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	06/16/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and document review the facility failed to ensure Notice of Medicare Non- Coverage (NOMNC) and Advanced Beneficiary Notice (ABN) was given to the resident's representative for signature for 1 of 4 residents (R139) with known cognitive impairment. Findings include: R139's 4/15/25, discharge Minimum Data Set (MDS) assessment identified R139 had a Brief Interview for Mental Status (BIMS) score of 9 indicating moderately impaired cognition. R139's 1/17/25, baseline St. Louis University Mental Status Examination (SLUMS) assessment, a screening test for Alzheimer's disease and other forms of dementia. The therapist performed the SLUMS assessment with a score of 15 out of 30 which indicated dementia. A re-assessed SLUMS on 2/28/25, identified a lower score of 11 out of 30, indicating dementia. On 3/4/25, the discharge note from occupation therapy identified a SLUMS score remained at 11 out of 30. R139's, Notice of Medicare Non-Coverage identified services will end on 4/3/25. R139 signed the form on 3/22/25. R139's 1/27/25, care plan identified R139 was a vulnerable adult and at risk for decreased cognitive and physical abilities. Alteration in cognition related to admission and BIMS score indicating cognitive impairment. R139 was at risk for self-care deficit related to cognitive communication deficit, muscle weakness, and hemiparesis. Review of R139's certified nurse practitioner (CNP)-F provider notes identified the following: 1) 1/21/25, resident was confused, has family member who was R139's decision-maker. R139 was very disoriented. 2) 2/4/25, resident certainly has significant impairment of learning, memory, and function. The provider identified this seemed to be dementia with reported history of cognition issues prior to R139's hospitalization. 3) 2/28/25, R139 was confused. 4) 3/28/25, provider identified they left message with family regarding ongoing cognitive issues and falls. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) 4/4/25, provider spoke with family member (FM)-E regarding R139's condition. 6) 4/11/25, R139 was discharged to another facility. R139 was identified as alert, oriented to self, confused to place, time, and situation. Interview on 6/10/25 at 3:41 p.m., with family member (FM)-E identified the facility had R139 sign the Medicare Non-Coverage notice. R139 did not have the ability to understand the form or contest the decision if he wanted to. R139 did not have access to a computer, or a phone and was a vulnerable person and was not able to convey what he had signed. FM-E reported that the facility knew R139 had a power of attorney (POA) and R139 had not signed pervious papers. FM-E had handled all the paperwork for R139. The family only found out about the situation when R139 converted back to private pay. He requested a copy of the signed denial form. The business manager did reach out and apologized, identifying that she was unaware R139 had a POA and had she known, she would have reached out to family. Interview on 6/10/25 at 9:28 a.m., with business office manager identified if a resident does not have a POA or a representative on file then the resident would sign all the facility forms. R139 did not have any proof of a POA or guardian. She reported she was out at the time the denial was provided to R139 to sign. She further, reported that she typically asked during admission if there was a POA or representative that the resident would like her to speak with regarding admission paperwork. She stated she did not complete his admission paperwork, and she had apologized to FM-E as the facility did not know. She showed me a hospital form that listed R139 as the guarantor and reported FM-E was listed as an emergency contact but nothing else, so the facility had R139 sign his form. Review of 5/8/25, email from administrator to the business office manager identified that the administrator had received a concern from the ombudsman related to R139, a resident who has a history of dementia and multiple strokes. R139 has a family member who was his power of attorney (POA) and health care who was very involved in his care. The facility inappropriately had R139 sign a Notice of Medicare Non-Coverage form rather than the family member (POA) when R139's skilled services were ending. The resident was unable to understand what he was signing. The notice was never communicated to the family and due to this error, there was an outstanding bill for the remainder of R139's stay. Per the statute and Medicare guidelines, to be notified of their right to appeal, and this was not done. The ombudsman asked what the facility could offer to the family as a resolution to this financial burden. The administrator asked the business office manager along with the corporate office manager to review the situation. The business office manager reported back to the administrator someone else had provided the NOMNC notice and there was no proof of a POA or guardian but would discuss this with the corporate business manager. There was no response of the outcome of the discussion in the email. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of 2/20/23, ABN/NOMNC policy identified the business office manager, social worker, MDS nurse, and administrator would be responsible for issuing a Notice of Medicare Non-Coverage. The notice would be provided 48 hours prior to last day covered. If the resident was not currently enrolled in Medical Assistance facility staff must offer them the ability to compete an application with the facility. When the last covered day was determined by the facility or the resident's insurance and there was benefit days remaining, the facility must issue a denial to the resident/legal responsible party (POA/Guardian). In some circumstances, the facility may have to issue the denial over the phone. The facility must speak to a person to confirm they received the information. The staff were to adequately explain as that was the best opportunity to avoid being provider liable for any changes post insurance. The policy had no mention of how to handle a resident with cognitive deficit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and document review, the facility failed to provide for Activities of Daily Living (ADL) related to assisting with toileting, turning and repositioning, queuing for food and hydration needs, and assisting with personal hygiene for 4 of 7 sampled dependent residents (R2, R7, R24, and R137). Findings include: R24 R24's 4/14/25 Significant Change Minimum Data Set (MDS) assessment identified she had severe cognitive impairment, required extensive to total assistance with ADLs including toileting and personal hygiene. She was incontinent of both bowel and bladder and wore a disposable brief. R24 had diagnoses of a cerebral vascular accident (CVA-stroke), Post Traumatic Stress Disorder (PTSD), seasonal affective disorder, skin cancer oh her left thigh, hemiplegia of right dominant side (paralysis of one side of the body), depression, and aphasia (inability to speak), and malnutrition and had been admitted to hospice due to rapid decline. R24 required supervision for eating or touching assistant and staff needed to provide verbal queues as R24 completed the task. R24's current undated care plan identified she was admitted to hospice on 4/8/25 for weight loss, poor food and fluid intake was noted to be expected and unavoidable related to her disease progression. Staff were to encourage food and fluids for pleasure as accepted by R24. Staff were to monitor and report to the physician concerns of choking, swallowing, holding food in her mouth as she makes several attempts at swallowing and has a known history of refusing to eat. Staff were also to monitor her malnutrition and report a significant weight loss and offer meals at later times if needed if the resident was asleep. The facility was to maintain communication with hospice and keep them informed of R24's condition and monitor R24 for non-verbal signs and symptoms of discomfort. Dietary supplements were also ordered and R24 was to be encouraged by staff to take them. Staff were also to assist R24 with personal hygiene, dressing and bathing. Random observations on 6/9/25 of R24 in her room identified at: 1) 1:00 p.m., R24 was lying in bed yelling out and crying. Staff entered the room and attempted to comfort R24. 1) 1:15 p.m. of she laid on her back in bed asleep and her eyes were closed and her knees were bent with her feet resting against the bed. Her noon meal tray sat on the bedside table uncovered and untouched. She had a water pitcher beside her tray that was partially filled and warm to the touch. An unidentified staff member entered R24's room, picked up the tray, without offering any food or drink and carried it to the cart to be returned to the kitchen. 2) 3:00 p.m. R24 was noted to remain in the same position in bed, crying and rubbing her knees. Her lips appeared dry. R24 made no attempt to reach for her water pitcher which remained in the same spot as previously noted and did not appear to have been refreshed. Staff persons were observed in the hall, but no one entered R24's room to attempt to queue her, assist her, or offer her a drink. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) 5:45 p.m. R24 remained on her back in bed, with head slightly elevated and knees bent with feet resting on bed. Her supper tray was on the bedside table beside her bed, uncovered and untouched. The water pitcher remained in the same location, and did not appear to have been refreshed. 4) 6:15 p.m. R24's tray had been placed on the cart to be returned to the kitchen and appeared untouched. R24 remained in the same positioned on her back and appeared to be sleeping at the time of observation. R24's physician progress notes identified on: 1) 11/27/24, R24's physician (MD) noted she had an 11-pound weight loss. The MD noted it was difficult to ascertain exactly what was causing her decreased appetite, although likely depression related to her significant CVA. 2) 1/28/25, during their visit, R24 was sobbing. She was unable to tell them what was wrong, stated she was having pain, but was unable to say where and continued to sob through the visit. Psychiatry was ordered with the addition of topical pain medication. 3) 2/21/25, R24's MD noted she was sobbing again. Staff reported she does that most mornings. She denies pain but was noted to be clearly distressed. R24 was on anti-depressants for mood. 4) 2/27/25, R24's MD note was noted to be alert, present, and lying comfortably in bed. She had not interacted meaningfully during her MD visit due to her stroke. 5) 3/28/25, R24 was referred to hospice related to her stroke, weight loss, and cognitive deficit. 6) 4/2/25, R24 was noted to have weight loss from poor oral intake with refusals of food or drink. Staff were to encourage food and fluid intake. Dietary supplements were being provided. A conversation was had with the nurse manager, administrator, and family about R24's hospice referral. R24 was noted to be in significant pain and was unwilling to let staff turn and reposition her. 7) 4/4/25, R24 was noted to remain intermittently tearful and had ongoing weight loss. R24's dietary note identified on 4/14/25, R24's weight status was reviewed. Her weight was noted to be quickly trending down which was reported to be expected related to (r/t) hospice care. R24 was noted to be often refusing meals. R24's weight loss and poor oral intake was noted to be expected and may be unavoidable r/t hospice and her disease progression. Staff were to encourage food and fluid intake for pleasure and as accepted by resident. R24's 4/27/25 Nursing behavior note identified R24 was refusing medications and eating. She was also crying. Her pain and anxiety medication was given and R24 was encouraged to drink fluids. Observation and interview on 6/10/25 at 7:51 p.m., of R24 in her room identified R24 was noted to be crying and lying in bed. Registered nurse (RN)-A was observed to enter the room and attempted to comfort R24. R24 continued to cry, so RN-A advised the nursing administering medication to administer pain medication to R24. R24 last received pain medicating at 5:12 a.m. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/10/25 at 8:25 a.m., with registered nurse (RN)-A identified R24 was not able to speak and had issues with anxiety and crying frequently and would touch and rub her knees due to pain. R24 remained in bed due to her leg contractures and discomfort, and would refuse repositioning and personal cares. RN-A reported she had orders for both scheduled and as needed (PRN) pain medications and PRN antianxiety medications. R24 had been admitted to hospice services the first part of April 2025 due to her CVA and decline in condition. RN-A identified PRN medication was given when a resident requested it and stated since R24 was not able to speak, staff would need to assess her for non-verbal indications for pain/anxiety. Interview on 6/10/25 at 11:24 a.m. with hospice nursing aide (HNA)-E as she prepared to perform personal cares for R24 identified when she came to visit, she frequently discovered R24 with a wet and/or soiled brief. Her top was often soiled, as was her bedding. NA-E had last visited R24 on 6/3/25. At that time she had noticed some redness alone her spine and coccyx area. Her feet were against the bed, but there were no open areas she noted. NA-E had updated both the case manager at the facility and the hospice nurse of her findings and documented it. R24 was often seen crying, moaning, and rubbing her knees and she would ask the facility nurse to see if she could assess R24 to see if pain or anxiety medication would need to be administered before she provided her cares. Review of the hospice nurse aide notes identified on: 1) 4/9/25, the NA initial visit was performed. The NA only noted she assisted with a transfer. No concerns noted at that time. 2) 4/16/25, R24 was given a bed bath and personal hygiene was performed. No concerns were noted on in the documentation. 3) 4/22/25, R24 was lying in bed and was very emotional. Staff noted they had to cut the back of her hair due to matting and washed it afterwards. Family was present. 3) 4/24/25, R24 was noted to have a big smile when the NA arrived. R24 was seen wearing the same shirt since her last visit on 4/22/25. 4) 4/29/25, R24's bath was completed, her hair washed, lotion applied, her brief changed. Redness was noted on her bottom and staff refilled her water glass. No concerns were noted on in the documentation and there was no documentation to support the hospice NA made the facility aware of the redness. 4) 5/1/25, hospice assisted with lunch and refilled her water. No concerns were noted on in the documentation. 5) 5/6/25, The NA completed a bath and washed her hair. [R24] didn't eat lunch. 6) 5/8/25, R24 was lying in bed, woke to the NA's voice. R24 was noted to be soiled in her brief and on her sheets. Her shirt, brief, and sheets were changed. No mention she performed any bathing. 7) 5/13/25, R24's bath was completed, hair was washed, and her brief changed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued interview 6/10/25 at 12:30 p.m. with RN-B identified there were 2 additional residents she had heard about whose hair had to be cut due to reported lack of care. RN-B further reported R24 frequently did not have fresh water. If her meal tray was in the room, it was often untouched. R24 was known to eat minimal bites of food but drank thirstily when liquids were offered. The hospice NA reported to her R24 was frequently wearing a soiled brief and needed a full bed bath in addition to her clothing and bedding changed when the NA would arrive for their visits. Telephone interview on 6/10/25 at 2:11 p.m., with hospice NA-F identified on 4/22/25, R24's FM-A and FM-B were in attendance and observed R24's hair extremely dirty and matted. She was not able to detangle it with a comb or brush due to the thickness of the matting, described it as appearing like dreadlocks. Both FM-A and FM-B had agreed with NA-F there was no other option except to cut her hair to remove the matting. She voiced their concern over the lack of care. NA-F contacted RN-B to obtain permission to cut R24's hair. FM-A and FM-B stated they had not reported their concerns about lack of care to the facility. NA-F further stated when she arrived for scheduled visits, she frequently noted R24's room smelled of urine and her clothing, bedding and brief were wet and required changing in addition to needing to provide a full bed bath. She identified she had reported this to the facility nurse manger, who responded, thank you for doing that, but nothing appeared to have changed. Review of a photograph of R24's cut hair from 4/22/25, provided by anonymous (A)-A identified a large amount of heavily matted, tangled, hair that had to be cut off R24 as it could not be combed through. Dense knots could be seen throughout the tightly-woven hair ball cluster. Interview on 6/10/25 at 1:30 p.m. with the DON reported she was aware of R24's hair having to be cut due to it being heavily matted. She expected staff to wash residents hair during bathing and combing and/or brushing was to be done with morning and evening cares each day. She agreed care had not been adequately provided to R24 related to ADL's, and staff should be offering liquids and/or food with interactions with R24. Interview on 6/10/25 at 4:28 p.m. FM-A identified they were concerned about R24's lack of care cares and stated they visit daily if possible. FM-A had been out of state intermittently from January 2025 through March of 2025, but returned during at times to visit and were shocked at R24's decline in condition. As a result of the decline, they made the decision to start Hospice services on 4/8/25 with the intent to keep R24 comfortable. FM-A stated R24's clothing was often soiled and not changed for days at a time. R24's room often smelled of urine and feces (BM). Her water pitcher was often empty. Both FM-A and FM-B had been in attendance when NA-F had to cut R24's hair due to the condition it was in. When they visited, her hair was always messy. They hadn't really visualized the back of her head prior to that day on 4/22/25, due to R24's positioning and being painful with repositioning, so they not certain how long it was in that condition. Interview on 6/10/25 at 5:23 p.m., with FM-B identified she voiced concerns about care provided for R24, and when she arrived her clothing was often soiled. She had waited 3 days once to see if her clothing was changed, and on the third day, she had to ask staff to please change R24's shirt. Continuous observations and interview on 6/11/25 of R24 in her room identified at: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) 7:15 a.m., R24 was seen lying on her back in bed, eyes open and breathing through her mouth. She exhibited no crying or moaning at that time. Her room door was partially closed. Multiple staff passed by out in hall, but none entered the room. R24 had a water pitcher on her bedside stand that was partially filled, and warm to the touch, and her lips appeared dry and flaky. 1) 8:11 a.m., a breakfast tray was delivered to R24's room by NA-A and placed on the bedside table. No attempt was made by NA-A to queue R24 to drink or eat or offer their assistance. 2) 8:32 a.m., several unidentified direct care staff were seen walking passed R24's room. None of those staff checked on R24 or attempting to assist her to eat or drink. 3) 8:43 a.m., no staff had yet entered her room to offer food, fluids, or repositioning. 4) 8:52 a.m., R24 remained lying on her back. R24 made no attempts to eat or dink. No staff have entered her room to provide queuing. 5) 9:05 a.m. NA-C walked down hall and looked in as he passed the room, but did not enter. R24's breakfast tray remained covered on the bedside table. 6) 9:15 a.m. NA-C entered R24's room, picked up her tray placed it on cart to return to the kitchen. NA-C was interviewed at the time of the observation. He confirmed the tray was untouched, and reported the staff who had delivered the tray should have returned to assist the resident with her meal. Upon this surveyors request, NA-C offered R24 a drink to identify if R24 would respond to queuing. R24 then drank some of her milk. NA-C stated he would go and check to see if staff had attempted to feed R24. 7) 9:20 a.m., NA-C reported NA-A had gotten busy and had forgotten to return. NA-C stated he would leave to go and warm the food on R24's tray and return with attempt to feed R24. 7) 9:30 a.m. NA-C returned and offered R24 fluids. R24 took a few sips when queued. NA-C offered bites of oatmeal. R24 accepted a couple of bites before turning her head away. NA-C stated R24 had not been eating much but was normally offered food and fluids. Interview on 6/11/25 at 3:30 p.m., with the nurse practioner who made rounds at the facility reported R24 had cognitive and emotional issues related to Pseudobulbar affect (a medical condition that causes crying and/or laughing that is sudden, frequent, uncontrollable, and exaggerated and exaggerated or doesn't match how a person feels). She was not aware of R24 routinely refusing cares. She reported she had not been informed of the concern of matted hair. She would have expected to be notified of the incident where her hair was so matted it had to be cut, and for administration to address the issue with staff. She was however, aware of a different resident who also had to have their hair cut due to excessive matting. The NP reported not only could the matting have caused skin breakdown but could have been painful for the resident. The NP voiced her concern that there had been a breakdown in communication between the facility and her office over the last 6 months and she was not certain why this had occurred. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and document review on 6/11/25 at 4:31 p.m. with the administrator, DON, nursing consultant identified they were made aware concerns regarding lack of staff offering food to R24. All had voiced agreement of their expectation for staff to offer and/or provide personal care, food, and fluids. When interviewed regarding R24's hair being matted and requiring cutting, the DON replied hair care was part of personal care, and should be washed with bathing, and combed or brushed with daily care. She agreed staff had not been performing personal care as they should have been. She had not completed audits or observations to ensure appropriate personal care was provided to all residents. The administrator reported known concerns with resident care or needs was discussed at daily interdisciplinary meetings, but documentation was not routinely kept. His expectation for personal cares identified hair care was to be provided to residents daily and as needed. Attempts to contact the medical director twice on via telephone on 6/12/25 at 4:00 p.m. with a message and return number left, and again on 6/16/25 at 11:30 a.m. with a message left requesting a return call. No call back was provided. R7 Review of the 10/29/24, facility reported State Agency (SA) report identified R7 had complaints of being left in a wet brief for extended lengths of time. R7's 3/26/25, quarterly Minimum Data Set (MDS) identified his cognition was intact, he felt down and depressed 2-6 days weekly, and had no behaviors. R7 required the use of a wheelchair, he was frequently incontinent of urine and occasionally incontinent of BM. He had diagnoses of heart failure, seizures, anxiety, depression, compression fracture, asthma, weakness, and was unsteady on his feet. R7 was at risk for pressure ulcers and took pain medications on a routine basis. R7's current care plan identified he had an alteration in elimination with a goal to be continent during waking hours. The care plan identified direct care staff would assist R7 with toileting but did not identify how often. Staff would provide assistance with peri cares every a.m. and h.s. and as needed. The care plan identified a toileting plan of a.m./h.s. cares, before/after meals, and PRN during the night. Interview on 6/9/25 at 1:57 p.m., during resident screening R7 identified it took a long time for staff to answer call lights and the facility was understaffed and over worked. He reports he has been incontinent from waiting to long to have his light answered, he stated it makes me feel pretty bad however, had no report it affected him physically or emotionally. He just said it makes him feel bad?. He identified he was not normally incontinent but he thinks the facility encourage incontinence when residents first come in. He has reported it to management but they just write it down and nothing changes. He was told by a nurses aid that the rule of thumb is 2 visits by staff per day and that it was a law but reported he knew that was not true. (continued on next page)

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	06/16/2025

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Follow up interview on 6/12/25 at 9:27 a.m., with R7 identified he could not recall this exact incident but reports the same situation has happened multiple times since he had been at the facility. He reported about 6 months ago he had been changed at 6:30 a.m., and did not get changed again until 6:30 a.m. the next morning, he said his whole bed was wet and covered in urine. It took staff about an hour to answer his call light. When they get him up in the morning, they only wash his face, and they gave him a bath once a week. He reports staff have never offered to wash more than just his face in the morning and says he did not know they were supposed to do any more than that. He reports staff have never offered to take him to the toilet, they only come change his brief when he requests it. He says it makes him feel terrible that he must go to the bathroom in his pants and it makes him angry that someone doesn't care enough to help him to the bathroom or answer his call light timely. R7 identified there were times when staff arrive in 5 minutes but that is unusual. He recalled another time when his son was visiting, and they had plans to go on an outing. He had put on his call light for assistance with changing and getting ready to leave, he reported they waited about an hour then his son finally went down to the nurse's station and complained. The staff did eventually come and assist him. Interview on 6/12/25 at 3:02 p.m., with family member (FM)-I identified he had been to the facility for a visit to take his dad on an outing, his dad put the call light on, and they waited for an hour, he went down to the nurse's station and complained. He could not recall who he spoke to but said it was one of the nurses. He reported it still took another 20 minutes for staff to come and assist his dad. He reports his dad has called him on other occasions and complained that it takes a long time for staff to come assist him when he puts his call light on. Interview on 6/11/25, at 2:30 p.m., with the director of nursing identified she did not have any documented audits completed to ensure staff were providing complete and thorough cares. Interview on 6/16/25 at 11:41 a.m., with registered nurse (RN)-A identified she does the care plans. She reports her expectation is when she notes on the care plan that staff should assist with hygiene they should be washing face, underarms, peri-care, oral cares, hair care. She would expect staff to answer call lights timely. R137 Review of State Agency (SA), complaint on 10/28/24 at 3:40 p.m., on 1/27/25, R137 was transferred to a local senior living community. Upon arrival, facility staff nurse identified R137 was found with dried poop on her back, feet was dirty and dry, hair appeared matted, and had a body odor. R137 had informed the staff nurse that R137 had not had a shower in three months. R137's current, undated diagnosis sheet identified R137 had a diagnosis of a diagnosis of paraplegia (inability to control or move lower half of the body) and myelitis (inflammation of the spinal cord). R137's 1/27/25, discharge Minimum Data Set (MDS) identified R137 was cognitively intact and had R137 had little interest or pleasure in doing things, felt down, depressed or hopeless never to 1 day. R137 was dependent on staff with activities of daily living (ADL's). R137 was 5 feet (ft) and 3 inches (in). R137 no pressure ulcers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/10/25 at 8:31 a.m., with clinical coordinator (CC)-A, was informed by a staff nurse that R137 was found with matted hair on the back of her head and was unable to comb it. CC-A identified that R137's skin appeared dry and dirty. R137 was given a bath and her hair was cut. CC-A was concerned about the lack of cleanliness of R137's hair and skin and filed a report on R137's behalf. Interview on 6/10/25 at 2:23 p.m., with registered nurse (RN)-A identified R137 refused cares from facility staff during her stay and had a personal caregiver come in to assist R137 with her activities of daily living (ADL's). Before R137's was discharged , RN-A had completed a physical assessment of R137 who appeared clean and had no matted hair. R137's 1/27/25, discharge instructions and summary progress note identified R137 had bowel and bladder incontinence, had adequate hearing and vision and performed activities of daily living (ADL's) as tolerated. The medical record lacked evidence that a physical assessment had been completed. Interview on 6/11/25 at 2:04 p.m., with personal care assistant (PCA)-A visit R137 in the mornings at the nursing home, approximately between 8:30 a.m. to 9:30 a.m., for about one hour to accompany R137 at the bedside. PCA-A would assist R137 with meals and basic grooming task. On several occasions, during her visit, PCA identified R137's hair appeared matted when R137 was in bed and would comb it out. R137 had complained to the PCA-A that staff would not change her. R137's concern was brought to the nurse manager and was not addressed. During PCA-A's visit, R137 would press the call light for assistance, nursing staff would enter and ask the PCA-A to assist them with R137. PCA-A informed nursing staff that she could not help them. Staff replied to PCA-A that that they would need 2 people to assist R137. R137 had waited 45 minutes for staff assistance and yelled in pain when moved. PCA-A identified R137 appeared frustrated at the nursing staff. Interview on 6/12/25 at 11:23 a.m., with R137's family member (FM)-O was aware that R137 had worn long hair down her back. When R137 arrived to her new facility, FM-O identified R137's hair was not brushed and appeared messy. FM-O stated, if someone had tried to comb it, R137 would be in pain. R2 R2's 3/27/25, quarterly Minimum Data Set (MDS) assessment identified R2 had severe cognitive deficit. R2 had other behaviors 1-3 days. R2 was able to eat after set-up assistance but was dependent on staff for all other cares. R2 received a scheduled pain medication, an antipsychotic, anticoagulant, anticonvulsant, and diuretic. R2 had the diagnoses of cancer, hypertension, arthritis, stroke affecting the left side, dementia, depression and one-sided weakness. R2's 9/5/24, care plan identified alteration in mobility related to cognitive impairment, limitation movement, and muscle weakness. R2 required assist of 2 staff with all transfer. Staff were to provide routine skin care in morning and evening. Weekly skin audits would be completed with bath or shower. R2 relied on extensive assist of 1-2 staff with her grooming and staff were to encourage her to participate as able. Interview on 6/9/25 at 3:21 p.m., with family member (FM)-K identified she did not want shaving done on R2's chin hairs but rather wanted staff to pluck the chin hairs. FM-K had a concern that cares were not being completed daily. Staff were not charting in the book that family had requested them to chart in each time care had been completed. FM-K reported that R2 had been admitted to hospice that morning and she had reported her concerns about good cares to the hospice nurse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/9/25 at 4:24 p.m., of R2 laying in her bed sleeping, whiskers are visible on chin, there are multiple whiskers that are approximately 1/8 inch long. Observation on 6/10/25 at 8:51 a.m., of licensed practical nurse (LPN)-A in R2's room talking to her, R2 does not open her eyes but responds to LPN-A. R2 has multiple visible chin whiskers observed. Observation on 6/10/25 at 9:58 a.m., of nursing assistant (NA)-B, NA-C, and NA-D who entered R2's room to provide morning cares. NA-D reported that it was easier to complete cares with 3 staff, but it could be done with 2 staff. The staff proceeded to provide a bed bath to R2. Staff did not wash R2's hair, nor did they shave R2's multiple long chin whiskers prior to exiting R2's room. Observation on 6/10/25 at 12:11 p.m., R2 was sleeping in her bed, multiple long chin whiskers are visible from the doorway. Interview on 6/10/25 at 12:30 p.m., with hospice nurse identified R2 had been admitted to hospice the day prior and that family was concerned with how cares had been done. FM-K reported to hospice that personal was a priority for the family and wanted to make sure that R2 received good thorough cares. Observation on 6/11/25 at 10:20 a.m., R2 in her bed looking at Bible, she has no visible chin hairs on her face. She is wide awake with the TV on. Interview on 6/11/25 at 1:51 p.m., with NA-C identified he had never shaved R2 or any female in the facility. NA-C reported there was a family member down the other hallway that shaved one of the ladies. NA-C revealed that the staff do not shave R2's whiskers and he was unsure if R2's family ever shaved her chin hairs. Interview on 6/11/25 at 1:54 p.m., with NA-B identified she shaved lady's whiskers but had not shave R2's chin hairs. She reported hospice had shaved R2's chin whisker earlier today. NA-B then said she did good care; we all do good care. Interview on 6/11/25 at 3:57 p.m., with nurse consultant identified resident cares including facial hair should be addressed how the resident or family wished. Staff should be providing all aspects of care including addressing facial hair on both male and female residents. Review of the 3/31/23, Activities of Daily Living (ADL)/Maintain Abilities policy identified following the resident's comprehensive assessment and choices. The facility will ensure that the residents ADL's do not diminish unless unavoidable due to clinical condition. The facility will ensure appropriate services are provided to maintain or improved the resident's ADL function. The facility will provide care and services to resident's including hygiene, bathing, grooming, dressing, and oral care. For resident's unable to carry out ADL's the staff will provide the necessary services to maintain good grooming, nutrition, and oral hygiene.