

### Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: The Estates at Greeley			Report Number: H5342043	Date of Visit: June 22 and 23, 2017	
Facility Address: 313 South Greeley Street		Time of Visit: 11:45 a.m. to 4:45 p.m. 8:00 a.m. to 2:30 p.m.	Date Concluded: December 11, 2017		
Facility City: Stillwater			Investigator's Name and Peggy Boeck, RN, Special		
State: Minnesota	<b>ZIP:</b> 55082	County: Washington			

#### Nursing Home

#### Allegation(s):

It is alleged that a resident was neglected when staff/alleged perpetrator failed to follow the care plan for tracheostomy care. The resident was found 20 minutes later in respiratory distress.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

#### Conclusion:

Based on a preponderance of evidence neglect occurred when the alleged perpetrator (AP) failed to follow the physician's orders for tracheostomy cares and the facility did not provided training. The AP blocked the resident's tracheostomy with a speaking valve, which prevented air from moving out of the resident's lungs. The AP inflated the balloon around the tracheostomy tube, which prevented air from entering the resident's lungs. The resident went into respiratory distress, and later died.

The resident came to the facility's transitional care unit a month prior to the incident. The resident's diagnoses included a history of neck cancer and difficulty swallowing due to radiation. The resident was dependent on a tracheostomy to breathe due to a history of chronic respiratory failure. Due to left side paralysis after a stroke the resident required the assistance of staff for all activities of daily living.

The resident came to the facility with a tracheostomy (a tube in the resident's windpipe/trachea to assist with breathing) and cuff (a balloon around the outside of the treacheostomy tube). When the balloon is filled with air it will fit the shape of the trachea. The resident received speech therapy services, which assisted him/her to talk using a device called a speaking valve. The speaking valve is a one-way device that

Facility Name: The Estates at Greeley Report Number: H5342043 lets air in, but not out. On the day of the incident, the alleged perpetrator (AP) performed tracheostomy cares on the resident and left the room. When the speech therapist entered the room a little while later, she noticed the resident was pale, did not respond to her questions, and did not appear to be breathing. The speech therapist immediately got a nurse (the AP) to come into the room to assess the resident. The AP came into the room, confirmed the resident was not breathing, and had no pulse. Additional nurses responded to the resident's room and began cardiopulmonary resuscitation (CPR). A nurse called emergency medical services and another nurse brought an automated external defibrillator. When the ambulance arrived a few minutes later, they took over CPR and transported the resident to the hospital, where s/he later died. When interviewed, a family member recalled there had been another incident during which a nurse left the speaking valve on and the cuff inflated. The family member removed the speaking valve to allow the resident to breathe and reported this to a nurse manager. When interviewed, the speech therapist and two nurses reported hearing the AP say s/he forgot to remove the speaking valve. When interviewed, the director of nursing stated s/he thought the nurses had training with written materials for placement of a speaking valve, but had no documentation. When interviewed, the AP stated s/he had no training at the facility on the speaking valve, but watched another nurse. The AP stated she was uncomfortable with the placement of the speaking valve but did not voice her discomfort to her supervisor. The AP completed the task several times because it was a doctor's order. Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557) Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557): Abuse Neglect Financial Exploitation **⊠** Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information: **Mitigating Factors:** The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was

by signature. The facility was unable to provide any training documentation on the placement or use of the

Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility did not have a policy or procedure on the placement or use of the speaking valve for individuals with a tracheostomy and alleged the licensed staff were given written materials to review and acknowledge

determined that the \overline{\text{N}} Individual(s) and/or \overline{\text{N}} Facility is responsible for the

☐ Abuse

Facility Name: The Estates at Greeley Report Number: H5342043

speaking valve. The AP stated she had no training by the facility on placement of speaking valves and learned the placement of the speaking valve by observation of another licensed staff. The AP placed the speaking valve on the resident nine times prior to the incident.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:
State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.
Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.
Deficiencies are issued on form 2567: ▼ Yes □ No
(The 2567 will be available on the MDH website.)
State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.
State licensing orders were issued: $\overline{\mathbf{x}}$ Yes $\square$ No
(State licensing orders will be available on the MDH website.)
State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 & 144A were not met.
State licensing orders were issued: ▼ Yes □ No
(State licensing orders will be available on the MDH website.)
Compliance Notes:
Definitions:

#### Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

Facility Name: The Estates at Greeley	Report Number: H5342043
(1) reasonable and necessary to obtain or maintain the vulnerable adult's ph	
or safety, considering the physical and mental capacity or dysfunction of the vulnera	ible adult;
Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated	and the deficition of
"Substantiated" means a preponderance of the evidence shows that an act that me maltreatment occurred.	ets the definition of
The Legisland in the health Collections	
The Investigation included the following: <u>Document Review</u> : The following records were reviewed during the investigation	on:
X Medical Records	
▼ Care Guide	
☐ Nurses Notes	
Assessments	
Physician Orders	
Treatment Sheets	
Physician Progress Notes	
X Care Plan Records	
<b>▼</b> Facility Incident Reports	
▼ Therapy and/or Ancillary Services Records	
Other pertinent medical records:	
Hospital Records     Ambulance/Paramedics     Death Certificate	काराच्या इस्तर एक स्थान कार विश्वविद्याले क्रिकाम्य विश्वविद्याचे विश्वविद्याच्या है । विश्वविद्या विद्यालय वि
Additional facility records:   Staff Time Sheets, Schedules, etc.	

| Facility Internal Investigation Reports Personnel Records/Background Check, etc. X **X** Facility In-service Records **X** Facility Policies and Procedures Number of additional resident(s) reviewed: Eight Were residents selected based on the allegation(s)? Yes O No  $\bigcirc$  N/A Specify: Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation? Yes No  $\bigcirc$  N/A Specify: The resident passed away. **Interviews:** The following interviews were conducted during the investigation: Interview with reporter(s) Yes O No  $\bigcirc$  N/A Specify: If unable to contact reporter, attempts were made on: Date: Time: Date: Time: Date: Time: Interview with family: 

Yes ∩ N/A Specify:  $\bigcirc$  No Did you interview the resident(s) identified in allegation: Yes Did you interview additional residents? 

Yes  $\bigcirc$  No Total number of resident interviews: Five Interview with staff: 

Yes ○ No **Tennessen Warnings** Tennessen Warning given as required: (•) Yes  $\bigcirc$  No Total number of staff interviews: Eight Physician Interviewed: ( ) Yes No Nurse Practitioner Interviewed: 

Yes ○ No Physician Assistant Interviewed: Yes No Interview with Alleged Perpetrator(s): 

Yes ○ No ○ N/A Specify: Attempts to contact: Date: Time: Date: Time: Date: Time:

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If unable to contact was subpoena issued: ( ) Yes, date subpoena was issued ○ No Were contacts made with any of the following: Emergency Personnel Police Officers Medical Examiner Other: Specify Observations were conducted related to: **X** Personal Care Nursing Services | Infection Control **X** Cleanliness **▼** Dignity/Privacy Issues Safety Issues **Transfers X** Meals **X** Facility Tour Incontinence Was any involved equipment inspected: () Yes N/A O No Was equipment being operated in safe manner: () Yes O No N/A Were photographs taken: 

Yes No Specify: cc: **Health Regulation Division - Licensing & Certification** Minnesota Board of Examiners for Nursing Home Administrators **Minnesota Board of Nursing** The Office of Ombudsman for Long-Term Care **Washington County Attorney Stillwater Police Department Stillwater City Attorney** 

Report Number: H5342043

Facility Name: The Estates at Greeley



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 12, 2017

Ms. Yaneque Walker, Administrator The Estates at Greeley LLC 313 South Greeley Street Stillwater, MN 55082

RE: Complaint Number H5342043

Dear Ms. Walker:

On October 16, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective October 21, 2017. (42 CFR 488.422)

We also recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Per day civil money penalty for the deficiency cited at F-309, effective October 3, 2017. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on October 3, 2017 to investigate complaint number H5342043. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 17, 2017, the Minnesota Department of Health, Office of Health Facility Complaints (OHFC) completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard abbreviated survey, completed on October 3, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective October 21, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of October 16, 2017:

• Per day civil money penalty for the deficiency cited at F-309, effective October 3, 2017. (42 CFR 488.430 through 488.444)

The Estates at Greeley LLC December 12, 2017 Page 2

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this electronic notice.

Sincerely,

Anne Petenson\_

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

PRINTED: 12/27/2017 FORM APPROVED OMB NO. 0938-0391

	AN OF CORDECTION INCLUDING INCLUDING			LTIPLE DING _	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245342	B. WING			R-C 11/17/2017	
	PROVIDER OR SUPPLIER	.LC		31	REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH GREELEY STREET FILLWATER, MN 55082	11/11/2017	
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{F 000}	INITIAL COMMEN	ГS	{F 0	00}			
	November 17, 2017 issued relate to cor Estates at Greeley Part 483, subpart E Care Facilities.	n revisit was conducted on 7, to follow up on deficiencies in plaint #H5342043. The is in compliance with 42 CFR 8, requirements for Long Term and in ePOC and therefore a				,	
	signature is not req page of the CMS-2 correction is require	uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents.					
					•		
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						12/12/2017

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

PRINTED: 01/08/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					No. 4444	С	
		245342	B. WING			10/03/2017	
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F 309 SS=G	to investigate case following deficiency enrolled in ePOC a required at the bott CMS-2567 form. EPOC will be used a PROVIDE CARE/S	#H5342043. As a result, the is issued. The facility is not therefore a signature is not om of the first page of the electronic submission of the s verification of compliance. ERVICES FOR HIGHEST	F3	309			10/3/17
	applies to all care a residents. Each re facility must provide services to attain o practicable physica well-being, consiste	fe undamental principle that and services provided to facility sident must receive and the e the necessary care and r maintain the highest I, mental, and psychosocial ent with the resident's sessment and plan of care.					
	applies to all treatm facility residents. B assessment of a re that residents recei accordance with pr practice, the comp	fundamental principle that nent and care provided to assed on the comprehensive isident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices, including					
	provided to resident consistent with protein the comprehensive	sure that pain management is ts who require such services, fessional standards of practice, person-centered care plan,					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						10/25/2017

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

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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and (I) D resires of p care pref This by: Bas facil com for c staff spea una and Fince R1's inclu side inha orde trace the date spea trace daily spea prog impa	Dialysis. The far dents who requires, consisten ractice, the consisten ractice, the consisten ractice, the consisten ractice, the consistences. It is a consistence of the far a consistence of the constant of the	age 1 goals and preferences.  Cility must ensure that ire dialysis receive such t with professional standards aprehensive person-centered residents' goals and  NT is not met as evidenced of and document review the ure staff were trained and the tracheostomy care needs dents, (R1), reviewed when acheostomy cuff while R1's son. R1 was harmed when went into respiratory arrest,  If was reviewed. R1 diagnoses of arction, heart disease, left and history of pneumonia due to not vomit. R1's physician's old, indicated R1 had a was to be suctioned every time and and the hub of R1's for up to four hours, twice the cuff inflated when the sonot on. R1's physician's displaying the control of the hub of R1's for up to four hours, twice the cuff inflated when the sonot on. R1's physician's displaying the control of the physician's order to the physician's order to	F3	809				

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	PROVIDER OR SUPPLIER	LC	STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082			10/03/2017		
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F 309	suction R1's trache cuff and place R1's R1's tracheostomy afternoon shifts. R2017, indicated RN order to deflate the speaking valve on tube eleven times. 2017, indicated LP physician's order to place R1's speakin tracheostomy tube TARs indicated RN physician's order to place R1's speakin tracheostomy tube. A facility incident reindicated R1 was for distress by a speed indicated RN-I had forgot to remove the indicated R1 was not medical services we cardiopulmonary reinitiated.	eostomy tube after deflating the speaking valve on the hub of tube on both the morning and it's TAR for May and June I-A had followed the physician's cuff, suction, and place R1's the hub of R1's tracheostomy R1's TAR for May and June N-B had followed the deflate the cuff, suction, and g valve on the hub of R1's two times. R1's May and June I-I had had followed the deflate the cuff, suction, and g valve on the hub of R1's nine times.  Poort dated 6/12/2017, bund at 1:30 p.m. in respiratory the therapist. The report said to an unnamed staff she is speaking valve. The report to the the speaking valve. The report to the speaking of the speaking takes in the speaking takes in the speaking takes in the speaking takes in the speaking valve. The report is the speaking takes in the speakin	F	309				
	the paramedics pro continued CPR unt reestablished. The R1 to the hospital v critical heart arrhyti	ovided medication and						
	(RN)-A at 1:54 p.m inflated cuff blocke	onducted with registered nurse . on 6/22/2017. RN-A stated an d the airway and prevented air to allow R1 to breathe. RN-A						

	OF DEFICIENCIES OF CORRECTION			COV	(X3) DATE SURVEY COMPLETED C		
		245342	B. WING			/ <b>03/2017</b>	
NAME OF PROVIDER OR SUPPLIER  THE ESTATES AT GREELEY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET STILLWATER, MN 55082			
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F 309	stated the procedur valve was to deflate tracheostomy tube, on the hub of the trastated she had receinformation on how passed on between An interview was copractical nurse (LPI 6/22/2017. LPN-B sher with no training valve prior to R1's a and other nurses lestated the procedur speaking valve was tracheostomy tube, on the hub of the trastated on the day or RN-I into R1's room forgot to deflate R1 An interview was comanager (RN)-C at RN-C stated on the the nurse's desk wher to come quickly upon entering R1's R1's arms and state and then RN-I threw across the room. For at the started CPR.  An interview was constructed CPR.  An interview was constructed CPR.	ge 3 re for placement of a speaking of the cuff, suction the and place the speaking valve acheostomy tube. RN-A gived no training, but the to place a speaking valve was a nurses from shift to shift.  Inducted with licensed N)-B at 2:27 p.m. on stated the facility had provided on placement of a speaking admission. LPN-B stated she arned from each other. LPN-B are for placement of the and place the speaking valve acheostomy tube. LPN-B are fitted the cuff, suction the and place the speaking valve acheostomy tube. LPN-B are for placement of the and place the speaking valve acheostomy tube. LPN-B are for placement of the and place the speaking valve acheostomy tube. LPN-B are for placement of the and place the speaking valve as the incident, she followed and heard RN-I say she are a speech therapist asked at the R1's room. RN-C stated are a speech therapist asked at the R1's room. RN-C stated are as the R1's speaking valve RN-C stated R1 was not no pulse, they called 911, and and on the morning of the she left R1's cuff was inflated alve was off. FM-E stated she alve was off. FM-E stated she alve was off. FM-E stated she	F3	09			

	ND PLAN OF CORRECTION INTERCATION NUMBER:		1 ' '	DING	(X3	COMPLETED	
		245342	B. WING	B. WING		C <b>10/03/2017</b>	
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F 309	recalled an incident unidentified nurse i take off the speakir removed the speak incident to RN-C. F nursing staff train e speaking valve after An interview was considered to provide speech to provide speech to walked into R1's roweredy for therapy. So the wheelchair with respond to her questing and not breath a nurse and returned ST-H stated RN-I stated RN-I stated states and states." ST-H stated states walve on and ST-H	in May 2017, when an inflated the cuff and did not ag valve. FM-E stated she ing valve and reported the M-E stated she had watched ach other on placement of the or that.  Inducted with speech therapist on 8/16/2017. ST-H stated on ent she had gone to R1's room herapy. ST-H stated she om and asked R1 if he was ST-H stated R1 was sitting in his head down, and did not stion. ST-H noticed R1 was sing. ST-H ran in the hall to get ed to R1's room with RN-I. aid she "did it wrong, I did it stated R1 had the speaking could tell the cuff was inflated, oon at the bottom of the		309			
	a.m. on 8/23/2017. previously been trainers with trach facilities where she knew the cuff had to speaking valve was speak. RN-I stated speaking valve were by withdrawing 6 m and then place the stated on the day of tracheostomy cares as his assigned nur	nnducted with RN-I at 11:23 RN-I stated she had ined and had suctioned leostomies at several other had worked. RN-I stated she to be deflated when the son, in order for the resident to the steps for placement of a e as follows: deflate the cuff illiliters of saline out of the cuff speaking valve on. RN-I f the incident she provided including suctioning, for R1 is RN-I stated the speaking tracheostomy tube hub when					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPI JEB/CLIA

	PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIEN/CLIA IDENTIFICATION NUMBER:		1 ' '	NG		COMPLETED		
		245342	B. WING		10	C / <b>03/2017</b>		
NAME OF PROVIDER OR SUPPLIER  THE ESTATES AT GREELEY LLC				STREET ADDRESS, CITY, STATE, ZIP COD 313 SOUTH GREELEY STREET STILLWATER, MN 55082				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHORE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 309	stated she inflated tracheostomy dome R1's tracheostomy dome R1's tracheostomy right side, and left twent into and came and said something stated she ran to R speaking valve was hub and the cuff was checked R1's pulse started CPR. RN-I when caring for R1 not trained on placed did so several time the physician's order A policy and proced considerations, pla Passy-Muir speaking 6/22/2017, but not The Passy-Muir speaking 6/22/2017, but not The Passy-Muir speaking didelines dated 20 placement of a speather resident's vital and responsivenes the cuff; place the search of the trached twist; and monitor the treathing in and out indicated the residemust be completely	om around 1:00 p.m. RN-I the cuff, replaced the e (for humidified oxygen) over placed R1's call light on his he room. RN-I stated ST-H e out of R1's room shortly after g was wrong with R1. RN-I 1's room and realized the s on R1's tracheostomy tube as inflated. RN-I stated she e, and she and another nurse stated she missed a step. RN-I stated although she was ement of a speaking valve, but s on R1 because she followed ers.	F3	09				



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 12, 2017

Ms. Yaneque Walker, Administrator The Estates at Greeley LLC 313 South Greeley Street Stillwater, MN 55082

Re: Complaint Number H5342043

Dear Ms. Walker:

On November 17, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on October 3, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Please feel free to call me with any questions.

Sincerely,

Licensing and Certification Program

Minnesota Department of Health

P.O. Box 64900

Anne Retension\_

St. Paul, MN 55164-0900

anne.peterson@state.mn.us

Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

PRINTED: 12/27/2017 FORM APPROVED

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_ R-C B. WING 00947 11/17/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 313 SOUTH GREELEY STREET THE ESTATES AT GREELEY LLC STILLWATER, MN 55082 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} Initial Comments {2 000} \*\*\*\*\*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:** A licensing order follow-up was completed to follow up on correction orders issued related to complaint #H5342 43. The Estates at Greelev was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

STATE FORM

**Electronically Signed** 

Minnesota Department of Health

6899

E1D012

If continuation sheet 1 of 2

12/12/17

PRINTED: 12/27/2017 FORM APPROVED

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_ R-C B. WING 11/17/2017 00947 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 313 SOUTH GREELEY STREET THE ESTATES AT GREELEY LLC STILLWATER, MN 55082 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} {2 000} Continued From page 1 page of the State form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.

Minnesota Department of Health

STATE FORM

**FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING 00947 10/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET THE ESTATES AT GREELEY LLC STILLWATER, MN 55082 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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:** 

Minnesota Department of Health

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

Bulletin 14-01, available at

A complaint investigation was conducted to investigate complaint #H5342043. As a result, the following correction order is issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational

TITLE

(X6) DATE

Minnesota Department of Health

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00947	B. WING		10/0	3/ <b>2017</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE, ZIP CODE		
		313 SOUT	H GREELEY	·		
THE EST	ATES AT GREELEY L	I C	ER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ae 1	2 000			
	http://www.health.s. obul.htm The Stat delineated on the a Department of Hea electronically. Althonecessary for State the word "corrected Then indicate in the process, under the date your orders wi	tate.mn.us/divs/fpc/profinfo/inf e licensing orders are ttached Minnesota Ith orders being submitted ough no plan of correction is e Statutes/Rules, please enter " in the box available for text. e electronic State licensure heading completion date, the Il be corrected prior to itting to the Minnesota				
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			
	by: Based on interview facility failed to ens competent to meet for one of four resic staff inflated R1's tr	ent is not met as evidenced and document review the ure staff were trained and the tracheostomy care needs dents, (R1), reviewed when racheostomy cuff while R1's s on the hub. R1 was unable to				

Minnesota Department of Health

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7110 7 2111	or connection	BENTI TOXTON NOMBER.	A. BUILDING:	<u> </u>		
		00947	B. WING		C 10/03	3/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT GREELEY L	313 SOUT	H GREELEY	STREET		
1112 201	AILS AI GILLLEI L	STILLWAT	ER, MN 550	082		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 2	2 830			
	breathe, went into r	respiratory arrest, and R1 died.				
	Findings include:					
	included cerebral in side hemiplegia, an inhalation of food a order dated 5/12/20 tracheostomy that withe cuff was deflated dated 5/12/2017, in speaking valve place tracheostomy tube daily, and to keep to speaking valve was	d was reviewed. R1 diagnoses afarction, heart disease, left and history of pneumonia due to and vomit. R1's physician's 017, indicated R1 had a was to be suctioned every time and				
	R1's treatment administration records (TARs) for May and June 2017, indicated eleven different nurses had followed the physician's order to suction R1's tracheostomy tube after deflating the cuff and place R1's speaking valve on the hub of R1's tracheostomy tube on both the morning and afternoon shifts. R1's TAR for May and June 2017, indicated RN-A had followed the physician's order to deflate the cuff, suction, and place R1's speaking valve on the hub of R1's tracheostomy tube eleven times. R1's TAR for May and June 2017, indicated LPN-B had followed the physician's order to deflate the cuff, suction, and place R1's speaking valve on the hub of R1's tracheostomy tube two times. R1's May and June TARs indicated RN-I had had followed the physician's order to deflate the cuff, suction, and place R1's speaking valve on the hub of R1's tracheostomy tube nine times.					

A facility incident report dated 6/12/2017,
Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DIAN OF CODDECTION INDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00947	B. WING		1	, 3/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE EST	ATES AT GREELEY L	1 C	H GREELEY			
		STILLWAT	TER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
	distress by a speed indicated RN-I had forgot to remove th indicted R1 was no medical services w	ound at 1:30 p.m. in respiratory th therapist. The report said to an unnamed staff she e speaking valve. The report t breathing, emergency as called, and esuscitation (CPR) was				
	R1's hospital records dated 6/12/2017, indicated the paramedics provided medication and continued CPR until a heartbeat was reestablished. The paramedics then transported R1 to the hospital where he was treated for critical heart arrhythmia's with medication and electrical shocks. R1 died at 5:57 p.m.					
	(RN)-A at 1:54 p.m inflated cuff blocke from going through stated the procedul valve was to deflate tracheostomy tube, on the hub of the tristated she had recinformation on how	onducted with registered nurse. on 6/22/2017. RN-A stated and the airway and prevented air to allow R1 to breathe. RN-A re for placement of a speaking e the cuff, suction the and place the speaking valve acheostomy tube. RN-A eived no training, but the to place a speaking valve was a nurses from shift to shift.				
	practical nurse (LP 6/22/2017. LPN-B sher with no training valve prior to R1's and other nurses lestated the procedu speaking valve was tracheostomy tube on the hub of the trackers.	onducted with licensed N)-B at 2:27 p.m. on stated the facility had provided on placement of a speaking admission. LPN-B stated she earned from each other. LPN-B re for placement of the sto deflate the cuff, suction the and place the speaking valve acheostomy tube. LPN-B of the incident, she followed		·		

Minnesota Department of Health

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AND BLAN OF CORRECTION DENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					С	
		00947	B. WING		10/0	3/2017
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
THE EST	ATES AT GREELEY L	A.C.	H GREELEY ER, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
		n and heard RN-I say she 's tracheostomy cuff.				
	manager (RN)-C at RN-C stated on the the nurse's desk wh her to come quickly upon entering R1's R1's arms and state and then RN-I threv across the room.	onducted with registered nurse 3:09 p.m. on 6/22/2017. In day of the incident she was at then a speech therapist asked of to R1's room. RN-C stated room she saw RN-I shake the "I forgot to deflate the cuff" of the R1's speaking valve RN-C stated R1 was not the pulse, they called 911, and				
	(FM)-E at 12:20 p.r she had been with incident and when and the speaking v recalled an incident unidentified nurse i take off the speakin removed the speak incident to RN-C. F	onducted with family member in. on 8/2/2017. FM-E stated R1 on the morning of the she left R1's cuff was inflated alve was off. FM-E stated she in May 2017, when an inflated the cuff and did not ing valve. FM-E stated she sing valve and reported the importance of the incomplete in				
	(ST)-H at 1:21 p.m the day of the incid to provide speech t walked into R1's ro ready for therapy. Sthe wheelchair with respond to her que pale and not breath a nurse and returne ST-H stated RN-I st	onducted with speech therapist on 8/16/2017. ST-H stated on ent she had gone to R1's room herapy. ST-H stated she om and asked R1 if he was ST-H stated R1 was sitting in his head down, and did not stion. ST-H noticed R1 was hing. ST-H ran in the hall to get ed to R1's room with RN-I. raid she "did it wrong, I did it stated R1 had the speaking				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
·				С		
00947			B. WING	10/03/2017		
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
THE EST	ATES AT GREELEY L	1 (:	H GREELEY ER, MN 550			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	1	COMPLETE DATE
2 830	Continued From pa	ge 5	2 830			
	as it had a little ball tracheostomy tube. An interview was co	onducted with RN-I at 11:23				
	a.m. on 8/23/2017. RN-I stated she had previously been trained and had suctioned residents with tracheostomies at several other facilities where she had worked. RN-I stated she knew the cuff had to be deflated when the speaking valve was on, in order for the resident to speak. RN-I stated the steps for placement of a speaking valve were as follows: deflate the cuff by withdrawing 6 milliliters of saline out of the cuff and then place the speaking valve on. RN-I stated on the day of the incident she provided tracheostomy cares, including suctioning, for R1 as his assigned nurse. RN-I stated the speaking					
	valve was on R1's tracheostomy tube hub when she entered the room around 1:00 p.m. RN-I stated she inflated the cuff, replaced the tracheostomy dome (for humidified oxygen) over					
	R1's tracheostomy right side, and left t went into and came	, placed R1's call light on his the room. RN-I stated ST-H e out of R1's room shortly after g was wrong with R1. RN-I				
	stated she ran to R speaking valve was hub and the cuff wa	1's room and realized the s on R1's tracheostomy tube as inflated. RN-I stated she				
	started CPR. RN-I when caring for R1 not trained on place did so several time	e, and she and another nurse stated she missed a step . RN-I stated although she was ement of a speaking valve, but s on R1 because she followed				
	considerations, pla	dure for how to use, special cement, and care of a ng valve was requested on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	00947	B. WING	C <b>10/03/2017</b>	
NAME OF PROVIDER OR SUPPLIER	STREET AD	•		

	STILLWAT	ER, MN 550	OZ	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6	2 830		
	The Passy-Muir speaking valve manufacturer's guidelines dated 2015, indicated instructions for placement of a speaking valve as follows: assess the resident's vital signs, breath sounds, color, and responsiveness; suction the trachea; deflate the cuff; place the speaking valve on the hub (end) of the tracheostomy tube with one quarter twist; and monitor the resident to ensure he is breathing in and out. The guideline's warning indicated the resident's tracheostomy tube cuff must be completely deflated before placement of the speaking valve or the resident will be unable to breathe.			
	SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance.	·		
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days.			
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights	21850		
	Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED			
		00947	B. WING	·		C <b>03/2017</b>
	F PROVIDER OR SUPPLIER	LC 313 SOU	DRESS, CITY, ST FH GREELEY TER, MN 550	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21850	authorized in writing resident's physiciar period of time, and protect the resident others.  This MN Requirem by: Based on interview facility failed to ens maltreatment for or reviewed when stat tracheostom cuff won the hub. R1 was respiratory arrest, a Findings include:  A policy and proced considerations, pla Passy-Muir speaking 6/22/2017, but not  The Passy-Muir speaking 6/22/2017, but not  The Passy-Muir speaking 6/22/2017, but not  The Passy-Muir speaking cated 20 placement of a speethe resident's vital and responsivenes the cuff; place the seath of the trached twist; and monitor the breathing in and out indicated the residemust be completely the speaking valve to breathe.  R1's medical record	g after examination by a not for a specified and limited only when necessary to a from self-injury or injury to the ent is not met as evidenced and document review the ure residents were free from the of four residents, (R1), if neglected to deflate R1's hile R1's speaking valve was a unable to breathe, went into and R1 died.	21850			

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PRINTED: 10/03/2017 **FORM APPROVED** Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ CB. WING 00947 10/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET THE ESTATES AT GREELEY LLC STILLWATER, MN 55082 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) 21850 Continued From page 8 21850 inhalation of food and vomit. R1's physician's order dated 5/12/2017, indicated R1 had a tracheostomy that was to be suctioned every time the cuff was deflated. R1's physician's order dated 5/12/2017, indicated R1 was to have a speaking valve placed on the hub of R1's tracheostomy tube for up to four hours, twice daily, and to keep the cuff inflated when the speaking valve was not on. R1's physician's progress note dated 5/18/2017, indicated R1 had impaired cognition. R1's treatment administration records (TARs) for May and June 2017, indicated eleven different nurses had followed the physician's order to suction R1's tracheostomy tube after deflating the cuff and place R1's speaking valve on the hub of R1's tracheostomy tube on both the morning and afternoon shifts. R1's TAR for May and June 2017, indicated RN-A had followed the physician's order to deflate the cuff, suction, and place R1's speaking valve on the hub of R1's tracheostomy tube eleven times. R1's TAR for May and June 2017, indicated LPN-B had followed the physician's order to deflate the cuff, suction, and place R1's speaking valve on the hub of R1's tracheostomy tube two times. R1's May and June TARs indicated RN-I had had followed the physician's order to deflate the cuff, suction, and place R1's speaking valve on the hub of R1's tracheostomy tube nine times.

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A facility incident report dated 6/12/2017,

distress by a speech therapist. The report indicated RN-I had said to an unnamed staff she forgot to remove the speaking valve. The report indicted R1 was not breathing, emergency

cardiopulmonary resuscitation (CPR) was

medical services was called, and

indicated R1 was found at 1:30 p.m. in respiratory

PRINTED: 10/03/2017 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00947 10/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET THE ESTATES AT GREELEY LLC STILLWATER, MN 55082 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21850 Continued From page 9 21850 initiated. R1's hospital records dated 6/12/2017, indicated the paramedics provided medication and continued CPR until a heartbeat was reestablished. The paramedics then transported R1 to the hospital where he was treated for critical heart arrhythmias with medication and electrical shocks. R1 died at 5:57 p.m. An interview was conducted with registered nurse (RN)-A at 1:54 p.m. on 6/22/2017. RN-A stated an inflated cuff blocked the airway and prevented air from going through to allow R1 to breathe. RN-A stated the procedure for placement of a speaking valve was to deflate the cuff, suction the tracheostomy tube, and place the speaking valve on the hub of the tracheostomy tube. RN-A stated she had received no training, but the information on how to place a speaking valve was passed on between nurses from shift to shift. An interview was conducted with licensed practical nurse (LPN)-B at 2:27 pm on 6/22/2017. LPN-B stated the facility had provided her with no training on placement of a speaking valve prior to R1's admission. LPN-B stated she and other nurses learned from each other. LPN-B stated the procedure for placement of the speaking valve was to deflate the cuff, suction the tracheostomy tube, and place the speaking valve on the hub of the tracheostomy tube. LPN-B stated on the day of the incident, she followed

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RN-I into R1's room and heard RN-I say she forgot to deflate R1's tracheostomy cuff.

An interview was conducted with registered nurse manager (RN)-C at 3:09 p.m. on 6/22/2017. RN-C stated on the day of the incident she was at the nurse's desk when a speech therapist asked

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tracheostomy tube.

the wheelchair with his head down, and did not respond to her question. ST-H noticed R1 was pale and not breathing. ST-H ran in the hall to get a nurse and returned to R1's room with RN-I. ST-H stated RN-I said she "did it wrong, I did it backwards." ST-H stated R1 had the speaking valve on and ST-H could tell the cuff was inflated. as it had a little balloon at the bottom of the

An interview was conducted with RN-I at 11:23 a.m. on 8/23/2017. RN-I stated she had previously been trained and had suctioned

PRINTED: 10/03/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ С B. WING 00947 10/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 313 SOUTH GREELEY STREET THE ESTATES AT GREELEY LLC STILLWATER, MN 55082 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) 21850 Continued From page 11 21850 residents with tracheostomies at several other facilities where she had worked. RN-I stated she knew the cuff had to be deflated when the speaking valve was on, in order for the resident to speak. RN-I stated the steps for placement of a speaking valve were as follows: deflate the cuff by withdrawing 6 milliliters of saline out of the cuff and then place the speaking valve on. RN-I stated on the day of the incident she provided tracheostomy cares, including suctioning, for R1 as his assigned nurse. RN-I stated the speaking valve was on R1's tracheostomy tube hub when she entered the room around 1:00 p.m. RN-I stated she inflated the cuff, replaced the tracheostomy dome (for humidified oxygen) over R1's tracheostomy, placed R1's call light on his right side, and left the room. RN-I stated ST-H went into and came out of R1's room shortly after and said something was wrong with R1. RN-I stated she ran to R1's room and realized the speaking valve was on R1's tracheostomy tube hub and the cuff was inflated. RN-I stated she checked R1's pulse, and she and another nurse started CPR. RN-I stated she missed a step when caring for R1. RN-I stated although she was not trained on placement of a speaking valve, but did so several times on R1 because she followed the physician's orders. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to

Minnesota Department of Health

ensure compliance.

Twenty-One (21) days.

determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to

TIME PERIOD FOR CORRECTION: