DEPARTMENT OF HEALTH

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 Title:** Peggy Boeck, RN, Special Investigator	
State: Minnesota	**ZIP:** 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

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 determined that the ☒ Individual(s) and/or ☒ Facility is responsible for the

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

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: ☒ Yes ☐ 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:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult;

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [ ] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Therapy and/or Ancillary Services Records

Other pertinent medical records:

- [x] Hospital Records [x] Ambulance/Paramedics [x] Death Certificate

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports
☒ Personnel Records/Background Check, etc.
☒ Facility In-service Records
☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Eight

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: The resident passed away.

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify:

If unable to contact reporter, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify:

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: The resident passed away

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Five

Interview with staff: ◉ Yes ○ No ○ N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ 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:

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:

☒ Personal Care
☒ Nursing Services
☒ Infection Control
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ Meals
☒ Facility Tour
☒ Incontinence

Was any involved equipment inspected: ◯ Yes ◯ No ◉ N/A

Was equipment being operated in safe manner: ◯ Yes ◯ 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

DEPARTMENT OF HEALTH

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)

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 Peterson

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

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 _____	R-C 11/17/2017

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 A Post Certification revisit was conducted on November 17, 2017, to follow up on deficiencies issued relate to complaint #H5342043. The Estates at Greeley is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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

Electronically 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.

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 10/03/2017

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 An abbreviated standard survey was conducted to investigate case #H5342043. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 309 SS=G	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 309		10/3/17

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

Electronically 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.

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 10/03/2017

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 309	Continued From page 1 and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure staff were trained and competent to meet the tracheostomy care needs for one of four residents, (R1), reviewed when staff inflated R1's tracheostomy cuff while R1's speaking valve was on. R1 was harmed when unable to breathe, went into respiratory arrest, and R1 died. Findings include: R1's medical record was reviewed. R1 diagnoses included cerebral infarction, heart disease, left side hemiplegia, and history of pneumonia due to 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	F 309		

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 10/03/2017

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 309	Continued From page 2	F 309		

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, indicated R1 was found at 1:30 p.m. in respiratory 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 medical services was called, and cardiopulmonary resuscitation (CPR) was 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 arrhythmia's 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

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 10/03/2017

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 309	Continued From page 3	F 309		

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 p.m. 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 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 her to come quickly to R1's room. RN-C stated upon entering R1's room she saw RN-I shake R1's arms and state "I forgot to deflate the cuff" and then RN-I threw the R1's speaking valve across the room. RN-C stated R1 was not breathing and had no pulse, they called 911, and started CPR.

An interview was conducted with family member (FM)-E at 12:20 p.m. on 8/2/2017. FM-E stated she had been with R1 on the morning of the incident and when she left R1's cuff was inflated and the speaking valve was off. FM-E stated 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 10/03/2017

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 309	Continued From page 4	F 309		

recalled an incident in May 2017, when an unidentified nurse inflated the cuff and did not take off the speaking valve. FM-E stated she removed the speaking valve and reported the incident to RN-C. FM-E stated she had watched nursing staff train each other on placement of the speaking valve after that.

An interview was conducted with speech therapist (ST)-H at 1:21 p.m. on 8/16/2017. ST-H stated on the day of the incident she had gone to R1's room to provide speech therapy. ST-H stated she walked into R1's room and asked R1 if he was ready for therapy. ST-H stated R1 was sitting in 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 tracheostomy tube.

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 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

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 10/03/2017

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 309	Continued From page 5 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. A policy and procedure for how to use, special considerations, placement, and care of a Passy-Muir speaking valve was requested on 6/22/2017, but not provided. 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.	F 309		

DEPARTMENT OF HEALTH

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,

Anne Peterson

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

Minnesota Department of Health

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 _____	R-C 11/17/2017

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: A licensing order follow-up was completed to follow up on correction orders issued related to complaint #H5342 43. The Estates at Greeley 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	{2 000}		

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

Electronically Signed | 12/12/17

Minnesota Department of Health

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 _____	R-C 11/17/2017

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 page of the State form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

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 10/03/2017

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: 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 Bulletin 14-01, available at	2 000		

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 10/03/2017

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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure staff were trained and competent to meet the tracheostomy care needs for one of four residents, (R1), reviewed when staff inflated R1's tracheostomy cuff while R1's speaking valve was on the hub. R1 was unable to	2 830		

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 10/03/2017

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
2 830	Continued From page 2 breathe, went into respiratory arrest, and R1 died. Findings include: R1's medical record was reviewed. R1 diagnoses included cerebral infarction, heart disease, left side hemiplegia, and history of pneumonia due to 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. A facility incident report dated 6/12/2017,	2 830		

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 10/03/2017

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
2 830	Continued From page 3 indicated R1 was found at 1:30 p.m. in respiratory 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 medical services was called, and cardiopulmonary resuscitation (CPR) was 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 arrhythmia's 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 p.m. 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	2 830		

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 10/03/2017

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
2 830	Continued From page 4 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 her to come quickly to R1's room. RN-C stated upon entering R1's room she saw RN-I shake R1's arms and state "I forgot to deflate the cuff" and then RN-I threw the R1's speaking valve across the room. RN-C stated R1 was not breathing and had no pulse, they called 911, and started CPR. An interview was conducted with family member (FM)-E at 12:20 p.m. on 8/2/2017. FM-E stated she had been with R1 on the morning of the incident and when she left R1's cuff was inflated and the speaking valve was off. FM-E stated she recalled an incident in May 2017, when an unidentified nurse inflated the cuff and did not take off the speaking valve. FM-E stated she removed the speaking valve and reported the incident to RN-C. FM-E stated she had watched nursing staff train each other on placement of the speaking valve after that. An interview was conducted with speech therapist (ST)-H at 1:21 p.m. on 8/16/2017. ST-H stated on the day of the incident she had gone to R1's room to provide speech therapy. ST-H stated she walked into R1's room and asked R1 if he was ready for therapy. ST-H stated R1 was sitting in 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	2 830		

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 10/03/2017

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
2 830	Continued From page 5 valve on and ST-H could tell the cuff was inflated, as it had a little balloon at the bottom of the tracheostomy tube. 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 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. A policy and procedure for how to use, special considerations, placement, and care of a Passy-Muir speaking valve was requested on 6/22/2017, but not provided.	2 830		

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 10/03/2017

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
2 830	Continued From page 6 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.	2 830		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights 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	21850		

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 10/03/2017

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
21850	Continued From page 7 authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure residents were free from maltreatment for one of four residents, (R1), reviewed when staff neglected to deflate R1's tracheostom cuff while R1's speaking valve was on the hub. R1 was unable to breathe, went into respiratory arrest, and R1 died. Findings include: A policy and procedure for how to use, special considerations, placement and care of a Passy-Muir speaking valve was requested on 6/22/2017, but not provided. 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. R1's medical record was reviewed. R1 diagnoses included cerebral infarction, heart disease, left side hemiplegia, and history of pneumonia due to	21850		

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 10/03/2017

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
21850	Continued From page 8 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. A facility incident report dated 6/12/2017, indicated R1 was found at 1:30 p.m. in respiratory 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 medical services was called, and cardiopulmonary resuscitation (CPR) was	21850		

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 10/03/2017

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
21850	Continued From page 9 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 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	21850		

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 10/03/2017

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
21850	Continued From page 10	21850		

her to come quickly to R1's room. RN-C stated upon entering R1's room she saw RN-I shake R1's arms and state "I forgot to deflate the cuff" and then RN-I threw the R1's speaking valve across the room. RN-C stated R1was not breathing and had no pulse, they called 911, and started CPR.

An interview was conducted with family member (FM)-E at 12:20 p.m. on 8/2/2017. FM-E stated she had been with R1 on the morning of the incident and when she left R1's cuff was inflated and the speaking valve was off. FM-E stated she recalled an incident in May 2017, when an unidentified nurse inflated the cuff and did not take off the speaking valve. FM-E stated she removed the speaking valve and reported the incident to RN-C. FM-E stated she had watched nursing staff train each other on placement of the speaking valve after that.

An interview was conducted with speech therapist (ST)-H at 1:21 p.m. on 8/16/2017. ST-H stated on the day of the incident she had gone to R1's room to provide speech therapy. ST-H stated she walked into R1's room and asked R1 if he was ready for therapy. ST-H stated R1 was sitting in 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 tracheostomy tube.

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

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 10/03/2017

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
21850	Continued From page 11 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 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		