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	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Greeley LLC	313 South Greeley 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure care planned interventions to reduce fall risk were implemented for 2 of 2 residents (R4 and R2) reviewed for falls. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE] identified R4 had intact cognition and no behaviors; had limited range of motion on one side of upper and lower extremity. R4 was dependent on a helper to do all the effort to transfer from chair to bed (or bed to chair). Sit to stand was not attempted due to medical condition or safety concerns. R4's care plan dated 6/9/25, identified she was at risk for falls due to impaired mobility and required assist of two staff for transfers using the MAXI lift (full body lift) r/t (related to) diagnoses of vascular dementia, non-traumatic intracerebral hemorrhage (type of stroke), and right sided weakness. R4's Follow Up Question Report dated 4/12/25 through 6/11/25, identified assist of two staff was required to transfer R4 using the MAXI lift with an XL sling size. During an interview on 6/9/25 at 4:08 p.m., R4 stated she had a fall earlier, because the nursing assistant attempted to transfer her using a standing lift and not the MAXI lift. R4 stated that did not work because the right side of her body was weak, and she fell without getting injured. During an interview on 6/9/25 at 7:32 p.m.,, nursing assistant (NA)-F stated she was called into R4's room earlier today by NA-H, because R4 had fallen. When NA-F entered R4's room, R4 was on the ground. NA-H stated she went to get the nurse to assess the situation. During an interview on 6/9/25 at 8:47 p.m., NA-F stated she attempted to transfer R4 with a standing lift instead of the MAXI lift, due to R4's request. When R4 started to stand up with the lift, her right leg buckled and she started to drop. NA-F lowered R4 to the floor and asked NA-H for help. NA-H left the room to get assistance, a nurse came in to assess R4's status, and then NA-H and NA-F assisted off the floor R4 using the full body lift. NA-F stated she should not have transferred R4 differently than what the care plan identified, however, R4 was in a hurry and requested the standing lift instead of the full body lift. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/11/25 at 10:10 a.m., NA-A and NA-B assisted R4 with a transfer from bed to wheelchair using the MAXI lift. NA-A and NA-B stated residents should be transferred using the care planned devices. During an interview on 6/10/25 at 11:09 a.m., the director of therapy services (DTS) stated R4 used to tolerate the standing lift, however, due to the progression of weakness from her stroke was switched over to the MAXI lift. The DTS stated R4 could bear some weight but the MAXI lift should be used for all transfers. During an interview on 6/11/25 at 1:10 p.m., licensed practical nurse (LPN)-E stated she was called to R4's room on 6/9/25, due to report of a fall. When LPN-E got to the room R4 was on the ground. LPN-E stated NA-H said she attempted a transfer using the standing lift instead of the MAXI lift, however, R4's leg gave out so NA-H lowered R4 to the ground. LPN-E assessed R4's vital signs and range of motion and determined it was acceptable to continue the transfer using the full body lift. R2's quarterly MDS dated [DATE], identified she had severely impaired cognition and no behaviors. Required substantial/maximal assistance putting on/taking off footwear, and supervision or touching assistance for sit to stand and for walking up to 50 feet. Diagnoses included heart failure, repeated falls, chronic pain, and palliative care. R2 had two falls without injury and one fall with minor injury since the previous MDS. R2's care plan dated 2/26/25, identified risk for falls related to heart failure, mild cognitive impairment, advanced age and end-stage disease processes on hospice care. Interventions were in place dated 4/11/25, to ensure resident always has appropriate footwear (gripper socks at HS/hour of sleep), and dated 6/10/25, to offer toileting upon rising, before and after meals, at HS, around 0100 to 0200 (1:00 a.m. to 2:00 a.m.) and PRN (as needed). Vulnerable Adult Maltreatment Report dated 4/8/25, identified R4's care planned interventions for falls were not implemented. During an observation on 6/10/25 at 2:52 p.m., R2 was in bed with tan socks on with no grip on the bottom. R2 did not have appropriate footwear on as care planned. During an interview on 6/10/25 at 3:24 p.m., NA-C R2 was a fall risk and should always have non-slip footwear on. NA-C observed the tan socks R2 had on and stated those were slippery and he would put gripper socks on now. During an interview on 6/10/25 at 3:25 p.m., LPN-A stated R2 was at risk of falls because she was impulsive and on-slip footwear should always be in place. During an observation at 6/11/25 at 8:25 a.m., R2 was in the dining room. At 9:15 a.m., NA-F took R2 out of the dining room and back to her room. Once in the room NA-F put shoes on R2's feet over her socks and gripper socks and brought her down to the commons area to watch TV. R2 was not offered to toilet after meals as care planned. During intermittent observations on 6/11/25 from 9:15 a.m., through 11:58 a.m., R2 remained in the commons are watching TV. At 11:58 a.m., family member (FM)-B came to visit and brought R2 back to her room and assisted R2 into a recliner in her room to have lunch together. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/11/25 at 12:27 p.m., NA-F entered R2's room, FM-B asked R2 if there was anything she needed from NA-F such as the bathroom. NA-F had not offered to toilet R2 before lunch as care planned. NA-F stated the bathroom should have been offered to R2 before and after meals. R2's Follow Up Question Report dated 6/11/25, identified toilet support was provided at 2:45 a.m., and 9:59 p.m. There was no documentation during the day shift of toileting before and after meals. During an interview on 6/11/25 at 12:03 p.m., registered nurse (RN)-A stated care planned interventions for falls should be carried out to prevent falls and injuries. During an interview on 6/11/25 at 12:56 p.m., the director of nursing (DON) stated fall interventions should be implemented as per the care plan. The facility policy Falls Prevention and Management dated 2/2024, identified care plans would be updated to reflect fall interventions. The facility policy Care planning dated 11/2024, identified the care plan would be used in developing the resident's daily care routines and would be utilized by staff personnel for the purposes of providing care or services to the resident.