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	07/02/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure physician-ordered passive range of motion (ROM) exercises were completed for 1 of 2 residents (R6) reviewed for range of motion.Findings include:R6's quarterly Minimum Data Set (MDS), dated [DATE], indicated R6 had moderate cognitive impairment. Diagnoses included cerebral infarction with hemiplegia and hemiparesis affecting the left non-dominant side following a cerebral infarction (blocked blood vessels that deprived part of the brain of oxygen and nutrients). The MDS indicated R6 was dependent on staff for mobility. The MDS also indicated a restorative nursing program had not been completed.R6's physical therapy order, dated 3/31/26, directed staff to complete passive range of motion (ROM) exercises to R6's left arm two to three times daily. The order instructed staff to review the restorative nursing program instructions which were posted on the wall in R6's room.R6's care plan, revised 2/26/26, indicated R6 had impaired mobility related to a cerebrovascular accident (CVA), left-sided hemiparesis, and a traumatic brain injury (TBI). Interventions initiated on 3/31/26 directed nursing staff to provide passive range of motion exercises to the left arm two to three times daily. The care plan also instructed staff to refer to the restorative rehabilitation handout posted on the wall and closet.R37's follow up documentation for nursing rehab passive ROM left arm 2-3 times a day *see handout on closet. indicated the following: -for 4/2026, R37 refused ROM one time, no further documentation of task completed or refused was documented. -for 5/2026, lacked indication any ROM was completed for R37-for 6/2026, lacked indication any ROM was completed for R37During observation and interview on 7/1/26 at 10:07 a.m., nursing assistant (NA)-A completed R6's activities of daily living (ADLs), including changing the brief and clothing, washing the face and body, applying powder and lotion, brushing the hair, and providing oral and lip care. However, NA-A did not perform the ordered passive ROM exercises, even though the instructions and photographs of the required care were posted in plain view.During the interview, NA-A stated resident care instructions were available in the care plan, Kardex, and task list within the electronic medical record (EMR). NA-A stated R6 required total assistance with all care and that if passive ROM was required, it would have been listed in the EMR. NA-A verified signs in the room, however, did not perform the task. During an interview on 7/2/26 at 11:59 a.m., NA-B stated resident care tasks were located in the Kardex/task tab of the EMR and were based on the care plan. NA-B stated the therapy department provided education and instruction regarding restorative rehabilitation. NA-B further stated the passive ROM task had not been completed because the task indicator in the EMR was not green, which indicated the task had not been performed.During an interview on 7/2/26 at 12:13 p.m., licensed practical nurse (LPN)-A stated the therapy department provided restorative rehabilitation orders and instructions, including signage and resident-specific information. LPN-A stated staff verified completion of restorative rehabilitation by reviewing the task tab in the EMR and by observing staff provide resident care. LPN-A stated it was important to follow physician orders to ensure resident care and safety. LPN-A was unable to verify in the EMR that R6's passive ROM exercises had been completed.During an interview on 7/2/26 at 12:28 p.m., the Director of Nursing (DON) stated the restorative (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rehabilitation process required staff to follow physician and therapy orders. When therapy initiated restorative rehabilitation, the task was entered into the EMR for staff to document whether it had been completed or refused. However, the DON was unable to locate documentation in the EMR indicating R6's restorative rehabilitation had been completed. The DON stated restorative rehabilitation was important to maintain a resident's baseline level of functioning after skilled therapy services had ended.During an interview on 7/2/26 at 12:55 p.m., the Director of Occupational and Physical Therapy (OT/PT) stated that when a resident met therapy goals or reached a plateau, therapy developed a restorative rehabilitation program. A restorative rehabilitation instruction sheet was completed and provided to the nurse managers. Therapy staff educated nursing staff regarding the resident's specific restorative rehabilitation orders. Information was communicated through written instructions, visual postings, and documentation within the EMR. Staff were expected to complete the ordered interventions. If questions or concerns arose, staff were instructed to submit communication forms to the therapy department. The Director of OT/PT stated therapy staff reviewed restorative care plans on admission, with new orders, quarterly, and during daily interdisciplinary meetings.A facility policy titled, Activities of Daily Living (ADLs)/Maintain Abilities Policy, updated 3/31/23, instructed the facility to individualize each resident's care to promote quality of life by ensuring staff provided person-centered care and services. The policy further instructed the facility to provide the care and services necessary to maintain each resident's ability to perform activities of daily living unless a decline was unavoidable due to the resident's clinical condition. Residents who were unable to perform activities of daily living independently were to receive the services necessary to maintain their highest practicable level of functioning.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to identify and appropriately monitor target behaviors for 1 of 1 residents (R22) reviewed for mood and behavior. Findings include:R22's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition, moderately severe depression, no exhibited behaviors, and received antidepressant medications. R22's diagnosis included major depressive disorder and spinal stenosis (narrowing of spaces in spine putting pressure on spinal cord and nerves causing pain and weakness). R22's care plan dated 6/11/26, indicated R22 had potential for adverse drug reactions (ADRs) related to daily use of psychotropic medications. R22's care plan further identified alteration in mood and behavior related to diagnoses, adjustment to placement, and loss of independence. The care plan instructed staff to monitor target behaviors and ADRs as ordered.R22's PHQ-9 assessment (screening tool used to diagnose and monitor severity of depression with a scale from 0 to 27) dated 6/10/26, identified a score of 19-moderately severe depression.R22's provider orders dated 6/9/26, indicated, Target Behavior Monitoring: A._____, B._____, C._____: Non-Pharmacological, Document # of those Interventions used: 0: N/A, 1: Redirection, 2: Ambulate, 3: Offer Activity, 4: Essential Oil, 5: Reposition, 6: Toileting, 7: Provide 1:1, 8: Offer food/fluids, 9: Offer pain relief every shift if Target Behavior was observed. Select chart other and enter findings including effectiveness of interventions in the Nursing Progress Notes. R22's treatment administration record (TAR) for 6/10/26 through 6/30/26, indicated, Target Behavior Monitoring: A._____, B._____, C._____: . Select chart other and enter findings including effectiveness of interventions in the Nursing Progress Notes. The task was documented as completed every shift except for one evening shift, and no target behaviors were identified. Interventions were documented as provided on seven occasions. R22's Informed Consent for Required Medications dated 6/12/26, identified R22 was taking antidepressants and antipsychotics for depression and insomnia. R22's progress notes 6/9/26 through 6/29/26, lacked evidence of identification or occurrence of any behaviors.During observation and interview on 6/29/26 at 12:26 p.m., R22 was in room in wheelchair. R22 stated feeling very depressed due to her loss of normal abilities. R22 stated she did not like having to rely on others for assistance and that her weakness had caused increased instability and chance of falling. R22 could not remember anyone discussing her depressed mood or behaviors, and felt like she had lost interest in a lot of her prior activities. During interview on 6/30/26 at 12:43 p.m., registered nurse (RN)-A stated behavior monitoring was documented on the TAR where the specific target behavior was identified. RN-A stated staff should document the behavior observed and any interventions provided. RN-A stated R22 often attempted to self-transfer and self-toilet and considered those target behaviors. RN-A reviewed R22's TAR and agreed R22's target behaviors were not identified and was not really sure what she should be monitoring for R22. RN-A stated she would just watch for anything out of the ordinary and document it in a progress note. During interview on 6/30/26 at 2:26 p.m., director of nursing (DON) stated target behaviors should be identified and monitored to assess medication effectiveness. DON stated R22's target behaviors should have been identified so staff understood what specifically to watch for, and that since she was taking an antidepressant, a general behavior of increased depression at a minimum should have been monitored. During interview on 7/1/26 at 11:47 a.m., consultant pharmacist (CP) stated would agree target behaviors should be identified for monitoring. CP further stated R22's order to monitor target behaviors failed to identify the specific medication nor its generic category and therefore, did not provide any instruction for actual behavior monitoring. CP stated the importance of behavior monitoring was to assess effectiveness of the medication and whether adjustments and or interventions were required. Facility policy on behavior monitoring was requested but not provided.

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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 document review, the facility failed to ensure staff used enhanced barrier precautions (EBP) for 1 of 1 residents (R6) reviewed who required EBP. Findings include:R6's quarterly Minimum Data Set (MDS), dated [DATE], indicated R6 had moderate cognitive impairment. Diagnoses included cerebral infarction with hemiplegia and hemiparesis affecting the left non-dominant side following a cerebral infarction (blocked blood vessels that deprived part of the brain of oxygen and nutrients). The MDS indicated R6 was dependent on staff for mobility and activities of daily living.R6's provider order, dated 2/10/26, instructed staff to follow enhanced barrier precautions (EBP) related to the gastrostomy tube (G-tube).R6's care plan dated 2/13/26, identified a problem related to the need for EBP due to the G-tube. Interventions included staff following EBP, using appropriate communication regarding EBP, explaining the reasons for EBP, and donning and doffing personal protective equipment (PPE), including gloves and a gown, before providing high-contact care. High-contact care included, but was not limited to, dressing, grooming, bathing, transferring, providing personal hygiene, changing linens, changing briefs, and assisting with toileting.During observation on 7/1/26 at 10:07 a.m., nursing assistant (NA)-A entered R6's room with a stand lift. After washing her hands and putting on gloves, she began providing personal care. NA-A cleaned and changed R6, applied powder under the breasts and armpits, assisted with dressing, and washed R6's face using a clean washcloth. NA-A removed her gloves after completing care in bed, washed her hands, without donning gloves, and transferred R6 to her wheelchair using an stand lift with the assistance of one staff member. While R6 was seated in the wheelchair, NA-A brushed R6's hair, applied lip balm, applied lotion to R6's legs, and put on R6's shoes. Although multiple high-contact care activities were performed, NA-A did not wear a gown. Gloves were worn only while care was provided in bed. There was a sign that stated Enhanced Barrier Precautions and PPE hanging on R6's door. During an interview on 7/1/26 at 10:30 a.m., NA-A stated resident care tasks were located in the electronic medical record (EMR) under the task tab and the information was based on the resident's care plan. NA-A stated EBP was only used when staff had contact with the G-tube during feedings. She stated the infection prevention process was to keep the G-tube site covered and notify the nurse if any issues were observed. NA-A verified there was a sign and PPE on the door. She stated that gown and gloves should have been worn during high-contact cares. During an interview on 7/2/26 at 9:25 a.m., licensed practical nurse (LPN)-C stated the EBP supplies and instructions were posted on the resident's door. LPN-C stated staff were expected to use the required PPE during all high-contact care activities. LPN-C stated EBP was important to help prevent the spread of infection.During an interview on 7/2/26 at 9:38 a.m., the Director of Nursing (DON) stated EBP was initiated when a resident met the applicable guidelines. The DON stated EBP was documented in the resident's EMR banner and that signage and the necessary PPE supplies were posted outside the resident's room. The DON stated staff were expected to wear the appropriate PPE whenever high-contact care was provided. The DON stated EBP was important to protect vulnerable residents and prevent the spread of infection.During an interview on 7/2/26 at 9:53 a.m., registered nurse (RN)-A stated EBP was to be followed. RN-A stated the sign posted on the resident's door identified the required PPE and that staff were expected to wear both gowns and gloves during all high-contact care activities.A policy titled, Enhanced Barrier Precautions, revised 4/1/24, instructed staff to implement enhanced barrier precautions to prevent the transmission of multidrug-resistant organisms (MDROs). The policy defined enhanced barrier precautions as the use of gowns and gloves during high-contact resident care activities for residents known to be colonized or infected with an MDRO, as well as residents at increased risk of MDRO acquisition, such as those with wounds or indwelling medical devices. The policy further instructed that all staff were to receive training on enhanced barrier precautions upon hire and at least annually and were expected to comply with all designated precautions.