STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Excelsior LLC	515 Division Street Excelsior, MN 55331

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** 40945 Based on interview and document review, the facility failed to implement the use of an air pressure redistribution mattress to aid in providing pressure ulcer relief for 1 of 3 residents (R1) reviewed for pain management. Findings include: R1's Face Sheet undated indicated R1 had the following diagnoses: hospice, history of cerebral infarction (stroke), peripheral vascular disease, adult failure to thrive and abnormal weight loss. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had moderate cognitive impairment, was dependent on staff for all activities of daily living (ADLs), required ongoing pain management and received hospice services. R1's care plan initiated 12/9/24 indicated R2 had an alteration in skin integrity related to peripheral vascular disease, adult failure to thrive, anorexia, and cerebral infarction (stroke). Interventions included pressure redistribution mattress to bed. R1's Wound Care note dated 12/3/24 indicated R1 was being seen for the evaluation and treatment recommendation of a Stage 3 pressure ulcer (a full-thickness tissue loss where subcutaneous fat is visible within the wound, but bone, tendon, or muscle are not exposed) to sacrum. R1 had complaints of pain with increased pressure. R1 reported relief with offloading (relieving pressure from the area). R1's wound orders included use of a pressure redistribution mattress. On 12/15/24 a progress note indicated R1 had a pre-existing wound to coccyx (sacral area). The area was cleansed and a dressing was applied. The pressure ulcer was noted to be bigger in size, and had more drainage compared to a few days ago. R1's heels were noted to be spongy, and protective boots were applied to both heels. On 12/20/24 a progress note indicated R1's sacral pressure ulcer was not improving, and there was black scab noted in the center of the pressure ulcer. The hospice case manager was called and reminded about the need for air mattress. On 12/21/24 a progress note indicated registered nurse (RN)-A had called hospice regarding R1's pressure ulcer, and the need to follow up with the delivery of the air mattress. (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	On 1/29/25 at 7:10 a.m., RN-A stated R1's physician orders had included a air pressure redistribution mattress. He had called hospice on 12/20/24, and 12/21/24, because the facility had not received the air pressure redistribution mattress from hospice. It was not until a few days after 12/21/24, when the facility had found the air pressure redistribution mattress in R1's room. On 1/29/25 at 8:55 a.m., RN-B stated she was the nurse manager for the unit R1 was on throughout her stay. She was unaware the air pressure redistribution mattress was not on R1's bed. When the order was placed on 12/3/24 the air pressure relieving mattress should have been immediately implemented. An air pressure redistribution mattress was important for not only slowing the progression of a pressure ulcer, but also for comfort and pain relief. On 1/29/25 at 10:33 a.m., the director of nursing (DON) stated her expectation was all medical provider orders were implemented immediately. She had been made aware of the order for the air pressure redistribution mattress on 12/9/24; however, she had not been updated by nursing staff it had not been implemented until after 12/21/24. The importance of implementing R1's air pressure redistribution mattress was for preventing worsening of R1's pressure ulcer. On 1/30/25, at 9:19 a.m., nurse practitioner (NP)-A verified she had ordered an air pressure redistribution mattress for R1 on 12/3/24. R1 was admitted to the facility with a non-healing pressure ulcer; however, the air pressure redistribution mattress was ordered for comfort and to aid with pain management. She had not been made aware of the delay in implementing the mattress. The facility policy Skin Assessment & Wound Management dated 3/19 directed the purpose of the policy was to provide guidelines for assessing and managing wounds. The policy's guidance for prevention included staff were to implement appropriate preventative skin measures. Examples include, but are not limited to-nutritional interventions, mobility and repositioning plan, pressure redistribution plan.

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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. 40945 Based on observation, interview, and document review, the facility failed to implement appropriate personal protective equipment (PPE) to prevent the spread of infection for 1 of 1 residents (R2) observed for enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multi drug-resistant organisms that employs targeted masks, gown and glove use during high contact resident care activities). Findings include: Review of Centers for Disease Control and Prevention(CDC) guidance dated 4/2/24 Implementation of PPE Use in Nursing Homes to Prevent Spread of Multi drug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for EBP included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. Guidance also included EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status and an infection or colonization with an MDRO. R2's Face Sheet printed on 1/29/25, identified R2 had diagnosis including Clostridioides difficile (C.diff, a bacterium that causes an infection of the colon and large intestine), nephrostomy tube (a tube inserted through the skin to the kidney to drain urine), sputum culture positive for methicillin-susceptible Staphylococcus aureus (MSSA), human immunodeficiency virus (HIV) and septic shock. R2's Order Summary Report dated 1/29/25 identified R2 required wound care to coccyx region and left foot, nephrostomy flush and tube change every three days, and Daptomycin (antibiotic) administered via peripherally inserted central catheter (PICC) and PICC line dressing changes. The order summary report identified the following: staff to follow contact enteric precautions. R2's hospital Discharge Summary for 1/12/25 through 1/27/25, indicated R2 was admitted and treated for septic shock, influenza, MSAA, C-diff infection, and required ongoing antibiotic treatment via PICC line at the time of R2's discharge and readmission to the NH facility. On 1/29/25 at 10:02 a.m., nursing assistant (NA)-A and NA-B were observed in R2's room performing peri care. NA-A and NA-B both were observed to be wearing face masks and gloves. Neither NA-A nor NA-B were wearing gowns. NA-A verified R2 was on EBP per signage on door. NA-A further stated he knew he was required to wear a gown, gloves, and face mask; however, he did not have enough time to don all the required PPE at times. NA-A verified he had training related to proper donning and doffing of required PPE. On 1/29/25, at 10:05 a.m. registered nurse (RN)-A verified R2 required EBP per signage on door. R2 recently returned from a hospital stay for an infection, had a PICC line, and open wounds. When performing peri care, staff should wear a face mask, a gown and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 2:25 p.m., director of nursing (DON) verified R2 required EBP due to having a current infection, PICC line and open wounds. Signage was posted with instructions on the required PPE for those residents who were on EBP. All staff were to follow proper infection prevention which included wearing proper PPE to prevent the spread of infection to other residents as well as staff. The facility policy Enhanced Barrier Precautions revised 4/1/24, identified the facility would implement enhanced barrier precautions for prevention of transmission of multi drug-resistant organisms. Indicated EBP employed targeted gown and glove use during high contact resident care activities which included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, wound care: any skin opening requiring a dressing. The policy further directed the facility to have gowns and gloves available near or outside of the resident's room; Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions and EBP would be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device was removed.