Electronically Delivered
April 9, 2021

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

RE: CCN: 245342
Cycle Start Date: February 24, 2021

Dear Administrator:

On April 8, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, 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

Electronically delivered
March 15, 2021

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

RE: CCN: 245342
Cycle Start Date: February 24, 2021

Dear Administrator:

On February 24, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro B 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: sarah.grebenc@state.mn.us
Office: (651) 201-3792

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by May 24, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 24, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On February 22, 23, and 24, 2021, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED : H5342058C (MN00069802), H5342059C (MN00060000), and H5342060C (MN00064677) with deficiencies identified at F609, F694, and F760. As a result of the investigation, additional concerns were found and cited at F759. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		4/2/21

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

Electronically Signed | 03/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 1 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of neglect to the State Survey Agency for 1 of 4 residents (R4) reviewed for potential neglect surrounding significant medication errors. Findings include: R4's Medication Error Reconciliation Form dated 2/15/21, indicated that an error had occurred on 2/15/21, at 9:30 a.m.. R4 was to have received Admelog Solostar (a short acting insulin that starts to work in 15 minutes and peaks in one hour. It keeps working for 2-4 hours) 10 units subcutaneous (subQ) with meals. R4 received 10 units of Basaglar (a long acting insulin that peaks	F 609	R4 from day of admission thru 2/24/21 BS range was from 44-488 with the majority of them being 165-266. She has had 5 changes to her Basaglar, 3 changes to her scheduled Admelog and 7 changes to her sliding scale admelog. There were no adverse side effects to the resident. MD notified at time of incident and opted to hold HS Dose. MD did not deem error to be significant and/or life threatening. Post incident blood sugars were 117-183-66-119 on 2/15 and 132-128-163-103-210 Medication error policy and procedure has been reviewed and updated, including	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 about 12 hours after administration and lasts for 24 hours) due to staff who misread the order. Corrective action taken was to monitor R4 for hypoglycemia (low blood sugar). Medication Error Reconciliation Form indicated the actions to prevent recurrence was education to the staff member who made the error. During interview on 2/23/21, at 1:18 p.m. P-C stated a medication error would be significant related to insulin would depend on what monitoring needed to be done and if medications were needed to be given to raise blood sugar levels or if medications needed to be held more than once as a result of the error. P-C stated R4's insulin error was significant. During interview on 2/24/21, at 9:13 a.m. the director of nursing (DON) stated she did not identify R4's medication error as significant because there was no harm. The DON stated R4's blood sugar at lunch was 183. The DON stated R4's Basaglar was held because the physician said to, not because there was an adverse reaction. The DON verified R4's medication error was never submitted to the state agency. During interview on 2/24/21, at 3:21 p.m. the DON explained always trying to report as soon as she heard of reportable concerns, and would even come in on the weekend if needed to report. The DON had started to review nursing notes to catch concerns that needed to be looked at closer so they did not get missed. The Medication Error Procedure last reviewed January 2020, required significant medication errors to be reported to the State agency.	F 609	what constitutes as a medication error. We also reviewed the VA policy and procedure. R/T medication error reporting. All nurses have been trained on administering medications, nursing care of the resident with diabetes mellitus. We will be doing insulin administration training as well. Staff have been trained on the VA policy and reviewed specifically section in regards to med errors and requirement of reporting suspected neglect that did not result in serious bodily injury to be reported within 24 hours Insulin administration audits will be conducted on nurses twice monthly until 0% error rate is maintained x 3 months. Audits on VA policy will be conducted weekly. Audit Findings will be reported to QAPI to determine future auditing schedule thereafter and will provide redirection/recommendations based on existing audits.¿ ADMIN/DON/designee is responsible for compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3 The Abuse Prohibition/Vulnerable Adult Plan revised 7/5/19, required suspected neglect that did not result in serious bodily injury to be reported within 24 hours. Neglect was defined as failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.	F 609		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review facility failed to ensure 1 of 1 resident (R3) received the ordered amount of total parental nutrition (TPN) in a 24 hour period. In addition the facility failed to ensure complete administration orders were obtained and available to staff for 1 of 1 resident (R8) reviewed for TPN administration. Findings include: R3's quarterly Minimum Data Set (MDS) dated 8/10/20, indicated R3 was cognitively intact, received assistance with activities of daily living (ADLs), received 51 percent or more of her nutrition and 501 plus cubic centimeters (cc) hydration by parenteral (intravenous) route. Diagnosis included dementia, tumor of the large intestine with a fistula to the abdomen.	F 694	R3 discharged 2/4/2021 and R8 discharged 2/25/2021 due to complications related to their abdominal fistulas. We changed our TPN protocol so only use the backpack if a resident needs to leave their room while the TPN is running. We reported and exchanged the malfunctioning pump with the pharmacy. Our TPN orders on the EMAR have been enhanced to include function and flow of TPN pump Q2H. The pharmacy determines the content of the TPN based on weekly lab results. A TPN order form was developed which lists the TPN components, quantity, units, max dose. It also includes cyclic instructions matching the original MD order and must match the	4/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 694	Continued From page 4 R3's order dated 8/12/20, instructed staff R3 was to receive 2050 milliliters (ml) of TPN daily over 14 hours with lipids. R3's Medication Administration Record (MAR) dated August 2020, indicated the TPN was to be started at 7:00 p.m. and completed at 9:00 a.m. An e-mail sent on 8/28/20, by RN-A to nurse practioner (NP)-B, indicated R3's TPN did not run on the night of 8/26/20, and that R3 went 36 hours without any nutrition. R3's progress notes and MAR did not contain documentation that resident did not receive TPN on 8/26/20. On 2/22/21, at 1:51 p.m. registered nurse RN-(B) verified she reported to the director of nursing (DON) the TPN had not run, but did not remember any details. On 2/23/21, at 12:09 p.m. RN-E stated she had set the TPN up on the the pump in the back pack for R3 just like she did every time she worked. RN-E stated she checked the window in the backpack and could see the pump that indicated the TPN was infusing. RN-E stated there were no alarms, so she did not actually look at the TPN bag. On 2/24/21, at 9:30 a.m. the DON stated the morning nurse reported to her at about 10:00 a.m. that R3's TPN had not infused. The DON indicated they interviewed the RN-E who had started the TPN. RN-E walked through the process she had completed. The DON stated RN-E had told her that she had checked the	F 694	TPN label. This is to be completed by the pharmacy and sent with the TPN. Nurses will be re-educated on parenteral nutrition with emphasis on label monitoring protocol. New policy and procedure have been developed with the pharmacy regarding TPN orders and correct labeling. An audit tool has been developed to monitor TPN administration, observation, and labeling. Audits will be completed whenever we have an order for TPN. Audit Findings will be reported to QAPI to determine future auditing schedule thereafter and will provide redirection /recommendations based on existing audits.¿ DON/designee is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 694	Continued From page 5	F 694		

pump and it stated it was infusing and there were no alarms going off. RN-E indicated she did not look at the TPN bag during her shift. The DON stated when the night nurse was interviewed they stated they only looked at the pump not the TPN. The DON stated the nurses were expected to monitor the TPN through out their shift including flow. The DON verified staff did check the TPN bag to see if it was infusing. The DON verified R3 did not receive any nutrition or fluids by mouth and the nurses did not document in the medical record that R3 had not received any nutrition from 8/26/20, at 9:40 a.m. until 8/27/20, at 7:08 p.m. The nurse practioner was notified on 8/27/20, about R3, and ordered to draw labs but no other monitoring.

R8's admission MDS dated 2/22/21, indicated R8 had moderate cognitive impairment and received assistance with ADLs. MDS included diagnoses of malnutrition and that R8 received 51 percent or more of her nutrition and 501 plus cc's of hydration by parenteral route.

R8's Medication Administration Record dated 2/20/21, identified TPN start rate at 95.1 milliliters/hour (ml/hr) one time a day. Order stop date was 2/22/21.

R8 was observed on 2/22/21, at 10:38 a.m. lying in bed with an intravenous (IV) line going from the TPN bag to her arm. RN-B stopped the TPN pump and disconnected R8 from the IV line correctly. RN-B reviewed the pump settings and stated the pump indicated total volume infused was 3602 ml. RN-B stated the main rate was 95.1 ml/hr with a ramp up and down of 1 hour 24 minutes. RN-B verified the total volume for the TPN bag was 1200 ml with some overfill. she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 694	Continued From page 6	F 694		

stated there remained approximately 100 ml's in the bag.
-at 10:45 a.m. RN-B verified electronic medication record did not contain complete orders for TPN. Order read "TPN: Start rate at 95.1 ml/hr. (hour) one time a day" stop time was indicated as 10:00 a.m. RN-B stated the order lacked TPN formula, total volume to be given.

On 2/22/21 at 11:42 a.m. RN-A stated the pharmacy sent a pump that was pre programmed so all staff had to do was start it. RN-A stated staff were to hang the TPN at 8:00 pm and discontinued it at 10:00 am. RN-A stated R8's 2/19/21, TPN order did not include the total volume to infuse, did not have the formula so staff could verify the correct TPN. RN-stated she could not tell if R8 was to receive Multi vitamins (MVI) with the TPN.

On 2/23/21 at 4:10 p.m. RN-A verified there was an extra vial of MVI for R8. RN-A stated that R8 most likely missed a dose of MVI between 2/19-2/21/21 because it was not included in the TPN order.

On 2/24/21 at 9:13 a.m. the DON of verified R8's TPN orders were incomplete and there had been a possible medication error.

On 2/24/21, at 1:51 p.m. pharmacist (P-B) stated TPN orders needed to include the formula, the number of hours the TPN was to run, the rate the TPN was to run at, the total volume to be infused so that the nurses could reconcile the TPN received from the pharmacy with the TPN they were going to run. P-B stated multivitamin orders should be a separate line item to ensure they were not missed. P-B stated one vial of MVI was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 694	Continued From page 7 sent per TPN bag as the MVI vial was very expensive. Facility Parenteral Nutrition policy dated July 2017, instructed staff, "The PN [parenteral nutrition] order should include the formula or a list of all individual ingredients/nutrients in the base solution, total volume and rate of administration as well as orders for monitoring laboratory results on a routine basis." It further instructed staff to verify orders comparing the orders to the bag label Staff were also to verify if there were any additives to be put in the bag. If so staff were to add them prior to starting PN. The policy also instructed staff to document when PN was administered any additives and any complications, interventions or changes to the PN formula	F 694		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 12 percent with 3 errors out of 25 opportunities for error involving 2 of 11 residents (R5, R6) who were observed during the medication pass. Findings include:	F 759	R5 and R6 med orders were reviewed to ensure administration times are reasonable and appropriate. The LPN stated that she was very nervous during the surveyors observation of med pass with R5. She didn□t think it would require a med error report because she gave the correct dose, not understanding that had the surveyor not pointed it out she would have given the incorrect dose.	4/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 8 R5's Admission Record (face sheet) dated 2/24/21, indicated R5 had diagnosis including dementia and rheumatoid arthritis. R5's Optum order dated 2/17/21, from nurse practioner (NP)-C, included orders for Prednisone Give 30 milligrams (mg) by mouth one time daily for three days and then decrease to Prednisone 20 mg by mouth one time daily for three days. Then give Prednisone 10 mg by mouth one time daily for three days, then discontinue. Diagnosis for Prednisone acute gout flair. R5's electronic medication administration record (EMAR) for 2/2021, directed the staff to administer prednisone 20 mg one time a day on 2/22/21, for acute gout flair. On 2/21/21, at 8:17 a.m. licensed practical nurse (LPN)-A was observed to prepare R5's medications that included: aspirin 81 mg, neurontin (pain medication) 100 mg., two capsules, acetaminophen 500 mg two caplets, Augmentin (antibiotic) 875 mg/125 mg, Polyethylene Glycol (laxative) powder 17 gram in 6 oz. of water, Calcium-D Tablet 600-400 mg-unit (supplement), and prednisone(an anti-inflammatory medication) 10 mg, 1 tablet. LPN-A put the medications in the medication cart, locked the cart and locked the computer screen. When LPN-A picked up the medication cup and turned toward R5's room, the surveyor asked if she had all of R5's medications. LPN-A said, "yes." Surveyor requested that LPN-A verify prednisone dose with card and eMAR order. LPN-A checked medications and stated that there was only 10 mgs of prednisone in the medication cup. LPN-A added a second prednisone 10 mg tablet and walked to R5's room. LPN-A gave R5 the morning	F 759	We are reviewing all resident□s prescribed medications to ensure administration times are reasonable and appropriate. Per our pharmacy consultant meds that read to be given with meals also have the one hour window either side of the meal. Nurses are being re-educated on administering medications, medication error reporting, add what constitutes a medication error. Our Polaris Pharmacy Nurse Consultant is assisting with completing med pass audits on our nurses. We will develop a calendar to complete semi-annual med pass audits on nurses to ensure safe practice is being maintained. Audit results will be shared with our QAPI committee. Additional education will be provided if warranted per QAPI committee. Once received medication reports will be reviewed immediately to determine if they should be reported. Reporting will be based upon severity, adverse effects or actual harm to resident. Medication errors, and the med error rate will be calculated monthly. They will be added to the monthly QAPI agenda. Errors will be reviewed at the IDT meeting Monday thru Friday. DON or Designee will be responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 9	F 759		

medications.
-At 8:26 a.m. LPN-A stated she had been nervous being observed

R6's Admission Record dated 2/24/21, indicated R6 had diagnoses including type two diabetes mellitus, and hyponatremia (low sodium levels).

R6's Order Summary Report dated 2/24/21, included orders for:
-Metformin (diabetic medication) 500 mg by mouth two times per day. Take with meals
-Sodium Chloride (supplement) 1 gram by mouth with meals.

On 2/22/21, at 3:50 p.m. registered nurse (RN)-C was observed to prepare the medications for R6 and deliver them.

The prescription label on R6's Metformin 500 mg package directed: with meals.
The prescription label on R6's Sodium Chloride 1 gram directed: with meals.

R6's EMAR directed the Metformin to be administered with meals and the Sodium Chloride was to be administered with meals. Both medications were scheduled to be given at 4:00 p.m.

-At 3:53 p.m. RN-C verified giving R6 two sodium chloride tablets. RN-C confirmed R6 had received the Metformin and sodium Chloride at 3:50 p.m. RN-C stated the medications could be given one hour before 4:00 p.m. or up to one hour after. RN-C stated 4:00 p.m. was when she normally gave R6's medications. RN-C stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 10 supper was at 5:15 p.m. -At 4:12 p.m. RN-D nurse manager stated supper was served around 5-5:15 p.m. RN-D stated if the order indicated with meals it was to be given when the resident had their meal. RN-D verified giving the medications without food would be a medication error. On 2/24/21, at 9:13 a.m. the director of nursing (DON) stated LPN-A had not completed a medication error report at the time of the error. The DON stated it was the expectation that facility medication error rate would be zero. The DON stated if a medication order indicated to give or take with meals, it was to be given as close to the meal as possible. Administering Medications policy revised 2019, directed the staff to administer medications in accordance to the physician orders including any required time frame. Policy also directed staff that "Medications are administered with in one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)."	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure 3 of 5 residents (R2, R1, R4) reviewed for medication errors were free from significant medication errors.	F 760	R2 discharged to community on 2/15/2021. R1 continues at facility with BS 95-232. R4 discharged home 3/23/2021 BS month of March range	4/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 11 Findings include: R2 admitted 4/1/20, had the following medical diagnoses listed in the electronic medical record (eMR): cellulitis (skin infection) of left lower limb, sepsis, non-pressure chronic ulcer of other part of left foot with necrosis (death) of muscle, osteomyelitis (bone infection), cutaneous abscess of foot. R2's Hospital Medicine Admission History and Physical from a hospitalization dated 3/21/20, noted R2 had a penicillin anaphylaxis (life threatening allergic reaction) allergy. R2's allergy tab in the facility eMR noted Penicillin's as an allergy of unknown severity, dated 4/1/20. A nursing home initial report submitted to the Nursing Home Incident Reporting Website 4/7/20, showed an allegation of potential neglect related to medications when a staff nurse administered intravenous (IV) Zosyn (antibiotic in the penicillin drug class) instead of IV Ceftriaxone (antibiotic in the cephalosporin drug class) to R2 on 4/6/20, at 10:00 a.m. R2 was prescribed Benadryl for a potential allergic reaction. The Investigation Summary dated 4/13/20, explained the nurse administering the medication forgot to double check the resident name on the antibiotic bottle. The primary physician was notified and prescribed Benadryl for a potential allergic reaction due to questionable history of penicillin allergies. Additional monitoring was done with the resident to watch for changes in vital signs, no adverse reaction was identified.	F 760	87-451 All residents receiving insulin, pharmacy interchange or IV therapy could be affected. Medication errors will reported in monthly QAPI. Education provided to licensed staff on: Adm (allergies), DM, insulin, sig med error, therapeutic interchange Audits will be random weekly audits. Audit Findings will be reported to QAPI to determine future auditing schedule thereafter and will provide redirection/recommendations based on existing audits.¿ DON/designee is responsible for compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 12	F 760		

R2's medication orders included an order from the nurse practitioner (NP)-B dated 4/6/20, at 11:38 a.m. Order description: "Regarding rash/allergic reaction: Mark the area on the neck and start Benadryl 50 mg [milligrams] q8h prn [every eight hours as needed] for allergic reactions for 3 days."

The Benadryl order was entered onto the medication administration record (MAR) on 4/6/20 at 2:45 p.m. Staff documented administering 50 mg of Benadryl to R2 one time on 4/6/20, at 3:00 p.m.

There was one progress note dated 4/6/20, at 10:35 p.m. that included documented vital signs, and "No signs of anaphylaxis reaction from medication error on AM shift. Rash on neck was outlined, per report from AM nurse it is unsure if the rash was there before the medication error. Benadryl was given at 1500 PM [3:00 p.m.] No c/o SOB [complaints of shortness of breath] or any breathing issues.... Nursing staff will continue to monitor." No additional documentation of monitoring could be found for R2 specific to the medication error in progress notes, or the medication and treatment administration records.

During interview on 2/22/21, at 2:35 p.m. registered nurse (RN)-A was asked about the incident. RN-A vaguely remembered the incident, but knew the the nurse involved in giving the incorrect IV medication no longer worked at the facility. RN-A did not remember what follow-up was done for the issue, but recalled R2 had a rash present on the day of the medication error, and staff monitored the area.

In a visit note dated 4/9/20, the NP-B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 13	F 760		

documented R2 was reportedly stable with respect to the rash that started when R2 was given another resident's expired Zosyn. NP documented R2 was allergic to penicillin's and this caused a rash on R2's throat. R2 was started on benadryl, and denied trouble with swallowing, breathing or rash that day.

During interview on 2/23/21, at 1:18 p.m. pharmacist (P)-C explained that Zosyn was an antibiotic in the penicillin class. P-C added that she wouldn't think expired Zosyn would be as potent, but also risk of bacterial contamination could be greater especially if the medication was not stored properly, or had no preservatives in it. P-C felt the neck rash could have been a potential allergic reaction, and this error would be considered significant. P-C did not recall being made aware of this error.

During interview on 2/23/21, at 3:50 p.m. the director of nursing (DON) stated R2 admitted to the facility on 4/1/20, and was on IV antibiotics. The DON did not recall the IV Zosyn being expired, because staff were supposed to get rid of expired medications. There was a question about whether R2 really had a penicillin allergy, as the DON recalled R2 thought he did, but R2 was not sure. The DON explained they tried to assess allergies from all sources such as hospital records, and resident knowledge. The DON explained she always sat down with the staff directly involved in the error to review policy, reviewed the five rights of medication administration, and tried to get to the root cause of why the error occurred, for example whether staff had been interrupted. When asked about the root cause of this error, the DON remembered the nurse involved felt bad, and thought she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 14	F 760		

grabbed the right IV medication, but she did not. The DON could not remember if R2 received the entire dose of incorrect medication, or if the mistake was caught before the full dose administered.

In an interview on 2/23/21, at 4:30 p.m. NP-B vaguely remembered a small rash on R2, but the rash never went beyond the marked borders. The rash developed, staff marked the rash, gave R2 Benadryl, and it went away with time. R2 never reported any trouble swallowing or breathing. NP-B expected staff would keep an eye on R2 at least every shift, but stated would refer to the facility policy on monitoring.

Requested documentation of the internal Medication Error Reconciliation Report, and the facility investigation including but not limited to any completed interviews at the time of the error, additional resident monitoring, training and re-education, staff competencies or audits, and other action taken to prevent a similar error from occurring in the future. Facility staff were not able to find the Medication Error Reconciliation Report, or internal investigation documentation.

In a follow-up interview on 2/24/21, at 2:14 p.m. the DON confirmed staff were unable to locate the facility internal investigation file for the incident. No additional resident monitoring, Medication Error Reconciliation Report, documented training, audits or competencies regarding this IV medication error were received.

R1's medication administration record (MAR) indicated R1 was diagnosed with type 2 diabetes mellitus, and had the following long acting insulin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 15	F 760		

order at bedtime: Inject 50 unit of Insulin glargine (long acting insulin) solution 100 Unit/milliliters (mL) subcutaneously at bedtime related to type 2 diabetes mellitus with unspecified complications, start date 2/1/21.

The pharmacy sent an Auto Substitution Notice Medication Change Order for the Insulin Glargine injection. This notice informed the facility that Basaglar was to be substituted for the previously used brand, Lantus, ordered on 2/1/21. The notice indicated staff were to discontinue the original order for Lantus on R1's MAR and in the physician orders, and replace it with the new order for Basaglar. Staff would then remove any currently available supply of Lantus from the medication cart, and sign and place the notice in the medical record. The notice was signed (unable to read) and dated 2/3/21.

The following order was entered in the MAR after receipt of the Auto Substitution Notice Medication Change Order: Basaglar KwikPen 100 Unit/mL solution pen-injector. Inject 50 Unit subcutaneously at bedtime related to type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema. Start date 2/4/2021.

Review of the MAR from February 2021, showed staff did not remove the prior order for 50 units of Lantus at bedtime before adding the new order for 50 units of Basaglar at bedtime. Staff documented giving R1 50 units of each brand of long acting insulin at bedtime on 2/4/21, resulting in a double dose.

A nursing home initial report submitted to the Nursing Home Incident Reporting Website 2/5/21,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 16	F 760		

reported the allegation of potential neglect when nursing staff gave R1 a double dose of insulin; 50 units of Lantus (brand name of insulin glargine), and 50 units of Basaglar (brand name of insulin glargine). The investigation summary dated 2/12/21, indicated the pharmacy sent paperwork to interchange one long acting insulin brand for another. Nursing staff did not follow the correct procedure for accepting the new medication, and as a result gave R1 a 50 unit dose of each brand (100 units total) of long acting insulin before bed on 2/4/21. The nurse practitioner (NP)-B was notified of the error and she did not feel it caused harm because R1's blood sugars were still within normal limits.

A progress note dated 2/5/21, at 2:04 a.m. stated staff took R1's blood sugar due to R1 not eating anything since lunchtime, and blood sugar at bedtime was 104 which was low for this resident. Blood sugar was 76, so staff gave R1 orange juice to sip. Staff wrote a follow-up progress note on 2/5/21, at 2:43 a.m. documenting R1's blood sugar at 2:30 a.m. was 99, and R1 was drinking orange juice. A progress note dated 2/5/21, at 1:11 p.m. noted the orders for 50 units of Lantus and 50 units of Basaglar at bedtime had been discontinued, and replaced by an order for 45 units of Lantus at bedtime. By 2:07 p.m. a progress note documented R1's blood sugar had come up to 132.

Review of the MAR showed initials for licensed practical nurse (LPN)-A, signed off on giving the two types of insulin on the night of 2/4/21, resulting in the double dose.

During interview 2/22/21, at 1:41 p.m. LPN-A did not remember the medication error resulting in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 17	F 760		

R1 getting a double dose of insulin at bedtime. LPN-A did not think that would occur, as if there were two orders for the same type of insulin, and there were two insulin pens of the same type but differing brands kept in a resident's insulin pouch (resident specific pouch kept on the medication cart to hold insulin pens), LPN-A would go back to the order and see which one was current. LPN-A stated all nurses recently had training on this exact process, how to double check insulin orders, and if something did not look right to go back to the doctor's orders and see which order superceded the other. LPN-A stated it did not make sense that someone would give two different brands of the same type of insulin.
During a follow-up interview at 2:08 p.m. LPN-A confirmed her initials on the MAR which documented giving R1 two doses of insulin on the night of 2/4/21. LPN-A was confused about why she would have done that, and wondered if the two insulin pens were in separate pouches on the medication cart, because she did not feel she would have give two doses of long acting insulin.
At 2:26 p.m. LPN-A added that sometimes the pharmacy might not send a new insulin right away, and when that happens she would either use the previous insulin ordered so the resident was covered, or would take the new ordered insulin from the emergency kit (e-kit). LPN-A stated the proper way to document this would be to document giving one insulin, and then instead of documenting giving the other type of insulin, she could have entered a progress note explaining why one insulin was given and the other was not. LPN-A stated this would be the proper way to document, instead of documenting that two different doses were administered.
LPN-A did not believe she gave both doses of the long acting insulin, Lantus and Basaglar, even

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 18	F 760		

though it was documented as such on the MAR, because giving 100 units of long acting insulin at one time might cause a resident to end up in the hospital from low blood sugar.

In an interview on 2/22/21, at 3:47 p.m. registered nurse (RN)-D remembered the medication error and said R1 had recently come back from the hospital, and his insulin orders were sent out to the pharmacy, but the evening of the error the new insulin had not arrived from the pharmacy. Since the new Basaglar insulin had not arrived, staff took the medication from the e-kit to use. RN-D stated both medications, Lantus and Basaglar, were still on the medication list. The next day R1's nurse practitioner (NP)-A was reviewing medications, and noticed both insulins were still current on the medication list, and that was how the error was discovered. RN-D did not speak with LPN-A at the time of error discovery, but spoke with LPN-A today, who felt she would not have given both doses. RN-D confirmed there was documentation in the MAR as if both doses were given. RN-D provided a copy of an Emergency Drug Kit Slip, showing the newly ordered Basaglar was taken out of the e-kit. The Emergency Drug Kit Slip was undated, but grouped together with other slips dated 2/4/21. On the slip was documentation that LPN-A took out one Basaglar insulin pen at 8 p.m. RN-D added, after the NP-A found the medication error, RN-D removed the old insulin pen (Lantus) from the medication cart so that it could not be used for R1.

On 2/23/21, at 1:18 p.m. pharmacist (P)-C explained getting a double dose of long acting insulin would lead to potential for low blood sugar, and the potential effect with long acting insulin is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 19	F 760		

over 24 hours. P-C expected staff would have needed to monitor R1 for shaking, dizziness, sweating, and fast heartbeat, to name a few. P-C considered this to be a significant medication error, and did not remember being notified of this error. P-C wanted to follow-up on the error to ensure staff were following proper procedures.

Interview on 2/23/21, at 2:04 p.m. with the pharmacy manager (PM) confirmed the pharmacy did not send out the Basaglar insulin on the day the auto substitution of Lantus to Basaglar was faxed to the facility. PM described the process for medication substitutions. After the pharmacist reviewed the substitution to ensure order accuracy, they faxed the substitution notice to the facility to indicate the change. If the pharmacy faxed the order, and staff pulled the new medication from their own supply, PM could see how there might be confusion among staff. PM stated they faxed a copy to the facility first, and then there was another copy of the substitution notice that is printed and sent with the new medication to the facility. PM wanted to make sure the facility got notification of the substitution, which was why the they faxed the paperwork ahead of time, in addition to sending it along with any new medication.

Review of the Medication Error Reconciliation Form dated 2/4/21, revealed NP-A did not believe R1 had received a second dose of insulin because he was asymptomatic and at baseline since readmission from the hospital shortly before the alleged error occurred. NP-A was not available for interview at the time of survey. Attached to the form included a plan to re-educate all nurses for the correct process of reviewing and implementing auto-substitutions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 20	F 760		

from the pharmacy.

On 2/24/21, at 2:14 p.m. the DON confirmed she clarified the auto-substitution process from the pharmacy, and wrote up a protocol on what to do when medications are substituted and staff receive an auto substitution form. The DON trained the nurses on this protocol, but stated recently there was a different notification form coming from the pharmacy, so the DON reached out to the pharmacy consultant about it. The DON felt there was a high risk for errors, and wanted to get this figured out with the pharmacy so she could re-train staff on the new form.
R4's Medication Error Reconciliation Form dated 2/15/21, indicated that an error had occurred on 2/15/21, at 9:30 a.m.. R4 was to have received Admelog Solostar (a short acting insulin that starts to work in 15 minutes and peaks in one hour. It keeps working for 2-4 hours) 10 units subcutaneous (subQ) with meals. R4 received 10 units of Basaglar (a long acting insulin that peaks about 12 hours after administration and lasts for 24 hours) due to staff member misreading the order. Corrective action taken was to monitor R4 for hypoglycemia (low blood sugar). Medication Error Reconciliation Form indicated the actions to prevent recurrence was education to staff member making the error.

R4's Hospital Discharge Summary dated 2/12/21, indicated R4's diagnosis of metabolic encephalopathy (an alteration in brain function or consciousness due to an imbalance in the blood) was secondary to recurrent hypoglycemia likely due to unintentional insulin overdose.

R4's admission MDS dated 2/19/21, indicated cognitive impairment and assistance with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 21	F 760		

activities including needing to be partially fed.

R4's progress notes for 2/15/21, were reviewed and indicated that at 8:05 a.m. prior to breakfast R4's blood sugar was 55 mg/dl (milligram/deciliter). The normal blood sugar range 70 to 130 mg/dl.
-At 8:15 a.m. RN-F gave R4 oral glucose gel because R4 was unable to swallow juice. R4's blood sugar came up to 117 mg/dl
-At 9:30 a.m. RN-F gave R4 Basaglar Insulin
-At 12:02 p.m. R4's blood sugar was 183 mg/dl
-At 12:30 p.m. R4's physician was notified.
-At 5:52 p.m. Prior to dinner R4's blood sugar was 66 mg/dl. Oral glucose gel was given. R4's Blood sugar was checked after supper and remained at 66 mg/dl.
Progress note dated 2/16/21, at 3:23 a.m. indicated R4's supper time insulin was held. R4's Blood sugar at 7:44 p.m. was 119 and insulin was held.
- At 12:59 p.m. nurse practioner gave new orders for R4 insulin meal coverage.

During interview on 2/23/21, at 1:18 p.m. the P-C stated a medication error would be significant related to insulin would depend on what monitoring needed to be done, what the residents and if medications were needed to be given to raise blood sugar levels or if medications needed to be held more than once as a result of the error. P-C stated R4's insulin error was significant.

During interview on 2/24/21, at 9:13 a.m. the DON stated she did not identify R4's medication error as significant because there was no harm. The DON stated R4's blood sugar at lunch was 183. The DON stated R4's Basaglar was held because the physician said to, not because there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 22 was and adverse reaction. On 2/24/21, at 3:21 p.m. the DON and administrator stated the QAPI (quality assurance and performance improvement) committee met monthly, and was made up of key staff, including a pharmacy representative. There was currently not a line item on the agenda for medication errors, although administrator explained the committee reviewed medication errors as needed. The DON noted the topic of medication errors was being added to the regular agenda starting in March 2021. Staff competencies or audits regarding IV medications and insulin errors were requested. None were provided. The Medication Error Procedure last reviewed January 2020, required completion of a Medication Error Reconciliation Report. In addition the procedure required staff to notify the pharmacist and document pharmacy follow-up, document the medication error in the medical record, complete investigation summary, report significant errors to the state agency, record education or follow-up action, and compile data regarding medication errors and adverse consequences and present to the Quality Assurance committee monthly or quarterly.	F 760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 15, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 8QTT11

Dear Administrator:

The above facility was surveyed on February 22, 2021 through February 24, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Sarah Grebenc, Unit Supervisor
Metro B 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: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 22, 23, and 24, 2021, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 completed. The following complaints were found to be SUBSTANTIATED: H5342058C (MN00069802), H5342059C (MN00060000), and H5342060C (MN00064677) with licensing orders issued.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent	2 930		4/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 930	Continued From page 2 aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review facility failed to ensure 1 of 1 resident (R3) received the ordered amount of total parental nutrition (TPN) in a 24 hour period. In addition the facility failed to ensure complete administration orders were obtained and available to staff for 1 of 1 resident (R8) reviewed for TPN administration. Findings include: R3's quarterly Minimum Data Set (MDS) dated 8/10/20, indicated R3 was cognitively intact, received assistance with activities of daily living (ADLs), received 51 percent or more of her nutrition and 501 plus cubic centimeters (cc) hydration by parenteral (intravenous) route. Diagnosis included dementia, tumor of the large intestine with a fistula to the abdomen. R3's order dated 8/12/20, instructed staff R3 was to receive 2050 milliliters (ml) of TPN daily over 14 hours with lipids. R3's Medication Administration Record (MAR) dated August 2020, indicated the TPN was to be started at 7:00 p.m. and completed at 9:00 a.m. An e-mail sent on 8/28/20, by RN-A to nurse practioner (NP)-B, indicated R3's TPN did not run	2 930	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 930	Continued From page 3 on the night of 8/26/20, and that R3 went 36 hours without any nutrition. R3's progress notes and MAR did not contain documentation that resident did not receive TPN on 8/26/20. On 2/22/21, at 1:51 p.m. registered nurse RN-(B) verified she reported to the director of nursing (DON) the TPN had not run, but did not remember any details. On 2/23/21, at 12:09 p.m. RN-E stated she had set the TPN up on the the pump in the back pack for R3 just like she did every time she worked. RN-E stated she checked the window in the backpack and could see the pump that indicated the TPN was infusing. RN-E stated there were no alarms, so she did not actually look at the TPN bag. On 2/24/21, at 9:30 a.m. the DON stated the morning nurse reported to her at about 10:00 a.m. that R3's TPN had not infused. The DON indicated they interviewed the RN-E who had started the TPN. RN-E walked through the process she had completed. The DON stated RN-E had told her that she had checked the pump and it stated it was infusing and there were no alarms going off. RN-E indicated she did not look at the TPN bag during her shift. The DON stated when the night nurse was interviewed they stated they only looked at the pump not the TPN. The DON stated the nurses were expected to monitor the TPN through out their shift including flow. The DON verified staff did check the TPN bag to see if it was infusing. The DON verified R3 did not receive any nutrition or fluids by mouth and the nurses did not document in the medical record that R3 had not received any nutrition from	2 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 930	Continued From page 4 8/26/20, at 9:40 a.m. until 8/27/20, at 7:08 p.m. The nurse practioner was notified on 8/27/20, about R3, and ordered to draw labs but no other monitoring. R8's admission MDS dated 2/22/21, indicated R8 had moderate cognitive impairment and received assistance with ADLs. MDS included diagnoses of malnutrition and that R8 received 51 percent or more of her nutrition and 501 plus cc's of hydration by parenteral route. R8's Medication Administration Record dated 2/20/21, identified TPN start rate at 95.1 milliliters/hour (ml/hr) one time a day. Order stop date was 2/22/21. R8 was observed on 2/22/21, at 10:38 a.m. lying in bed with an intravenous (IV) line going from the TPN bag to her arm. RN-B stopped the TPN pump and disconnected R8 from the IV line correctly. RN-B reviewed the pump settings and stated the pump indicated total volume infused was 3602 ml. RN-B stated the main rate was 95.1 ml/hr with a ramp up and down of 1 hour 24 minutes. RN-B verified the total volume for the TPN bag was 1200 ml with some overfill. she stated there remained approximately 100 ml's in the bag. -at 10:45 a.m. RN-B verified electronic medication record did not contain complete orders for TPN. Order read "TPN: Start rate at 95.1 ml/hr. (hour) one time a day" stop time was indicated as 10:00 a.m. RN-B stated the order lacked TPN formula, total volume to be given. On 2/22/21 at 11:42 a.m. RN-A stated the pharmacy sent a pump that was pre programmed so all staff had to do was start it. RN-A stated staff were to hang the TPN at 8:00 pm and	2 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 930	Continued From page 5 discontinued it at 10:00 am. RN-A stated R8's 2/19/21, TPN order did not include the total volume to infuse, did not have the formula so staff could verify the correct TPN. RN-stated she could not tell if R8 was to receive Multi vitamins (MVI) with the TPN. On 2/23/21 at 4:10 p.m. RN-A verified there was an extra vial of MVI for R8. RN-A stated that R8 most likely missed a dose of MVI between 2/19-2/21/21 because it was not included in the TPN order. On 2/24/21 at 9:13 a.m. the DON of verified R8's TPN orders were incomplete and there had been a possible medication error. On 2/24/21, at 1:51 p.m. pharmacist (P-B) stated TPN orders needed to include the formula, the number of hours the TPN was to run, the rate the TPN was to run at, the total volume to be infused so that the nurses could reconcile the TPN received from the pharmacy with the TPN they were going to run. P-B stated multivitamin orders should be a separate line item to ensure they were not missed. P-B stated one vial of MVI was sent per TPN bag as the MVI vial was very expensive. Facility Parenteral Nutrition policy dated July 2017, instructed staff, "The PN [parenteral nutrition] order should include the formula or a list of all individual ingredients/nutrients in the base solution, total volume and rate of administration as well as orders for monitoring laboratory results on a routine basis." It further instructed staff to verify orders comparing the orders to the bag label Staff were also to verify if there were any additives to be put in the bag. If so staff were to add them prior to starting PN. The policy also	2 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 930	Continued From page 6 instructed staff to document when PN was administered any additives and any complications, interventions or changes to the PN formula SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to administration of medication and enteral feeding solution by a feeding tube. The DON or designee, could provide training for all nursing staff related to the administration of medications and enteral feeding solution by a feeding tube. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident	21545		4/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 7 discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 12 percent with 3 errors out of 25 opportunities for error involving 2 of 11 residents (R5, R6) who were observed during the medication pass. Findings include:	21545	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 8 R5's Admission Record (face sheet) dated 2/24/21, indicated R5 had diagnosis including dementia and rheumatoid arthritis. R5's Optum order dated 2/17/21, from nurse practioner (NP)-C, included orders for Prednisone Give 30 milligrams (mg) by mouth one time daily for three days and then decrease to Prednisone 20 mg by mouth one time daily for three days. Then give Prednisone 10 mg by mouth one time daily for three days, then discontinue. Diagnosis for Prednisone acute gout flair. R5's electronic medication administration record (EMAR) for 2/2021, directed the staff to administer prednisone 20 mg one time a day on 2/22/21, for acute gout flair. On 2/21/21, at 8:17 a.m. licensed practical nurse (LPN)-A was observed to prepare R5's medications that included: aspirin 81 mg, neurontin (pain medication) 100 mg., two capsules, acetaminophen 500 mg two caplets, Augmentin (antibiotic) 875 mg/125 mg, Polyethylene Glycol (laxative) powder 17 gram in 6 oz. of water, Calcium-D Tablet 600-400 mg-unit (supplement), and prednisone(an anti-inflammatory medication) 10 mg, 1 tablet. LPN-A put the medications in the medication cart, locked the cart and locked the computer screen. When LPN-A picked up the medication cup and turned toward R5's room, the surveyor asked if she had all of R5's medications. LPN-A said, "yes." Surveyor requested that LPN-A verify prednisone dose with card and eMAR order. LPN-A checked medications and stated that there was only 10 mgs of prednisone in the medication cup. LPN-A added a second prednisone 10 mg tablet and walked to R5's room. LPN-A gave R5 the morning medications.	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 9 -At 8:26 a.m. LPN-A stated she had been nervous being observed R6's Admission Record dated 2/24/21, indicated R6 had diagnoses including type two diabetes mellitus, and hyponatremia (low sodium levels). R6's Order Summary Report dated 2/24/21, included orders for: -Metformin (diabetic medication) 500 mg by mouth two times per day. Take with meals -Sodium Chloride (supplement) 1 gram by mouth with meals. On 2/22/21, at 3:50 p.m. registered nurse (RN)-C was observed to prepare the medications for R6 and deliver them. The prescription label on R6's Metformin 500 mg package directed: with meals. The prescription label on R6's Sodium Chloride 1 gram directed: with meals. R6's EMAR directed the Metformin to be administered with meals and the Sodium Chloride was to be administered with meals. Both medications were scheduled to be given at 4:00 p.m. -At 3:53 p.m. RN-C verified giving R6 two sodium chloride tablets. RN-C confirmed R6 had received the Metformin and sodium Chloride at 3:50 p.m. RN-C stated the medications could be given one hour before 4:00 p.m. or up to one hour after. RN-C stated 4:00 p.m. was when she normally gave R6's medications. RN-C stated supper was at 5:15 p.m. -At 4:12 p.m. RN-D nurse manager stated supper was served around 5-5:15 p.m. RN-D stated if the	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 10 order indicated with meals it was to be given when the resident had their meal. RN-D verified giving the medications without food would be a medication error. On 2/24/21, at 9:13 a.m. the director of nursing (DON) stated LPN-A had not completed a medication error report at the time of the error. The DON stated it was the expectation that facility medication error rate would be zero. The DON stated if a medication order indicated to give or take with meals, it was to be given as close to the meal as possible. Administering Medications policy revised 2019, directed the staff to administer medications in accordance to the physician orders including any required time frame. Policy also directed staff that "Medications are administered with in one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly received from the pharmacy and administered. Audits for effectiveness of corrective action could be completed. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 11	21545		

Based on document review and interview, the facility failed to ensure 3 of 5 residents (R2, R1, R4) reviewed for medication errors were free from significant medication errors.

Findings include:

R2 admitted 4/1/20, had the following medical diagnoses listed in the electronic medical record (eMR): cellulitis (skin infection) of left lower limb, sepsis, non-pressure chronic ulcer of other part of left foot with necrosis (death) of muscle, osteomyelitis (bone infection), cutaneous abscess of foot.

R2's Hospital Medicine Admission History and Physical from a hospitalization dated 3/21/20, noted R2 had a penicillin anaphylaxis (life threatening allergic reaction) allergy.

R2's allergy tab in the facility eMR noted Penicillin's as an allergy of unknown severity, dated 4/1/20.

A nursing home initial report submitted to the Nursing Home Incident Reporting Website 4/7/20, showed an allegation of potential neglect related to medications when a staff nurse administered intravenous (IV) Zosyn (antibiotic in the penicillin drug class) instead of IV Ceftriaxone (antibiotic in the cephalosporin drug class) to R2 on 4/6/20, at 10:00 a.m. R2 was prescribed Benadryl for a potential allergic reaction. The Investigation Summary dated 4/13/20, explained the nurse administering the medication forgot to double check the resident name on the antibiotic bottle. The primary physician was notified and prescribed Benadryl for a potential allergic reaction due to questionable history of penicillin allergies. Additional monitoring was done with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 12	21545		

resident to watch for changes in vital signs, no adverse reaction was identified.

R2's medication orders included an order from the nurse practitioner (NP)-B dated 4/6/20, at 11:38 a.m. Order description: "Regarding rash/allergic reaction: Mark the area on the neck and start Benadryl 50 mg [milligrams] q8h prn [every eight hours as needed] for allergic reactions for 3 days."

The Benadryl order was entered onto the medication administration record (MAR) on 4/6/20 at 2:45 p.m. Staff documented administering 50 mg of Benadryl to R2 one time on 4/6/20, at 3:00 p.m.

There was one progress note dated 4/6/20, at 10:35 p.m. that included documented vital signs, and "No signs of anaphylaxis reaction from medication error on AM shift. Rash on neck was outlined, per report from AM nurse it is unsure if the rash was there before the medication error. Benadryl was given at 1500 PM [3:00 p.m.] No c/o SOB [complaints of shortness of breath] or any breathing issues.... Nursing staff will continue to monitor." No additional documentation of monitoring could be found for R2 specific to the medication error in progress notes, or the medication and treatment administration records.

During interview on 2/22/21, at 2:35 p.m. registered nurse (RN)-A was asked about the incident. RN-A vaguely remembered the incident, but knew the the nurse involved in giving the incorrect IV medication no longer worked at the facility. RN-A did not remember what follow-up was done for the issue, but recalled R2 had a rash present on the day of the medication error, and staff monitored the area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 13	21545		

In a visit note dated 4/9/20, the NP-B documented R2 was reportedly stable with respect to the rash that started when R2 was given another resident's expired Zosyn. NP documented R2 was allergic to penicillin's and this caused a rash on R2's throat. R2 was started on benadryl, and denied trouble with swallowing, breathing or rash that day.

During interview on 2/23/21, at 1:18 p.m. pharmacist (P)-C explained that Zosyn was an antibiotic in the penicillin class. P-C added that she wouldn't think expired Zosyn would be as potent, but also risk of bacterial contamination could be greater especially if the medication was not stored properly, or had no preservatives in it. P-C felt the neck rash could have been a potential allergic reaction, and this error would be considered significant. P-C did not recall being made aware of this error.

During interview on 2/23/21, at 3:50 p.m. the director of nursing (DON) stated R2 admitted to the facility on 4/1/20, and was on IV antibiotics. The DON did not recall the IV Zosyn being expired, because staff were supposed to get rid of expired medications. There was a question about whether R2 really had a penicillin allergy, as the DON recalled R2 thought he did, but R2 was not sure. The DON explained they tried to assess allergies from all sources such as hospital records, and resident knowledge. The DON explained she always sat down with the staff directly involved in the error to review policy, reviewed the five rights of medication administration, and tried to get to the root cause of why the error occurred, for example whether staff had been interrupted. When asked about the root cause of this error, the DON remembered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 14	21545		

the nurse involved felt bad, and thought she grabbed the right IV medication, but she did not. The DON could not remember if R2 received the entire dose of incorrect medication, or if the mistake was caught before the full dose administered.

In an interview on 2/23/21, at 4:30 p.m. NP-B vaguely remembered a small rash on R2, but the rash never went beyond the marked borders. The rash developed, staff marked the rash, gave R2 Benadryl, and it went away with time. R2 never reported any trouble swallowing or breathing. NP-B expected staff would keep an eye on R2 at least every shift, but stated would refer to the facility policy on monitoring.

Requested documentation of the internal Medication Error Reconciliation Report, and the facility investigation including but not limited to any completed interviews at the time of the error, additional resident monitoring, training and re-education, staff competencies or audits, and other action taken to prevent a similar error from occurring in the future. Facility staff were not able to find the Medication Error Reconciliation Report, or internal investigation documentation.

In a follow-up interview on 2/24/21, at 2:14 p.m. the DON confirmed staff were unable to locate the facility internal investigation file for the incident. No additional resident monitoring, Medication Error Reconciliation Report, documented training, audits or competencies regarding this IV medication error were received.

R1's medication administration record (MAR) indicated R1 was diagnosed with type 2 diabetes mellitus, and had the following long acting insulin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 15	21545		

order at bedtime: Inject 50 unit of Insulin glargine (long acting insulin) solution 100 Unit/milliliters (mL) subcutaneously at bedtime related to type 2 diabetes mellitus with unspecified complications, start date 2/1/21.

The pharmacy sent an Auto Substitution Notice Medication Change Order for the Insulin Glargine injection. This notice informed the facility that Basaglar was to be substituted for the previously used brand, Lantus, ordered on 2/1/21. The notice indicated staff were to discontinue the original order for Lantus on R1's MAR and in the physician orders, and replace it with the new order for Basaglar. Staff would then remove any currently available supply of Lantus from the medication cart, and sign and place the notice in the medical record. The notice was signed (unable to read) and dated 2/3/21.

The following order was entered in the MAR after receipt of the Auto Substitution Notice Medication Change Order: Basaglar KwikPen 100 Unit/mL solution pen-injector. Inject 50 Unit subcutaneously at bedtime related to type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema. Start date 2/4/2021.

Review of the MAR from February 2021, showed staff did not remove the prior order for 50 units of Lantus at bedtime before adding the new order for 50 units of Basaglar at bedtime. Staff documented giving R1 50 units of each brand of long acting insulin at bedtime on 2/4/21, resulting in a double dose.

A nursing home initial report submitted to the Nursing Home Incident Reporting Website 2/5/21, reported the allegation of potential neglect when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 16	21545		

nursing staff gave R1 a double dose of insulin; 50 units of Lantus (brand name of insulin glargine), and 50 units of Basaglar (brand name of insulin glargine). The investigation summary dated 2/12/21, indicated the pharmacy sent paperwork to interchange one long acting insulin brand for another. Nursing staff did not follow the correct procedure for accepting the new medication, and as a result gave R1 a 50 unit dose of each brand (100 units total) of long acting insulin before bed on 2/4/21. The nurse practitioner (NP)-B was notified of the error and she did not feel it caused harm because R1's blood sugars were still within normal limits.

A progress note dated 2/5/21, at 2:04 a.m. stated staff took R1's blood sugar due to R1 not eating anything since lunchtime, and blood sugar at bedtime was 104 which was low for this resident. Blood sugar was 76, so staff gave R1 orange juice to sip. Staff wrote a follow-up progress note on 2/5/21, at 2:43 a.m. documenting R1's blood sugar at 2:30 a.m. was 99, and R1 was drinking orange juice. A progress note dated 2/5/21, at 1:11 p.m. noted the orders for 50 units of Lantus and 50 units of Basaglar at bedtime had been discontinued, and replaced by an order for 45 units of Lantus at bedtime. By 2:07 p.m. a progress note documented R1's blood sugar had come up to 132.

Review of the MAR showed initials for licensed practical nurse (LPN)-A, signed off on giving the two types of insulin on the night of 2/4/21, resulting in the double dose.

During interview 2/22/21, at 1:41 p.m. LPN-A did not remember the medication error resulting in R1 getting a double dose of insulin at bedtime. LPN-A did not think that would occur, as if there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 17	21545		

were two orders for the same type of insulin, and there were two insulin pens of the same type but differing brands kept in a resident's insulin pouch (resident specific pouch kept on the medication cart to hold insulin pens), LPN-A would go back to the order and see which one was current. LPN-A stated all nurses recently had training on this exact process, how to double check insulin orders, and if something did not look right to go back to the doctor's orders and see which order superceded the other. LPN-A stated it did not make sense that someone would give two different brands of the same type of insulin.
During a follow-up interview at 2:08 p.m. LPN-A confirmed her initials on the MAR which documented giving R1 two doses of insulin on the night of 2/4/21. LPN-A was confused about why she would have done that, and wondered if the two insulin pens were in separate pouches on the medication cart, because she did not feel she would have give two doses of long acting insulin.
At 2:26 p.m. LPN-A added that sometimes the pharmacy might not send a new insulin right away, and when that happens she would either use the previous insulin ordered so the resident was covered, or would take the new ordered insulin from the emergency kit (e-kit). LPN-A stated the proper way to document this would be to document giving one insulin, and then instead of documenting giving the other type of insulin, she could have entered a progress note explaining why one insulin was given and the other was not. LPN-A stated this would be the proper way to document, instead of documenting that two different doses were administered.
LPN-A did not believe she gave both doses of the long acting insulin, Lantus and Basaglar, even though it was documented as such on the MAR, because giving 100 units of long acting insulin at one time might cause a resident to end up in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 18 hospital from low blood sugar. In an interview on 2/22/21, at 3:47 p.m. registered nurse (RN)-D remembered the medication error and said R1 had recently come back from the hospital, and his insulin orders were sent out to the pharmacy, but the evening of the error the new insulin had not arrived from the pharmacy. Since the new Basaglar insulin had not arrived, staff took the medication from the e-kit to use. RN-D stated both medications, Lantus and Basaglar, were still on the medication list. The next day R1's nurse practitioner (NP)-A was reviewing medications, and noticed both insulins were still current on the medication list, and that was how the error was discovered. RN-D did not speak with LPN-A at the time of error discovery, but spoke with LPN-A today, who felt she would not have given both doses. RN-D confirmed there was documentation in the MAR as if both doses were given. RN-D provided a copy of an Emergency Drug Kit Slip, showing the newly ordered Basaglar was taken out of the e-kit. The Emergency Drug Kit Slip was undated, but grouped together with other slips dated 2/4/21. On the slip was documentation that LPN-A took out one Basaglar insulin pen at 8 p.m. RN-D added, after the NP-A found the medication error, RN-D removed the old insulin pen (Lantus) from the medication cart so that it could not be used for R1. On 2/23/21, at 1:18 p.m. pharmacist (P)-C explained getting a double dose of long acting insulin would lead to potential for low blood sugar, and the potential effect with long acting insulin is over 24 hours. P-C expected staff would have needed to monitor R1 for shaking, dizziness, sweating, and fast heartbeat, to name a few. P-C considered this to be a significant medication	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 19	21545		

error, and did not remember being notified of this error. P-C wanted to follow-up on the error to ensure staff were following proper procedures.

Interview on 2/23/21, at 2:04 p.m. with the pharmacy manager (PM) confirmed the pharmacy did not send out the Basaglar insulin on the day the auto substitution of Lantus to Basaglar was faxed to the facility. PM described the process for medication substitutions. After the pharmacist reviewed the substitution to ensure order accuracy, they faxed the substitution notice to the facility to indicate the change. If the pharmacy faxed the order, and staff pulled the new medication from their own supply, PM could see how there might be confusion among staff. PM stated they faxed a copy to the facility first, and then there was another copy of the substitution notice that is printed and sent with the new medication to the facility. PM wanted to make sure the facility got notification of the substitution, which was why the they faxed the paperwork ahead of time, in addition to sending it along with any new medication.

Review of the Medication Error Reconciliation Form dated 2/4/21, revealed NP-A did not believe R1 had received a second dose of insulin because he was asymptomatic and at baseline since readmission from the hospital shortly before the alleged error occurred. NP-A was not available for interview at the time of survey. Attached to the form included a plan to re-educate all nurses for the correct process of reviewing and implementing auto-substitutions from the pharmacy.

On 2/24/21, at 2:14 p.m. the DON confirmed she clarified the auto-substitution process from the pharmacy, and wrote up a protocol on what to do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 20	21545		

when medications are substituted and staff receive an auto substitution form. The DON trained the nurses on this protocol, but stated recently there was a different notification form coming from the pharmacy, so the DON reached out to the pharmacy consultant about it. The DON felt there was a high risk for errors, and wanted to get this figured out with the pharmacy so she could re-train staff on the new form.

R4's Medication Error Reconciliation Form dated 2/15/21, indicated that an error had occurred on 2/15/21, at 9:30 a.m.. R4 was to have received Admelog Solostar (a short acting insulin that starts to work in 15 minutes and peaks in one hour. It keeps working for 2-4 hours) 10 units subcutaneous (subQ) with meals. R4 received 10 units of Basaglar (a long acting insulin that peaks about 12 hours after administration and lasts for 24 hours) due to staff member misreading the order. Corrective action taken was to monitor R4 for hypoglycemia (low blood sugar). Medication Error Reconciliation Form indicated the actions to prevent recurrence was education to staff member making the error.

R4's Hospital Discharge Summary dated 2/12/21, indicated R4's diagnosis of metabolic encephalopathy (an alteration in brain function or consciousness due to an imbalance in the blood) was secondary to recurrent hypoglycemia likely due to unintentional insulin overdose.

R4's admission MDS dated 2/19/21, indicated cognitive impairment and assistance with activities including needing to be partially fed.

R4's progress notes for 2/15/21, were reviewed and indicated that at 8:05 a.m. prior to breakfast R4's blood sugar was 55 mg/dl

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 21	21545		

(milligram/deciliter). The normal blood sugar range 70 to 130 mg/dl.
-At 8:15 a.m. RN-F gave R4 oral glucose gel because R4 was unable to swallow juice. R4's blood sugar came up to 117 mg/dl
-At 9:30 a.m. RN-F gave R4 Basaglar Insulin
-At 12:02 p.m. R4's blood sugar was 183 mg/dl
-At 12:30 p.m. R4's physician was notified.
-At 5:52 p.m. Prior to dinner R4's blood sugar was 66 mg/dl. Oral glucose gel was given. R4's Blood sugar was checked after supper and remained at 66 mg/dl.
Progress note dated 2/16/21, at 3:23 a.m. indicated R4's supper time insulin was held. R4's Blood sugar at 7:44 p.m. was 119 and insulin was held.
- At 12:59 p.m. nurse practioner gave new orders for R4 insulin meal coverage.

During interview on 2/23/21, at 1:18 p.m. the P-C stated a medication error would be significant related to insulin would depend on what monitoring needed to be done, what the residents and if medications were needed to be given to raise blood sugar levels or if medications needed to be held more than once as a result of the error. P-C stated R4's insulin error was significant.

During interview on 2/24/21, at 9:13 a.m. the DON stated she did not identify R4's medication error as significant because there was no harm. The DON stated R4's blood sugar at lunch was 183. The DON stated R4's Basaglar was held because the physician said to, not because there was and adverse reaction.

On 2/24/21, at 3:21 p.m. the DON and administrator stated the QAPI (quality assurance and performance improvement) committee met monthly, and was made up of key staff, including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 22 a pharmacy representative. There was currently not a line item on the agenda for medication errors, although administrator explained the committee reviewed medication errors as needed. The DON noted the topic of medication errors was being added to the regular agenda starting in March 2021. Staff competencies or audits regarding IV medications and insulin errors were requested. None were provided. The Medication Error Procedure last reviewed January 2020, required completion of a Medication Error Reconciliation Report. In addition the procedure required staff to notify the pharmacist and document pharmacy follow-up, document the medication error in the medical record, complete investigation summary, report significant errors to the state agency, record education or follow-up action, and compile data regarding medication errors and adverse consequences and present to the Quality Assurance committee monthly or quarterly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for significant medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure significant medication were correctly received from the pharmacy and administered. Audits for effectiveness of corrective action could be completed. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 23	21995		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of neglect to the State Survey Agency for 1 of 4 residents (R4) reviewed for potential neglect surrounding significant medication errors. Findings include: R4's Medication Error Reconciliation Form dated 2/15/21, indicated that an error had occurred on 2/15/21, at 9:30 a.m.. R4 was to have received Admelog Solostar (a short acting insulin that starts to work in 15 minutes and peaks in one hour. It keeps working for 2-4 hours) 10 units subcutaneous (subQ) with meals. R4 received 10 units of Basaglar (a long acting insulin that peaks about 12 hours after administration and lasts for 24 hours) due to staff who misread the order. Corrective action taken was to monitor R4 for hypoglycemia (low blood sugar). Medication Error Reconciliation Form indicated the actions to prevent recurrence was education to the staff member who made the error.	21995	corrected	4/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 24 During interview on 2/23/21, at 1:18 p.m. P-C stated a medication error would be significant related to insulin would depend on what monitoring needed to be done and if medications were needed to be given to raise blood sugar levels or if medications needed to be held more than once as a result of the error. P-C stated R4's insulin error was significant. During interview on 2/24/21, at 9:13 a.m. the director of nursing (DON) stated she did not identify R4's medication error as significant because there was no harm. The DON stated R4's blood sugar at lunch was 183. The DON stated R4's Basaglar was held because the physician said to, not because there was an adverse reaction. The DON verified R4's medication error was never submitted to the state agency. During interview on 2/24/21, at 3:21 p.m. the DON explained always trying to report as soon as she heard of reportable concerns, and would even come in on the weekend if needed to report. The DON had started to review nursing notes to catch concerns that needed to be looked at closer so they did not get missed. The Medication Error Procedure last reviewed January 2020, required significant medication errors to be reported to the State agency. The Abuse Prohibition/Vulnerable Adult Plan revised 7/5/19, required suspected neglect that did not result in serious bodily injury to be reported within 24 hours. Neglect was defined as failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: _____ B. WING _____	C 02/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 25 SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframe's for reporting. The facility could re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits could be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21995		