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	05/16/2024

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 49657 Based on record review and interview, the facility failed to provide a written notification/copy of a bed hold for 2 of 2 (R1, R20) residents reviewed for hospitalization . Findings include: R1's face sheet dated 5/16/2024, listed the following diagnoses: dysphagia (difficulty speaking), obesity, syncope (fainting-dizziness), hypotension (low blood pressure), chronic pain syndrome, hyponatremia (low salt levels), diabetes mellitus type two (DM), hypertension (HTN-high blood pressure), and chronic obstructive pulmonary disease (COPD-disease that difficulty breathing). Progress notes indicated R1 went to an emergency department on 10/4/23, and was hospitalized two times on the following dates: -9/2/23 thru 9/7/23 -9/19/23 thru 9/23/23 R1's medical record lacked evidence a written notification of the bed hold policy was provided to R1 or their representative prior to or during the hospitalization . R20's face sheet dated 5/16/24, listed the following diagnoses: immunodeficiency, malnutrition, weakness, shortness of breath, lung transplant, DM, HTN, pneumonia, bronchitis, end stage renal disease, renal dialysis, and syncope. Progress notes indicated R20 was hospitalized from 2/21/24 thru 3/4/24. R20's medical record lacked evidence a written notification of the bed hold policy was provided to R20 or their representative prior to or during the hospitalization . On 5/15/24 at 3:10 p.m., the director of social services (SS)-A stated bed holds were completed by the nursing staff or administration if available, depends on when the event happened. (continued on next page)

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 2:57 p.m., the director of nursing (DON) stated nursing staff was responsible for completing the bed holds when a resident was transferred. The DON's expectation was bed holds were to be completed prior to transferring, or to contact a family member if it was not done at the time of transfer. The DON stated the importance of reviewing the bed hold with the residents so they may return to their room if they choose, and it was their policy to complete it. The facility's Bed-Holds and Returns Policy last updated 2/2023, indicated prior to a transfer, written information will be given to the resident and their representative that explains the rights and limitations of bed holds.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49654 Based on observation, interview, and document review, the facility failed to ensure insulin pens were appropriately labeled according to manufacturer's guidelines with an opened date in 1 of 2 medication carts(North) for 2 of 2 residents (R20, R22) whom required use of an insulin pen. In addition, the facility failed to ensure three bottles of eye drops were appropriately labeled with an open date to prevent expired eye drops from being administered. This deficient practice affected 1 of 2 medication carts reviewed for storage and 5 of 5 residents (R1, R12, R20, R22 and a previously discharged resident) reviewed for medication administration. Findings include: Observation on 5/14/24 at 08:56 a.m., of the north medication cart was reviewed with registered nurse (RN)-A. A single opened Humulin 70/30 insulin pen labeled for R22, and a single opened NPH insulin pen labeled for R20 were inside the top left drawer of the medication cart. Both pens had visible insulin removed (administered) ; however, neither label had anything to identify when the pens had been removed from the refrigerator and opened for their first use. In addition, three bottles of opened eye drops were also located in the top drawer without a label identifying an open date. These eyedrops were labeled for R1, R12, and a resident who had been previously discharged . When interviewed immediately following the discovery of the unlabeled pens, (RN)-A stated when a pen is removed from refrigerator staff should immediately put a sticker on it to identify the date it is opened. Additionally, (RN)-A acknowledged the two pens, and the three bottles of eye drops were lacking labels identifying an open date and(RN)-A immediately removed the unlabeled items and brought them to the medication room for disposal. During interview on 5/14/24 at 05:35 p.m., director of nursing (DON) stated when staff are opening a new insulin pen or eye drops they should put a sticker on the item with the date identifying when it is opened. DON stated it was her expectation staff adhere the label to the insulin pen or bottle of eye drops immediately upon removal from the med room and prior to administration of either medication. DON stated this practice is crucial to ensure staff are not administering expired medications. Facility policy Administration procedures for all medications with a review date of May 2022 indicated staff check the expiration date on the package before administering any medication. When opening a multi-dose container, place the date on the container. Facility policy Storage of medications with a review date of May 2022 indicated the nurse will place a date opened sticker on the medication and enter the date opened and the date of expiration; the nurse will check the expiration date of each medications before administering it; no expired medications will be administered to a resident; all expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46885 Based on interview and document review, the facility failed to ensure the Quality Assurance Process Improvement (QAPI) committee was effective in maintaining appropriate action plans to correct a quality deficiency identified during a previous survey related to infection control practices for indwelling foley catheters which resulted in a deficiency identified during this survey: Findings include: The Facility Assessment Tool dated 4/12/24, indicated under the heading, Part 2: Services and Care We Offer Based on our Residents' Needs bowel and bladder toileting programs, incontinence prevention and care, intermittent or indwelling urinary catheter, ostomy, colostomy, responding to requests for assistance to the bathroom, toilet promptly to maintain continence and promote resident dignity. Further, infection prevention and control and identification and containment of infections, prevention of infections. The facility QAPI plan for 2024, identified five goals that included: work to improve the new hire orientation and training process to increase retention. work to improve staffing and be free from use of external agency by the end of 2024. aim to achieve an average daily census of 40 or more residents by the end of the calendar year. aim to reduce grievances pertaining to call light times and have an average response time of less than 10 minutes. work to decrease urinary tract infections (UTI's) by having urinalysis/urine culture results back prior to initiated antibiotics. Review of the CASPER Report dated 5/2/24, indicated the facility was cited for F880 related to hand hygiene, leaving a catheter bag on the floor and not cleaning the catheter with an alcohol wipe on which the survey exited on 6/2/23. See F880, based on observation, interview, and document review, the facility failed to ensure proper hand hygiene during wound cares for 1 of 1 resident (R15), failed to ensure proper personal protective equipment (PPE) for 2 of 2 residents (R331, R5), and failed to ensure proper placement of foley catheter bag and cleaning with catheter cares for 1 of 1 resident (R4) reviewed for infection control. QAPI meeting minutes provided by the facility were reviewed from 6/2023, to 4/2024. The minutes lacked information regarding audits completed for infection control related to catheter cares and not leaving bags on the floor, and cleaning catheter bag with alcohol. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	QAPI meeting minutes dated 11/28/23, indicated next to F880, an audit to ensure hand hygiene was completed at intervals and or resident catheter bag remains in proper placement during activity of daily living (ADLs) cares, transfers, and mobility. (completed 3 times per week for 2 weeks; 2 times per week for 4 weeks; and monthly thereafter for 1 month). Facility forms, Survey Prep Tag F880 Infection Prevention and Control indicated the audit was to ensure hand hygiene was completed at intervals according to facilities policy and procedure and or resident catheter bag remains in proper placement during ADL cares, transfers, and mobility and identified the following audits conducted: 12 audits were completed in July 2023, and 11 indicated the regulation was met and under comments, 3 audits identified a resident's foley bag was in the correct bag and not touching the floor, 1 audit identified the registered nurse performed hand hygiene before and after administering medications, 1 audit identified the nursing assistant performed hand hygiene after providing toileting assistance, 6 audits identified staff washed their hands according to the policy. 1 audit was not met because the foley bag holder was not in place and a new holder was placed on the wheelchair. 2 audits were completed in August 2023, and indicated the regulation was met and under comments for each identified hand hygiene procedures were followed correctly. 2 audits were completed in February 2023, and indicated the regulation was met, however did not indicate what was audited. 2 audits were completed in March 2024, and indicated the regulation was met, however did not indicate what was audited. 1 audit was completed in April 2024, and indicated the regulation was met, however did not indicate what was audited. During interview on 5/16/24 at 11:33 a.m., the administrator stated the QAPI committee met monthly and each department went over problem areas and stated they worked on therapy staffed routinely, culinary menus, therapy and missed visits and conducted audits and reviewed what was cited the previous year. The administrator further stated he did not believe they conducted audits on catheters, but was a topic they covered regarding trends with catheter usage. The administrator further stated infection control audits were included in their own binder. During interview on 5/16/24 at 1:24 p.m., the administrator stated he would check with the director of nursing for a stack of audits regarding catheter cares. During interview on 5/16/24 at 1:41 p.m., the administrator verified there were no additional audits completed regarding catheter care and stated there was no documentation in the QAPI minutes for catheter cares. The QAPI minutes since last recertification were requested, along with any additional audits, and the QAPI policy. During interview on 5/16/24 at 3:28 p.m., the administrator provided minutes related to catheter cares. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A policy, Quality Assurance and Performance Improvement (QAPI) Plan undated indicated the facility will develop, implement, and maintain an ongoing, facility-wide QAPI plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. The objectives of the QAPI plan are to provide a means to identify and resolve present and potential negative outcomes related to resident care and services; provide structure and processes to correct identified quality and or safety deficiencies, establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome; establish systems and processes to maintain documentation relative to the QAPI program as a basis for demonstrating that there is an effective ongoing program. A policy, QAPI Program dated 2020, indicated the objective of the QAPI program was to provide a means to measure current and potential indicators for outcomes of care and quality of life, provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators, reinforce and build upon effective systems and processes related to the delivery of quality care and services, establish systems through which to monitor and evaluate corrective actions. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of the process include: tracking and measuring performance, establishing goals and thresholds for performance measurement, identifying and prioritizing quality deficiencies, systematically analyzing underlying causes of systemic quality deficiencies, developing and implementing corrective action or performance improvement activities and monitoring or evaluating the effectiveness of corrective action and revising as needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene during wound cares for 1 of 1 resident (R15), failed to ensure proper personal protective equipment (PPE) for 2 of 2 residents (R331, R5), and failed to ensure proper placement of foley catheter bag and cleaning with catheter cares for 1 of 1 resident (R4) reviewed for infection control. Findings include: R331's Optional State Assessment (OSA) dated 5/7/24, indicated intact cognition, did not have behaviors or reject cares, required extensive assist with transfers, bed mobility and toileting, had cerebral palsy, hemiplegia (paralysis affecting one side of the body) or hemiparesis (one sided muscle weakness), and had a surgical wound. R331's physician orders indicated the following orders: 5/2/24, staff to follow enhanced barrier precautions. 5/8/24, venous ulcer right posterior calf: cleanse wound with wound cleanser and pat dry; apply skin prep around wound, cover with Adaptic, secure with an ABD and Kerlix one time a day every Monday, Wednesday, and Friday. R331's care plan dated 5/2/24, indicated R331 was on enhanced barrier precautions and the goal indicated all staff would follow isolation precautions with interventions that indicated infection control precautions per protocol, sign on resident's door, treatment for current infection per order. R331's care plan dated 5/2/24, indicated R331 required an assist of two using an EZ stand. R331's CNA (certified nursing assistant) Report Sheet: Group 2 form dated 5/10/24, indicated R331 required an assist of two with a hoyer lift. The form lacked information R331 was on enhanced barrier precautions. During observation on 5/13/24 at 2:00 p.m., R331 had an enhanced barrier precautions sign located on her door and a cart with masks, gowns, and gloves was located outside the room. During observation on 5/14/24 at 7:41 a.m., nursing assistant (NA)-A and another staff person were in R331's room without gowns on but had not started cares. During observation on 5/14/24 at 7:46 a.m., registered nurse (RN)-A and an unnamed nurse practitioner donned PPE including a gown and entered R331's room. During observation on 5/14/24 at 8:02 a.m., a staff person was in R331's room and R331 had a full body mechanical lift sling under her and the staff person was standing by the bed with no gown on. At 8:03 a.m., nursing assistant (NA)-A sanitized her hands and entered the room, but did not don a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview and observation on 5/14/24 between 8:03 a.m., and 8:05 a.m., RN-B stated R331 was on enhanced barrier precautions and staff need to wear a gown, masks, and gloves with contact such as dressing, transfers, and changing briefs. RN-B further stated the NA's should have a gown and gloves on. At 8:05 a.m., RN-B opened R331's door and R331 was in the air in the full body mechanical lift and verified both nursing assistants did not have gowns on during the transfer. RN-B stated it was important to have PPE in order to prevent the spread of any possible infections. During interview on 5/14/24 at 8:11 a.m., NA-B stated when a resident is on enhanced barrier precautions, a gown, gloves, and mask is donned. NA-B stated she was told R331 was off of enhanced barrier precautions (EBP) and verified she did not have a gown on during R331's transfer. During observation on 5/14/24 at 8:18 a.m., R331 had signage on her door that indicated enhanced barrier precautions and everyone must clean their hands before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high contact resident care activities dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, assisting with toileting, device care or use, central line, urinary catheter, feeding tube, tracheostomy, wound care any skin opening requiring a dressing. A cart with gloves and gowns and masks were located outside the door. During interview on 5/14/24 at 1:50 p.m., the regional nurse consultant (RNC) stated they followed CMS (Centers for Medicare and Medicaid) guidance for EBP and expected gowns and gloves be worn when completing high contact activities, but had been a learning curve for staff when to apply PPE and when not to. R5: R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated R5 had intact cognition, did not have behaviors or reject care, had heart failure, renal insufficiency, neurogenic bladder, diabetes, and required substantial assistance with toileting, showering, lower body dressing, and upper body dressing, and had an indwelling foley catheter. R5's physician orders indicated the following order: 4/10/24, staff to follow enhanced barrier precautions every shift. 5/9/24, please exchange foley catheter once monthly with a new 14 french 30 cubic centimeters (cc) balloon catheter. 5/14/24, BMP weekly on Tuesdays for hypokalemia (low potassium) related to chronic kidney disease, stage four. R5's care plan dated 4/10/24, indicated R5 was on enhanced barrier precautions and all staff were to follow precautions. Interventions included infection control precautions per protocol, signage on resident's door, and treatment for current infection per order. R5's CNA (certified nursing assistant) Report Sheet: Group 2 form dated 5/10/24, indicated R5 had a foley catheter and lacked information R5 was on enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 5/13/24 at 4:09 p.m., R5 had enhanced barrier precautions signage on her door and a cart was located outside her door. During interview and observation on 5/14/24 at 8:30 a.m., laboratory assistant (LA) was in R5's room and drawing R5's blood from R5's left arm without a gown. Registered nurse (RN)-B verified the LA was not wearing a gown and verified R5 was on enhanced barrier precautions (EBP) and LA should have worn a gown. R5's door had signage for EBP, additionally, there was a cart located outside the door with gowns, gloves, and hand sanitizer. During interview on 5/14/24 at 8:34 a.m., R5 verified she had blood drawn today from her left arm. During interview on 5/14/24 at 8:35 a.m., LA stated she did not see the sign on the door and verified she did not donn a gown when drawing blood for R5. During interview on 5/14/24 at 1:54 p.m., the regional nurse consultant (RNC) stated she expected staff from outside the facility follow signage on the doors and ask staff at the facility who the signs on the door are intended for in order to best protect themselves and the residents. R4 R4's quarterly MDS dated [DATE], indicated intact cognition, did not have behaviors, did not reject care, required partial to moderate assistance with toileting hygiene, was dependent for showering and bathing, required substantial assist with upper and lower body dressing, and personal hygiene. Additionally, the MDS indicated R4 had an indwelling catheter, had coronary artery disease, heart failure, and obstructive uropathy (a disorder of the urinary tract). R4's care plan dated 4/10/24, indicated R4 was on enhanced barrier precautions and all staff were to follow precautions and interventions indicated treatment for current infection per order, sign on resident's door, infection control precautions per protocol. R4's care plan dated 2/19/24, indicated R4 had an alteration in elimination due to BPH (benign prostatic hyperplasia). R4 had a foley catheter and often felt the catheter bag needed emptying when there is not a lot of urine in it. Interventions indicated monitor foley catheter output and change foley catheter per policy, provide incontinent products and assist to change as needed, provide total assistance with peri-cares. Monitor for and report suspected signs and symptoms of a UTI (urinary tract infection). R4's care plan dated 11/4/21, indicated R4 had a self care deficit and required assist of 1 for bathing, hygiene, and dressing. R4's CNA Report Sheet: Group 3 form dated 5/10/24, indicated R4 required assist of 1 with transfers and had a foley catheter. R4's nursing progress notes dated 3/6/24 at 11:01 p.m., indicated R4 had a UTI. R4's nursing progress notes dated 4/22/24 at 1:17 a.m., indicated R4 was on Macrobid (an antibiotic used to treat bladder infections) 100 mg twice a day and had a UTI. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview and observation on 5/15/24 between 7:01 a.m., and 7:42 a.m., nursing assistant (NA)-C assisted R4 with his activities of daily living (ADLs). At 7:01 a.m., the catheter was hanging off of the bed. At 7:09 a.m., NA-C emptied R4's catheter and clasped the drainage port back into place without first cleaning the end. At 7:12 a.m., NA-C donned R4's underwear and at 7:13 a.m., put R4's pants on lower legs and at 7:15 a.m., donned R4's slippers. The catheter bag was on the floor and no barrier was between the floor and the bag. NA-C assisted R4 with washing and at 7:28 a.m., R4 reported his pants were too tight and NA-C offered a choice of other clothes and at 7:29 a.m., assisted R4 in applying new pants. At 7:33 a.m., NA-C assisted R4 in a transfer to his wheelchair. During interview at 7:42 a.m., NA-C stated she would normally clean the catheter drainage port with alcohol after draining the urine bag, but did not have alcohol wipes and had to work with what she had, additionally, NA-C stated normally the catheter should not be on the floor but had to make it work with the convenience of R4 to stand up. During interview on 5/15/24 at 1:00 p.m., with the director of nursing (DON) who was also the infection preventionist (IP) and the regional nurse consultant (RNC), the RNC stated catheters were emptied when full and should not be located on the floor, additionally catheters should be cleaned with alcohol wipes after they are drained. RNC stated it was important for infection control because it was a direct line to R4's bladder and they want to prevent any cross contamination and would let staff know what the process is for cleaning and would start education right away. A policy, Enhanced Barrier Precautions, dated 4/1/24, indicated it was the practice to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug resistant organisms. EBP refer to the use of gown and gloves for use during high contact resident care activities for residents known to be colonized or infected with a MDRO (multidrug resistant organism) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions. EBP will be implemented for residents with any of the following: wounds such as chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers, indwelling medical devices, e.g. central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, even if the resident is not known to be infected or colonized with a MDRO. Implementation of EBP includes making gowns and gloves available. High contact resident care activities include: 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. Additionally, EBP should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed. A policy Indwelling Catheter Care Procedure dated 7/21/23, indicated the purpose of the policy was to provide guidelines for indwelling catheter care. When emptying the catheter bag, don new gloves, uncap bottom outlet of bag, drain urine into measuring container, cleanse outlet with alcohol swab and recap the outlet. Measure urine and dispose of it in the toilet. The policy lacked information regarding keeping the catheter bag off of the floor. 49657 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's face sheet dated 5/16/24, identified diagnoses including diabetes mellitus (DM), lymphedema (swelling of the legs related to lymph) obesity, hyperlipidemia (HLD-high blood cholesterol), anxiety, insomnia, obstructive sleep apnea, hypertension (HTN-high blood pressure), asthma, and cellulitis (inflammation of cells). R15's quarterly minimum data set (MDS) dated [DATE], identified R15 had severe cognitive impairment, required substantial assistance with mobility and daily self-cares. R15's Order Summary Report dated 5/16/24, indicated R15's wound care orders for a stage 3 pressure ulcer on their left buttock were as follows: Left gluteal stage 3 pressure ulcer (PU) cleanse wound with cleanser, pat dry, pack with Medi-honey alginate, and cover with a foam dressing. On 5/15/24 at 7:06 a.m., registered nurse (RN)-A donned their personal protective equipment (PPE) and removed the soiled dressing and removed their gloves, no hand hygiene was performed. RN-A put on new gloves and used the wound cleanser to clean the site and patted it dry. RN-A removed their gloves, no hand hygiene was performed. RN-A put on another pair of gloves and packed the wound with Medi-honey and covered the site with foam dressing. RN-A placed a clean brief and made the resident comfortable. RN-A then removed their PPE and performed hand hygiene upon exiting the room. On 5/15/4 at 7:20 a.m., RN-A verified they did not perform hand hygiene after removing their gloves during the wound cares. RN-A verbalized they should have performed hand hygiene to prevent infection for the resident or spreading infections to others in the facility. On 5/15/4 at 2:57 p.m., the director of nursing (DON) indicated they expected their staff to perform hand hygiene before and after cares, and anytime their hands were visibly soiled. DON indicated importance of performing hygiene to prevent spread of infections and new infections. The facility's Wound care treatment Procedure last revised 2/2024, indicated during wound cares, after removing previous dressing, remove your gloves and complete hand hygiene. Assess the wound, cleanse, remove you gloves and complete hand hygiene. Complete dressing, remove your gloves and perform hand hygiene.

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	05/16/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review, the facility failed to ensure 1 of 5 resident (R5) were offered or received pneumococcal vaccination in accordance to Center for Disease Control (CDC) recommendations. Findings include: The CDC Pneumococcal Vaccine Timing for Adults undated, indicated adults aged [AGE] years and older who have had no prior pneumococcal vaccinations could either have option A which indicated PCV20, or option B, give PCV15 and follow with PPSV23 after at least one year of giving PCV15. If only the PPSV23 vaccination was administered prior at any age, option A indicated PCV20 could be administered after 1 year or option B indicated PCV15 could be administered after 1 year. If only the PCV13 vaccination was administered at any age, option A indicated PCV20 could be administered after 1 year, or PPSV23. If PCV13 was administered at any age, and PPSV23 was administered prior to [AGE] years of age, option A indicated PCV20 could be administered after five years, or option B indicated PPSV23 could be administered after 5 years. Additionally, for those who already completed PCV13 at any age, and PPSV23 at age 65 or greater, together, with the patient, vaccine providers may choose to administer PCV20 to adults greater than [AGE] years old who have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of [AGE] years old. R5's Admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, admitted to the facility 1/12/24, and R5's pneumococcal vaccination was up to date. R5's quarterly MDS dated [DATE], indicated R5 was [AGE] years old, had intact cognition, did not have behaviors or reject cares and pneumococcal vaccinations were up to date. R5's Medical Diagnosis form indicated the following diagnoses: acute on chronic diastolic congestive heart failure, chronic kidney disease, type two diabetes mellitus. R5's physician orders dated 1/12/24, indicated the facility may use standing orders per facility policy. R5's standing orders dated 1/25/24, indicated per CDC guidelines, administer pneumococcal vaccinations unless contraindicated. R5's Immunization form indicated R5 received PCV-13/Prevnar 13 on 10/18/15, and received PPSV23 on 7/12/17. R5's Vaccine Consent form dated 2/6/24, indicated R5 did not wish to receive influenza and COVID-19 vaccinations. The box next to pneumococcal vaccine was left unchecked. Additionally, under the heading, Recent Vaccinations to be Completed by the Facility indicated an unchecked box for Pneumo Conjugate (PCV15, PCV20, PCV13, Prevnar 13). R5's medication administration record (MAR) and treatment administration record (TAR) dated January 2024, lacked evidence PCV20 was administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's MAR and TAR dated February 2024, lacked evidence PCV20 was administered. R5's medical record was reviewed and lacked evidence PCV20 was administered or that shared clinical decision making occurred. R5's nursing progress notes dated 1/22/24, indicated R5 was admitted to the hospital for possible pneumonia and cellulitis. R5's nurse practitioner encounter note dated 1/29/24, indicated R5 was readmitted to the facility after being hospitalized for cellulitis. The note further indicated per the hospital discharge summary, R5 was admitted from the emergency department for possible pneumonia. During interview on 5/15/24 at 1:00 p.m., with the director of nursing (DON) who was also the infection preventionist (IP) and the regional nurse consultant (RNC), the RNC stated the facility had a vaccination schedule and they pulled the MIIC report to see where residents were at with immunizations received, and reviewed their age, diagnoses, and followed the CDC Adult Immunization Schedule. RNC further stated pneumococcal vaccinations were given almost immediately after signing a consent form and immunizations were documented in the Immunizations form and consents were in the medical record. RNC further stated pneumococcal vaccination discussions were in the nurse practitioner notes and prescriptions for pneumococcal vaccinations were sent through their portal and would check to see if a discussion occurred for the PCV20 vaccination. During interview on 5/15/24 at approximately 2:25 p.m., RNC stated they were deficient in getting the shared clinical decision making and providing R5 PCV20 vaccination and planned to make it right by talking with R5 today. A new consent form dated 5/15/24, indicated R5 wanted the PCV20 vaccination and a new order dated 5/15/24 at 2:38 p.m., indicated PCV20 0.5 milliliters (ML) intramuscularly one time for health maintenance. A policy, Pneumococcal Policy, dated 4/6/22, indicated the purpose of the policy was to follow recommendations of the Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control (CDC) and or the state department of health for prevention of pneumococcal disease and offering pneumococcal vaccination. Prior to or upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine. Within 30 days of admission, resident will be offered the vaccine, when indicated, unless the resident has already been vaccinated or the vaccine is medically contraindicated. Refer to the current CDC recommended Adult Immunization Schedule to determine recommended vaccines i.e types, frequencies, intervals and special instructions. Consent will be obtained and the pneumococcal vaccination will be administered to residents, per physician order and CDC recommendations, and will be documented in the resident's medical record. Documentation will include the date of the vaccination, person administering, and the site of the vaccination.