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	11/26/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and documentation review the facility failed to protect 1 of 1 resident (R1) from abuse, when R1 bit the director of nursing (DON). DON responded by pushing R1 on the bed, struggling with her until physically separated by nursing assistant (NA)-A and licensed practical nurse (LPN)-A. Then the DON rushed back in the room and pushed R1 down a second time and yelled out profanity and threatened to make R1's life a living hell. R1 suffered a bruise and pain to her left chest and shoulder. In addition, R1 had increased anxiety and fear of the DON returning to the facility. The immediate jeopardy began on 11/14/25, when the DON responded to a resident biting her with physical and verbal abuse, the facility did not recognize this as abuse until 11/16/25, when the witness called the administrator to recant her original statement regarding the DON's actions towards R1. The administrator and regional clinical nurse (RNC)-A were notified of the immediate jeopardy at 4:04 p.m. on 11/26/25. The immediate jeopardy was removed and the deficient practice was corrected on 11/17/25, prior to the survey and was therefore issued at Past Noncompliance (PNC). Findings include: R1's care plan dated 4/10/24, indicated she had altered mood and behaviors related to major depression and anxiety. She could be resistant to cares and argumentative. She made verbally aggressive comments to staff. Targeted behavior monitoring included verbal outbursts and crying. Interventions dated 8/15/25, included providing support, validation and comfort measures. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated she had normal cognition, mild depression and no behaviors during the seven days look back. She received anxiety and depression medication. She had diabetes, high blood pressure, abnormal weight loss with protein malnutrition, weakness, major depression, anxiety disorder, bipolar disease, and cognitive impairment. DON's written statement dated 11/14/25, indicated R1 lunged at DON's chest and would not let go. DON attempted to get R1 off, but R1 bit DON's right elbow. DON asked for R1 to stop biting but R1 only bit harder. DON pushed R1 on the bed, but R1 got up again and lunged at her. R1 would not let DON go. DON asked R1, are you fighting me? and pushed R1 again on to the bed. Staff arrived at the room to quell the situation. DON cleaned her wound and called the police. R1's written statement dated 11/14/25, indicated the DON entered her room and moved her table. R1 felt constricted and did not know what to do. R1 was not proud of biting the nurse. The police entered R1's room, and R1 gave her statement. R1 also apologized to the DON. NA-A's written statement dated 11/14/25, indicated she saw R1 attacking the DON and biting her. NA-A separated them and notified the administrator. The administrator's written statement dated 11/14/25, indicated he went to R1's room, she was alone in her room. He asked R1 what happened. R1 told the administrator she felt constricted in her room and when the DON moved her table, R1 did not know what to do. R1 bit the DON and was not proud of it and felt sorry. The administrator left the room to check on the DON. LPN-A's written statement dated 11/14/25, indicated when she entered R1's room, LPN-A saw the DON and R1 in a tussle. The DON showed her where R1 bit her. The DON walked back towards R1 and pushed her on the bed. R1 and DON started to struggle with each other. The DON told R1 she was going to get her a roommate that she could not bully. NA-A's second written statement dated 11/14/25, indicated when she first (continued on next page)

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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	entered R1's room she observed the DON struggling with R1. NA-A pulled the DON away from R1. The DON walked back to R1 and pushed her again and started to hit her. Once separated, the DON told R1 she was going to make her life a living hell. R1's progress note written by the DON on 11/14/25 at 4:25 p.m., indicated she went to R1's room to ensure the room was shared 50/50. While she attempted to move R1's tray table, R1 sprung toward her biting her. She pushed R1 off her, but she continued to kick and charge after her. Staff came into the room to calm R1 down. She left the room with staff to check her bite wound. R1's progress note dated 11/14/25 at 6:55 p.m., the administrator indicated he first learned about the situation when he was in another resident's room. He started his investigation by talking with the DON and police. R1 told him the DON was moving her table, and she felt constricted. She did not know what to do and ended up biting her. She said she was not proud of her actions. She felt safe, and he left the room. The DON told him she was moving R1's table when she bit her. She yelled out and sat R1 on the bed. When staff entered the room, R1 was still combative but no one else was harmed and the incident was deescalated. The roommate was moved to another room for safety, and the police and nurse practitioner (NP) were notified. The police wanted to take R1 to the hospital for a mental health exam, but the ambulance would take 2-4 hours to transfer. They felt with the room change, and police interventions a transfer was not necessary. R1's skin assessment note dated 11/15/25, indicated a bruise on R1's left chest near her shoulder. Administrator's written statement dated 11/16/25, indicated he received a phone call from NA-A who wanted to change her statement to reflect the DON's rough handling of R1 on 11/14/25. The administrator was out of town and instructed her to write down her statement and put it under his office door. He would read it when he returned on 11/17/25. R1's social worker progress note dated 11/17/25 at 2:26 p.m., indicated R1 told her a staff member attacked her and should have been placed on administrative leave. Now when she lays down, she's afraid someone will attack her especially if she thinks she hears her [DON's] voice. She reported not trusting the staff member anymore and she wanted to speak to a psychologist about the incident. R1's nursing progress note dated 11/17/25 at 4:40 p.m., RCN-A indicated during a skin assessment R1 had a bruise on her upper left chest the size of a thumb. She rated her left shoulder pain at a 6 out of 10. On 11/17/25, the administrator provided Abuse Prohibition/Vulnerable Adult training to 21 staff. The abuse policy was reviewed to include all staff were responsible to report any situation consider abuse or neglect. The supervisor would be notified immediately, along with the administrator. All forms of abuse was reviewed. Staff were trained all incidents of abuse needed to be reported to the state within 2 hours. R1's Associate Clinic of Psychology (ACP) note dated 11/18/25, indicated R1 Reported increased depression and anxiety rated at a 6 out of 10 after the incident with the DON. She reported feeling increased anxiety and angry once she received a roommate. Since the incident she was worried about being homeless because she bit the nurse and would be discharged . Interview on 11/25/25 at 1:48 p.m., LPN-A stated when she entered R1's room, she observed the DON tussling with R1. The two were separated and LPN-A told the DON to leave the room. The DON told her R1 bit her. NA-A was trying to calm R1 down when the DON reapproached R1 pushing her to the bed and threatening to make her life a living hell. The DON was physically removed from the room. She felt the administrator was misled about the situation prior to talking to LPN-A because the administrator spoke to the DON first and LPN-A read the DON's progress note detailing the DON's side of the story. When LPN-A spoke with the administrator, she felt confused about what she saw and was unsure how to tell him what she observed. Interview on 11/25/25 at 2:59 p.m., NA-A stated when she entered R1's room, she saw R1 on the bed, and the DON was hitting R1. NA-A separated the two and the DON walked towards the door. While NA-A was attempting to calm R1 down, the DON came back and pushed R1 down on the bed again and started fighting with her. It took two staff to pull the DON off R1. In 20 years, NA-A had never witnessed a staff member fighting and cussing with a resident. She felt intimidated by the DON, so did not tell the truth on her first written statement. Interview on 11/25/25 at 3:41 p.m., R3 stated the DON brought her to room [ROOM NUMBER] to discuss her complaint with R1 regarding the shared space. She observed the DON move (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's table, and R1 was standing behind her shaking her fist. R1 then ran up and started biting the DON. R3 ran out of the room frightened by R1 and what R1 would do to her. Interview on 11/25/25 at 4:06 p.m., DON stated R1's tray table was pushed into R3's space. DON told R1 the table could not push against the privacy curtain and moved it away. R1 pushed the table back and when DON went to move the table again, R1 lunged at her biting her elbow. The more DON told R1 to stop biting, the harder she bit. DON pushed R1 to a sitting position on the bed, but R1 got up again. DON asked R1, You want to fight me? when the other staff arrived. DON was angry and in a lot of pain. DON left the room to clean her wound. After the police spoke with R1, R1 apologized to her. DON added, when R1 stood up again she was frightened and in shock. She realized she should have left the room but I got upset. Interview on 11/26/25 at 10:34 a.m., the administrator stated after the incident on 11/14/25, he reached out to his supervisor. He was instructed to have the DON fill out a workers' compensation form. He had R3 transferred to another room for safety and spoke with the police. The police did not have any concerns and offered to transfer R1 to the hospital but there would be a delay. He spoke with NA-A and LPN-A but what they told him was unclear to the actual events. He did not interpret what they were saying was an indication of rough handling by the DON. He interviewed the DON but did not receive her written statement until 11/17/25. Once he spoke with NA-A on 11/16/25, he immediately told his supervisors to escalate the investigation. The DON was suspended pending the investigation. He called the facility to complete a skin assessment, and a small bruise was found on R1's chest. He reported his findings to the state on the evening of 11/16/25 at 6:54 p.m. Interview on 11/26/25 at 1:39 p.m., registered nurse (RN)-A stated while talking with R1 after the incident she thought she heard the DON and became anxious. RN-A told R1 the DON was not at the facility. If she had been at the incident, she would have reported the DON's actions towards R1 to the administrator right away. The facility policy Abuse Prohibition and Vulnerable Adult policy dated 4/20/25, indicated all staff are required to report a situation of abuse immediately. A prompt investigation would include determining probable cause. All staff who witness abuse are responsible to report the incident by notifying their supervisor immediately. If the alleged perpetrator was a staff member, they would be suspended immediately pending the investigation findings. If the alleged perpetrator was a department head, their supervisor would be notified or [NAME] President of Social Services and Behavioral Health. Definition of abuse was a willful infliction of injury. Suspected abuse would be reported to the state no later than 2 hours after the incident. Employees are encouraged to report any reasonable suspicion of a crime and they would be protected from retaliation. The PNC IJ began on 11/14/25, was removed on 11/17/25, when it was verified the facility implemented the following:- All staff were re-educated on what constitutes abuse, when to report and what allegations to report.- DON was suspended, then terminated.