Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 15, 2025

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

RE: CCN: 245342
Cycle Start Date: March 21, 2025

Dear Administrator:

On April 14, 2025, 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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 03/21/2025

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 3/20/25 and 3/21/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53421620C (MN00111591) and H53421620C (MN00111639) with deficiencies issued at F609, F610, and F656. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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 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	F 609		4/4/25

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

Electronically Signed | 04/03/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	C 03/21/2025

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 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 immediately report (within two hours) allegations of sexual abuse to the State Agency (SA) for 1 of 3 residents (R1) reviewed for abuse. Findings include: R1 R1's annual Minimum Data Set (MDS) dated 3/6/25, indicated she was moderately cognitively impaired with diagnoses that included dementia, anxiety, depression, psychotic disorder and post-traumatic stress disorder. R2 R2's quarterly MDS dated 1/28/25, indicated R2	F 609	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Incident reported on 3/20/2025. R2 was discharged from the facility on 2/12/25. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. The facility's reporting policy and procedures were reviewed and remains current. The facility completed an investigation and no further concerns were brought forward. What measures will be put into place, or	

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 03/21/2025

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 was cognitively intact with diagnoses that included a fractured rib and weakness. The Nursing Home Incident Report filed on 3/20/25 at 1:32 p.m., identified staff were aware of an incident 3/18/25 at 3:12 p.m., in which R1 reported R1 and R2 had a sexual interaction that started off as consensual and escalated to nonconsensual. R1 alleged R2 pinned or grabbed R1's hands during the incident. On 3/20/25 at 11:22 a.m., during an interview, the administrator stated the report he received from the hospital social worker (SW) on 3/18/25, indicated R1 was held down by R2 during the incident and was penetrated. The administrator stated he did not report when R1 initially reported the incident to the facility on 2/18/25, because R1 stated it was consensual. The administrator stated the usual process for reporting allegations of abuse was to report immediately to the SA. On 3/20/25, at 12:38 p.m., during an interview, social worker (SW)-A stated allegations of sexual abuse were expected to be reported to the SA. SW-A stated she did not report the allegations reported by the hospital SW on 3/18/25, because the SW from the hospital was already reporting it however, acknowledged the facility should have reported it, too. The SW-A stated she did not report the initial allegation from R1 on 2/18/25, because she determined it was a consensual incident. On 3/20/25 at 2:06 p.m., during an interview the nurse practitioner (NP)-A stated she was aware of the allegation of sexual abuse, did not report it because R1 was an inpatient and not in the facility when she became aware of the incident.	F 609	systemic changes made, to ensure that the deficient practice will not recur. Training and Education was provided to all staff on Reporting Suspicion of a Crime, Sexual Abuse Allegations, Abuse Prohibition/Vulnerable Adult Policy, including reporting timeframes, identifying abuse, and who to report suspicions to. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The facility designee will conduct timely reporting mock drills 1x per week for 4 weeks to ensure staff are following the facility's policies and procedures on timely reporting. Reportable event investigations, including allegations of abuse and/or neglect, will be reviewed by the Administrator monthly to ensure compliance with timely reporting as required by regulations. The results will be shared at facility QAPI committee for input on the need to increase, decrease or discontinue the drills and audits. The date that each deficiency will be corrected. 4/4/2025	

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 03/21/2025

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 NP-A stated it was not her responsibility to report the allegation when the resident was not at the facility. On 3/21/25 at 10:57 a.m., during an interview, licensed practical nurse (LPN)-A stated she did not believe R1 would have appreciated being touched by R2. LPN-A stated R1 had anxiety, and would not consent, and if R2 touched R1, it should have been reported as abuse. On 3/21/25 at 2:52 p.m., during a follow-up interview, the administrator stated the report he received from the hospital social worker (SW) on 3/18/25, indicated R1 was held down by R2 during the incident and was penetrated. The administrator confirmed the facility had not reported the incident to the SA timely. On 3/21/25 at 3:46 p.m., during an interview with the director of nursing (DON), the DON confirmed all allegations of abuse should be reported within two hours to the SA. Review of facility policy titled The Abuse Prohibition / Vulnerable Adult Policy dated 2/2025, indicated the facility would promptly report all incidents of alleged or suspected abuse to the SA, no later than two hours after forming the suspicion of abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		4/9/25

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 03/21/2025

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 610	Continued From page 4 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 complete a thorough investigation for allegations of sexual abuse for 1 of 3 residents (R1) reviewed for abuse. Findings include: R1 R1's annual Minimum Data Set (MDS) dated 3/6/25, indicated she was moderately cognitively impaired with diagnoses that included dementia, anxiety, depression, psychotic disorder and post-traumatic stress disorder. R2 R2's quarterly MDS dated 1/28/25, indicated R2 was cognitively intact with diagnoses that included a fractured rib and weakness. The Nursing Home Incident Report filed on 3/20/25 at 1:32 p.m., identified staff were aware of an incident 3/18/25 at 3:12 p.m., in which R1 reported R1 and R2 had a sexual interaction that	F 610	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Facility completed an investigation. Results of the investigation determined R1's allegations were unsubstantiated. R2 discharged on 2/12/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility will report and investigate all allegations of abuse to the State Agency within two hours of being notified. Training and Education will be provided to all staff on the following policies and procedures: Reporting Suspicion of a Crime, Sexual Abuse Allegations, Abuse Prohibition/Vulnerable Adult Policy. What measures will be put into place, or	

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 03/21/2025

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 610	Continued From page 5 started off as consensual and escalated to nonconsensual. R1 alleged R2 pinned or grabbed R1's hands during the incident. The investigative file dated 2/18/25, for the incident between R1 and R2, included an interview by the social worker (SW)-A with R1, a list of R1's diagnoses, a signed statement from SW-A about the interview, R1's care plan, staff interviews about witnessing abuse, and resident interviews about witnessing abuse. Additionally, the file included R1's heath care directive and psychiatric directive. The investigative file lacked additional investigative information after the hospital SW provided additional information to the facility on 3/18/25, about the incident. On 3/20/25, at 12:38 p.m., during an interview, SW-A stated allegations of sexual abuse from the hospital SW for R1 were not further investigated because it was similar to the same report and the facility had already investigated it. The SW-A stated the facility should have investigated further once the additional information had been received from the hospital SW. On 3/21/25 at 2:52 p.m., during an interview, the administrator stated he investigated the initial information received about the incident reported on 2/18/25 by R1. The administrator reviewed R1's care plan, interviewed staff and residents about witnessing abuse and stated the SW-A interviewed R1 for the initial investigation. The administrator stated he received additional information from the hospital SW on 3/18/25, which indicated R1 was held down by R2 during the incident and was penetrated. The administrator stated when the hospital SW called to report additional information about the incident	F 610	systemic changes made, to ensure that the deficient practice will not recur. Administrator, DON and Social Services have been education on the facilities reporting policy titled Abuse Prohibition/Vulnerable Adult Policy. The state agency will be notified within two hours of any allegations of abuse. The facility will complete a comprehensive verification of investigation (VOI) to gather resident and employee statements, evidence and contributing factors of any sexual abuse allegations. Based on the investigation, the facility will determine the scope and severity of the allegation, as well as implement the necessary interventions to ensure resident safety. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Administrator or designee will audit all VOI□s monthly to ensure the proper steps were followed and the facility investigation process is thoroughly completed. The administrator or designee will review audit results in monthly QAPI meeting and make recommendations and revisions as needed. The date that each deficiency will be corrected. 4/9/2025	

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 03/21/2025

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 610	Continued From page 6 to the administrator, the facility did not reinvestigate it. On 3/21/25 at 3:46 p.m., during an interview with the director of nursing (DON), the DON confirmed the facility did not reinvestigate the incident after additional information had been received from the hospital SW. Review of facility policy titled The Abuse Prohibition / Vulnerable Adult Policy dated 2/2025, indicated the facility would investigate all incidents of alleged or suspected abuse.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		4/4/25

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 03/21/2025

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 656	Continued From page 7 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the comprehensive care plan was updated to include interventions to address relationships and behaviors for 1 of 4 residents (R2) reviewed for abuse prevention. Findings include: R2's quarterly Minimum Data Set (MDS) dated 1/28/25, indicated R2 was cognitively intact with diagnoses which included a fractured rib and weakness. R2's care plan printed 3/20/25, indicated R2 was a vulnerable adult however, lacked mention of a	F 656	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R2 was discharged on 2/12/2025 How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility completed care plan audits and made revisions as necessary. What measures will be put into place, or	

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 03/21/2025

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 656	Continued From page 8 relationship between R1 and R2 and lacked instruction to staff to monitor R2's behavior and interactions with female residents. On 3/20/25, at 12:38 p.m., during an interview, social worker (SW)-A stated she informed the director of nursing about R2's behaviors and informed staff to monitor the interactions. The SW-A stated she expected care plans to address monitoring of behaviors and confirmed the behavior was not addressed in R2's care plan. On 3/20/25 at 2:29 p.m., during an interview, nurse practitioner (NP)-A stated staff had a meeting about R2's behavior of touching others however, could not recall the date. NP-A stated she thought interventions had been placed on R2's care plan. On 3/21/25 at 2:52 p.m., during an interview, the administrator stated he was sure the staff had discussed adding R2's behavior of kissing and touching women in his care plan however, confirmed it was not on the care plan. On 3/21/25 at 3:46 p.m., during an interview with the director of nursing (DON), the DON stated if staff were instructed to monitor R2's behavior, it should have been identified on the care plan and verified it was not on R2's. A policy for care planning was requested however, was not provided.	F 656	systemic changes made, to ensure that the deficient practice will not recur. Education was provided to all staff related to Reporting Suspicion of a Crime, Sexual Abuse Allegations, Abuse Prohibition/Vulnerable Adult Policy. Monthly care plan audits by Director of Nursing or designer. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing (DON) or designee will audit 5 care plans weekly for 4 weeks to ensure known behaviors are included. Results of the audit will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The date that each deficiency will be corrected. 4/4/2025	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 15, 2025

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

Re: Reinspection Results
Event ID: WNSU12

Dear Administrator:

On April 14, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 21, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us