

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2024
NAME OF PROVIDER OR SUPPLIER  The Estates at Greeley LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46885</p> <p>Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R37).</p> <p>Findings include: R37's Optional State Assessment (OSA) dated 7/10/24, indicated R37 had severe cognitive impairment, did not have behaviors, required extensive assistance with bed mobility, transfers, and toileting.</p> <p>R37's quarterly Minimum Data Set (MDS) dated [DATE], indicated R37 continuously had inattention, disorganized thinking, and an altered level of consciousness that fluctuated. Additionally, R37 rejected care 1 to 3 days, wandered 1 to 3 days, was frequently incontinent of bowel and bladder, had two or more falls with no injury, two or more falls with injury except major injury, was on hospice, and did not use restraints.</p> <p>R37's Medical Diagnosis form indicated the following diagnoses: Alzheimer's disease with late onset, traumatic subdural hemorrhage with loss of consciousness, fracture of unspecified part of neck of right femur, muscle weakness, anxiety disorder, age-related osteoporosis without current pathological fracture, and history of falling.</p> <p>R37's physician's orders were reviewed and lacked orders for a restraint.</p> <p>R37's care plan dated 1/23/24, indicated R37 was at risk for falling, had an altered cognition, and communication, and had an alteration in mood and behavior due to loss of independence and become anxious when R37 was not in her room, and interventions included to provide cues, reorientation, and supervision as needed, anticipate and meet resident's needs, speak to resident in simple to understand terms, repeat as needed.</p> <p>R37's care plan dated 1/29/24, indicated R37 got antsy around meal times and wheeled self around asking staff where she ate and word searches helped calm R37.</p> <p>R37's care plan dated 2/21/24, indicated R37 was at risk for elopement due to Alzheimer's disease.</p> <p>The care plan lacked interventions R37's wheelchair should be locked when at the dining room table.</p> <p>(continued on next page)</p>

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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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A form, [NAME] CNA (certified nursing assistant) Report Sheet indicated R37 transferred with assist of 1 with a walker, was continent of bowel, had mixed continence of bladder, and self-transfers and was at risk for falls. The form lacked information on specific fall interventions.</p> <p>R37's nursing progress notes dated 6/16/24, indicated R37 frequently self-transferred.</p> <p>During interview on 8/6/24 at 12:58 p.m., hospice registered nurse (RN)-D stated R37 has needed increased cares and was in her own world, oriented to self, and was nonsensical. Additionally, R37 has had several falls and did not know to ask for help and was impulsive and much more forgetful and stated R37's falls went in spurts.</p> <p>During interview and observation on 8/7/24 between 8:03 a.m., and 8:11 a.m., housekeeper (H)-A brought R37 up to the table in the dining room and locked R37's wheelchair after setting her up at the table and left the area. H-A stated she brought R37 out to the dining room so she could sweep R37's room and verified she locked the brakes and stated she always locked the brakes of the wheelchair so R37 can't try to get up. R37 was trying to pick up her crossword puzzle and H-A assisted in picking it up for R37.</p> <p>During interview on 8/7/24 at 8:14 a.m., licensed practical nurse (LPN)-A stated they did not lock wheelchairs because it was considered a restraint if they can't unlock it and stated it didn't matter if R37's wheelchair was locked and stated R37 was at a very high risk for falling.</p> <p>During interview on 8/7/24 at 8:21 a.m., registered nurse (RN)-E stated R37 was at risk for falling and stated locking the wheelchair would be considered a restraint and could cause more of a safety issue because R37 was not able to move and not able to back up.</p> <p>During interview on 8/7/24 at 9:22 a.m., the director of nursing (DON) stated housekeeping would need education and further stated housekeeping did not have access to the care plan and stated R37 could unlock the chair.</p> <p>During interview on 8/7/24 at 10:27 a.m., nursing assistant (NA)-D stated they had a sheet that indicated the cares a resident required and stated she could look at the documentation in the electronic medical record (EMR). NA-D stated R37 could propel her wheelchair and further stated R37 would not be able to think to know how to unlock and lock her wheelchair and stated R37's wheelchair had been locked before such as in the bathroom and when R37 first sits down in the chair and NA-D stated R37 thinks the wheelchair is stuck and does not know how to unlock it.</p> <p>An email sent on 8/7/24 at 1:02 p.m., from the DON indicated the facility did not have a policy on restraints because they did not use restraints.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</b></p> <p>Based on observation interview and record review the facility failed to ensure skin assessments were completed under a removable device for R16 and failed to ensure interventions were implemented for R20 who both were reviewed and at risk for pressure injury.</p> <p>Findings include:</p> <p>R16's admission Minimum Data Set (MDS) dated [DATE], indicated R16 was cognitively intact and had diagnoses of left ankle fracture, lung disease, and schizoaffective disorder. R16's MDS further indicated R16 required assistance with mobility, was at risk for pressure injury and required pressure relieving devices for the chair and bed.</p> <p>R16's orthopedic consultation/clinic referral form dated 7/31/24, indicated R16 had a cam boot (removable splint) for the left lower extremity to wear while weightbearing.</p> <p>R16's provider order dated 6/6/24, indicated R16's left leg splint was to remain clean, dry, and intact until next clinic visit.</p> <p>R16's provider and nursing orders lacked indication they had been updated following R16's orthopedic appointment on 7/31/24.</p> <p>R16's nursing progress note dated 7/31/24 at 4:55 p.m., indicated R16's left lower extremity cast was removed and replaced with a cam boot (removable splint).</p> <p>R16's progress notes dated 7/31/24-8/6/24, lacked indication R16's cam boot was removed for skin assessment.</p> <p>R16's weekly skin assessment dated [DATE], indicated R16 had lower extremity edema and intact skin. The skin assessment lacked indication R16 had healing surgical incisions, peeling skin on the left foot, or R16's cam boot was removed for assessment.</p> <p>R16's care plan dated 6/7/24, indicated R16 was at risk for alteration in skin integrity related to decreased mobility, assistance required with activities of daily living (ADL), transfers, and left ankle surgery to repair a fracture. Interventions included monitor for skin breakdown and for signs or symptoms of infection.</p> <p>R16's care plan revised after survey entrance on 8/7/24, indicated R16's cam boot could be removed when in bed and had to be in place when R16 was out of bed or ambulating.</p> <p>When interviewed on 8/5/24 at 2:25 p.m., R16 was sitting in the wheelchair and had the cam boot on the left ankle. R16 stated they had broken their ankle and had surgery to fix it. R16 had not been aware of any skin problems from the boot and further stated nurses do not remove the boot or look at skin or the incision. R16 stated the cam boot could be taken off when in bed but never was.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 8/7/24 at 10:19 a.m., nursing assistant (NA)-E stated they were not aware of R16's boot ever being removed. It was always on.</p> <p>When interviewed on 8/7/24 at 9:03 a.m., RN-A stated skin assessments were completed once a week on bath day. If a new skin issue was noted the nurse would open a skin management note and notification goes to the provider and Director of Nursing (DON). RN-A stated for surgical wound or treatments, the surgical providers will determine the treatment needed. When there is a removable splint there were orders to remove it for skin checks at least once a day. RN-A acknowledged R16's orders stated to leave splint dry and intact until follow up and acknowledged the orthopedic order to wear cam boot when weight bearing. RN-A stated he hadn't cared for R16 since the cast was removed and would need to follow up on the orders as they were conflicting.</p> <p>An observation on 8/7/24 at 9:43 a.m. registered nurse (RN)-A had clarified orders and entered R16's room to assess R16's skin under the cam boot. R16 was seated in the wheelchair with the left leg resting on an elevated wheelchair leg. RN-A unstrapped and removed the cam boot. The top half of the boot was removed and showed R16 had a sock that went just above their ankle. RN-A lifted R16's leg and first removed the sock and placed it on the floor, then removed the bottom part of the boot. R16 set his leg back down on the wheelchair leg rest. There was a strong odor coming from R16's foot. R16's foot was swollen. There was indentation from R16's sock just above the ankle. R16's surgical incision was located on the outside of the left ankle had no drainage and was almost completely healed. There was some betadine surgical scrub still on R16's heel and ankle area. R16's foot bottom was very cracked and very dry, and the sides of the foot had large amounts of dry dead skin peeling off. R16's skin was otherwise intact. RN-A used their gloved hand to brush some of the flaky skin off R16's foot. RN-A had obtained a washcloth and water and proceeded to wash R16's ankle area and foot paying close attention to the areas of flaky skin and in between toes. R16 apologized about the smell and stated this was the first time the boot was taken off. After washing, RN-A then applied lotion. R16's cam boot was noted to have skin flakes inside of the boot. With a cleaning wipe, RN-A held the boot over the garbage to wipe out the skin that had flaked off into the boot when R16's sock was removed. RN-A then placed a clean sock on R16's foot and placed the cam boot back on.</p> <p>A follow up interview on 8/7/2, at 11:00 a.m., RN-A verified the very dry and flaky skin R16 had on the left ankle/foot. RN-A stated R16's orders were updated to clarify what was needed and R16's provider had been notified and ordered additional treatment for R16's skin and edema.</p> <p>When interviewed on 8/7/24 at 11:40 a.m., the DON stated when residents come back from appointments orders were provided either electronically or written. The orders were placed by either the health unit coordinator or the nurse depending on the time of day. DON verified R16's orders and expected them to have been updated upon return from the clinic. DON further stated R16's cam boot should have been removed with CMS checks as it was a closed boot and expected staff to follow up on any skin concerns.</p> <p>When interviewed on 8/7/24 at 1:18 p.m., RN-C verified they supported wound rounds and documentation. RN-C stated when a resident required a removable device there should be orders directing staff to remove it at least daily to perform a skin assessment. This was important to ensure skin breakdown was not occurring from pressure in the splint or device. Furthermore, if provider orders were contraindicating to this the nurse should call and clarify.</p> <p>R20</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R20's quarterly MDS dated [DATE], indicated R20 was cognitively intact and had diagnoses of Parkinson's disease, diabetes, and peripheral vascular disease. Furthermore, R20 was at risk of pressure injury and had no suspected deep tissue injury (DTI) or other skin concerns. R20 required a pressure reducing device for the chair and bed.</p> <p>R20's care plan dated 1/26/24, indicated R20 was at risk for skin alteration related to decline in condition, falls, decreased mobility and Parkinson's disease. Interventions included to monitor skin integrity daily during cares and provide a pressure distribution mattress and cushion.</p> <p>A facility document titled [NAME] NA Report Sheet no date, lacked indication R20 was at risk for skin alterations or required additional interventions.</p> <p>R20's provider and nursing orders dated 6/27/24, indicated R20 required wound care monitoring and skin prep application to left heel twice a day. R20 also required blue boots on while in bed, feet reclined/elevated while in recliner at all times due to DTI (deep tissue injury).</p> <p>R20's electronic medical record lacked evidence R20 had a skin and wound evaluation for the DTI.</p> <p>An observation on 8/7/24 at 7:32 a.m., NA-F entered R20's room to assist with morning cares. R20 was laying in bed. NA-F removed R20's blue heel protection boots. R20's heels were intact. NA-F helped to sit up and placed shoes on R20 and assisted to the bathroom. After the bathroom, NA-F assisted R20 to their recliner to sit and moved R20's bedside table over in front of them. NA-F provided R20 with their dentures and a washcloth to wash their face. Once completed, NA-F left R20's room without asking, encouraging, or assisting R20 to elevate their legs in the recliner.</p> <p>When interviewed on 8/7/24 at 7:53 a.m., NA-F stated R20 usually was up in their chair most of the day and wasn't sure if R20 liked their legs elevated in the recliner. NA-F further stated R20 was not at risk for pressure injuries and was not aware of any interventions other than the blue heel boots that were in place to protect R20 from skin injury. NA-F stated any interventions were known by the care sheet. NA-F verified the care sheet did not list interventions R20 required.</p> <p>When interviewed on 8/7/24 at 11:09 a.m., licensed practical nurse (LPN)-A stated if a skin concern was noted RN-C was notified for orders and a progress note was documented. LPN-A verified R20 had a heel that was pink, but soft and boggy. LPN-A had not been working and had not seen it the past couple of days and was unsure if it had changed. LPN-A stated when R20 gets in to the recliner staff should request and encourage him to elevate legs to minimize pressure and prevent swelling.</p> <p>When interviewed on 8/7/24 at 11:40 a.m., the DON expected staff to complete a progress note or skin note when a skin concern was noted. Anything that is then identified was followed up by RN-C for review. Furthermore, NA staff knew what interventions were in place from their task sheets. DON stated R20 was able to put his feet down when wanted and staff needed to encourage R20 to elevate when in the recliner. If the staff were the ones placing R20 in the recliner they were expected to encourage and ask R20 to elevate their feet.</p> <p>When interviewed on 8/7/24 at 1:18 p.m., RN-C stated hospice reported R20's DTI and were managing it. All the monitoring was done through hospice. RN-C further stated they usually would also follow but had not been since hospice was. RN-C acknowledged they never assessed the DTI and should have looked at it and documented it.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility policy titled Skin Assessment and Wound Management revised 3/20/24, directed staff to complete a weekly skin assessment and implement appropriate interventions. Furthermore, the policy directed staff to initiate a skin wound evaluation when new skin problems were identified and update resident care lists and care plan.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</b></p> <p>Based on observation, interview, and document review, the facility failed to ensure podiatry services were obtained for 1 of 1 resident (R16) reviewed for foot care.</p> <p>Findings include:</p> <p>R16's admission Minimum Data Set (MDS) dated [DATE], indicated R16 was cognitively intact and had diagnoses of left ankle fracture, lung disease, and schizoaffective disorder. R16's MDS further indicated R16 required substantial assistance for personal cares and was dependent on staff for bathing and dressing the lower body and feet.</p> <p>R16's weekly skin inspection dated 6/14/24, indicated R16 had overgrown toenails however trimming was not necessary.</p> <p>R16's weekly skin inspection dated 6/21/24, indicated R16's toenails were not trimmed and R16 required podiatry to cut toenails due to thickness.</p> <p>R16's weekly skin inspection dated 6/28/24, indicated R16 required a podiatrist for toenail clipping.</p> <p>R16's weekly skin inspection dated 7/19/24, indicated R16 required podiatry to cut toenails due to thickness.</p> <p>R16's care plan dated 6/7/24, indicated R16 had a self-care deficit related to ankle fracture and required assistance with personal hygiene.</p> <p>R16's medical record lacked indication R16 had been seen or referred for podiatry services.</p> <p>An observation on 8/7/24 at 9:43 a.m. registered nurse (RN)-A entered R16's room to assess R16's skin. R16 was seated in the wheelchair with the left leg resting on an elevated wheelchair leg. R16's left leg was in a cam boot (removable splint). RN-A removed the boot and R16's sock that was in place under the boot. R16's foot was extremely dry with peeling skin on bottom and sides of feet. R16's toenails were yellowed and thick. R16's toenails were slightly curled over the top of R16's toes.</p> <p>When interviewed on 8/7/24 at 11:00 a.m., RN-A was not sure of the process to obtain podiatry services for residents when needed and referred to RN-B. RN-B stated if nurses were unable to provide toenail care for residents, they would be placed on the list to be seen by podiatry. Podiatry services were offered about every 2-3 months. If the need was urgent, a consult order for an outside provider was obtained. RN-B stated RN- C reviewed weekly skin notes and alerted the admission coordinator (AC) who had the list or would work on an outside appointment.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 8/7/24 at 11:11 a.m., the AC stated in house podiatry services were offered every 2-3 months. AC stated they had a list of residents who need to be seen but if the need was more urgent, an order would be obtained for an outside referral. AC stated the last time podiatry was here was 7/11/24 and was scheduled to be onsite next on 9/12/24. AC verified R16 had not been placed on the list to be seen and would add them.</p> <p>When interviewed on 8/7/14 at 11:40 a.m., the Director of Nursing (DON) stated AC had the list and was responsible to update it when notified of residents needing podiatry services. Since R16 was a short-term resident admitted for therapy services for the broken ankle they may not have the chance to see podiatry and then a referral would be made at discharge. DON expected residents who required services by podiatry to be on the list and seen when podiatry was in house.</p> <p>When interviewed on 8/7/24 at 1:39 p.m., RN-B stated they review any weekly skin assessments that were completed the previous day to ensure they were completed and to identify new skin concerns. RN-B further stated any nail care concerns for podiatry was usually addressed by the bedside nurse and if needed the bedside nurse would get them onto the podiatry list to be seen.</p> <p>The facility admission agreement no date, indicated special services available at the facility included podiatry services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46885</p> <p>Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R37) with repeated falls had implemented interventions to promote safety and reduce the risk of falls and the facility failed to ensure R37 was free from physical restraints.</p> <p>Findings include:</p> <p>R37's Optional State Assessment (OSA) dated 7/10/24, indicated R37 had severe cognitive impairment, did not have behaviors, required extensive assistance with bed mobility, transfers, and toileting.</p> <p>R37's quarterly Minimum Data Set (MDS) dated [DATE], indicated R37 continuously had inattention, disorganized thinking, and an altered level of consciousness that fluctuated. Additionally, R37 rejected care 1 to 3 days, wandered 1 to 3 days, was frequently incontinent of bowel and bladder, had two or more falls with no injury, two or more falls with injury except major injury, was on hospice, and did not use restraints.</p> <p>R37's Medical Diagnosis form indicated the following diagnoses: Alzheimer's disease with late onset, traumatic subdural hemorrhage with loss of consciousness, fracture of unspecified part of neck of right femur, muscle weakness, anxiety disorder, age-related osteoporosis without current pathological fracture, and history of falling.</p> <p>Refer to F604, based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R37).</p> <p>R37's care plan dated 1/23/24, indicated R37 was at risk for falling due to history of closed right hip fracture, late onset Alzheimer's dementia, osteoporosis, diabetes mellitus type two, and anxiety. R37's goal was to be safe and free from falls and had the following interventions:</p> <p>2/20/24, ensure the TV remote is within reach while in the room</p> <p>3/16/24, encourage resident to be in common areas for safety</p> <p>4/12/24, call light reminder signage posted on the wall in the room</p> <p>6/5/24, stop sign and wait for assistance posted on resident's bathroom door.</p> <p>6/13/24, night light to room</p> <p>6/17/24, floor mat next to bed only while patient is in bed, otherwise please remove mat from the floor.</p> <p>6/27/24, ensure gripper socks are on at all times</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6/27/24, toileting schedule offer toileting upon rising, before and after meals, before bedtime, start of nights, midnight, and 4-5 a.m., and as needed.</p> <p>7/31/24, offer snack between lunch and dinner.</p> <p>8/6/24, soft touch call light</p> <p>The care plan lacked interventions R37's wheelchair should be locked when at the dining room table.</p> <p>A form, [NAME] CNA (certified nursing assistant) Report Sheet indicated R37 transferred with assist of 1 with a walker, was continent of bowel, had mixed continence of bladder, self-transferred, and was at risk for falls. The form lacked information on specific fall interventions.</p> <p>R37's physician's orders dated 6/9/24, indicated staff were to stay in the bathroom with R37 during toileting until R37 was finished and assisted bath the R37's wheelchair. After toileting, staff to bring R37 into the TV lounge or dining room to be monitored by staff.</p> <p>R37's medication administration record (MAR) and treatment administration record (TAR) dated August 2024, indicated R37 was to have a floor mat next to the bed every shift for fall intervention that started on 6/14/24, and was discontinued on 8/6/24.</p> <p>R37's progress note dated 4/11/24 at 10:37 a.m., indicated R37 had an unwitnessed fall at 9:00 p.m., R37 was trying to shut the door to her room and tripped on the mat next to the bed and the floor mat was removed.</p> <p>R37's progress note dated 6/5/24 at 10:04 a.m., indicated R37 fell at 9:35 a.m., while ambulating to the bathroom.</p> <p>R37's progress note dated 6/8/24 at 6:10 p.m., indicated R37 was ambulating in her bathroom and fell bumping her head on the wheelchair wheel of another resident.</p> <p>R37's progress note dated 6/10/24 at 6:26 a.m., indicated R37 was found sitting on the floor next to her bed.</p> <p>R37's progress note dated 6/14/24 at 3:46 p.m., indicated R37 had an unwitnessed fall at 2:30.</p> <p>R37's progress note dated 6/25/24 at 4:07 a.m., indicated the nursing assistant (NA) entered R37's room at 12:10 a.m., and found R37 had slid off the bed that was in the low position and was sitting on the floor mat and planned to continue with toileting plan.</p> <p>R37's progress note dated 6/25/24 at 3:53 p.m., indicated R37 was found sitting on the floor in the hall with her back against the wall.</p> <p>R37's progress note dated 7/7/24 at 10:13 p.m., indicated staff noted R37 sitting on the floor at 9:00 p.m., and had her gown and socks on and R37 stated she slid out of bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R37's progress note dated 7/26/24 at 10:37 p.m., indicated R37 was found on the floor and was unsteady with a transfer.</p> <p>R37's progress note dated 8/6/24 at 10:11 p.m., indicated R37 was calling for help at 3:00 p.m., and was noted to be sitting on the floor next to her bed with the wheelchair in [NAME] of her and the plan was to keep the bed at normal height when R37 was out of bed and inquire about new shoes and torn shoes would be removed.</p> <p>R37's Incident Review and Analysis form dated 4/11/24 at 10:39 a.m., indicated R37 fell while ambulating on 4/10/24 at 9:00 p.m. and tripped on her floor mat and the floor mat was immediately removed.</p> <p>R37's Incident Review and Analysis form dated 6/5/24 at 11:36 a.m., indicated R37 fell on [DATE] at 9:35 a. m., while ambulating to the bathroom and a stop sign and ask for assistance with bathroom transfer sign was placed on R37's bathroom door and staff were educated on following the toileting schedule.</p> <p>R37's Incident Review and Analysis form dated 6/12/24 at 1:20 p.m., indicated R37 was found on the floor on 6/8/24 at 6:10 p.m. and staff were educated on best practices to stay with resident until toileting was finished.</p> <p>R37's Incident Review and Analysis form dated 6/13/24 at 11:05 a.m., indicated R37 was found on the floor on 6/12/24 at 9:46 p.m. R37 was closing the room door after toileting and laying down in bed. An intervention added included a night light was added to the room.</p> <p>R37's Incident Review and Analysis form dated 6/17/24 at 9:41 a.m., indicated R37 was found on the floor on 6/14/24 at 2:30 p.m., R37 was unsure what she was doing and was checked for incontinence, was not incontinent and was toileted and assisted to bed. An intervention implemented was to have the floor mat next to the bed only while R37 was in bed, otherwise the floor mat was to be removed from the floor.</p> <p>R37's Incident Review and Analysis form dated 6/27/24 at 2:52 p.m., indicated R37 was found sitting in the hallway on 6/25/24 at 4:06 p.m., and a hospice evaluation was requested along with offering activity and encourage R37 to be in common areas.</p> <p>R37's Incident Review and Analysis form dated 7/9/24 at 12:40 p.m., indicated R37 slid out of her bed on 7/7/24 at 9:52 p.m., and glow tape was added to the call light.</p> <p>R37's Incident Review and Analysis form dated 7/30/24 at 10:29 a.m., indicated R37 was found on the floor on 7/26/24 at 4:25 p.m., and was self-transferring. Interventions included to offer a snack between lunch and dinner.</p> <p>R37's Incident Review and Analysis form dated 8/7/24 at 9:12 a.m., indicated R37 was found on the floor on 8/6/24 at 3:00 p.m., and was self-transferring to her bed from the wheelchair. An intervention included to keep the bed in the standard position when R37 was out of bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 8/5/24 at 1:15 p.m to 1:16 p.m., an un-named staff person brought R37 into her room in R37 was in her wheelchair with the back of the wheelchair facing the nightstand. R37 had a mat located on the floor and the bed was positioned in the low position almost to the floor.</p> <p>During observation on 8/6/24 at 11:38 a.m., R37 was in her room working on a crossword and the mat was not located on the floor.</p> <p>During interview and observation on 8/7/24 between 8:03 a.m., and 8:11 a.m., housekeeper (H)-A brought R37 up to the table in the dining room and locked R37's wheelchair after setting her up at the table and left the area. H-A stated she brought R37 out to the dining room so she could sweep R37's room and verified she locked the brakes and stated she always locked the brakes of the wheelchair so R37 can't try to get up. R37 was trying to pick up her crossword puzzle and H-A assisted in picking it up for R37. See also F604.</p> <p>During observation on 8/7/24 at 8:13 a.m., R37's fall mat was located on the floor in R37's room and R37 was in the dining room.</p> <p>During interview and observation on 8/7/24 at 8:14 a.m., licensed practical nurse (LPN)-A verified the mat was on the floor by R37's bed and stated the mat was not a hindrance for R37 and added it was there because R37 tries to get in and out of bed constantly and the mat was kept there to prevent R37 from falling. LPN-A further stated wheelchairs were not locked because it was considered a restraint and stated it did not matter if R37's wheelchair was locked and added R37 was at a very high risk for falling.</p> <p>During interview on 8/7/24 at 8:21 a.m., registered nurse (RN)-E stated R37 was at risk for falling and stated fall interventions included a soft touch call light and a floor mat while in bed, a toileting schedule and keep R37 in high traffic areas. RN-E further stated locking the wheelchair would be considered a restraint and could cause more of a safety risk because R37 was not able to move and not able to back up.</p> <p>During interview on 8/7/24 at 9:22 a.m., the director of nursing (DON) stated they always try to follow the care plan and planned to talk with the aides to see why the mat was on the floor and further, housekeeping did not have access to the care plan and stated R37 could unlock the chair and stated it would be important to provide education to housekeeping.</p> <p>During interview on 8/7/24 between 10:27 a.m., and 10:37 a.m., nursing assistant (NA)-D stated they had a sheet that indicated the cares a resident required and stated she could look at the documentation in the electronic medical record (EMR). NA-D stated R37 could propel her wheelchair and further stated R37 would not be able to think to know how to unlock and lock her wheelchair and stated R37's wheelchair had been locked before such as in the bathroom and when R37 first sits down in the chair and NA-D stated R37 thinks the wheelchair is stuck and does not know how to unlock it. NA-D further stated R37's mat was supposed to be on the floor at all times and verified the mat was on the floor and R37 was in the wheelchair. At 10:37 a.m. , NA-D viewed the [NAME] CNA Report sheet form and verified the form lacked fall prevention interventions including whether the mat was supposed to be off the floor when R37 was in the chair.</p> <p>During interview on 8/7/24 at 10:43 a.m., the DON was notified R37 was in her room and the mat was located on the floor and staff were going down to R37's room to follow up.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An email sent on 8/7/24 at 1:02 p.m., from the DON indicated the facility did not have a policy on restraints because they did not use restraints.</p> <p>A policy, Fall Prevention and Management revised 2/2024, indicated the purpose of the protocol was to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. After an observed or probable fall staff will clarify the details of the fall, when the fall occurred, where, and what the individual was trying to do at the time the fall occurred.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885</b></p> <p>Based on observation, interview, and document review, the facility failed to ensure complete required nurse staffing information was posted and was timely on a daily basis. This had the potential to affect all 48 residents, staff, and visitors who could wish to review this information.</p> <p>Findings include:</p> <p>On 8/6/24 at 1:57 p.m., form, Estates at [NAME], dated 8/6/24, was located next to the adminstartor's office. The form identified an area to document the census, however, the census number was undocumented. Additionally, the form identified some staff and their titles, but did not identify all staff and their titles and lacked information on the total number and actual hours worked by registered nurses (RNs), licensed practical nurses (LPNs), and nursing assistants (NAs).</p> <p>During interview on 8/6/24 at 2:00 p.m., the administrator verified the form, Estates at [NAME], was the staff posting and stated it usually included the census and verified the census was not added on the form and proceeded to write the census number on the form. When asked about the total hours worked, the administrator stated after the shift was worked it was broken down on how many hours were worked.</p> <p>During interview on 8/7/24 at 9:34 a.m., the director of nursing (DON), verified staff posting forms reviewed from 7/26/24, through 8/6/24, lacked tallied hours. Further, the DON stated she corrected the posting for 8/7/24, and going forward to include the tally for the total number and actual hours worked. A policy was requested, but not received.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46885</p> <p>Based on interview and document review, the facility failed to ensure gradual dose reductions (GDR) were attempted, or an adequate medical justification for the use of psychotropic medications for 2 of 5 residents (R19, R14) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R19's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderate cognitive impairment, did not have hallucinations, delusions, physical behaviors. R19 had verbal behavioral symptoms 1 to 3 days and did not have other behavioral symptoms and did not reject cares. Further, R19 took antipsychotic and antidepressant medications, a gradual dose reduction had not been attempted and had not been documented by a physician as clinically contraindicated.</p> <p>R19's Medical Diagnosis form indicated the following diagnoses: Parkinson's disease, dementia in other diseases classified elsewhere without behavioral disturbance, history of falling, and insomnia.</p> <p>R19 had the following physician order:</p> <p>4/28/23, trazodone 150 milligrams (MG) by mouth daily for insomnia at bedtime.</p> <p>R19's medication administration record (MAR) dated August 2024, indicated give trazodone 150 mg by mouth one time a day for insomnia at bedtime and side effects included sedation, orthostatic hypotension (a form of low blood pressure that happens from standing up from sitting or lying down), anticholinergic symptoms, extra pyramidal symptoms and if observed document in a progress note.</p> <p>R19's care plan dated 5/9/23, indicated R19 had the potential for psychotropic drug ADR (adverse drug reaction) related to daily use of psychotropic medication and interventions included: administer medication as ordered monitoring for ADR's. Report suspected ADR's to nursing, physician, physician assistant (PA). Medications are reviewed by physician, PA, and pharmacist, update physician, PA regarding efficiency of medications and or ADR's as needed.</p> <p>R19's care plan dated 12/5/23, indicated R19 had a potential for alteration in sleep due to a diagnosis of insomnia and interventions included medication for sleep per physician order and provide with a quiet environment to sleep.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R19's Consultant Pharmacist Recommendation to Physician form dated 4/14/24, indicated R19 took trazodone 150 mg at bedtime since 4/28/24, (the order was from 4/28/23), for insomnia. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. R19 was due for a dose reduction assessment and the pharmacist inquired if during the next visit if the physician could review whether R19 continued to be on the lowest effective dose of their regimen and if a dose reduction was contraindicated to document the clinical rationale. Under the heading, Physician/Prescriber Response, indicated Patient refuses and was signed on 4/15/24. The form lacked any clinical rationale or justification for continued use.</p> <p>During observation on 8/6/24 at 2:29 p.m., R19 was observed to be in bed snoring.</p> <p>During interview on 8/7/24 at 9:55 a.m., the director of nursing (DON) stated the pharmacist consultant sends the pharmacy recommendation electronically to the team and the provider reviews them and they act on the revisions and the physician signs them and the physician should write a rationale as to why they disagree. The DON stated they liked to have a conversation about the consultant pharmacist recommendation and stated patient refused was not a good reason for a rationale and stated the nurse practitioner signed the form.</p> <p>During interview on 8/7/24 at 10:58 a.m., the consultant pharmacist (CP) stated typically they needed clinical documentation for a rationale for a GDR not completed such as the resident is stable and stated if a resident refused or the power of attorney refused, the pharmacist stated she thought the provider would respect the resident or POA's decision if they did not want a GDR and stated she would accept a refusal and stated she did not look to see if someone was capable of making their own decisions and stated it would be the provider's determination.</p> <p>A policy, Gradual Dose Reduction (GDR), dated 12/2019, indicated the facilities goal was to monitor ongoing use of psychotropic medications and other medications that impact brain activity that are ordered in place of a psychotropic medication. Gradual dose reductions and or documentation of contraindications per current documentation of contraindications per current pharmacy and federal guidelines. Within the 1st year the facility must attempt a GDR in two separate quarters with at least one month between the attempts unless clinically contraindicated. Clinically contraindicated means: the continued use is in accordance with relevant current standards or practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or the resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.</p> <p>42586</p> <p>R14's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and a diagnosis of major depressive disorder. It further indicated R14 received an antidepressant on a routine basis.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R14's physician's orders dated 2/8/23, indicated escitalopram oxalate tablet 10 milligrams (mg). Give 5 mg by mouth one time a day related to major depressive disorder, single episode, mild. If the following symptoms are observed, document in the progress notes: sedation, orthostatic hypotension, anticholinergic, and extra pyramidal.</p> <p>R14's care plan dated 7/24/24, indicated R14 had a potential for psychotropic drug adverse reactions related to daily use of antidepressant medications. Side effects may include: sedation, orthostatic hypotension, anticholinergic, and extra pyramidal symptoms. If observed document in progress notes with an intervention for the medications to be reviewed by medical doctor (MD) and Pharmacist.</p> <p>R14's consultant pharmacy recommendation dated 6/19/2024, indicated R14 was currently receiving escitalopram 10 mg daily for major depressive disorder since the last gradual dose reduction (GDR) in February 2023. Per state operation manual (SOM) guidelines, an attempt to taper the medication must be done every year, unless clinically contraindicated. R14 was due for a dose reduction assessment. During your next visit could you please review whether resident continues on the lowest effective doses of his regimen. If a dose reduction is contraindicated, please document clinical rationale below. The recommendation was signed by the nurse practitioner (NP) on 7/2/24 with a handwritten notation indicating pt [patient] POA [Power of Attorney] refused and lacked clinical rationale and was not noted to be clinically contraindicated.</p> <p>During interview on 8/7/24 at 9:55 a.m., the director of nursing (DON) stated the pharmacist consultant sends the pharmacy recommendation electronically to the team and the provider reviews them and they act on the revisions and the physician signs them and the physician should write a rationale as to why they disagree. The DON stated they liked to have a conversation about the consultant pharmacist recommendation and stated patient refused was not a good reason for a rationale and stated the nurse practitioner signed the form.</p> <p>During interview on 8/7/24 at 10:58 a.m., the consultant pharmacist (CP) stated typically they needed clinical documentation for a rationale for a GDR not completed such as the resident is stable and stated if a resident refused or the power of attorney refused, the pharmacist stated she thought the provider would respect the resident or POA's decision if they did not want a GDR and stated she would accept a refusal and stated she did not look to see if someone was capable of making their own decisions and stated it would be the provider's determination.</p> <p>On 8/7/24 at 12:06 p.m., the survey called and left a message for the medical director (MD) but did not receive a call back.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A policy, Gradual Dose Reduction (GDR), dated 12/2019, indicated the facilities goal was to monitor ongoing use of psychotropic medications and other medications that impact brain activity that are ordered in place of a psychotropic medication. Gradual dose reductions and or documentation of contraindications per current documentation of contraindications per current pharmacy and federal guidelines. Within the 1st year the facility must attempt a GDR in two separate quarters with at least one month between the attempts unless clinically contraindicated. Clinically contraindicated means: the continued use is in accordance with relevant current standards or practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or the resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42586</p> <p>Based on interview and document review the facility failed to provide menu's and alternate food choices to 2 of 2 residents (R14, R98) reviewed for food.</p> <p>R14's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of congestive heart disease (CHF), type II diabetes. and required setup/clean up assistance with eating.</p> <p>R14's physician's orders dated 6/30/24, indicated a consistent carbohydrate diet, regular texture, regular (thin) consistency, no added salt. Offer assistance cutting foods, related to type II diabetes mellitus.</p> <p>R14's care plan dated 7/24/24, indicated a potential for alteration in nutrition related to diabetes mellitus type II (DMII), obesity, and history of COVID 19, iron deficiency anemia, depression, dementia, dysphagia, and hypertension (HTN) with an intervention to offer substitute for dislikes or when not eating.</p> <p>During interview on 8/5/24 at 1:35 p.m., R14 stated he never knows what he's going to get to eat for each meal and he hadn't received a menu. He also stated staff do not come in and ask him what he would like to eat before each meal, therefore he doesn't feel he get's a choice stating I just have to eat what they give me.</p> <p>During a follow up interview on 8/7/24 at 8:40 a.m., the surveyor showed R14 the weekly menu and a Bistro (alternate) menu. He stated he had never been given a menu up until a week ago and he had to ask for it. He further stated he had never been given or seen the alternate menu and didn't know he had a choice of those items.</p> <p>R98's admission Minimal Data Set (MDS) report dated 8/2/24, indicated intact cognition, diagnoses of R98's of enterocolitis due to c-diff, sepsis, urinary tract infection (UTI), and was independent with eating.</p> <p>R98's physician's orders dated 8/1/24, indicated a 2 gram (gm) sodium diet, regular texture, regular (thin) consistency.</p> <p>R98's care plan dated 8/2/24, indicated R98 had a potential alteration in nutrition related to C-Diff, sepsis, urinary tract infection (UTI), DMII, depression, HLD, and HTN. Decreased sodium/saturated fat needs related to HTN, HLD as evidenced by therapeutic diet order. Diet: 2 grams (gm) no added salt diet, regular texture, regular (thin) consistency. It further indicated an intervention to offer a substitute for dislikes or when not eating.</p> <p>During interview on 08/05/24, at 5:40 p.m. R98 stated she didn't know what she was going to get to eat each meal until it showed up in her room and there were a lot of things she didn't like. She further stated she hadn't received a menu and didn't know their were alternative menu items she could choose from.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  The Estates at Greeley LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  313 South Greeley Street Stillwater, MN 55082	
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow up interview on 8/7/24 at 8:43 a.m., surveyor showed R98 the weekly menu and the alternate menu, in which she stated she'd never been given one and she didn't know their were alternate food items she could choose from, she just eats what she get's and theirs been things she didn't want to eat, for example the green beans had all kinds of other stuff in them and I couldn't eat it.</p> <p>During interview on 8/6/24 at 8:37 a.m., the cook (C)-A stated the resident's know what they are having for each meal because the menu was posted on each end of the the dining halls. Also during activities often times the resident's will ask what was on the menu for that day. When a resident was admitted they received a menu. Staff do not go in the resident's room and ask what they would like for each meal. The resident's don't get two choices It's more of a fixed menu. I think they get menu's or they can ask if they want to get a menu.</p> <p>During interview on 8/6/24 at 12:02 p.m., the dietary manager stated their menu was a 5 week fixed menu which only included one food option unless they're serving fish or pork. They also provide a Bistro menu which lists alternative options the residents can choose from. The Bistro menu was not passed out to residents or posted on the wall with the weekly menu but was located in a hanging file on the wall next to the kitchen. The kitchen manager further stated he feels the dietary staff would make the residents anything they wanted even if it wasn't listed on the menu.</p> <p>During interview on 8/7/24 at 8:28 a.m., nursing assistant (NA)-E stated each resident get's a weekly menu and an alternate menu every week so they can choose what they would like to eat.</p> <p>During interview on 8/7/24 at 8:48 a.m. NA-G stated residents know what they are going to eat each day by looking at the menu's that are posted at the end of the each hallway. NA-G further stated the residents can ask for a menu or ask a staff member what the meal was going to be. It was the responsibility of the resident to ask for a menu or tell a staff member if they don't like what was being served.</p> <p>During interview on 8/7/24 at 8:53 a.m., registered nurse (RN)-A stated the nursing assistants were responsible for passing out menu's to the residents but anyone can do it. RN-A stated he didn't know if staff passed out the Bistro (alternate) menu to residents or not or if it was posted.</p> <p>During interview on 8/7/24 at 9:53 a.m., licensed practical nurse (LPN)-C stated staff provide menu's to the residents who are conscious and those that aren't don't receive menu's because it doesn't matter. They don't pass out the alternate menu because if the resident wants something different they will ask for i</p> <p>The facility's policy regarding menus dated 10/2017 indicated, menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. Menus for regular and therapeutic diets are written at least two (2) weeks in advance, and are dated and</p> <p>posted in the kitchen at least one (1) week in advance. Copies of menus are posted in at least two (2) resident areas, in positions and in print large enough for residents to read them.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42586</p> <p>Based on observation, interview and record review the facility failed to ensure transmission-based precautions (TBP) were utilized for 1 of 1 residents (R98) who required contact precautions for clostridium difficile (C. diff, a highly contagious infection). Furthermore, the facility failed to ensure enhanced barrier precautions (EBP) and appropriate hand hygiene was used for 1 of 1 residents (R20) observed during personal cares.</p> <p>Findings include:</p> <p>R98's admission Minimum Data Set (MDS) report dated 8/2/24, indicated intact cognition and a diagnoses of enterocolitis due to c-diff, sepsis, and urinary tract infection (UTI).</p> <p>R98's physician's orders lacked indication R98 required contact precautions.</p> <p>R98's care plan dated 8/2/24, lacked indication R98 required contact precautions.</p> <p>R98's progress note dated 8/6/24, indicated R98 was receiving Vancomycin oral solution 250 mg/5 milliliters (ml) and had one large loose stool.</p> <p>During observation on 8/6/24 at 2:31 p.m., R98's room had a sign on the door indicating contact precautions: everyone must clean hands before entering and leaving the room. Providers and staff: put on gloves and a gown before room entry, discard before exiting. R98 was sitting in her wheelchair in the dining room with certified occupational therapy assistant (COTA)-A. After a few minutes COTA-A assisted R98 to stand up and was walking behind R98 in the hallway holding onto her gait belt with one hand and pulling the wheelchair behind her with the other. They stopped at her room and went inside. COTA-A removed R98's gait belt and assisted her to sit down in her recliner. Then she picked up two water pitchers and exited the room, walked down the hallway to the water cooler in the common/television area, filled up the water pitchers, and brought them back to R98's room. Then exited the room. COTA-A was not wearing a gown or gloves during this process and did not wash or sanitize her hands upon entering/exiting the room.</p> <p>During interview on 8/6/24 at 2:34 p.m., COTA-A stated R98 was on contact precautions for C-diff, verified not donning appropriate personal protective equipment (PPE), and stated another therapist (unknown) said a gown and gloves only needed to be worn if they were performing cares.</p> <p>During interview on 8/6/27 at 3:00 p.m., licensed practical nurse (LPN)-B stated staff working with residents who are on contact precautions should wear gloves and a gown upon entering the room and performing cares. They should also be washing their hands with soap and water as opposed to hand sanitizer.</p> <p>During interview on 8/7/24 at 9:55 a.m., the director of nursing (DON) stated staff working with residents on contact precautions (specifically R98) should be wearing a gowns, gloves, and washing their hands with soap and water, when entering the room to provide cares. The DON further stated therapy was considered to be providing cares and if staff don't wear the appropriate PPE, C-diff can spread very easily throughout the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>44647</p> <p>R20's quarterly MDS dated [DATE], indicated R20 was cognitively intact and had diagnoses of Parkinson's disease, diabetes, and peripheral vascular disease.</p> <p>R20's provider and nursing orders lacked indication R20 required EBP.</p> <p>R20's care plan dated 1/26/24, lacked indication R20 required EBP.</p> <p>A facility document titled [NAME] NA Report Sheet no date, lacked indication R20 required EBP.</p> <p>An observation on 8/5/24 at 12:48 p.m., R20 was sitting in their room in a wheelchair. Their door was open and on the outside of the door was a sign. The sign directed staff to gown and glove when providing close contact cares.</p> <p>Upon R20's door was also a hanging storage rack that had gowns and gloves.</p> <p>An observation on 8/7/24 at 7:32 a.m., NA-F entered R20's room to assist with morning cares. NA-F performed hand hygiene before entering R20's room and then obtained gloves from the bathroom. NA-F did not place a gown on. NA-F took a urinal half filled with urine from R20's table and went into the bathroom to empty. The urinal was brought back to the bedside and placed on the floor near R20's bed. Without removing gloves or performing hand hygiene, NA-F went over to R20's door and obtained a transfer belt. NA-F returned to R20's bed and grabbed the bed control to lift the bed up. R20's blue boots were removed, and compression socks placed. R20's bed was lowered and NA-F assisted R20 to sit up. Once at the end of the bed, R20 was assisted to put on their slippers and NA-F placed the transfer belt around R20. With assistance, R20 was walked into the bathroom and to stand in front of the toilet. NA-F assisted with R20's pants and removed R20's brief soiled with urine and placed in the garbage. R20 then sat on the toilet. NA-F removed gloves and without hand hygiene donned new gloves and shut the door slightly and straightened R20's bed. R20 was done and NA-F went in to assist R20 to stand and provided personal cleaning for R20. Without removing gloves or performing hand hygiene, NA-F assisted with placing a clean brief and pulled up R20's pants. R20 was assisted out of the bathroom to sit in their recliner. NA-F then obtained a washcloth and wet down with warm water. The washcloth was given to R20 to wash his face. NA-F then removed gloves and without performing hand hygiene NA-F donned new gloves and assisted R20 with a clean shirt. R20 asked for dentures and NA-F took the white denture container, brought them to the sink and took the dentures out of the case to rinse before handing to R20 to place in mouth. After R20 was done, NA-F removed gloves and tied up R20's soiled garbage. NA-F left room and brought soiled bag to soiled utility room garbage. NA-F then washed hands.</p> <p>When interviewed on 8/7/24 at 7:53 a.m., NA-F verified they did not change gloves after emptying the urinal and assisting with personal cares for R20. NA-F further verified hand hygiene was not completed after glove removal. NA-F further stated they usually keep hand sanitizer in their pockets however the shirt they were wearing did not have pockets to keep sanitizer handy. NA-F verified R20 had enhanced barrier sign or the hanging container of gowns and gloves. NA-F stated they should have been in a gown and gloves when providing cares.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>When interviewed on 8/7/24 at 11:40 a.m., the Director of Nursing (DON) expected staff to remove gloves and perform hand hygiene when moving from unclean to clean areas. DON further stated staff were expected to wear gown and gloves when assisting with cares for residents on EBP.</p> <p>When interviewed on 8/7/24 at 1:18 p.m., the infection preventionist (IP) expected staff to follow any precautions that were posted outside of the rooms. IP stated R98 had admitted with C. Diff and was going to remain on precautions until the antibiotic was completed. IP stated staff were instructed that if they are only dropping something off and not having hands on contact with the environment or resident, gowning and gloves was not needed. Any staff who had contact with the environment or hands on with the resident were expected to gown and glove. IP reviewed the contact isolation sign that was posted on R98's door and verified it said all staff who enter were required to gown and glove. IP wasn't sure about why the contact isolation sign said only staff were required to gown and glove and did not instruct hand washing with soap and water. IP stated the facility had another sign for enteric precautions that instructed all who enter gown, gloves and wash hands with soap and water to due to how easily C. Diff was spread. IP further stated hand sanitizer was not enough. IP stated the enteric precautions sign should be in place for residents with C. Diff. Residents who require EBP are identified with signage on the doors. Staff were expected to wear gown and gloves with any hands-on resident cares such as toileting or transferring. Furthermore, IP expected staff to perform hand hygiene after any glove removal and when moving from dirty tasks to clean tasks. This was important to minimize risk of infections.</p> <p>A facility policy titled Transmission-Based Precautions revised 7/2023, directed staff to use TBP for residents who are known to be infected with an infectious agent. Contact precautions was used when the infection was spread directly person to person or indirect contact with the resident or environment. Appropriate PPE included gown and gloving upon entering the room or making direct contact with the resident or environment. Upon exiting the room, hand hygiene was required. The facility policy lacked direction on enteric precautions or when hand washing with soap and water required.</p> <p>A facility policy titled Handwashing Policy revised 2/2024, directed proper hand washing should be used to protect the spread of infection. Hand washing shall be completed after changing incontinent products. Furthermore, hand hygiene was required after glove removal and before glove donning.</p> <p>A facility policy titled Enhanced Barrier Precautions dated directed staff to initiate EBP for residents with residents with wounds and PPE should be worn during high contact resident care activities such as dressing, transferring and hygiene.</p>		