken by the facility.	F8	380			
infection.	p and oproduction					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From paraccepted national states of the but are not limited to the persons in the facility (ii) A system of surve possible communication infections before the persons in the facility (iii) When and to who communicable disereported; (iii) Standard and the tobe followed to proviv) When and how it resident; including It (A) The type and dudepending upon the involved, and (B) A requirement to least restrictive postircumstances. (v) The circumstances (v) The circumstances (v) The circumstance infected contact with resider contact will transmit (vi) The hand hygier by staff involved in \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must hall transport linens so	PROVIDER OR SUPPLIER ATES AT GREELEY LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 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. \$483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	PROVIDER OR SUPPLIER ATES AT GREELEY LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 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 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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	A BUILDING 245342 B. WING 245342 B. WING PROVIDER OR SUPPLIER ATES AT GREELEY LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 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 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. \$483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	PROVIDER OR SUPPLIER ATES AT GREELEY LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FROM 1 Standard and transmission-based precautions to be followed to prevent spread of infections; (ii) 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 problib employees with a communicable disease or infections agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible from fired to: (vi) The circumstances under which the facility must prohibit employees with a communicable 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. \$483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	ROVIDER OR SUPPLIER 245342 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082 SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 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 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 contac

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245342	B. WING _		I	C 29/2020	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		23/2020	
THE EST	ATES AT GREELEY I	LC		313 SOUTH GREELEY STREET STILLWATER, MN 55082			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From pa	age 12	F 88	80			
	IPCP and update the This REQUIREMENT by: Based on observation failed to ensure state when providing directly for 5 of 7 residents. Failed to ensure state protective equipment prevent the potential resident (R12) who precautions. In additional screening and survice COVID-19 symptom recommended by Coving the Regular to the state of the state o	duct an annual review of its neir program, as necessary. NT is not met as evidenced tion and interview the facility ff were wearing eye protection ect care and/or in close contact (R8, R9, R10, R11, R13). aff removed personal ent (PPE) in a manner to all spread of infection for 1 of 1 or required contact and droplet lition, failed to ensure active reillance of staff for potential ens after entering the facility as Centers for Disease Control te Health department		PERSONAL PROTECTIVE (PPE) Residents R8, R9, R10, R11, received cares with staff weather PPE. R12 has received care removing personal protective (PPE) in a manner to prevent spread of infection while on a droplet precautions. Staff have ducated to be wearing PPE and proper Donning and Doffacility to include eye protection—COVID-19 residents.	R13 have aring proper with staff equipment the potential contact and we been for all cares fing in the		
	conference the dire were no resident or facility however the re-admitting resider residents were put a negative Covid te-7:27 a.m. during the nurse (RN)-E was a R11 in the room adder goggles were administration she -At 7:28 a.m. survet the nursing station	ne tour of the facility, registered observed standing right next to ministering medications and observed on top of her head.		POLICIES/PROCEDURES/S CHANGES: The Quality Assurance and F Improvement Committee cor cause analysis (RCA) to ider problem(s) that resulted in the and developed intervention to recurrence. The facility COVID policy was and is current to CDC and M guidelines, specifically to: "policies and procedures donning/doffing PPE during (with current guidelines to incistandard of care, contingenciare and standard care.	Performance nducted a root atify the is deficiency or prevent s reviewed DH current for COVID-19 lude crisis		

PRINTED: 10/28/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245342	B. WING			09/2	29/2020
NAME OF PROVIDER THE ESTATES AT		LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
goggle: -At 7:29 room, s she app to the r -At 7:39 coming hallway office, a office a the time down th nursing DA was -At 7:39 enter th came of nursing vendor RN-C le screen was ob the Sou bathroo been se -At 7:42 bathroo betwee and still sympto -At 7:43 driver a screen provide	er staff were is properly. Pa.m. RN-Estill with her proached Right in the proached Right in the proached Right in the proached Right in the past the nutral was not remind was not remind and into the past the nutral was not remind a station. RN driver and soft paper to Right in the pape	not reminded to apply the was observed to go into R9's goggles on top of her head as of then came out and returned art by the nursing station. The etary aide (DA) was observed ditchen, walked down the ersing station, nurse manager director of nursing (DON)'s wearing any eye protection at m. DA was observed going ack to the kitchen past the ere other staff stood, however ed to apply eye protection. The dord driver was observed to ough the back door, then out hallway and approached the expoke to him as he handed a export that the exponent of the exponen	F	380	" policy and procedure for source control masks. " policies regarding standard and transmission based precautions an revise as needed. TRAINING/EDUCATION: The facility provide training for the Infection Preventionist, the Director Nursing, all staff providing direct caresidents, and all staff entering resirooms, whether it be for residents dietary needs or cleaning and maintenance services. The training cover standard infection control praincluding, transmission-based precautions, appropriate PPE use, donning and doffing of PPE. The training will include competence testing of staff and this must be documented. " Residents and their representativill receive education on the facility Infection Prevention Control Programelated to them and to the degree possible/consistent with resident scapacity. MONITORING/AUDITING: " The Director of Nursing, the Inference of the preventionist, and other facility lead will conduct audits of donning/doffing with Transmission Based Precaution Droplet precautions. " The Director of Nursing, Infection Preventionist, and other facility lead will conduct routine audits on all shull conduct routine audits of all shull research research	d d d d d d d d d d d d d d d d d d d	

PRINTED: 10/28/2020 FORM APPROVED OMB NO. 0938-0391

OLIVILI	TO TOTA MEDIONIA	A MEDICAID SERVICES			01	VID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245342	B. WING			09/2	29/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	ıc			13 SOUTH GREELEY STREET		
				S	STILLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	approached the me-At 7:49 a.m. to 7:5 preparing R10's me RN-E carried the mwearing the goggle then approached R wheelchair and was approximately a ha administered the meye protection. -At 8:25 a.m. two mobserved entering the door with their gogg they approached the distance of ten feet providers pulled the and walked down the Unit (TCU) hallway to the nursing static	administered insulin, and then edication cart. 1 a.m. RN-E was observed edications and at 7:54 a.m. edications into R10's room still so on top of her head. RN-E 10 who was up seated in the sobserved standing If foot away as she edications, without wearing decical providers were the facility through the side gles on top of their heads. As the surveyor approximately a within the facility, both a goggles to cover their eyes the South Transitional Care past multiple resident rooms on which was approximately	F 8	380	weekly for one week once compliar met. Audits will continue until 100% compliance is met on source control masking for staff, visitors and resid." The Director of Nursing, Infection Preventionist, and other facility lead will conduct real time audits on all aerosolized generating procedures ensure PPE is in use. "The Director of Nursing, Infection Preventionist, or designee will review results of audits and monitoring with Quality Assurance Program Improving QAPI) program. and monitoring with Quality Assurance Program Improving QAPI) program.	ents. on dership to on w the h the ement th the	
	RN-FAt 8:29 a.m. RN-D facility and as she as observed applied the mask. F past the nursing sta office without being and was observed and came back to then was screened -At 10:35 a.m. licenwas screening and was observed glasses as her gog chestAt 10:42 a.m. LPN	was observed entering the approached the nursing station reaching for a mask and RN-D then was observed going ation and the nurse manager screened for Covid symptoms clocking in, then turned around he nursing station and was by RN-F. Is sed practical nurse (LPN)-B ther staff at the nursing station wearing regular reading gles were hanging on her			All staff have active screening and surveillance of staff for potential COVID-19 symptoms after entering facility as recommended by Center Disease Control (CDC) and the State Health department guidelines. POLICIES/PROCEDURES/SYSTE CHANGES: The Quality Assurance and Perforn Improvement Committee conducted cause analysis (RCA) to identify the problem(s) that resulted in this definant developed intervention to prevene recurrence.	s for te M nance d a root e ciency	

were in the aviary room and then went and stood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245342	B. WING				C 29/2020
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	
					SOUTH GREELEY STREET		
THE EST	ATES AT GREELEY	LLC			LLWATER, MN 55082		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 880 Continued From page			F 8	380			
	at the medication or room. -At 10:43 a.m. LPN protection, approa During the observa R8's wheelchair; non 9/28/20, at 9:30 regarding the Covistated all staff were the back door and symptom screened stated, "we are supposed to don't have anyone acknowledged not going in and out of "they fog up all the On 9/28/20, at 10:20 acknowledged she protection earlier be kitchen and the goinal hallway where other on when she came hallway where other on 9/28/20, at 11:00 and explained that room or in close or sure to eye protect when at the nursing the control of the	cart parked outside R14's N-B still without proper eye ched R8 to the right side. ation LPN-B stood right next to o social distancing observed. B a.m. RN-E was interviewed d screening process. RN-E e supposed to enter through they were supposed to be d right away upon entry. RN-E posed to have goggles and o into resident rooms or areas I if they are on precautions wear a gown. Right now we in this hallway." RN-E wearing eye protection when residents rooms, and stated			The facility COVID policy was reand is current to CDC and MDH guidelines, regarding active scretemperature and signs and sym COVID-19, in accordance with 0 guidelines to be conducted at the entry for every person who enterescility. The procedures and policentrance to anyone who does not the criteria as outlined by the CI procedure includes actively meand recording staff temperature assessment of shortness of breor changed cough, and sore threor changed cough, and sore threory the facility will provide training for the facility will provide training for the facility, as well as responsible for the screening. The Director of Nursing, the Preventionist, and other facility will conduct audits on all shifts, as week for one week, twice week and biweekly thereafter, used to ensure screening is being completed at of entry for all persons who entered facility. The Director of Nursing, Infection Preventionist or designee will responsible or designee	current eening for ptoms of CDC e point of rs the cy restrict of meet DC. The asuring and eath, new pat. or ther staff he training reening. Infection eadership four times kly for one ntil 100% re active the point er the	
	acknowledged she protection on whe	should have had the eye n standing right next to R8. 06 a.m. RN-D explained being		I	results of audits and monitoring Quality Assurance Program Imp (QAPI) program.	with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245342	B. WING			1	C 29/2020
	PROVIDER OR SUPPLIER	LC		313	SOUTH GREELEY STREET LLWATER, MN 55082	1 031	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	lot of commotion at time, so decided to the desk. RN-D sta probably not done in On 9/28/20, at 11:0 DON and the const completed. During and corporate RN is to enter the building DON then stated, "reinforce the eyewer it the last time an indone here." The DO were supposed to a providing cares to the ducated this and the completed. The contained are to wear it if they area," and identified here." DON stated supposed to be sort at the nursing static expectation. The counit was previously doffing stations were hallway and this protect the unit was no long re-educate the staff are leaks, we have staff" and indicated moved into the room to being aware of PPE off outside results.	hask and saw that there was a the desk for screening, at the o "clock in" and then return to ted, "I know I should have t." 8 a.m. an interview with the altant corporate RN was the interview both the DON stated all staff were supposed by through the back door. The we have been very strict to ear because we were cited for fection control survey was DN also explained that all staff wear eyewear protection when the residents, staff had been that audits had been porate RN then stated "staff or are within the resident care at the care area, "is everywhere all staff and/or visitors were eened upon entry to the facility	F8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245342	B. WING			1	C 29/2020
	PROVIDER OR SUPPLIER	LC	STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082			1 031	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	of the Center for Di Department of heal exposure. PPE removal: During a continuous 8:07 a.m. NA-A can a gown, face mask down the hallway a room prior to R12's and placed it in a bi -At 8:08 a.m. physic came out of R12's mask and eye prote hallway to approxim prior to R12's and placed it in a bi -At 8:15 a.m. RN-C wearing a gown, face walked down the har R12's and removed placed it in a binAt 8:31a.m. occup; (OTA)-K came out of gown, face mask, a down the hallway be where NA-A was paresidents, to the root the PPE in the hallway be wearing a gown, face mask, a down the hallway be where NA-A was paresidents, to the root the PPE in the hallway be wearing a gown, face mask, and gown, face mask,	sease Control (CDC) and the th to prepare and minimize the sobservation on 9/28/20, at ne out of R12's room wearing and eye protection, walked pproximately ten feet to the and removed PPE in hallway n. cal therapy assistant (PTA)-J room wearing a gown, face ection, walked down the nately ten feet to the room emoved PPE in the hallway	F8	80			
	RN-C indicated the	on 9/28/20, at 9:18 a.m. y were trying to have staff take but laundry had issues with					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	CON	E SURVEY MPLETED
		245342	B. WING			C / 29/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 313 SOUTH GREELEY STREET STILLWATER, MN 55082	ZIP CODE	23/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	removing the bins f explained that there contaminated if the the room and identi room would not allo feet from the reside During an interview indicated they were because they were	rom the rooms. RN-C also were concerns about being PPE was removed while in fied taking off the PPE in the low for social distancing of 6	F8	380		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 14, 2020

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

Re: State Nursing Home Licensing Orders

Event ID: 6Y9S11

Dear Administrator:

The above facility was surveyed on September 28, 2020 through September 29, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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:

Susanne Reuss, 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: susanne.reuss@state.mn.us

Office: (651) 201-3793

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

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00947	B. WING		09/2	9/2020
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE EST	ATES AT GREELEY L	I C	TH GREELEY TER, MN 550	*		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTENTION*****					
	NH LICENSING CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I with a schedule of f	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited cted, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	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.					
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	survey was conduct with State Licensure NOT in compliance Please indicate in y correction that you	S: & 29, 2020, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed.				

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

Electronically Signed 10/23/20

TITLE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			,
		00947	B. WING		09/2	9/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT GREELEY L	I.C.	TH GREELEY TER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: order issued at 026 The facility is enroll	plaint was found to be H5342054C with a licensing 5 and 1385. ed in ePOC and therefore a uired at the bottom of the first				
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status		2 265			10/20/20
	A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:					
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ration in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				

6899

Minnesota Department of Health STATE FORM

6Y9S11 If continuation sheet 2 of 14

Minnesota Department of Health

Millinesc	ita Department of He	eaith				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						;
		00947	B. WING			9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS CITY S	STATE, ZIP CODE		
		313 SOUT	H GREELE	•		
THE EST	TATES AT GREELEY L	1.C	ER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPERTY OF THE APPROPRO	D BE	(X5) COMPLETE DATE
17.0		,	17.0	DEFICIENCY)		
2 265	Continued From pa	ge 2	2 265			
	D. a decision to transfer or discharge the resident from the nursing home; or					
	E. expected and unexpected resident deaths.					
	by: Based on document facility failed to report in condition for 1 of condition change of weakness and new the facility to inform decline resulted in his with a critical low he blood cells that carrithe rest of the body transfusions. Findings include: R1's initial admission dated 8/24/20, indicated many facility impairment.	ent is not met as evidenced at review and interview, the ort a significance of a change 3 residents (R1) reviewed for f dark stool, increased incontinence. The failure of the physician of a three day narm for R1 when hospitalized emoglobin (Hgb protein in red ries oxygen from the lungs to) and required blood on Minimum Data Set (MDS) cated R1 had moderate int, with diagnoses which erebral vascular accident		corrected		
	(CVA) and malnutring R1's document reviprogress notes (IPN indicated a lab valudeciliter (normal valuation and blood admitted to the hoson 8/17/20 with a Haransfusions.					

Minnesota Department of Health

STATE FORM 6899 6Y9S11 If continuation sheet 3 of 14

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00947	B. WING		I	C 29/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	, ,	
THE EST	ATES AT GREELEY L	I C	H GREELEY			
		STILLWAT	TER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 3	2 265			
	independently."					
	nurse (RN-A) docur assistant registered resident is feeling was up assessment or was R1's IPN's dated 9/documented, "Pt into visit at the windowstroke earlier in the weakness. Stroke a [F-A's] request, no stroke noted. Pt had temporal artery, ten auxiliary. Ice pack a continue to monitor	D/20, at 1:08 p.m. registered mented, "NAR [nursing I] reported to writer that weak." There was lack of follow vital signs noted in chart. 20/20, at 9:53 p.m. RN-B formed family [F-A] who came w that [R1] thought [R1] had a day, when Pt experienced assessment initiated per S/sx [signs/symptoms] of d elevated temp up to 102.0 np was 98.3 orally and 98.5 applied to forehead, will . Vs [vital signs] 114/60, 102.0, air]." RN-B did not document				
	Writer [RN-B] called a change in condition chest X-ray and lab documented, "Pt's to via temporal artery PRN [whenever new syrup administered restlessness noted, cup of water for oral had urinal on mouth removed it from mouth address dark stowith new incontinents." R1's IPN dated 9/2 writer received a called	21/20 at 1:14 a.m. read, d the on call provider to report on and the on call ordered a work. At 5:43 a.m. RN-B temp fluctuated all night, temp down to 100.0, orally 98.6. cessary] Tylenol and cough. Pt increased anxiety and asking for ice chips and using all swabs for drinking. Pt also n, writer intervened and both," The documentation did ools or a three day decline ice.				

Minnesota Department of Health

STATE FORM 6899 6Y9S11 If continuation sheet 4 of 14

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00947			00/2	
NAME OF					09/2	9/2020
	PROVIDER OR SUPPLIER	313 SOUT	H GREELEY	STATE, ZIP CODE 'STREET		
THE EST	TATES AT GREELEY L	I C	ER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 4	2 265			
	via EMS (emergency medical services). R1 was admitted to the hospital on 9/21/20, with dx of critically low hemoglobin and required blood transfusions.					
	stated on 9/20/20, a 9:00 p.m. through the closed window visite [RN-B] and told [RN a stroke, why was the needed to send [R1 nurse to do a stroke [R1] was so weak a condition. The nurse be concerned about told that nurse to seand they did not do facility because of 0 big change [R1] was the nurse did not list to the hospital. I left nurse wouldn't liste something was very me [R1] had another bleeding internally, needed transfusion listen to me that so	on 9/25/20, at 2:17 p.m. F-A at sometime between 8:30 - the window during an outside and a specific probably the left eye drooping and they are told the eassessment and find out why and this is a big change in the told me there was nothing to the and everything was fine. I send [R1] 911 to the hospital and it. We aren't allowed in the Covid but I knew there was a se too weak to even talk and sten when I said send [R1] 911 to trying I was so upset that the into me, I could see y wrong. The hospital did tell er stroke and [R1] was critical low of blood and send the nurse would not mething was very wrong. I was				
	nursing assistant (Nencouragement to get the last three days went down hill, [R1] the urinal, [R1's] stodark, I reported it to iron deficiency, I re	on 9/28/20, at 10:55 a.m. NA-A) stated, "[R1] needed get up and get motivated, [R1] wasn't walking, the strength was incontinent, would spill bols were dark, usually not that [RN-A] but was told that was ported the dark stools, nurses stools, they said it was normal				

Minnesota Department of Health

STATE FORM 6899 6Y9S11 If continuation sheet 5 of 14

Minnesota Department of Health

Millinesc	ota Department of He	eaith				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
)
		00947	B. WING		1	9/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	I.C.	H GREELEY			
		STILLWAT	TER, MN 550	082		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 5	2 265			
	certified nurse prace was complex with a neurology and on mitme. The CNP indichange the color of been prudent for the physician the fact the thought there had be past three days esplethargy, incontinent color. Furthermore, the information from pertaining to the chand increased lethal incontinence, and the evaluation, it would the NP of those facts sent [R1] to the ER. When interviewed of verified [NA-A] report feeling good, ar recall if [NA-A] report usual. When interviewed of director of nursing (that the NA-A report change in [R1's] contained in [R1's] con	the family insisting on an have been prudent to inform ts and I probably would have for evaluation right away." on 9/28/20, at 1:24 p.m. RN-A orted that [R1] was weak and had being incontinent but did not orted the stool was darker than on 9/28/20, at 1:32 p.m. the (DON) verified now knowing ted 9/20/20, at 1:08 p.m. the ndition to the nurse should nurse to evaluate the a and the Hgb of 6.1 g/dL in red hospitalization for blood be information the on call ave been made aware of. ON verified the family wishes ue to stroke concerns should				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER	. [` ′		(X3) DATE SURVEY COMPLETED	
	A. BUILDING:		6	
00947	B. WING		C 09/29/2020	
NAME OF PROVIDER OR SUPPLIER STR	EET ADDRESS, CITY, STAT	TE, ZIP CODE		
THE ESTATES AT GREEL BY LLC	SOUTH GREELEY ST LLWATER, MN 55082			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉ	ETE
When interviewed on 9/28/20, at 1:57 p.m. physician for R1 verified importance to listenthe family concerns and as a team the information the nursing assistant shared was important for the on call physician to have be made aware of to help in determining the chin condition of a patient. When interviewed on 9/28/20, at 2:15 p.m. Fiverified speaking with [F-A] on 9/20/20, through the window and indicated performing a strok assessment and everything seemed fine, the [R1] was just tired. RN-B verified [F-A] was demanding [R1] be sent to the ER. Regarding speaking with the on call physician RN-B verified is be evaluated immediately. RN-B stated, "Sinthe vital signs were fine, I thought it would be better to find out what the labs and chest X-were before sending [R1] in." RN-B verified on call physician was not informed that [R1] received blood transfusions 8/13/20 with and diagnosis. Document review of the policy titled, Change Resident Condition, dated 6/2019, read, The facility shall notify the resident/representative physician health care provider of changes in resident condition and/or status. 1. The licen Nurse will notify the resident's physician/healthcare provider when there have been: A significant change in the resident's physical, emotional/mental condition, A need alter the resident's medical treatment significantly; A need to transfer the resident hospital/treatment center. 2. Prior to notifying physician/healthcare provider, the nurse will make detailed observations and gather relevant performation for the provider.	een ange EN-B igh ee at gified 1] to ce e ay he emia in e and the sed es to o a gified in the sed es to o a gified en the sed en t			

Minnesota Department of Health

STATE FORM 6899 6Y9S11 If continuation sheet 7 of 14

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00947	B. WING		09/2) 9/2020
THE ESTATES AT GREELEY LLC 313 SO		313 SOUT	DRESS, CITY, S TH GREELEY TER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	director of nursing (review applicable properties of the properti	CHOD OF CORRECTION: The (DON), or designee, could colicies and procedures, entified needs and chen audit to ensure cility' policies regarding plan information for anemia	2 265			
21385	Staff assistance Subp. 3. Staff assi Personnel must be infection control protection control protection and in the policies and procedure program. This MN Requirement	istance with infection control. assigned to assist with the ogram, based on the needs of ursing home, to implement occdures of the infection	21385			11/4/20
	failed to ensure star when providing director of 7 residents. Failed to ensure star protective equipments prevent the potential resident (R12) who precautions. In add screening and surve COVID-19 symptom recommended by Covince of the providing starting starting of the providing starting of the providing starting of the providing starting starting of the providing starting st	on and interview the facility ff were wearing eye protection ect care and/or in close contact (R8, R9, R10, R11, R13). aff removed personal nt (PPE) in a manner to al spread of infection for 1 of 1 required contact and droplet ition, failed to ensure active eillance of staff for potential ns after entering the facility as centers for Disease Control e Health department		corrected		

Minnesota Department of Health

STATE FORM 6899 6Y9S11 If continuation sheet 8 of 14

Minneso	<u>ta Department of He</u>	ealth				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						:
		00947	B. WING		1	9/2020
						00_
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE EST	ATES AT GREELEY L	I C	H GREELEY			
		STILLWAT	TER, MN 550	082		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
17.0		,	17.0	DEFICIENCY)		
04005	O		04205			
21385	Continued From pa	ige 8	21385			
	Findings include:					
		a.m. during the entrance				
		ector of nursing stated there				
		staff Covid 19 cases at the				
		facility was admitting and				
		nts from the hospital and these				
	a negative Covid te	on quarantine precautions and				
		ne tour of the facility, registered				
		observed standing right next to				
		ministering medications and				
		bserved on top of her head.				
	After RN-E complete					
		walked out of R11's room.				
	-At 7:28 a.m. surve	yor came down the hallway to				
		where multiple staff were				
	either being screen	ed in or doing other duties				
	however staff were	not reminded to apply the				
	goggles properly.					
		was observed to go into R9's				
		goggles on top of her head as				
		then came out and returned				
		art by the nursing station.				
		etary aide (DA) was observed				
		itchen, walked down the rsing station, nurse manager				
		director of nursing (DON)'s				
		wearing any eye protection at				
		m. DA was observed going				
		ack to the kitchen past the				
		ere other staff stood, however				
		ed to apply eye protection.				
		dor driver was observed to				
		ough the back door, then				
		ort hallway and approached the				
		-C then approached the				
		poke to him as he handed a				
	sheet of paper to R	N-C. RN-C then stated to the				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 9 of 14 6Y9S11

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		OATE SURVEY OMPLETED	
		00947	B. WING		I	C 29/2020	
	PROVIDER OR SUPPLIER	313 SOU ⁻	DRESS, CITY, S TH GREELEY TER, MN 550				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21385	vendor driver he wa RN-C left the nursir screening the vend was observed to wa the South hallway a bathroom by the nubeen screened. -At 7:42 a.m. the vend bathroom and was between the bathroom and still had not be symptoms. -At 7:43 a.m. the Dodriver and asked his screened by license provided him a pair -At 7:45 a.m. RN-E R13's room still we head after she had approached the meron approached the meron approached R wheelchair and was approximately a hard administered the meron approached the meron approached R wheelchair and was approximately a hard administered the meron approached the me	as going to find the DON. ag station area without or driver. The vendor driver alk into the nursing station on and then went into the arsing station and still had not endor driver came out of the observed going back and forth om and nursing station area en screened for Covid ON approached the vendor m to come to the desk to get ed practical nurse (LPN)-C and of goggles. was observed coming out of aring her goggles on top of her administered insulin, and then edication cart. 1 a.m. RN-E was observed edications and at 7:54 a.m. edications into R10's room still s on top of her head. RN-E 10 who was up seated in the s observed standing					

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00947	B. WING		09/2) 9/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	I C	H GREELEY			
	OLIMANA DV. OTA		ER, MN 550			4.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
21385	Continued From pa	ge 10	21385			
21385	-At 8:29 a.m. RN-D facility and as she as she was observed applied the mask. Fpast the nursing star office without being and was observed and came back to the then was screened and came back to the was screening and was observed glasses as her gogethestAt 10:42 a.m. LPN the West hallway pawere in the aviary reat the medication caroomAt 10:43 a.m. LPN protection, approach During the observating the Covid Stated all staff were the back door and the symptom screened stated, "we are supmasks when we gowith residents, and we're supposed to don't have anyone in acknowledged not we supposed to the state of the sack of the supposed to the supposed	was observed entering the approached the nursing station reaching for a mask and RN-D then was observed going ation and the nurse manager screened for Covid symptoms clocking in, then turned around he nursing station and was by RN-F. Is each practical nurse (LPN)-B ther staff at the nursing station wearing regular reading gles were hanging on her B was observed to walk down ast a couple residents who com and then went and stood art parked outside R14's B still without proper eye hed R8 to the right side. It ion LPN-B stood right next to be social distancing observed. a.m. RN-E was interviewed a screening process. RN-E is supposed to enter through they were supposed to be right away upon entry. RN-E posed to have goggles and into resident rooms or areas if they are on precautions wear a gown. Right now we in this hallway." RN-E wearing eye protection when residents rooms, and stated	21385			
		3 a.m. the dietary aide did not have eyewear				

Minnesota Department of Health

STATE FORM 6899 6Y9S11 If continuation sheet 11 of 14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	
AND I LAN OF GOTTLEGTION	IDENTIFICATION NOMBER.	A. BUILDING:			
	00947	B. WING		09/2	; 9/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
THE ESTATES AT GREELEY LLC		H GREELEY ER, MN 550			
PREFIX (EACH DEFICIENCY MUS	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
kitchen and the goggle had removed them and on when she came out hallway where other resonance on when she came out and explained that whe room or in close contact sure to eye protection of when at the nursing state it was tight around the acknowledged she sho protection on when state of commotion at the time, so decided to "cluthe desk. RN-D stated, probably not done it." On 9/28/20, at 11:08 a. DON and the consultar completed. During the and corporate RN states to enter the building the DON then stated, "we have reinforce the eyewear build the last time an infect done here." The DON awere supposed to wear providing cares to the reducated this and that completed. The corporare to wear it if they are area," and identified the here." DON stated all states.	use she had been in the es were fogging up so she d forgot to put them back to of the kitchen to the esidents and staff were. .m. LPN-B was interviewed en she enters a resident ct to a resident she made on, but at other times, like ation, she did not because sides of her face. LPN-B ould have had the eye anding right next to R8. .m. RN-D explained being k and saw that there was a e desk for screening, at the lock in" and then return to , "I know I should have .m. an interview with the nt corporate RN was interview both the DON ed all staff were supposed rough the back door. The have been very strict to because we were cited for stion control survey was also explained that all staff or eyewear protection when residents, staff had been audits had been rate RN then stated "staff er within the resident care are area, "is everywhere staff and/or visitors were need upon entry to the facility	21385			

Minnesota Department of Health

STATE FORM 6899 6Y9S11 If continuation sheet 12 of 14

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			D WINC			
		00947	B. WING		09/2	9/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	TATES AT GREELEY L	I C	H GREELEY			
	I		ER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFERENCY)	.D BE	(X5) COMPLETE DATE
21385	Continued From pa	ge 12	21385			
	expectation. The counit was previously doffing stations wer hallway and this prothe unit was no long re-educate the staff are leaks, we have staff" and indicated moved into the room not being aware of PPE off outside res The facility Coronav 8/25/20, directed stinfection control praof the Center for Directions.	orporate RN explained which a Covid unit and said that the e outside the rooms in the ocess was not changed when ger a Covid unit; "we will if, we have systems but there already started to educate the the doffing stations were ms. The DON commented on who instructed staff to take idents rooms in the hallway. Virus (COVID-19) policy dated aff to adhere to appropriate actices per recommendations sease Control (CDC) and the th to prepare and minimize the				
	8:07 a.m. NA-A can a gown, face mask, down the hallway a room prior to R12's and placed it in a bi-At 8:08 a.m. physic came out of R12's mask and eye prote hallway to approxim prior to R12's and rand placed it in a bi-At 8:15 a.m. RN-C wearing a gown, face walked down the harmonia R12's and removed placed it in a binAt 8:31a.m. occupation (OTA)-K came out of	cal therapy assistant (PTA)-J room wearing a gown, face ection, walked down the nately ten feet to the room emoved PPE in the hallway				

Minnesota Department of Health

STATE FORM 6899 6Y9S11 If continuation sheet 13 of 14

Minnesota Department of Health

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	ΓED
THE ESTATES AT GREELEY LLC 313 SOUTH GREELEY STREET STILLWATER, MN 55082 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X COMPRES) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	2020
THE ESTATES AT GREELEY LLC STILLWATER, MN 55082 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
down the hallway between the wall and a cart where NA-A was passing breakfast trays to residents, to the room prior to R12's and removed the PPE in the hallway and placed it in a bin. -At 8:59 a.m. NA-A came out of R12's room wearing a gown, face mask, and eye protection, placed a breakfast tray on top of the meal cart, walked down the hallway to the room prior to R12's and removed the PPE in the hallway and placed it in a bin. During an interview on 9/28/20, at 9:18 a.m. RN-C indicated they were trying to have staff take PPE off in the room, but laundry had issues with removing the bins from the rooms. RN-C also explained that there were concerns about being contaminated if the PPE was removed while in the room and identified taking off the PPE in the room would not allow for social distancing of 6 feet from the resident During an interview on 9/28/20 at 9:40 a.m. NA-A indicated they were removing PPE in the hallway because they were told that they could be contaminated if they removed the PPE in the room. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures, inservice staff on identified needs and requirements, and then audit to ensure compliance with facility policies regarding infection control practices. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	

6899

Minnesota Department of Health STATE FORM



Protecting, Maintaining and Improving the Health of All Minnesotans

DIRECTED PLAN OF CORRECTION

A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- 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.

POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
 - The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare

Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC AA refVal=https%3A%2F%2Fwww.cd

c.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care

Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program. and monitoring with the Quality Assurance Program Improvement (QAPI) program.

ACTIVE SCREENING

- 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.

POLICIES/PROCEDURES/SYSTEM CHANGES:

• The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

• Develop and implement procedures, policies, and forms regarding active screening for temperature and signs and symptoms of COVID-19, in accordance with CDC guidelines to be conducted at the point of entry for every person who enters the facility. The procedures and policy must restrict entrance to anyone who does not meet the criteria as outlined by the CDC. This procedure must include actively measuring and recording staff temperature and assessment of shortness of breath, new or changed cough, and sore throat. The results must be documented. The MDH COVID-19 Toolkithttps://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf has examples of forms to utilize for staff screening.

TRAINING/EDUCATION:

As part of a corrective action plan, the facility must provide training for Infection Preventionist and all other staff who enter the facility, as well as staff responsible for the screening. The training must cover the need for active screening. The CDC has training videos available for COVID-19 which may be utilized, Training for Healthcare Professionals; https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html and the MDH COVID-19 Toolkit may be utilized.

- Include documentation of the completed training with a timeline for completion.
- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/

Healthcare Infection Prevention and Control FAQs for COVID-19:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC AA refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:

Personal Protective Equipment (PPE) for Infection Control:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf

Interim Guidance on Alternative Facemasks (PDF):

https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19

(PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf

Droplet Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html Airborne Precautions:

https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

• The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits on all shifts, four times a week for one week, twice weekly for one week and biweekly thereafter, until 100% compliance is achieved to ensure active screening is being completed at the point of entry for all persons who enter the facility.

The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation should be uploaded as attachments through ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Item	Checklist: Documents Required
	for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with
	signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was
	fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any
	other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed
	post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action
	plan

In order to speed up our review, identify all submitted documents with the number in the "Item" column.

Attach all items into ePOC.