DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
June 2, 2021

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

RE: CCN: 245342
Cycle Start Date: April 26, 2021

Dear Administrator:

On May 27, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Electronically delivered
May 3, 2021

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

RE: CCN: 245342
Cycle Start Date: April 26, 2021

Dear Administrator:

On April 26, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

## DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 26, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 26, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
Feel free to contact me if you have questions.

Sincerely,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245342 | A. BUILDING _____ B. WING _____ | C 04/26/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>On 4/26/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be SUBSTANTIATED: H5242064C (MN72049), with a deficiency cited at F609.<br><br>The following complaints were found to be UNSUBSTANTIATED: H5342065C (MN72150).<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance.<br><br>Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown | F 609 | | 5/20/21 |

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

Electronically Signed | 05/11/2021

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| F 609 | Continued From page 1<br>source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to report an allegation of resident-to-resident abuse to the state agency (SA) within two hours for 1 of 3 residents (R2) reviewed for abuse.<br><br>Findings include:<br><br>A Nursing Home Incident Report (NHIR) submitted to the SA 4/20/21, at 9:40 a.m. indicated one resident (R1) turned off the oxygen of another resident (R2) on 4/19/21, at 11:30 p.m.<br><br>R1's annual Minimum Data Set (MDS) dated 2/26/21, identified R1 as moderately cognitively intact. R1's diagnoses included dementia, and | F 609 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br><br>R1 had been placed on 30-minute visual checks prior to the incident due to her behaviors. As a result of this monitoring, the action of R1 turning off the oxygen concentrator was immediately detected and corrected. This resident was redirected by staff. R1 was approached with a room change to a private or semi-private room. The Administrator, DON, and Social Services Director, in collaboration with her son, did a room | |

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| F 609 | Continued From page 2<br>psychotic disorder.<br><br>R2's quarterly MDS dated 2/18/21, identified R2 as severely cognitively impaired. R2's diagnoses included chronic obstructive pulmonary disorder (COPD), and Alzheimer's disease. R2 required assist of one for most activities of daily living (ADLs). R2's current physician orders indicated, "Oxygen 2 liters (L) continuous at night while sleeping at bedtime for COPD."<br><br>R1's progress note dated 4/20/21, at 12:52 a.m. indicated, "Increased behaviors noted at beginning of shift. Resident shut off roommate's O2[oxygen] @ [at]11:30 pm."<br><br>When interviewed on 4/26/21, at 11:30 a.m. social services (SS)-A stated at the time of the incident the facility tried to move R1 to a different room due to verbal complaints made by R1 to staff about R2, however R1 refused to move rooms. SS-A further stated R1 was on 30-minute checks to ensure R1 was not verbally aggressive towards R2. SS-A stated since R1 turned off R2's oxygen on 4/19/21, R1 was involuntarily moved to a new room on 4/20/21. SS-A stated staff acted appropriately and would not have expected the incident to have been handled any differently.<br><br>When interviewed on 4/26/21, at 1:04 p.m. nursing assistant (NA)-A stated on 4/19/21, 30-minute checks were done on R1 due to previous disagreements with roommate. NA-A stated during one of the checks, R1 said the noise was too loud, and she could not sleep. NA-A explained to R1 the noise was from R2's oxygen and that it needed to be on overnight. NA-A stated on 4/19/21, at approximately 11:15 p.m. she heard a beeping sound from R1 and | F 609 | change. During this time, R1 son also requested an evaluation by her PMD regarding a mood stabilizing drug. Resident's recent actions, and R1 son's request, were reviewed at the QAPI/Behavior committee meeting on 4/23/21. It was determined that R1 could possibly benefit from the addition of Risperidone 0.5mg QD. The team chose a 12 noon dispense time to help with evening hours. R1 was also seen by the house psychologist from ACP on 4/28/21. He reviewed boundaries regarding the importance of not touching others medical equipment.<br><br>There was no negative impact on R2 from this incident. R2 demonstrates no changes in mood or behaviors, physical ability, or changes in R2 customary routine. R2 continues to reside in the facility.<br><br>The assessments and care plan for R1 and R2 have been reviewed and revised to meet psych-social/behavior needs.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>We will conduct reviews of progress notes and grievances for the last 3 months (Feb. 1st to present) to determine if there are other residents who had roommate concerns, and verify residents are satisfied with the resolution. | |

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| F 609 | Continued From page 3<br>R2's room and noticed the oxygen was off. NA-A immediately turned the oxygen back on and confronted R1 who admitted she turned the machine off because it was too loud and that she did not like R2 anyway. NA-A again explained to R1 it needed to be kept on. NA-A further stated the license practical nurse (LPN)-A was informed of the incident immediately.<br><br>When interviewed on 4/26/21, at 1:12 p.m. LPN-A stated worked the night shift on 4/19/21, and was aware of the 30-minute checks on R1. LPN-A stated they watched R1 due to her sporadic behaviors and wanted to ensure R2's safety until they could move R1. LPN-A stated the incident was not reported to anyone because she did not think it was an abuse situation. LPN-A stated she was not told that R1 had said she did not like R2 anyway. LPN-A further stated if there was suspected or potential harm the policy was to contact the director of nursing (DON) or administrator. LPN-A did not feel this incident met that criteria.<br><br>When interviewed on 4/26/21, at 1:25 p.m. DON was aware that R1 was at times "a not so nice person with comments and such." DON further stated R1 would just turn lights off when they bugged her regardless of whether R2 wanted the light on. DON stated the 30-minute checks were initiated because R1 had put up a fuss about the room change and it was a safety precaution. DON further stated a resident who turned off the oxygen of another resident was considered abuse and her expectation was that LPN-A would notify DON or administrator immediately.<br><br>The facility policy Abuse Prohibition/Vulnerable Adult Plan dated 7/5/19, indicated suspected | F 609 | Oxygen concentrators are naturally noisy, current resident's who share a room with someone that uses a concentrator will be interviewed to determine if the noise level is acceptable/bothersome.<br><br>The facility maintains a VA abuse prevention policy and procedure which includes reporting requirements of alleged violations.<br><br>What measures will be put in place or what systematic changes will you make to ensure that the deficient practice does not recur?<br><br>Training will be conducted for direct care staff, licensed staff, and leadership on:<br><br>How to identify resident to resident abuse/altercations and immediately stopping the abuse, and implementing interventions to prevent re-occurrence. The training will include how to identify and implement appropriate interventions for care of a cognitively impaired resident.<br><br>The training will include reporting to the administrator via the chain of command, and the appropriate state agency as required. More detailed education and training will be done with IDT team who have access to make online reports via the MDH nursing home incident report website.<br><br>Education on reporting timeframes: Must be reported immediately, but not later than 2 hours after the allegation is made, if the | |

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| F 609 | Continued From page 4<br>abuse must be reported to facility administration immediately following the appropriate chain of command. | F 609 | events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur (i.e., what quality assurance program will be put into place).<br><br>Audits regarding behaviors impacting roommates will be conducted daily for five resident x 2 weeks. Then audits will be weekly for five residents x 2 weeks and then monthly for five residents. Audit findings will be reported to QA Team monthly. QA team will determine the frequency and continuation of audits based on the results.<br><br>Ad Hoc QAPI meeting was held on 5/7/21 with the IDT, Nurse Consultant, and our Medical Director to discuss the 2567 and review our POC. Medical Director supported and agreed with the proposed POC.<br><br>DON and Social Service Director Responsible | |

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DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
May 3, 2021

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

Re: Event ID: PW9111

Dear Administrator:

The above facility survey was completed on April 26, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

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| | 00947 | A. BUILDING: _____ B. WING _____ | C 04/26/2021 |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 4/26/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.<br><br>The following complaints were found to be | 2 000 | | |

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

Electronically Signed | 05/11/21

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 2 000 | Continued From page 1<br>SUBSTANTIATED: H5242064C (MN72049), however no licensing orders issued.<br>The following complaints were found to be UNSUBSTANTIATED: H5342065C (MN72150).<br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents. | 2 000 | | |