| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245332 | A. Building<br>B. Wing | 06/16/2025 |

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

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>Based on observation, interview, and document review, the facility failed to act promptly and provide resolution for resident concerns related to the dietary department failure to post upcoming menus.<br><br>Findings include:<br><br>Review of resident council minutes identified the following:<br><br>1.) January 2025, 4 residents attended the meeting, 2 residents voiced a concern that the menu was not posted, and the facility did not provide them to the residents.<br><br>A Resident Council Departmental Response Form noting an identified issue: residents state the lunch and dinner menu was never posted, they never get a menu and when they ask the kitchen staff what the next meal is, they are often told food' or I don't know.<br><br>The Response/Actions Taken: Due to cooler and freezer space we did not have the room to store all the ingredients on the menu. Moving forward we will be working with the director of nutrition to make ends meet. He was working with staff on better communication with the residents. Going forward the following weeks menus will be posted by the end of each week. The form was signed by the dietary manager and the administrator.<br><br>2.) February 2025, Old Business: Menus being posted or handed out have had no improvement.<br><br>3.) March 2025, Old Business: Menu doesn't get posted and menu is not handed out. No improvement.<br><br>Resident Council Departmental Response Form: The menu has not been posted consistently and residents have not been given a menu to choose from.<br><br>Dietary director response: due to the Avian flu effecting the availability of eggs and a cooler being down, staff were unable to get all the products for the menu. As of 3/28/25 menus have been posted. The form was signed by dietary manager and administrator on 4/2/25.<br><br>4.) May 2025, no residents attended resident council.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 6/12/25, at 1:41 p.m., with the activity director identified she organizes and attends and records minutes for the resident council. She confirmed the above findings and identified that in February of 2025, when residents reported there was no improvement with the posting of menus, she brought that information forward to the Quality Assurance and Performance Improvement (QAPI) committee and submitted a second department response form to the dietary manager.<br><br>Review of March 2025 QAPI minutes identified resident council members stated the menu did not get posted and they would like it posted. The QAPI minutes made no mention of how the facility was going to ensure menus would be posted going forward.<br><br>Observation on 6/12/25 at 12:00 p.m., of facility hallways, resident rooms, and entrance to dining room identified no upcoming menu posted.<br><br>Interview on 6/12/25 at 12:23 p.m., with the dietary manager confirmed they have not been posting the weekly or monthly menus. He was notified that resident council had complained about upcoming menus not being posted. He attended a meeting and explained to the residents that kitchen has had some supply issues and a cooler that was temporarily down so he has had to adjust the menu on a daily basis. Going forward, he would print the weekly menu and leave them at the nurse's station for nursing assistants to pass out. He acknowledged he had not followed through or maintained the resolution and said he had the menus; however, he did not print them for residents or get them posted.<br><br>Interview on 6/12/25 at 2:10 p.m., with the administrator identified he was aware there were concerns brought forward at resident council regarding the menus not being posted. He agreed there should be at least one week's menu posted in a resident area and reports he gave the dietary manager a copy of the policy to review and sign. He was not aware if the menus were currently being posted or not. He was unable to provide any documentation that he had completed any audits or follow up with residents to ensure the education provided was effective or to ensure the concern had been resolved.<br><br>Review of the current, undated Facility Menus Policy identified menus would be written at least two weeks in advance and copies of the menus would be posted in at least two resident areas, in positions and in print large enough for residents to read them. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>R18's 4/9/25, quarterly Minimum Data Set (MDS) assessment identified R18's cognition was intact, R18 was dependent on staff for transfers and R18 attended dialysis.<br><br>R18's care plan identified R18 had nutritional risk for malnutrition related chronic disease. R18 required increased protein related to end stage renal disease (ESRD), required a fluid restriction of 1200 milliliters (ml). R18 would receive supplements and be offered a liberalized diet. Staff were to communicate with renal dietician at dialysis, and explain and reinforce the importance of maintaining the diet ordered. The facility staff would provide and serve R18's diet as ordered, a modified renal, large portions, and a 1200 fluid restriction with snacks between meals three times a day.<br><br>Observation and interview on 6/9/25 at 5:30 p.m., R18 was observed in his bed with his evening meal on the bedside table in front of him. R18 had roast beef with gravy over it, mashed potatoes with gravy, broccoli, grapes, a glass of milk, and a glass of apple juice. R18 said he was not supposed to get milk. He did not like apple juice, potatoes, or broccoli and it was right here on his diet slip, but staff send it anyway.<br><br>Observation on 6/9/25 at 5:32 p.m., R18 had pushed his bedside table away from him and laid back down on the bed without eating anything.<br><br>R18's dietary slips identified he was on a renal diet. R18 was on a 1200 ml fluid restriction per day. At breakfast R18 would get 4 ounces of cranberry juice, 4 ounces of milk. At lunch and dinner meal R18 was to receive 8 ounces of cranberry juice. He was not to get milk at lunch or supper and no apple juice. The dietary slip identified R18's dislikes as No tomatoes or tomato products, potatoes, melon, orange juice, bananas, yogurt, ice cream, pudding, dairy desserts, milk (except at breakfast). No apple juice, broccoli, cauliflower, or Brussel sprouts. No hot cereal, Raisin Bran, or strawberry Nepro supplement. No spicy foods. R18 was to get double portions with fluid restriction of 1200 ml.<br><br>Review of July 2017, Resident Food Preferences policy identified upon admission the dietician or nursing staff will ask about the resident's food preferences. The residents' preferences will be documented in their care plan. The residents' preferences may be reviewed by the physician if there may be a conflict with the resident's food choices and the prescribed therapeutic diet. The dietician will discuss with the resident or representative the rationale for a prescribed diet. The dietary department will offer a variety of foods at each meal, as well as access to nourishing snacks throughout the day.<br><br>Interview on 6/11/25 at 2:01 p.m., with the administrator identified he would expect dietary staff would follow resident food preferences on the tray ticket and if they had dislikes, they should be offered an alternative.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of July 2017, Resident Food Preferences policy identified upon admission the dietician or nursing staff will ask about the resident's food preferences. The residents' preferences will be documented in their care plan. The residents' preferences may be reviewed by the physician if there may be a conflict with the resident's food choices and the prescribed therapeutic diet. The dietician will discuss with the resident or representative the rationale for a prescribed diet. The dietary department will offer a variety of foods at each meal, as well as access to nourishing snacks throughout the day.<br><br>Based on observation, interview, and document review, the facility failed to honor food preferences identified on resident food preference sheets for 3 of 3 residents (R18, R22, R187).<br><br>Observation on 6/11/25 at 8:02 a.m., of nursing assistant (NA)-A was passing breakfast room trays. NA-A removed a tray from the cart, entered R187's room, placed the tray in front of her on the overbed table and removed the lid. R187's plate contained one egg and two slices of toast. R187 stated clearly to NA-A, I don't eat toast, what am I supposed to eat? NA-A proceeded to leave the room without responding to R187's question and failed to offer an alternative replacement.<br><br>Interview on 6/11/25 at 8:53 a.m., with NA-A confirmed he heard R187 say she didn't want what was on the plate. He reported he did not have time to notify the kitchen because he was the only one passing trays. If someone had been helping him, he would have told the kitchen. Normally, if someone doesn't like what is served he gets them a snack like Jello. He reported he was not aware of an alternative or anytime menu and stated he had not received training on what to do if someone did not like the food they were served.<br><br>Review of R187's 6/11/25, diet slip provided by the dietary manager noted she disliked toast.<br><br>Interview on 6/11/25 at 9:31 a.m., with the director of nursing identified she would have expected staff to offer an alternative food choice if they reported they did not like what had been served to them.<br><br>Interview on 6/12/25 at 8:24 a.m., with R22 identified he was feeling frustrated. felt it was as if staff did not follow his preference sheet. The meal served the evening before included mushrooms. He stated, I hate mushrooms . they disgust me He was able to get a new plate from the cook when he asked but thought the staff should have not served it to him in the first place.<br><br>Review of R22's diet slip provided by the dietary manager noted he disliked mushrooms. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** R7<br><br>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 diagnosis of seizures, anxiety, and depression, and received antipsychotics on a routine basis.<br><br>R7's current care plan identified he had a diagnosis of major depressive disorder and generalized anxiety disorder. The focus was for R7 to remain stable and R7 to respond to interventions by staff to calm and redirect. the interventions were to complete assessments, redirect as needed, and provide emotional support. The care plan lacked any individualized target behaviors staff should be monitoring for.<br><br>R7's June 2025, administration record identified he received risperidone 3 milligrams (mg) by mouth daily and aripiprazole 20 mg by mouth daily for major depressive disorder. The medical record lacked any identified target behavior that staff should be monitoring to identify if the medication was effective.<br><br>Interview on 6/10/25 at 8:57 a.m., with the director of nursing identified they do a meeting weekly to review nursing progress notes related to behaviors, but they do not identify in the medical record any individualized target behaviors for residents taking psychotropic medications.<br><br>The undated, Psychotropic Medication Use Policy identified the facility would complete ongoing documentation that would include behavioral indicators or symptoms, monitoring for effectiveness and potential adverse consequences.<br><br>Based on interview and document review the facility failed to ensure psychotropic medications had identified target behaviors or symptoms and failed to monitor the target behaviors or symptoms for 3 of 5 residents (R5, R7, and R24) reviewed for psychotropic medication use.<br><br>Findings include:<br><br>R5<br><br>R5's undated, current diagnoses list identified R5 had non-[NAME] (cancer of the blood) lymphoma, dementia and anxiety.<br><br>R5's 5/15/25, 5-day Minimum Data Set (MDS) identified R5 was moderately cognitive impaired and had no behaviors. R5 required staff set-up assistance with meals, supervision or touching assistance with dressing, transfers, and mobility. R5 had taken antipsychotics and antidepressants on a routine basis.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R5's June 2025, medication administration record (MAR) identified mirtazapine 7.5 milligrams (mg) an (antidepressant) medication at bedtime for dementia and anxiety. Quetiapine Fumarate (Seroquel) 25 mg at bedtime (antipsychotic medication) for dementia and anxiety. The orders lacked evidence that identify specific target behaviors the medication was ordered to treat.<br><br>R5's current, undated care plan identified R5 was to have alteration in mood and behavior related to current health conditions related to current health conditions. The goal was R5's mood/behavior was to remain stable. Interventions was for facility nurses to conduct PHQ 9 (to evaluate depression) screenings per regulation and as needed (PRN), monitor and document mood state/behaviors, redirect PRN, and provide emotional support, validation, and comfort measures PRN. In addition, R5's care plan identified R5 had not displayed behaviors toward herself, other residents, or staff that was of concern.<br><br>Interview on 6/10/25 at 2:06 p.m., with certified nursing assistant (NA)-C identified R5 showed irritability towards other residents on a few occasions. R5 would cover her ears when multiple residents would talk at the same time in a group setting held in the lobby. However, NA-C could not identify any specific target behaviors for R5.<br><br>Interview on 6/10/25 at 2:09 p.m., with licensed practical nurse (LPN)-B was unsure what R5's specific target behaviors were. LPN-B confirmed there was nothing on the MAR or care plan that identified target behaviors for R5's medication use.<br><br>Interview on 6/10/25 at 4:10 p.m., with registered nurse (RN)-A she was not aware that R5 had target behaviors. In addition, RN-A was not aware target behaviors was to be reflected on R5's care plan. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** R27's 4/24/25, 14-day admission assessment, MDS identified her cognition was intact, and she required supervision to moderate assistance with activities of daily living, (ADLS). Her diagnosis list included ataxia, (impaired balanced or coordination), weakness, COPD, chronic back pain, and paranoid schizophrenia.<br><br>R27's medical record identified MDS assessment:<br><br>1)4/8/25 entry tracking record<br><br>2) 4/13/25 discharge with return anticipated, with a 4/18/25 entry tracking record<br><br>3) 4/24/25 14-day admission assessment<br><br>Review of R27's Hospital after visit summary identified she was hospitalized [DATE] through 4/18/25 with acute midline low back pain with right-sided sciatica, ((pain radiating along the sciatic nerve, which runs down one or both legs from the lower back).<br><br>R27's 4/13/25 at 10:35 p.m. progress note identified she had called 911 from her room with complaints of back pain. The ambulance arrived and she was transferred North Memorial hospital and admitted to acute care. Review of the transfer and facility documentation failed to identify the Ombudsman had been notified of R27's discharge to acute care hospitalization.<br><br>Interview on 6/11/25 at 4:45 p.m. with the director of nursing (DON) identified the Ombudsman had not been notified of R27's discharge to acute hospitalization on 4/14/25.<br><br>Based on interview and document review, the facility failed to notify the Ombudsman of transfers and discharge for 4 of 5 residents (R7, R18, R27, R35) reviewed for hospitalizations. Additionally, the facility failed to ensure the resident and/or legal representative had been informed of bed hold rights and ensure a written notice of transfer was provided for 1 of 5 resident (R18) reviewed for hospitalizations.<br><br>Findings include:<br><br>Ombudsman notices:<br><br>R18's 4/9/25, quarterly Minimum Data Set (MDS) assessment identified R18's cognition was intact, R18 was dependent on staff for transfers and R18 attended dialysis.<br><br>R18's 6/12/25, printed Medical Diagnosis list identified cystic fibrosis, immunodeficiency, lung transplant, dependence on renal dialysis, pulmonary nocardiosis (infection of lung), invasive pulmonary aspergillosis (a type of fungal infection of the lungs affects immunocomprised patients), diabetes, end stage renal disease, major depressive disorder. History of malignant neoplasm of thyroid, and attention-deficit hyperactivity disorder.<br><br>R18's medical record identified the following MDS assessments:<br><br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1) 7/4/24 discharge with return anticipated, with a 7/12/24 entry tracking record<br><br>2) 7/15/24 discharge with return anticipated, with a 7/20/24 entry tracking record<br><br>3) 10/4/24 discharge with return anticipated, with a 10/11/24 entry tracking record<br><br>4) 10/12/24 discharge with return anticipated, with a 10/15/24 entry tracking record<br><br>5) 10/26/24 discharge with return anticipated, with a 11/1/24 entry tracking record<br><br>6) 1/2/25 discharge with return anticipated, with a 1/5/25 entry tracking record<br><br>R35's 4/10/24, admission MDS assessment identified R35's cognition was moderately impaired. R35 wandered 1-3 days during assessment period, was independent with grooming with supervision. Attended speech, occupational, and physical therapy and planned to return to community.<br><br>R35's 6/12/25, printed Medical Diagnosis list identified traumatic subdural hemorrhage without loss of consciousness, dementia, multiple fractures of ribs, weakness, hyponatremia, anemia, and hypertension.<br><br>R35's medical record identified MDS assessment 4/18/24 discharge, return not anticipated.<br><br>Review of the notices to the ombudsman that the facility provided identified:<br><br>1) 8/1/24 monthly notice for July 2024 discharges-R18 was not listed<br><br>2) 9/4/24 monthly notice for August 2024 discharges-R18 was not listed<br><br>3) 11/1/24 monthly notice for October 2024 discharges-R18 was not listed<br><br>There were no other notices to the ombudsman provided by the end of the survey.<br><br>Bed hold notice:<br><br>R18's 4/9/25, quarterly Minimum Data Set (MDS) assessment identified R18's cognition was intact, R18 was dependent on staff for transfers and R18 attended dialysis.<br><br>R18's 6/12/25, printed Medical Diagnosis list identified cystic fibrosis, immunodeficiency, lung transplant, dependence on renal dialysis, pulmonary nocardiosis (infection of lung), invasive pulmonary aspergillosis (a type of fungal infection of the lungs affects immunocomprised patients), diabetes, end stage renal disease, major depressive disorder. History of malignant neoplasm of thyroid, and attention-deficit hyperactivity disorder.<br><br>R18's medical record identified the following MDS assessments; 1/2/25 discharge with return anticipated, with a 1/5/25 entry tracking record. The medical record had no documentation that a bed hold had been verbally or physically provided.<br><br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A copy of the bed holds for hospital transfer on 1/2/25, was requested but not provided by end of survey.<br><br>Review of 6/16/25, email from administrator identified that there was not a bed hold for R18 for 1/2/25.<br><br>R7's 8/26/24, discharge return anticipated Minimum Data Set (MDS) assessment identified R7 had an unplanned discharge to an acute care hospital.<br><br>R7's 2/4/25, discharge return anticipated Minimum Data Set (MDS) assessment identified R7 had an unplanned discharge to an acute care hospital.<br><br>R7's 8/29/24, discharge summary identified he admitted to the hospital on 8 26/24 and returned to the facility on 8/29/24.<br><br>R7's 2/5/25, discharge summary identified he admitted to the hospital on [DATE] and returned to the facility on 2/5/25.<br><br>Review of a facility provided Action Summary report noted R7 had discharged on 8/26/24, to Park Nicollet Hospital, however, there was no confirmation the report had been provided to the Ombudsman. In addition, there was no information provided for the 2/4/25 discharge notification to the ombudsman. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>Based on interview and document review, the facility failed to complete a 48 hour baseline care plan upon admission for 1 of 10 residents (R187) reviewed.<br><br>Findings include:<br><br>R187's 6/5/25, admission Minimum Data Set (MDS) assessment identified her cognition was intact, she felt down and depressed 2 to 6 days weekly, and had no behaviors. R187 was independent with transfers, required assistance from staff with hygiene, and was occasionally incontinent of urine. She had diagnosis of heart failure, diabetes, COPD, respiratory failure, and atrial fibrillation. She was at risk for pressure ulcers, took insulin, and anticoagulant and a diuretic on a routing basis.<br><br>Review of R187's baseline care plan identified she required assistance with bathing, dressing, hygiene, mobility, and transfers. The baseline care plan lacked mention of what level of assistance or the number of staff required to provide assistance.<br><br>Interview on 6/11/25 at 2:15 p.m., with registered nurse (RN)-C identified she uses the care plan to identify how to provide care to a resident and how to determine how many staff are required. RN-C reviewed R187's care plan and reported she would be unable to determine care requirements based on the information provided on R187's care plan.<br><br>Interview on 6/11/25 at 2:30 p.m., with the director of nursing (DON) agreed R187's baseline care plan was missing pertinent information needed to provide care. She identified it was her expectation the baseline care plan should be completed upon admission. The DON reported they also have care sheets that nursing assistance use to reference how to provide ADL's, transfers, diet, and precautions, however, R187 had not yet been added to those care sheets.<br><br>The facility provided Care Planning Policy identified a baseline plan of care would be developed within 48 hours of admission to ensure that the resident's immediate basic needs are met and maintained. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>The facility failed to develop and implement a comprehensive person-centered care plan for 1 of 2 sampled residents (R5) that addressed anticoagulant (prevents and breaks down blood clots) therapy with safety precautions.<br><br>Findings include:<br><br>R5's undated, current diagnoses list identified R5 had a transient ischemic attack (TIA) (blockage of blood flow to the brain that causes stroke-like symptoms) and cerebral infarction (reduce blood flow to a part of the brain that is obstructed by a blood clot).<br><br>R5's 5/15/25, 5-day Minimum Data Set (MDS) identified R5 was moderately cognitive impaired and had no behaviors. R5 required staff set-up assistance with meals, supervision or touching assistance with dressing, transfers, and mobility. R5 had taken anti-platelets on a routine basis.<br><br>R5's June 2025, medication administration record (MAR) identified clopidogrel bisulfate (Plavix) 75 milligrams (mg) daily (anti-platelet medication that prevents blood clot formation) for myocardial infarction (heart attack) on 5/13/25.<br><br>R5's current, undated care plan lacked evidence of anti-platelet, interventions, and safety precautions.<br><br>Interview on 6/10/25 at 2:09 p.m., with licensed practical nurse (LPN)-B identified interventions for R5's use of anti-platelet therapy would be signs and/or symptoms of bleeding or bruising. LPN-B confirmed R5's medication orders and care plan lacked identification of parameter for anti-platelet use.<br><br>Interview on 6/10/25 at 4:10 p.m., with registered nurse (RN)-A voiced agreement that R5's care plan should have included interventions and monitoring for anti-platelet therapy.<br><br>Review of the July 2023, Care Planning policy identified that the care plan was the responsibility of the interdisciplinary team, and the residents care plans were to be individualized for each resident. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on interview and document review, the facility failed to revise the care plan to reflect current care needs for 2 of 13 sampled residents (R2 and R18) reviewed.<br><br>Findings include:<br><br>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, high blood pressure, arthritis, stroke affecting the left side, dementia, depression and one-sided weakness.<br><br>R2's 1/31/25, care plan identified she was on enhanced barrier precautions related to Foley catheter. R2 relied on extensive assist of 1-2 staff with her grooming and staff were to encourage her to participate as able.<br><br>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 with no Foley catheter observed.<br><br>Interview on 6/10/25 at 10:30 a.m. with nursing assistant (NA)-D confirmed R2 did not have a Foley catheter, and she was not aware that R2 ever had one.<br><br>Interview on 6/11/25 at 10:39 a.m. with NA-C confirmed R2 did not have a Foley catheter. He reported he had never known her to have one.<br><br>R18's 4/9/25, quarterly Minimum Data Set (MDS) assessment identified R18's cognition was intact, R18 was dependent on staff for transfers and R18 attended dialysis. R18 had diagnoses of cystic fibrosis, severe protein-calorie malnutrition, immunodeficiency, lung transplant, fluid overload, end stage renal disease, renal dialysis, and diabetes.<br><br>R18's 5/13/24, care plan identified staff were to encourage R18 to go for his scheduled dialysis appointments. Metro mobility picked R18 up at 11:30 a.m., with a return ride at 5:15 p.m.<br><br>Interview on 6/9/25 at 1:27 p.m., with R18 identified he left for dialysis at 9:00 a.m., and he has gone at that same time for months.<br><br>Interview on 6/11/25 at 3:57 p.m., with consulting nurse confirmed that R2 and R18's care plans did not reflect the resident's current status. R2 did not have a Foley catheter and R18's dialysis pick-up time from Metro mobility was inaccurate as he now left at 9:00 a.m. in the morning. She reported the care plan was meant to guide staff and the information on the care plan should be current of what ever type of cares are needed. Staff should be accessing the Kardex (staff view of care plan) for resident care needs.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the 7/21/23, Care Planning policy identified that the care plan was the responsibility of the interdisciplinary team and the residents care plans were to be individualized for each resident. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>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).<br><br>Findings include:<br><br>R24<br><br>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.<br><br>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.<br><br>Random observations on 6/9/25 of R24 in her room identified at:<br><br>1) 1:00 p.m., R24 was lying in bed yelling out and crying. Staff entered the room and attempted to comfort R24.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>R24's physician progress notes identified on:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>5) 3/28/25, R24 was referred to hospice related to her stroke, weight loss, and cognitive deficit.<br><br>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.<br><br>7) 4/4/25, R24 was noted to remain intermittently tearful and had ongoing weight loss.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>Review of the hospice nurse aide notes identified on:<br><br>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.<br><br>2) 4/16/25, R24 was given a bed bath and personal hygiene was performed. No concerns were noted on in the documentation.<br><br>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.<br><br>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.<br><br>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.<br><br>4) 5/1/25, hospice assisted with lunch and refilled her water. No concerns were noted on in the documentation.<br><br>5) 5/6/25, The NA completed a bath and washed her hair. [R24] didn't eat lunch.<br><br>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.<br><br>7) 5/13/25, R24's bath was completed, hair was washed, and her brief changed.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 8) 5/27/25, R24 was noted to be very emotional and cried the entire visit. Staff completed her bath and washed her hair.<br><br>etc.<br><br>Interview on 6/10/25 at 12:30 p.m. with the hospice RN-B reported she was notified of R24 having areas of bruising on her coccyx and heels on Sunday 6/8/25, and had visited R24 on Monday 6/9/25, but had not assessed the areas due to R24 sleeping. As a precaution, she had ordered cushioned blue boots (Prevalon boots) and an air mattress on 6/9/25. RN-B expressed concern for the lack of communication between facility staff and Hospice. RN-B verbalized her concern with personal care provided to residents at the facility and explained R24 had been admitted to Hospice on 4/8/25, and at that time, the room smelled strongly of urine and feces. In addition, during one of nursing assistant (NA)-F's first visits, not only did R24's room smell of urine and feces, she was wearing soiled clothing, and her incontinent brief and bedding was soiled with urine and feces, necessitating a complete bed bath and full bedding change. The HNA contacted her to report R24's hair was so dirty and matted, it would need to be cut as there was no way it could be washed and combed. Family members (FM)-A and FM-B were in attendance at that time and in agreement with cutting the matted hair which was so thick it appeared as dreadlocks (a hairstyle purposefully made of rope-like strands of matted hair).<br><br>Review of R24's hospice nursing notes identified on:<br><br>1) 4/11/25, R24 was noted to be up in bed resting comfortably watching TV. R24 had normal vitals.<br><br>2) 4/22/25, 4/25/25, 4/29/25, and 5/2/25, hospice noted they were providing routing visits. R24's skin was intact, and they had no concerns at any of those times.<br><br>3) 5/13/25, R24 was noted to be tearful on their arrival. Hospice repositioned R24 and comforted her and assisted her with breakfast. Facility staff administered pain and anxiety medication during the visit. Upon hospice leaving, R24 was noted to be calm and speaking with family. No concerns were noted at that time and they would continue to monitor her appetite, weight and mood.<br><br>4) 5/16/25, Hospice noted R24 was resting comfortably. The facility was noted to be utilizing the as needed (PRN) pain and anti-anxiety medication more frequently to avoid tearful episodes. No concerns were noted.<br><br>5) 5/20/25 and 5/27/25, hospice noted No concerns at that time.<br><br>6) 6/9/25, hospice noted the facility had updated them on 6/8/25 at 7:00 p.m., that R24 had 3 new pressure ulcers. The hospice nurse noted they came to the facility on 6/9/25, however, she did not assess R24's pressure ulcers as she was asleep and resting comfortably and had not wished to disturb her due to significant pain when moving and repositioning.<br><br>7) 6/10/25, hospice did attempt to observe her heels somewhat but R24 started to yell out in pain and swatted the hospice nurse away. Hospice called the family, and per their wishes, no wound care was to be provided as it is painful and distressing to R24. Hospice supported the decision, and the focus would be to keep R24 as comfortable as possible. Hospice ordered an air mattress. R24 was noted to be in her final moments and had daily hospice and nurse aide visits. Hospice would continue to monitor and assess R24's rapid decline and comfort level.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>Continuous observations and interview on 6/11/25 of R24 in her room identified at:<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>3) 8:43 a.m., no staff had yet entered her room to offer food, fluids, or repositioning.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| | 245332 | A. Building<br>B. Wing | 06/16/2025 |

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| The Estates at Excelsior LLC | 515 Division Street<br>Excelsior, MN 55331 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>R7<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>R137<br><br>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.<br><br>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).<br><br>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.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>R2<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on observation, interview and document review, the facility failed to identify appropriate turning and repositioning schedule based off professional standards of practice and document when staff performed repositioning for 1 of 2 residents (R32) who has a pressure ulcer and to minimize the risk of further pressure ulcer development and ensured interventions were implemented.<br><br>Findings include:<br><br>R32's current, undated diagnosis list identified R34 had a diagnoses of pressure ulcers, diabetes, and neurocognitive disorder with Lewy body dementia (dementia that causes a rapid decline in cognition and lack of physical function).<br><br>R32's 5/22/25, admission Minimum Data Set (MDS) identified R34 was severely cognitively impaired. R32 had little interest or pleasure in doing things and trouble falling asleep never to 1 day, had felt down or depressed 12 to 14 days, felt tired, poor appetite 2 to 6 days. R32 was independent with eating, required substantial/maximal assistance with grooming, and supervision, and supervision or touching assistance with transfers. R32 was 5 feet (ft) and 3 inches (in) and weighed 233 pounds (lb). Section M, skin condition of the MDS, identified R32 had a unstageable pressure ulcer with deep tissue injury that was present on admission. Section V, care area assessment (CAA) of the MDS identified R32 was at risk for pressure ulcer development. There was no mention on the MDS that R32 was on a turning/repositioning program.<br><br>R32's current, undated care plan identified R32 was at risk for alteration in skin integrity. The facility staff was to monitor R32's skin integrity during personal cares and on a weekly basis, turn and reposition or offer reminders to offload every 2 to 3 hours and as needed (PRN), encourage adequate fluid intake, use of dietary supplements and nutrition interventions, medicate for comfort and effectiveness, apply treatment to open areas per orders, complete weekly wound measurements and assessment of wound and monitor for skin breakdown of signs/symptoms of infection and report it to R32's physician, as directed.<br><br>R32's 5/27/25, wound care progress notes identified R32's wound was 11.1 centimeters (cm) in length, 4.7 cm in width, and 0.1 cm in depth. Wound measurements identified heavy serosanguineous (clear, thin, and watery fluid) drainage, 5% granulation (connective tissue and blood vessels that form on the surface of a wound), 50% eschar (hardened black or brown dead tissue that appears as a scab-like cover over a wound) and 40% slough (dead tissue within the wound that appears white or yellow in color). The note identified R32's wound was improving.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and interview on 6/10/25 at 9:13 a.m., with licensed practical nurse (LPN)-B reviewed R32's wound order and gathered supplies. Nursing assistant (NA)-C met LPN-B in front of R32's door. LPN-B and NA-C applied hand sanitizer and applied personal protection equipment (PPE), gown and was tied to the back of their neck and wait. LPN-B knocked on R32's room door and introduced themselves to R32. LPN-B informed R32 that she was to be repositioned for dressing change. R32's nodded in agreement. Wound care and dressing change was completed by LPN-B. NA-C and LPN-B repositioned R32's to her right side and had placed a gel-like pressure relieving pillow under R32's lower back near R32's buttock. NA-C applied a pillow to R32's head and elevated R32's feet. LPN-B placed a pillow under R32's feet. When asked how frequent R32 is repositioned, LPN-B stated every 2 hours, as directed by nursing staff. However, LPN-B stated she sometimes would reposition R32 under 2 hours on her shift, but did not document when any repositioning occurred. R32's head of bed appeared to be in a low position, NA-C had placed a blanket over R32's body and LPN-C placed R32's call light next to her hand. LPN-B and NA-C removed PPE and disposed of it in R32's isolation bin and applied hand sanitizer to their hands and rubbed them outside of R32's room. R32's door was left slightly open by LPN-B.<br><br>Observation on 6/10/25 at 11:13 a.m., with LPN-B and NA-C left R32's room and completed hand hygiene. R32 was lying supine (flat on back) in bed. R32 appeared calm and said, hello.<br><br>Interview on 6/11/25 at 3:42 p.m., with director of nursing (DON) had concerns and informed facility staff to monitor residents who was cognitively impaired and would be at risk for pressure ulcer development during their hourly rounds. DON identified R32's pressure ulcer required frequent monitoring and repositioning and identified R32's care plan lacked personalized interventions to promote wound healing.<br><br>Interview on 6/12/25 at 8:25 a.m., with registered nurse (RN)-A identified the facility had implemented hourly checks and 2-hour repositioning on the units for all residents and was updated daily to reflect those interventions on the CNA report sheet. RN-A reviewed the CNA report sheet and identified interventions were not identified on the sheet for but was communicated to the facility nursing staff to complete while on shift. She identified the facility had policies, in addition, to nursing resources that was to direct nursing care on the units, however, RN-A was not aware of a nursing resource the facility had used as a reference.<br><br>Review of 12/04/24, CNA Report Sheet identified R32's was on contact isolation related to methicillin resistance staphylococcus aureus (MRSA) of the wound and required 2-person maximum assistance for bed mobility and incontinence. R32 was to be reposition every 2 hours and required use of hoyer lift for transfers.<br><br>Interview on 6/12/25 at 9:19 a.m., with certified nursing assistant (NA)-A identified nursing staff was expected to complete hourly safety rounds on the units. However, nursing staff was not required to use a checklist to document that hourly rounding was completed.<br><br>Interview on 6/12/25 at 2:41 p.m., with nurse practitioner (NP)-S, who is the wound care nurse, identified R32 was at risk for friction (when skin is rubbed together) and shearing (when skin is dragged across a surface) to occur that would cause further skin breakdown. R32 required staff assistance with repositioning, often and identified 2-hour repositioning was not often enough to promote wound healing.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the July 2023, Care Planning policy identified that the care plan was the responsibility of the interdisciplinary team, and the residents care plans were to be individualized for each resident. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to provide a prescribed therapeutic diet to 1 of 1 resident (R18) reviewed for dialysis.<br><br>Findings include:<br><br>R18's 4/9/25, quarterly Minimum Data Set (MDS) assessment identified R18's cognition was intact, R18 was dependent on staff for transfers and R18 attended dialysis. R18 had diagnoses of cystic fibrosis, severe protein-calorie malnutrition, immunodeficiency, lung transplant, fluid overload, end stage renal disease, renal dialysis, and diabetes.<br><br>Observation and interview on 6/9/25 at 5:30 p.m., R18 was observed in his bed with his evening meal on bedside table next to him. R18 had roast beef with gravy over it, mashed potatoes with gravy, broccoli, grapes, a glass of milk, and a glass of apple juice. R18 said he was not supposed to get milk. He did not like apple juice, potatoes, or broccoli and it was right here on his diet slip, but they send it anyway. Staff returned to R18's room and placed a bottle of Nepro supplement on his bedside table and walked out.<br><br>Observation on 6/9/25 at 5:32 p.m., R18 had pushed his bedside table away from him and laid back down on the bed without eating anything.<br><br>R18's dietary slips identified he was on a renal diet. R18 was on a 1200 ml fluid restriction per day. At breakfast R18 would get 4 ounces of cranberry juice and 4 ounces of milk. At lunch and dinner meal R18 was to receive 8 ounces of cranberry juice. He was not to get milk at lunch or supper and no apple juice. The dietary slip identified R18's dislikes as no tomatoes or tomato products, potatoes, melon, orange juice, bananas, yogurt, ice cream, pudding, dairy desserts, milk (except at breakfast). No apple juice, broccoli, cauliflower, [NAME] sprouts. No hot cereal, raisin bran, or strawberry Nepro supplement. No spicy foods. R18 should get double portions with fluid restriction of 1200 ml.<br><br>R18's 6/10/25, printed care plan identified R18 had nutritional risk for malnutrition related chronic disease. R18 required increased protein related to end stage renal disease (ESRD), required a fluid restriction of 1200 milliliters (ml). R18 would receive supplements and be offered a liberalized diet. Staff were to communicate with renal dietician at dialysis, explain and reinforce the importance of maintaining the diet ordered. Facility staff would provide and serve diet as ordered, modified renal, large portions, and a 1200 fluid restriction with snacks between meals three times a day.<br><br>Observation and interview on 6/10/25 at 5:39 p.m., R18 requested writer to come to his room. Upon entry to his room R18 was observed to be sitting up in his bed with his bedside table in front of him and his evening meal on the table. R18 had a piece of baked chicken on a bun with no condiments and a ½ glass of cranberry juice and a bottle of Nepro supplement. R18's roommate had the same thing but also had a slice of watermelon and no supplement. R18 said see what I got, this is nothing, no calories. He reported he had left early that morning for 2 appointments and had been gone all day and only ate a few snacks while out, no meal. He reported this will never fill him up.<br><br>(continued on next page) |

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| | 245332 | A. Building<br>B. Wing | 06/16/2025 |

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| The Estates at Excelsior LLC | 515 Division Street<br>Excelsior, MN 55331 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 6/10/25 at 5:47 p.m. with dietary manager identified the menu for the evening meal was a crispy chicken sandwich, chopped salad with dressing, chilled fruit, and a glass of milk. R18 should have been served crispy chicken sandwich, with lettuce as the renal diet identified with no tomatoes. R18 should have received a salad with oil and vinegar along with a slice of watermelon. Residents were allowed to ask for second helpings however, he revealed he had just had a talk with some staff about that as they were not giving out second helpings without an order. The dietary manager agreed that R18 did not receive the correct diet on 6/9/25 nor did he on 6/10/25 and would be going to visit with him to ensure he got enough to eat.<br><br>Interview on 6/11/25 at 3:13 p.m., with registered dietician (RD) identified she relies on the dietary staff to serve residents their prescribed diets. She was unaware R18 had not consistently been served the correct diet. The menu identified what to serve and or be substituted for a renal diet and would expect the correct diet to be served.<br><br>On 6/12/25 at 4:00 p.m., a message was left for medical director, with no return call.<br><br>On 6/16/25 at 11:30 a.m., a message was left for medical director, with no return call.<br><br>A policy related to prescribed diets was requested but not provided by the end of the survey.<br><br>Review of July 2017, Resident Food Preferences policy identified upon admission the dietician or nursing staff will ask about the resident's food preferences. The residents' preferences will be documented in their care plan. The residents' preferences may be reviewed by the physician if there may be a conflict with the resident's food choices and the prescribed therapeutic diet. The dietician will discuss with the resident or representative the rationale for a prescribed diet. The dietary department will offer a variety of foods at each meal, as well as access to nourishing snacks throughout the day. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement their dialysis contract and arrange for transportation to dialysis for 1 of 1 resident (R18) who missed their regularly scheduled ride service for dialysis treatment.<br><br>Findings include:<br><br>R18' s 4/9/25, quarterly Minimum Data Set (MDS) assessment identified R18's cognition was intact, R18 was dependent on staff for transfers and R18 attended dialysis.<br><br>R18's care plan identified R18 was a vulnerable adult with decreased physical abilities. R18 has difficulty being mobile on his own. Staff were to encourage R18 to go for his scheduled dialysis appointments. Metro mobility picked up at 11:30 a.m., with a return ride at 5:15 p.m. R18's anxiety makes communication difficult at times when delivering information. R18 had alternation in mobility and required assistance in and out of his bed with a mechanical stand lift and 2 staff.<br><br>Interview on 6/9/25 at 1:26 p.m., with R20 the roommate of R18, identified that R18 was supposed to get up for dialysis but the staff did not get him up, he heard the whole thing they tried to blame him but they were the ones who dropped the ball so he did not go to dialysis today.<br><br>Interview on 6/9/25 at 1:27 p.m., with R18 identified he was supposed to leave for dialysis at 9:00 a.m., and he has gone at that same time for months. He missed his ride this morning so now he was not sure what was happening. He was unsure why they did not get him up for dialysis since he has been on this same schedule for months.<br><br>R18's 6/9/25, 10:49 a.m., progress note identified R18 was alert and able to make his needs known. R18 was scheduled for dialysis pick up at 9:00 a.m., and staff had him ready, but he refused to get up and sit in his wheelchair until the ride arrived. Staff went to assist R18 when the ride arrived and by the time they were done the ride had already left since they were only allowed to wait for 5 minutes. The dialysis center was called to reschedule, and there was an opening at 3:00 p.m. which needed R18 to pay privately for his ride, but he refused, saying he did not have money. An alternative for the following day in the morning was offered to him. He reported he had 2 appointments one in the morning and the other in the afternoon, he was requested to reschedule the morning appointment to attend dialysis however he refused. The director of nursing (DON) updated and explained to him, but he still refused. The primary provider was then updated and explained the risks and benefits of missing dialysis to the resident.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 6/10/25 at 9:46 a.m., with director of nursing (DON) identified R18 missed his ride as he was not ready. The bus driver came and only waited for 5 minutes, usually they wait for 10 minutes. The facility tried to find another ride as he was a Metro Mobility member, but you must call them 24 hours in advance otherwise the resident has to pay privately out of pocket and R18 was not willing to pay. The facility had contacted the dialysis center, and he could have gone at 3:00 p.m., but he refused. The dialysis center could have also seen him on Tuesday morning however, he would not reschedule the other appointment he had. The dialysis center now had added an additional day of this Thursday. R18 had the funds to pay he just choose not to pay. The facility does not pay or offer to pay since he was a member of Metro Mobility. R18 refused the later dialysis time on Monday, refused the Tuesday morning time also, so he will go now on Thursday.<br><br>Interview on 6/10/25 at 10:31 a.m., with nursing assistant (NA)-B identified R18 was up and ready but the bus drive did not wait for him yesterday, we had him at the door on time, but the driver did not wait.<br><br>Interview on 6/10/25 at 11:32 a.m., with Metro Mobility staff scheduler identified that 6/9/25 note said R18 was a no show and was cancelled at the door. She reported a no show was described as the driver knocked on the door and a cancelled at the door meant that the front desk told the driver the client was not there.<br><br>Review of the current, undated Metropolitan Council website, located at https://metrocouncil.org/transportation/services/metro-mobility-home.aspx, identified R18's normal transportation service provided 1 cent [NAME]. Metro mobility certified riders can take same-day rides (POD) with contracted private transportation companies at subsidized rate. Premium direct rides straight from the origin to the destination and can be booked the same day. All POD providers can accommodate wheelchairs and scooters. Metro mobility [NAME] are as follows:<br><br>Peak Fare: $4 (Monday-Friday, 6:30 a. m. to 9:30 a.m. and 2:00 p.m. to 5:30 p.m.)<br><br>Off-Peak Fare: $3.50<br><br>Holiday fare all day: $3.50<br><br>Downtown Fare Zone: $1<br><br>Trips that are over 15 miles in length and fall outside of the federally mandated ADA service area are subject to an additional 75-cent surcharge.<br><br>Observation on 6/11/25 at 7:33 a.m., R18 was up and sitting in his wheelchair in his room.<br><br>Interview on 6/11/25 at 9:00 a.m., with unknown Metro Transit bus driver identified that the driver goes into the facility to pick R18 up. The drivers are to only wait 5 minutes and then are to leave due to having other riders scheduled. The driver reported for R18, he was not always up front when we come, and staff act surprised that we are there at times. The driver reported he has waited up to 15 minutes for R18 at times.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 6/11/25 at 3:57 p.m., with consulting nurse identified she was unaware of what the dialysis contract had in it, she was only aware of what the DON had told her which was R18 refused to get ready to go to dialysis on time. The facility did offer other times that R18 declined, and he was now going an extra day on Thursday.<br><br>Interview on 6/11/25 at 4:11 p.m., with administrator identified that the facility gave R18 an opportunity to go to dialysis as a ride had been set up for the morning. R18 had refused and had the right to refuse. R18 was not able to gather himself, it was not that he was not provide a ride to dialysis. The facility would make reasonable accommodation to get R18 to dialysis, but they were not obligated to pay for that. R18 was able to make it to his dialysis appointment and a ride was here to pick him up. If it was a failure on the facilities part, the facility would reassess that and make reasonable accommodations. If R18 was not playing his part in his own care the facility was not obligated to pay for those additional arrangements.<br><br>Interview on 6/11/25 at 5:40 p.m., with R18 who reported the facility told him he had to pay to go to dialysis on Monday afternoon. He reported he would have attended the afternoon appointment if he did not have to pay for the ride. He then stated loudly yes, it was their fault they should have made it right!<br><br>On 6/12/25 at 4:00 p.m., a message was left for medical director, with no return call.<br><br>On 6/16/25 at 11:30 a.m., a message was left for medical director, with no return call.<br><br>Review of the 5/16/24, Total Renal Care Inc dialysis contract identified section 4.: Transportation of Designated Resident. The facility shall have the responsibility for arranging suitable transportation of the resident to and from [Dialysis] Center, including the selection of the mode of transportation, qualified personnel to accompany the resident and transportation equipment usually associated with this type of transfer. The facility shall be responsible for all costs of transportation associated with the transfer of the resident to and from Center and Facility. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on interview and document review, the facility failed to ensure supply and administration of ordered medications for 1 of 1 resident (R24) reviewed for pharmacy services.<br><br>Findings include:<br><br>R24's current, undated face sheet identified R24 had a diagnosis of diabetes mellitus type 2, neuromuscular dysfunction of the bladder (lack of bladder control due to brain, spinal cord or nerve problems), and neurogenic bowel (lack of bowel control due to nerve problems).<br><br>R24's 4/14/25, Significant Change Minimum Data Set (MDS) assessment identified she had severe cognitive impairment and was dependent on staff for activities of daily living (ADL's). R24 was admitted to Hospice services with a terminal diagnosis of CVA, weight loss, and decline in physical condition.<br><br>R24's 12/06/24, hospital discharge summary identified R24 presented to the local hospital with abdominal pain, nausea, vomiting, diarrhea and low blood pressure on 12/02/24. R24's imaging of the abdomen/pelvis identified acute diarrheal illness and was positive for clostridium difficile (C-Diff) (bacteria in the gut that causes severe diarrhea).<br><br>R24's 12/06/24 at 1:54 p.m., progress note identified R24 was admitted to the facility with septic shock and diarrhea. R24 had orders for administration of Vancomycin (antibiotic).<br><br>R24's December 2024, Medication Administration Record (MAR) identified R24 had been prescribed vancomycin 25 milligram (mg) per milliliter (ml), give 5 ml by mouth four times a day for clostridium difficile (C-diff) and was to start on 12/06/24 and end 12/14/24. The MAR identified on 12/07/24 at 7:00 a.m., 12/13/24 at 8:00 p.m., 12/14/24 at 7:00 a.m., 12/14/24 at noon, and 12/14/24 at 4:00 p.m., 5 doses of antibiotics was missed. The progress notes lacked evidence that the provider or pharmacy was notified that R24's medication dosage was missed.<br><br>Review of Medication Error Incident summary identified R24 had missed 7 doses of vancomycin and interventions to prevent future errors was for facility nurses to notify the provider and pharmacy when medication was not available at the facility.<br><br>Interview on 6/11/25 at 3:31 p.m., with nurse practitioner (NP) was not aware R24 had not received the complete antibiotic treatment as prescribed. NP identified the lines of communication with the facility of resident updates had been a challenge for months.<br><br>Interview on 6/11/25 at 4:09 p.m., with director of nursing (DON) identified a medication error report was completed during survey of R24's missed antibiotic dosage. The facility nurses had not notified R24's physician or pharmacy of the lack of medication supply and would expect the provider to be notified and find an alternative option to continue R24's treatment.<br><br>Interview on 6/12/25 at 4:36 p.m., with administrator would expect nurses to follow physician orders of prescribed medications and refer to medication administration guidelines, per the facility policy.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 6/16/25 10:02 a.m., with licensed pharmacist identified the facility was sent 100 ml of oral vancomycin on 12/06/24. The facility could call, fax, email or fill out a medication request form electronically for additional supply of the medication. The pharmacy did not receive a notification from the facility for R24's medication to be refilled. When asked if R24's missed medications lead to a potential complication for R24's treatment of C-diff, he stated the pharmacy does not manage R24's medication treatment and did not want to speculate if harm was to occur when R24 had missed the prescribed medication dosages.<br><br>Review of February 2024 medication and treatment orders identified the facility staff was to transcribe medication orders accurately and must include the name and strength of the drug, doses, start and stop date, duration of therapy, frequency of administration, route of administration, clinical conditions/symptoms, follow up requirement, such as, mediation monitoring, labs, culture reports, and staff personnel was to call in orders to the pharmacy of the prescribed medications, as directed. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>Based on observation, interview, and document review the facility failed to offer an alternative food item for 1 of 1 residents (R187).<br><br>Findings include:<br><br>Observation on 6/11/25 at 8:02 a.m., of nursing assistant (NA)-A passing room trays identified he removed a tray from the cart and entered R187's room, placed the tray on the overbed table in front of her and removed the cover. Her plate had 1 egg and 2 slices of toast. R187 picked up the toast and said to NA-A I don't eat toast, now what am I supposed to eat? NA-A did not respond, he left the room, passed the remainder of the room trays, then went to assist another resident with her meal. NA-A never returned to R187's room to offer an alternative and did not notify the kitchen that she had received food she would not or could not eat.<br><br>Interview on 6/11/25 at 8:53 a.m., with NA-A confirmed he heard R187 say she did not eat toast but said because he was the only one passing trays, he did not have time to tell the kitchen. He reports when someone doesn't like what is served, he offers a snack like Jello. He identified he was not aware of a alternate menu and reports he has never received any training on what to do in this situation.<br><br>Interview on 6/11/25 at 9:31 a.m., with the director of nursing identified she would expect that when nursing assistants are passing room trays and a resident voice a dislike for a food item on their plate, an alternative food item with equal nutritional value should be offered.<br><br>Review of facility provided undated Resident Food Preference policy identified they would determine current food preferences, document preferences on the resident's care plan, and the dietary department would offer a variety of foods at each scheduled meal. The policy made no mention what staff were to do when a resident received food they could not or would not eat. |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.<br><br>Based on observation, interview, and document review, the facility failed to offer a snack to residents on a routine basis when meals were greater than 14 hours apart. This had the potential to affect all 35 residents residing at the facility.<br><br>Findings include:<br><br>R187's 6/5/25, admission Minimum Data Set (MDS) assessment identified her cognition was intact and had no behaviors. R187 was independent with transfers, required assistance from staff with hygiene, and was occasionally incontinent of urine. She had diagnosis of heart failure, diabetes, and COPD. She was at risk for pressure ulcers and took insulin daily.<br><br>Review of R187's baseline care plan identified she required assistance with bathing, dressing, hygiene, mobility, and transfers.<br><br>Interview on 6/9/25 at 7:35 P.M., with R187 during the initial screen, she reported she had never been offered a snack during this stay or her last stay at the facility. She reported she was also not aware she could request a snack and stated, it would be nice to have a snack to get through the night.<br><br>Interview on 6/9/25 at 7:40 p.m., with registered nurse (RN)-D reports sometimes they have a snack basket at the desk, she identified they have some people who are given a snack, but they do not have a snack cart to pass. RN-D reports if nursing wants a snack for the residents they must go ask the kitchen.<br><br>Interview on 6/10/25 at 11:28 a.m., with the dietary manager identified the kitchen should be putting some snack in a basket at the nurse's station daily. He confirmed no snacks were put out yesterday and he was not sure what the process was. He agreed they are not getting snacks out for residents daily and identified he was working to correct the problem at that moment.<br><br>Interview on 6/10/25 at 12:20 p.m., with the registered dietitian identified she agreed with the above findings, she reports they have residents at the facility that would benefit from having snacks and fluids offered at minimum once daily. She reports she was new to her role as the facilities dietitian so she was not familiar with all the facilities processes and stated this was something she could help them improve.<br><br>Interview on 6/10/25 at 2:13 p.m., with the administrator identified he agreed whole heartedly they have a problem with their process for offering residents snacks. In addition, he agreed they have 15 hours between supper and breakfast and residents should have a substantial snack along with a beverage offered in the evening to get them through to the next meal and he was currently working with the dietary manager to correct the concern.<br><br>(continued on next page) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the facility provided undated Snacks Between Meal and Bedtime Policy identified staff were to place a snack on a table in front of the resident, provide assistance as needed. When the resident was finished with the snack staff were to assist resident with clean up, reposition them, document the amount eaten, and report to the charge nurse if the resident refuses a snack. The policy lacked any mention what time or how frequently a snack should be offered. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to ensure infection control practices were maintained in the kitchen when 1 of 1 staff were observed eating in the facility food preparation area. This had the ability to affect all 35 residents.<br><br>Findings include:<br><br>Observation on 6/11/25 at 7:28 a.m., of cook-A in the kitchen leaning over the food preparation counter near the microwave eating a sub sandwich. On the counter was a plate with food on it. Cook-A finished her sandwich, crumpled up a wrapper that said Subway on it and sat it on the hot holding steam table counter.<br><br>Interview on 6/11/25 at 1:06 p.m., with the dietary manager identified staff should not be eating in the kitchen. Cook-A has some physical challenges, and the staff break room is located down a flight of stairs in the basement. He identified he has asked her in the past to at minimum step outside the kitchen door into the back hallway when she is eating her lunch.<br><br>Interview on 6/11/25 at 1:26 p.m., with Cook-A identified she should not have been eating in the kitchen at a food prep counter. She reports she normally eats her lunch in the employee break room in the basement.<br><br>Interview on 6/11/25 at 3:13 p.m., with the registered dietician identified she was made aware of the staff eating in the kitchen at the food prep counter. She agreed this was an infection control concerns, and all staff should only be eating in the designated staff break room.<br><br>A policy was requested; however, nothing was provided before the end of the survey period. |

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|---|---|---|---|
| | 245332 | A. Building<br>B. Wing | 06/16/2025 |

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

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Based on interview and document review, the facility failed to ensure data submitted to the Quality Assurance and Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 35 residents.<br><br>Findings include:<br><br>Review of the QAPI meeting minutes from March 2025 through May 2025 that was provided, identified department heads were bringing data forth to QAPI on various topics such as; pressure injuries which was above national average, falls with trends identified, psychoactive medications, activities of daily living (ADL)'s assistance with a sharp increase in help needed, infection control with an upward trend of antibiotics identified, hospitalizations with 6 unplanned hospitalizations identified. There were no identified goals, no specific action plans of what the facility was going to do to make improvements, and no analysis of any data brought forward to the committee for the areas identified.<br><br>Interview on 6/12/25 at 3:58 p.m., with administrator identified that the facility wanted to do better and there was room for improvements. There was work that needed to be done and he wanted to approach the multiple areas in a holistic manor. He agreed that the QAPI meeting minutes lacked identification of goals, action plans, and analysis of data brought forth. As a new interim administrator, he wanted to make improvements and did see that there were areas that needed to be improved. The survey would help the facility to hold accountability and make improvements.<br><br>On 6/12/25 at 4:00 p.m., a message was left for medical director, with no return call.<br><br>On 6/16/25 at 11:30 a.m., a message was left for medical director, with no return call.<br><br>Review of the undated, Quality Assurance and Performance Improvement (QAPI) policy identified the QAPI committee would oversee areas for improvement, develop an action plan, and analyze the results of the plan. The facility would maintain evidence of the ongoing QAPI program with documentation of data, analysis, and implementation and evaluation of actions for improvement activities. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>Based on interview and document review, the facility failed to have evidence of a goal, an action plan, and analysis of data brought forth for the identified Performance Improvement Projects (PIP). This had the potential to affect all 35 residents residing at the facility.<br><br>Findings include:<br><br>Review of QAPI minutes provided from March 2025 through May 2025 identified the facility PIP plan for 2025 as follows:<br><br>March 2025:<br><br>1) Call light response times, a trend had been identified. The facility was going to initiate call light audits, identify a root cause, and provide staff education. The director of nursing and nurse manager would provide oversight. There was no goal identified.<br><br>2) Notification of change in condition, identified there was an action plan however, there was no documentation of what the action plan was. There was no identified goal, or analysis of any data that had been brought forward to the committee.<br><br>3) Enhanced barrier precaution identified there was an action plan however, there was no documentation of what the action plan was. There was no identified goal, or analysis of any data that had been brought forward to the committee<br><br>4) Air mattress monitoring identified there was an action plan however, there was no documentation of what the action plan was. There was no identified goal, or analysis of any data that had been brought forward to the committee<br><br>April 2025:<br><br>1) Call light response times, a trend had been identified. The facility was going to initiate call light audits, identify a root cause, and provide staff education. The director of nursing and nurse manager would provide oversight. There was no goal identified. Documentation remained the same from previous month.<br><br>2) Notification of change in condition, identified there was an action plan however, there was no documentation of what the action plan was. There was no identified goal, or analysis of any data that had been brought forward to the committee. Documentation remained the same from previous month.<br><br>3) Air mattress monitoring identified there was an action plan however, there was no documentation of what the action plan was. There was no identified goal, or analysis of any data that had been brought forward to the committee. Documentation remained the same from previous month.<br><br>QAPI minutes lacked identification of the PIP of enhanced barrier precaution or analysis of the data brought forth and decision to end the PIP project.<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | May 2025:<br><br>1) Notification of change in condition, identified there was an action plan however, there was no documentation of what the action plan was. There was no identified goal, or analysis of any data that had been brought forward to the committee. Documentation remained the same from previous month.<br><br>QAPI minutes lacked identification of the PIP of call light response times or analysis of the data brought forth and decision to end the PIP project. The QAPI minutes also lacked identification of the PIP of air mattress monitoring or analysis of the data brought forth and decision to end the PIP project.<br><br>Interview on 6/16/25 at 1:03 p.m., via email communication identified the facility had no material or details of the PIP projects other than what was mentioned in the QAPI minutes.<br><br>On 6/12/25 at 4:00 p.m., a message was left for medical director, with no return call.<br><br>On 6/16/25 at 11:30 a.m., a message was left for medical director, with no return call.<br><br>A policy was requested but not provided by end of the survey. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>Based on interview and document review, the facility failed to ensure employee illnesses were tracked to identify when employee would be able to return to work after an illness, dependent upon their symptoms for 3 of 3 sampled staff (housekeeping aide (HA)-A, speech therapist (ST)-A, and certified nursing assistant (NA)-A. This had the potential to affect all 35 residents.<br><br>Findings include:<br><br>Review of Employee Absence Report sheets from February through June 2025 identified the following areas of documentation: employee name, department, job title, symptom onset, illness reported, last shift worked, resolution date, return to work, specimen source, and treatment results. However, the facility did not accurately complete the logs to ensure all necessary information was monitored or identified how staff were cleared to return to work.<br><br>Review of the February 2025, employee illness log identified: housekeeping aide (HA)-A was noted to have called in to work with symptoms of fever on 2/20/25. HA-A returned to work on 3/03/25.<br><br>Review of February 2025 resident infection log identified the facility had coronavirus disease (COVID) outbreak in the facility.<br><br>Review of the March 2025, employee illness log identified: speech therapist (ST)-A was noted to have called in to work with symptoms of sore throat on 3/06/25. ST-A returned to work on 3/17/25. The log identified ST-A had completed a COVID test, however the log lacked evidence of the results.<br><br>Review of March 2025 resident infection log identified no residents with COVID.<br><br>Review of the June 2025 employee illness log and matching timesheets identified certified nursing assistant (NA)-G was noted to have called in to work with symptoms of diarrhea (loose watery stools) on 6/02/25. NA-G returned to work on 6/04/25.<br><br>There was no mention when or if HA-A, ST-A or NA-G symptoms resolved prior to returning to work.<br><br>Interview on 6/12/25 at 4:22 p.m., with administrator identified employees who were ill reported their symptoms to the director of nursing (DON). Employees was to notify the DON of their next day of work. The DON was to review the employee health status for clearance to return to work. Administrator identified NA-G symptoms had improved once NA-G had returned to work. However, the administrator was not aware if NA-G had potential norovirus or if NA-G was prescribed medications to treat diarrheal symptoms. Administrator would expect employee illness logs to reflect accurate documentation and tracking of employee illnesses, review facility and Center of Disease Control (CDC) policies of when an employee was to return to work.<br><br>Review of November 2024, Infection Prevention and Control Program policy, under section: Monitoring Employee Health identified the facility staff, contractors, vendors, visitors and volunteers was to report infections such as, draining skin wounds, active respiratory infections or frequent diarrheal stools to the infection preventionist (IP).<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of December 2024, Return to Work Criteria for Healthcare Workers (HCW) policy identified employees requested to return to work was self- monitor for symptoms and seek evaluation from IP or designee, if symptoms reoccur or worsen.<br><br>HA-A and ST-A timecards was requested but not provided. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>Based on interview and document review, the facility failed to complete a comprehensive assessment for continued use of antibiotics for 2 of 3 (R24 and R238) sampled residents reviewed for antibiotic stewardship.<br><br>Findings include:<br><br>Review of the current, undated, Centers for Disease Control (CDC): The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf, identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the resident current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an antibiotic time-out [ATO].<br><br>Review of Monthly Infection Summary reports from December 2024 through May 2025 identified the columns for resident's name, infection date, body system affected, date symptoms resolved, infection, medication, source of the infection and if the criteria was met. However, the log lacked evidence that the antibiotic had met criteria for continuation of use.<br><br>Review of the December 2024 infection control log identified R24 had been prescribed vancomycin (antibiotic medication) 125 milligrams (mg) for eight days for clostridium difficile (bacteria in the gut that causes severe diarrhea) (C-diff) infection. The onset of the infection occurred on 12/06/24 and had met criteria for the continuation of use.<br><br>R24's current, undated diagnosis sheet identified R24 had a diagnosis of diabetes mellitus type 2, neuromuscular dysfunction of the bladder (lack of bladder control due to brain, spinal cord or nerve problems), and neurogenic bowel (lack of bowel control due to nerve problems).<br><br>R24's current, undated care plan identified R24 had an alteration in elimination related to weakness and inability to communicate. The facility nursing staff was to assist with peri-cares every shift, monitor for signs and symptoms of infection, and monitor bowel movements as they occur.<br><br>R24's 12/06/24, progress note identified R24 arrived at the facility from the local hospital with septic shock and diarrhea. R24 had orders for vancomycin antibiotic therapy. R24's medical record lacked any initial comprehensive assessment.<br><br>Review of the January 2025, infection control log identified R38 had been prescribed Metronidazole (flagyl) 250 mg four times a day and tetracycline 500 mg four times a day (antibiotics) 250 mg four times a day for helicobacter pylori (bacteria in the stomach that causes ulcers). The onset of infection occurred on 1/29/25 and had met criteria for the continuation of use.<br><br>R238's current, undated diagnosis sheet identified R238 had a diagnosis of duodenal ulcer with hemorrhage.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R238's current, undated care plan identified R238 was at risk for alteration in skin integrity related to post surgery of the digestive system. The facility nursing staff was to monitor skin daily during cares and weekly, monitor for skin breakdown of signs and symptoms of infection, document skin condition and report to the physician of skin changes.<br><br>R238's 1/29/25, progress note identified R238 was admitted to the nursing home from the local hospital. R238's medical record lacked any initial comprehensive assessment.<br><br>Interview on 6/11/25 at 4:13 p.m., with the director of nursing (DON) identified resident symptoms of infection was assessed and communicated to the resident's physician. The facility would receive an antibiotic order and was reviewed by the DON before the medication was administered. DON identified the facility used Mcgreer's criteria (a surveillance tool to identify and track infections), but currently does not have an accessible form for staff to use to identify the criteria had been met.<br><br>Review of March 2023, Antibiotic Stewardship Program policy identified the facility was to use Mcgreer's criteria for signs and symptoms of suspected infection, the facility was to review orders for antibiotic therapy for appropriateness and completeness of the medication therapy. The IP, or designee was to review all antibiotic orders to determine if treatment is appropriate. The IP, consultant pharmacist, will monitor antibiotic use by utilizing a facility approved infection/antibiotic surveillance tracking form and monthly medication reviews.<br><br>Copy of Mcgreer's criteria was requested but was not received. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 5 (R5) were offered and/or provided updated vaccination for pneumococcal disease, in accordance with Centers for Disease Control (CDC).<br><br>Findings include:<br><br>Review of the current, 10/26/24, Centers for Disease Control (CDC) Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV21) at any age and a PPSV23 at or after the age of [AGE] years old.<br><br>R5 was admitted [DATE].<br><br>R5's, 5/16/25, 5-day Minimum Data Set (MDS) identified R5 was [AGE] years old and had a diagnosis of non-[NAME] (blood cancer) lymphoma, anemia, and dementia. R5 had received PPSV-23 on 2/26/16 and PCV-13 on 4/15/19. Section O-Special Treatments and Programs identified R5's vaccines were up to date. The medical record lacked evidence that R5 was offered or had signed a declination for the vaccine.<br><br>Interview on 6/11/25 04:05 p.m., with director of nursing (DON) would expect R5 vaccines to be current.<br><br>Review of January 2023, Standing House Orders for Symptom Management, under immunization section identified residents was to receive pneumococcal vaccines per Center of Disease Control (CDC), unless contraindicated.<br><br>Review of February 2024 Pneumococcal policy identified residents to be assessed within 5 days after admission for review of current immunization status, within 30 days of admission, residents was to be offered the vaccine, when indicated, unless the resident has been vaccinated or the vaccine was medically contraindicated. Facility staff was to document the date of the vaccination, the person administering the vaccine, and the site of administration. The Infection Preventionist (IP) was to conduct periodic audits of resident medical records to determine compliance with vaccinations. |