STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Linden LLC	105 West Linden Street Stillwater, MN 55082

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure call lights were accessible for 1 of 1 resident (R11). Findings include:R11's modified significant change in status Minimum Data Set (MDS) dated [DATE], indicated R11 made himself understood and understood others, had moderate cognitive impairment, had impairment in range of motion to lower extremities, used a wheelchair, was dependent on staff for toileting hygiene, showering and bathing, and transfers. Further, R11 had multiple sclerosis, dementia, anxiety, and depression.R11's Kardex dated 1/8/26, indicated R11 was alert and oriented times two to three and lacked information R11 required his call light.R11's care plan revised 11/13/25, indicated R11 had an alteration in mood and behavior and interventions included to ensure the call light was visible and within reach. During observation on 1/5/26 at 2:19 p.m., R11 was in bed, and his call light was hanging off the foot of the bed between the foot board and the air mattress out of R11's reach.During observation on 1/7/26 between 7:30 a.m., and 8:11 a.m., R11 was in his room watching television in a reclining chair and his call light was located at the foot of the bed and draped between the foot board and the air mattress and out of R11's reach. At 8:11 a.m., two staff persons walked by R11's room and one staff person looked inside R11's room and went into another room down the hallway.During observation on 1/7/26 at 8:17 a.m., nursing assistant (NA)-B and NA-C brought R11 from his room to the dining room.During observation on 1/7/26 at 8:39 a.m., R11's call light was draped between the foot board and the air mattress. During interview and observation on 1/7/26 at 9:58 a.m., R11 was in his room in the reclining chair. NA-C stated R11 used his call light and verified R11's call light was between the foot of the bed and the mattress and was out of R11's reach. During interview on 1/7/26 at 10:40 a.m., registered nurse (RN)-C stated R11 used his call light and verified a call light intervention was not on the Kardex and expected staff to ensure R11's call light was within reach.During interview on 1/7/26 at 11:01 a.m., the director of nursing (DON) stated she expected staff to follow the care plan and stated it was important for R11 to have his call light in order to call for assistance. During interview on 1/7/26 at 1:02 p.m., the DON stated they did not have a policy on accessible call lights and stated it was general practice to have an accessible call light.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement pressure ulcer interventions for 1 of 1 resident (R11) reviewed for pressure ulcers.Findings include:R11's modified significant change in status Minimum Data Set (MDS) dated [DATE], indicated R11 had moderate cognitive impairment, had impairment in range of motion to lower extremities, used a wheelchair, was dependent on staff for most activities of daily living (ADLs) including putting on and taking off footwear and required substantial to maximal assistance with rolling left to right. Additionally, R11 did not reject care, had an indwelling catheter, was occasionally incontinent of bowels, had an unstageable pressure ulcer (pressure injury caused by prolonged pressure to a specific area of the skin that is completely obscured and cannot be staged) and was at risk of developing pressure ulcers. Furthermore, R11 had multiple sclerosis, dementia, diabetes, anxiety, and depression.R11's Physician's Orders form saved on 1/7/26 at 8:13 a.m., indicated the following orders:8/19/25, Wound, remove Prevalon boots (boots used to help protect heels from developing pressure injury) to inspect skin for any skin breakdown. Apply lotion and reapply boots every morning and at bedtime. Update hospice and provider with any changes. 9/17/25, Prevalon heel protector boots to be worn on bilateral feet at all times.10/23/25: wound to right great toe, cleanse with wound cleanser, pat dry. Apply a 2 by 2 saturated with quarter strength Dakin's solution to the wound base and cover with a small ABD pad twice a day. R11's Kardex saved on 1/7/26 at 10:17 a.m., directed staff to apply Prevalon boots to both feet at all times and to remove daily to inspect R11's skin for skin breakdown.R11's care plan saved on 1/7/26 at 8:23 a.m., indicated R11 had an alteration in mobility due to weakness from multiple sclerosis. R11's care plan saved on 1/7/26 at 8:23 a.m., indicated R11 had an alteration in skin integrity and had a pressure ulcer to his left buttocks and an abrasion to the right great toe. R11 had the following intervention, Prevalon boots to bilateral feet at all times remove daily to inspect skin for any skin breakdown. R11's Braden Scale for Predicting Pressure Sore Risk form dated 9/17/25 at 9:27 a.m., indicated R11 was at moderate risk for developing a pressure sore.R11's progress notes saved on 1/8/26 at 8:41 a.m., were reviewed from 1/1/26, and lacked documentation R11 refused to wear Prevalon boots. R11's nurse practitioner progress note dated 2/16/25 at 10:01 a.m., indicated R11 had an unstageable pressure ulcer to the right heel under a heading, Past Medical History. During observation on 1/7/26 at 7:30 a.m., R11 was in his room watching television in a reclining chair. R11's Prevalon boots were located on the counter in the room.During observation on 1/7/26 at 8:17 a.m., nursing assistant (NA)-B and NA-C brought R11 from his room to the dining room. R11 did not have the Prevalon boots on. During interview on 1/7/26 at 9:58 a.m., NA-C stated they received a sheet of paper with information when they started their shift to know what cares a resident required. NA-C stated R11 had a wound on his bottom and required a mechanical lift to get up and further stated R11 did not refuse cares. NA-C verified R11 was not wearing the Prevalon boots and stated she did not know whether R11 wore Prevalon boots while in his chair but wore the boots in bed. NA-C verified the sheet of paper lacked information R11 required boots. During interview on 1/7/26 at 10:07 a.m., nurse practitioner (NP)-A who conducted wound rounds at the facility stated she expected R11 to have the Prevalon boots on at all times and further stated everyone should know that. Licensed Practical Nurse (LPN)-A verified R11's boots were not on and stated he expected R11 to have the Prevalon boots on at all times. During interview on 1/7/26 at 10:16 a.m., LPN-A verified R11's care plan indicated R11 required the Prevalon boots at all times. During interview on 1/7/26 at 10:40 a.m., registered nurse (RN)-C stated she expected R11 have the Prevalon boots on at all times to protect R11's skin. RN-C stated residents had Kardex's in their closets, but the most accurate information was located in the computer. During interview on 1/7/26 at 11:01 a.m., the director of nursing (DON) stated she expected staff to follow the care plan and stated the boots should be on when resident was in bed and up in the chair. The DON further stated it was important R11 wear the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	boots for his skin integrity.A policy, Skin Assessment and Wound Management dated 2/2025, indicated the purpose of the policy was to provide guidelines for assessing and managing wounds and included implementing appropriate preventative skin measures. Additionally, for ongoing skin issues to follow ongoing treatments per provider orders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure environmental services staff (EVS) followed infection control measures for handling potentially contaminated laundry and linens for 1 of 1 resident (R34) observed for TBP. Additionally, the facility failed to ensure infection control tracking and surveillance was completed for R25 who had symptoms of a respiratory infection. Findings include:R34 R34's discharge/readmit Minimum Data Set (MDS) dated [DATE], indicated R34 was unable to complete the cognitive assessment and required supervision to partial/moderate assistance for most activities of daily living (ADLs). R34's diagnoses included cellulitis of right lower limb and cutaneous (affecting skin) abscess of right lower limb. R34's care plan (CP) dated 11/5/25, indicated R34 had potential self-care deficit related to wound on right leg and required assistance of one person for bathing, personal cares, and dressing. The CP indicated R34 required staff to follow enhanced barrier precautions (EBP) due to the need for wound care on right leg. During an observation and interview on 1/5/26 at 4:33 p.m., environmental services (EVS)-A was in R34's bathroom cleaning the surfaces and toilet with cleaning rags with no gown or gloves on. When EVS-A was done, she held the cleaning cloths against her shirt and carried them out of the resident room into the hallway, where she obtained a plastic bag, put the used cleaning rags in the bag and brought the bag down to the soiled utility room. Upon return, when asked, EVS-A stated linen should be bagged before it touches staff clothing. During interview and observation on 1/7/26 at 7:57 a.m., environmental services (EVS)-B came out of a resident's room and down the hallway with unbagged white linens that were touching her body. EVS-B stated the linens were on the bathroom floor and stated they should have been placed in a bag. During an interview on 1/7/26 at 10:33 a.m., the director of nursing (DON)/infection preventionist (IP) stated soiled resident Linens and EVS cleaning towels should be bagged before taking out resident's rooms and not touch staff clothing to prevent the spread of potential infections. R25 R25's comprehensive Minimum Data Set (MDS) dated [DATE], indicated moderate cognitive impairment, did not reject care, required substantial to maximum assist with toileting hygiene, bathing, and lower body dressing. Further, R25 had rheumatoid arthritis (an autoimmune disease), and an unspecified fracture of the skull. R25's Physician's Orders form indicated the following orders: 12/3/25, acetaminophen (a medication used for pain and for reducing fever) oral tablet, give 1000 milligrams (MG) three times a day for pain. 1/5/26, cough drops give 1 lozenge by mouth every hour as needed for cough/sore throat for 14 days. 1/5/26, Mucinex oral tablet Extended Release 12-hour 600 mg tablet every 12 hours as needed for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	congestion for 14 days. 1/5/26, geri-tussin oral liquid 100 mg/5 milliliters (ML) give 10 ml by mouth every 4 hours as needed for cough for 14 days. R25's medication administration record (MAR) and treatment administration record (TAR) dated January 2026, and saved on 1/8/26 at 9:35 a.m., indicated R25 utilized geri-tussin on 1/6/26, 1/7/26, and 1/8/26. Further, R25 utilized Mucinex on 1/5/26, 1/6/26, and 1/7/26. R25's progress notes dated 1/5/26 at 5:39 a.m., indicated R25 reported a sore throat. R25's progress notes dated 1/5/26 at 2:49 p.m., indicated R25 had cold symptoms and a sore throat and a message was sent to Aeris. R25's progress notes dated 1/5/26 at 8:49 p.m., 1/6/26 at 8:03 p.m., 1/7/26 at 1:44 a.m., 1/7/26 at 1:01 p.m., indicated Mucinex extended-release tablet was given and was effective for congestion. R25's progress notes dated 1/6/26 at 9:17 p.m., 1/7/26 at 2:31 p.m., 1/7/26 at 9:45 p.m., and 1/8/26 at 9:31 a.m., indicated that Geri-Tussin was effective for coughing. R25's care plan was reviewed and lacked information R25 had cold symptoms. R25's Kardex dated 1/8/26, was reviewed and lacked information R25 had cold symptoms. R25's Vital Signs form indicated R25's temperature was 99.7 on 1/7/26 at 1:44 p.m. Antibiotic logs provided by the facility for December and January year unspecified, indicated under a heading, Type of Infection R25 had rheumatoid arthritis upon admission and was on Hydroxychloroquine Sulfate (a medication used to treat autoimmune diseases) 200 mg twice daily that started on 12/1. Change in Condition logs provided by the facility for January 2026, indicated various residents with noted changes in condition on 1/5/26, and 1/7/26, however lacked information R25 had a change in condition. Resident Illness Tracker for January 2026, and provided on 1/8/26, lacked indication R25 had signs or symptoms of a respiratory infection. During interview and observation on 1/5/26 at 1:42 p.m., licensed practical nurse (LPN)-B entered R25's room and R25 stated her throat hurt and was on fire. R25 stated it started that morning. R25 had an occasional cough. During interview and observation on 1/5/26 at 1:49 p.m., LPN-B stated she spoke to the nurse practitioner and provided R25 ice chips for her sore throat. During interview on 1/7/26 at 2:14 p.m., R25 stated she started on three different drugs and stated she didn't have a sore throat but had a cough. During interview on 1/8/26 at 10:22 a.m., LPN-B stated staff wore masks when they had cold (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms and if a resident had cold signs or symptoms, they report to the nurse practitioner and added R25 had a cough and will cover her cough and staff made sure R25's hands were washed. LPN-B stated they monitored residents' symptoms at first and residents did not go on any precautions, but their symptoms were monitored. During interview on 1/8/26 at 10:31 a.m., the DON/IP stated when residents had signs or symptoms of a respiratory infection, they were encouraged to wear a mask if leaving their room and they monitored to see if there were any patterns or trends and further stated residents did not go on precautions, they were kept in their rooms as they allowed and if staff had symptoms should wear a mask and were encouraged to wear masks but was not required when caring for a resident with cold signs and symptoms. The DON further stated they tracked dates of onset of signs and symptoms and specific symptoms and temps based on a resident's baseline and was documented on a tracker. The DON further stated they were made aware of new signs and symptoms through review of progress notes. The DON stated she had a tracker that was completed on a daily basis and one completed at the end of the month and included daily symptoms, and type of medications. The DON was asked how trends were tracked or how potential outbreaks were tracked and stated they were a small facility but did not have a tracking system for this. The DON verified the Illness tracker log had not been updated. The DON further stated for testing, staff would test based on working with the provider and types of symptoms such as fevers, oxygen levels and heart rates and they document in their Change of Condition log and verified the log was not updated and stated it was supposed to be updated every day and will clear the week prior unless a resident continued to show symptoms and verified R25 was not on the change in condition form and the morning meeting change of condition notes and stated they missed R25. The DON further stated scheduled acetaminophen could mask symptoms of an elevated fever and added she would talk with the provider today to see if R25 should be on any sort of testing and R25 would be encouraged to stay in her room and if testing was pending, R25 would be placed on respiratory precautions. A policy, Infection Prevention and Control Program (IPCP), dated 11/2024, indicated the IPCP's mission was to prevent the development and transmission of communicable disease and infections and addresses detection, prevention and control of infections among residents and personnel and major elements of the program included surveillance, data analysis, outbreak management, and prevention of infection. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections and detecting unusual pathogens with infection control implications. Data analysis gathered during surveillance is used to oversee infections and spot trends. Furthermore, the policy indicated to educate staff and ensure adherence to proper infection control techniques and to implement appropriate isolation precautions when necessary to prevent the spread of infection. The undated EVS policy titled Daily Cleaning Procedures identified place soiled rags in a plastic bag on cart, remove and discard gloves, and wash hands prior to leaving room. The policy lacked instruction on how staff must handle, store, process, and transport linen to prevent the spread of infection.