STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. Building B. Wing	04/07/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with professional standards of practice, including failure to document clinical indications for medications, failure to monitor medications as ordered (including failure to monitor heart rate parameters prior to medication administration), and failure to ensure PRN psychotropic medications had appropriate stop dates, for 5 of 6 residents (R2, R5, R6, R16, and R26) reviewed for unnecessary medications.Findings include: R2's quarterly Minimum Data Set (MDS), dated [DATE], identified R2 had intact cognition and required assistance with activities of daily living (ADLs). R2's diagnoses included heart failure (a condition where the heart cannot pump blood effectively), hypertension (high blood pressure), end-stage renal disease [ESRD] (advanced kidney failure requiring dialysis or transplant), anxiety disorder (a condition involving excessive worry or fear), depression (persistent sadness or loss of interest), and unspecified atrial fibrillation (an irregular and often rapid heart rhythm). Review of R2's electronic medical record (EMR) identified medications were administered without documented medical diagnoses or clinical indications to support their use, including: Calcitriol (medication used to treat low calcium levels and/or hypoparathyroidism) Oral Capsule 0.25 mcg, give 0.25 mcg by mouth one time a day, start date 03/25/2025. Gabapentin (medication used to treat certain seizure disorders and/or nerve pain) Oral Capsule 300 mg, give 1 capsule by mouth at bedtime, start date 12/04/2024. Further review of physician orders, progress notes, and care plans lacked documentation identifying the conditions being treated for these medications. R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated R5 had mild cognitive impairment and was independent with activities of daily living (ADLs). Diagnoses included cardiomegaly (enlarged heart), atrial fibrillation (rapid, irregular heartbeat), hypertension (high blood pressure), congestive heart failure (chronic condition where heart muscle too weak or stiff to pump blood efficiently), chronic kidney disease, anxiety, delusional disorder, and dementia. R5's order summary report printed 3/2/26, included order for metoprolol tartrate 75 mg by mouth twice daily, hold for SBP less than100 or heart rate less than 55. Review of R5's medication administration records for January, February and March 2026, failed to indicate R5's heart rate was monitored and recorded for R5's metoprolol. When interviewed on 4/6/26, at 11:15 a.m. registered nurse (RN)-C stated R5 had parameters to check blood pressure for each done of the metoprolol, but heart rate was not being monitored. RN-C (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed R5's electronic medical record (EMR) stated the order did have a parameter to hold the medication if the heart rate was less than 55, however they were not monitoring R5's heart rate. When interviewed on 4/7/26, at 2:05 p.m. director of nursing (DON) stated when a resident had parameters for medication administration the expectation was the nurses would check and record the blood pressure and/or heart rate as ordered, if the medication was held due to the blood pressure or heart rate the expectation was to document in a progress note the medication was held an reason. Following the parameters was important for resident safety. R6's significant change MDS dated [DATE], identified R6 had intact cognition and required assistance with ADLs. R6's diagnoses included atrial fibrillation (an irregular and often rapid heart rhythm), hypertension (high blood pressure), anxiety disorder (a condition involving excessive worry or fear), depression (persistent sadness or loss of interest), and seizure disorder (a condition causing recurrent seizures). Review of R6's EMR identified physician's orders for the following PRN psychotropic medications without a 14-day end date or documented stop date: Haloperidol (antipsychotic used to treat schizophrenia, acute psychosis, Tourette syndrome, and severe behavioral problems) Oral Tablet 0.5 mg, give 1 tablet sublingually every 1 hour as needed for agitation or moderate nausea; start date 01/21/2026. Lorazepam (used for short-term anxiety relief, anxiety-related insomnia, and status epilepticus) Oral Tablet 0.5 mg, give 1 tablet by mouth every 2 hours as needed for anxiety or sleep; start date 01/21/2026. Further review of R6's physician orders, progress notes, and medication records lacked evidence these medications were time-limited or included a stop date. Review of R6's EMR also identified a physician's order for orthostatic blood pressures, initiated on 1/26/26; however, review of the treatment administration record (TAR) for February 2026 and March 2026, as well as nursing documentation, lacked evidence orthostatic blood pressures were consistently monitored and documented as ordered. R16's quarterly MDS dated [DATE], identified R16 had moderate cognitive impairment and required assistance with bathing and was independent with all other ADLs. R16's diagnoses included polyneuropathy (damage to multiple peripheral nerves causing weakness, numbness, or pain), hypertension (high blood pressure), anxiety disorder (a condition characterized by excessive worry or fear), schizophrenia (a chronic mental disorder affecting thinking, perception, and behavior), and adverse effect of unspecified antipsychotics and neuroleptics (negative side effects from medications used to treat mental health conditions). Review of R16's EMR identified a physician's order for orthostatic blood pressures, initiated on 10/25/24; however, review of the TAR for October 2025, February 2026, and March 2026, as well as nursing documentation, lacked evidence orthostatic blood pressures were consistently monitored and documented as ordered. R26's 5-day MDS dated [DATE], identified R26 had intact cognition and required assistance with ADLs. R26's diagnoses included heart failure (a condition where the heart cannot pump blood effectively), hypertension (high blood pressure), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), and paroxysmal atrial fibrillation (an irregular heart rhythm that starts and stops suddenly). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R26's EMR identified medications were administered without documented medical diagnoses or clinical indications to support their use, including: Calcium Carbonate-Vitamin D (used to treat or prevent low calcium levels, supporting bone health, muscle function, and nerve health) Oral Tablet 600-5 mg-mcg, give 2 tablets by mouth in the morning, start date 08/06/2024. Diltiazem HCl ER (calcium channel blocker used to treat high blood pressure, chronic stable angina, and certain heart rhythm disorders) 240 mg capsule extended release, give 1 capsule by mouth in the morning, start date 07/25/2024. Fluticasone Propionate (corticosteroid nasal spray used to treat seasonal, perennial, and nonallergic rhinitis symptoms) Nasal Suspension 50 mcg/act, 1 spray in both nostrils in the morning, start date 07/13/2024. Folic Acid (used to treat anemia) Oral Tablet 1 mg, give 1 tablet by mouth in the morning, start date 07/13/2024. Montelukast Sodium (used to treat asthma, prevent exercise-induced bronchoconstriction, and relieve allergy symptoms) Oral Tablet 10 mg, give by mouth in the morning, start date 07/25/2024. Omega-3 Fatty Acids (used for heart and brain health, reducing inflammation, and lowering blood triglycerides) Oral Capsule 1000 mg, give by mouth in the morning, start date 07/13/2024. Further review of R26's physician orders, progress notes, and care plans lacked documentation identifying the conditions being treated for these medications. Review of R26's EMR also identified a physician's order for orthostatic blood pressures, initiated on 12/3/25; however, review of the TAR for December 2025, January 2026, February 2026, and March 2026, as well as nursing documentation, lacked evidence orthostatic blood pressures were consistently monitored and documented as ordered. During interview on 4/6/26 at 11:32 a.m., the registered nurse (RN)-A stated admission orders were entered upon admission and nursing staff were responsible for double-checking them. RN-A further stated nurses should clarify and add diagnoses or clinical indications if they were not present or were identified as missing. RN-A stated orthostatic blood pressures were completed if they were on the TAR and involved obtaining blood pressures with the resident lying, sitting, and standing, typically at 15-minute intervals. RN-A stated he was aware of residents ordered for orthostatic blood pressures, including R26 and R15. During interview on 4/6/26 at 11:48 a.m., the registered nurse case manager (RN)-B stated nursing staff were responsible for ensuring diagnoses or clinical indications were documented for each medication. RN-B stated that, while most medications typically had associated diagnoses, vitamins and supplements did not always have documented indications. RN-B further stated diagnoses or indications should be included so staff, including agency nurses, understood the reason a resident was receiving each medication. RN-B confirmed diagnoses or indications were not documented for the identified medications for R2 and R26. During interview on 04/06/2026 at 1:51 p.m., the registered nurse case manager (RN)-B stated orthostatic blood pressures were typically obtained when therapy (PT) completed their evaluation and might be monitored during the first week. RN-B stated she could not recall any residents currently requiring ongoing orthostatic monitoring and was not aware of any residents with active orthostatic blood pressure orders at that time. RN-B stated she would expect staff to obtain blood pressures in lying, sitting, and standing positions, if able, and report results. RN-B confirmed orthostatic blood pressures were not completed for R16. RN-B also stated PRN haloperidol and lorazepam were often used for hospice residents and were typically managed by hospice staff. RN-B confirmed R6's PRN lorazepam and PRN haloperidol orders did not include stop dates. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 4/6/26 at 2:17 p.m., the director of nursing (DON) stated all medications should have a corresponding diagnosis documented so the person administering the medication understood the reason it was prescribed. The DON further stated orthostatic blood pressures should be completed when ordered by the physician and documented on the MAR/TAR, including measurements in lying, sitting, and standing positions. The DON stated this monitoring was important to assess for conditions such as dizziness or falls and confirmed that if ordered, orthostatic blood pressures must be completed and documented. The DON further stated if a resident was unable to tolerate any position, this should be documented in the medical record. The DON stated PRN psychotropic medications should include a 14-day limit or a clearly defined stop date unless clinically justified and documented. During interview on 4/7/26 at 11:02 a.m., the consultant pharmacist (CP) stated orthostatic blood pressures should be obtained on an ongoing basis, such as monthly, when indicated. The CP stated orthostatic measurements should include obtaining a blood pressure in one position (lying or sitting) and repeating the measurement in another position after 5–10 minutes. The CP further stated if a resident was unable to stand or complete any position, this should be documented. The CP indicated this monitoring was important to identify significant drops in blood pressure that could increase the risk for falls. The CP also stated PRN psychotropic medications should include a 14-day stop date, and if continued beyond 14 days, a new physician order with documented rationale should be obtained. The CP stated the provider should document justification if a stop date was not included and indicated lack of a stop date was not appropriate. The CP further stated for hospice residents, extended use may be appropriate if clinically justified and documented. The CP stated medications should have a documented diagnosis or clinical indication, as administration without a documented diagnosis would not support the reason for use. Review of the facility's Psychotropic Medication Use Policy, dated 5/25, identified psychotropic medications must be supported by a documented diagnosis and clinical indication in the medical record. The policy required ongoing monitoring for effectiveness and adverse consequences, including completion of ordered monitoring such as orthostatic blood pressures. The policy further required PRN psychotropic medications be limited to 14 days unless the physician documented a clinical rationale for continued use and specified duration. The policy also required documentation of non-pharmacological interventions, interdisciplinary involvement, and ongoing evaluation to ensure medications were necessary and appropriate. Facility police on following medication orders with parameters was requested, however none was provided.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a catheter bag containing urine was concealed from public view for 1 of 3 residents (R3) reviewed for dignity.Findings include:R3's admission Minimum Data Set (MDS) dated [DATE], indicated moderate cognitive impairment and required staff assistance with activities of daily living (ADLs). R3's care plan dated 2/13/26, indicated an alteration in elimination related to foley catheter, with interventions including staff to monitor foley catheter output and foley catheter care per policy. When observed on 4/2/26 at 12:48 p.m., R3 was in his wheelchair, staff was propelling wheelchair from the dining room towards R3's room. Foley catheter was observed hung from the side of wheelchair armrest uncovered with urine visible. R3 stated he was embarrassed and preferred the bag not to be hung out in the open for everyone to see, R3 further stated he was embarrassed. When interviewed on 4/6/26 at 1:42 p.m., nursing assistant (NA)-A stated there were blue privacy bags for urine bags. It was expected to place the privacy covers on wheelchairs and used them every time the resident came out of their room. NA-A was unsure why R3 did not have a privacy bag. When interviewed on 4/7/26 at12:05 p.m., director of nursing (DON) stated catheter bags were expected to be placed in a privacy bag at all times especially when out in public for the privacy of the resident and the dignity of both the resident with the catheter and other residents in the area. Facility policy regarding covering of catheter bags was requested, however, none was provided.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure residents were assessed, determined safe to self-administer medications, and that self-administration practices were consistently implemented in accordance with physician orders and facility policy for 2 of 2 residents (R22 and R17) reviewed for self-administration of medications. Findings include: R22's annual Minimum Data Set (MDS) dated [DATE], identified intact cognition and required assistance with activities of daily living (ADLs). R22's diagnoses included osteoarthritis of the knee (degenerative joint disease causing pain and stiffness in the knee joint), hypertension (high blood pressure), renal insufficiency (reduced kidney function), diabetes mellitus (a condition affecting blood sugar regulation), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), adjustment disorder with anxiety (emotional or behavioral response to stress causing anxiety), and personality disorder (a pattern of thinking and behavior that differs from cultural expectations). During review on 3/31/26, R22's electronic medication record (EMR) indicated most recent self-administration of medications assessment, dated 7/14/23, indicated R22 was permitted to self-administer certain medications. There was no evidence of subsequent reassessments completed quarterly or with any change in condition or physician orders. Review of physician orders revealed conflicting and unclear directives regarding R22's ability to self-administer medications, including: An order dated 7/14/23 indicated the resident may self-administer diclofenac gel and nystatin powder and keep them at bedside. An order dated 10/30/24 indicated the resident may order and self-administer multiple supplements, including turmeric, [NAME] oil, biotin, phytosterol [NAME], coq10, zinc, vitamin e, alpha-lipoic acid, cholest, women's multivitamin, and osteo bi-flex. An order dated 3/6/25 indicated diclofenac may be kept at bedside for self-administration, with nursing to provide teaching on application. An order dated 10/28/25 indicated staff were to administer medications and R22 was no longer permitted to self-administer medications. During observation on 3/31/26 at 6:22 p.m., R22 asked the surveyor what time it was. After the surveyor responded 6:25, R22 stated she could take her medications at that time. R22 then removed a paper medication cup from the left side of her wheelchair, which had been placed between her hip and the wheelchair seat, containing acetaminophen, and self-administered the medication while conversing with the surveyor. During observation on 3/31/26 at 3:57 p.m., R22 had five bottles of medications/supplements present in her room. Three bottles (magnesium 400 mg, alpha lipoic acid 200 mg, and [NAME]-c 1000 mg) were observed sitting on the bedside table. Two additional bottles (osteo bi-flex and multi-50+ for her) were observed on top of the nightstand within reach of the resident. During review on 4/2/26, R22's EMR failed to identify a current assessment evaluating R22's ability to safely self-administer medications following the change in physician orders discontinuing self-administration on 10/28/25. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/6/26 at 11:32 a.m., registered nurse (RN)-A stated R22 was no longer on a self-administration program due to concerns she would pocket medications and not take them as directed. RN-A further confirmed staff were responsible to ensure R22 took her medications as prescribed. During interview on 4/6/26 at 1:51 p.m., registered nurse case manager (RN)-B stated residents who participate in a self-administration of medications (SAM) program should be alert and oriented, and assessments should be completed at least quarterly or with any significant change. RN-B stated that, in practice, residents at the facility were not routinely self-administering medications; however, with a provider order, staff may set medications at the bedside for the resident to take, such as during meals. RN-B further stated residents may request to take supplements, which should be reviewed and approved by the nurse practitioner (NP). RN-B indicated staff could set up medications and leave them at bedside under certain orders but acknowledged she did not complete SAM assessments. Upon review of R22's physician orders, RN-B expressed surprise regarding the 10/28/25 order indicating R22 was no longer permitted to self-administer medications. During interview on 4/6/26 at 2:17 p.m., director of nursing (DON) stated residents participating in a SAM program should have an assessment completed in the EMR at least quarterly to ensure they remained able to safely self-administer medications. The DON stated R22 should not have any medications in her room. The DON further stated if a resident declined medications at the time of administration, nursing staff would retain the medications and allow the resident to take them when ready under staff supervision. The DON confirmed R22's last self-administration assessment was completed on 7/14/23. R17's quarterly Minimum Data Set (MDS) dated [DATE], indicated R17 had severe cognitive impairment. R17's diagnoses included hypertension, weakness, moderate intellectual disabilities, and adult failure to thrive. During observation on 4/6/26, at 1:30 p.m. registered nurse (RN)-A set up Lasix (a diuretic) to administer to R17. Upon entering room R17 was in the bathroom. RN-A placed the medication cup that contained Lasix on the overbed table that was next to R17's bed then exited the room. RN-A did not inform R17 that the medication was on the table. When interviewed after exiting the room RN-A stated R17 had an order for self-administration and would take the medication when done in the bathroom. RN-A stated he did not complete self-administration assessments, that was the nurse manager. R17's electronic medical record (EMR) was reviewed, although R17 had an order which identified may self-administer all medications after setup by staff, the EMR lacked evidence a self-administration of medication assessment had been completed to ensure R17 was safe and able to administer medications left at bedside by nursing. Further, R17's care plan, printed 3/30/26, lacked any evidence R17 had been care planned for self-administration of medication, or any interventions to ensure monitoring and/or safety with self-administration. When interviewed on 4/6/26, at 2:12 p.m. nurse manager registered nurse(RN)-B stated she did not complete any self-administer of medication assessments. RN-B stated, we do not have a form or assessment to assess the residents to ensure they are safe to self-administer medications, RN-B stated it was up to the doctor or the nurse practitioner to provide the order. When interviewed on 4/7/26, at 12:05 p.m. director of nursing (DON) stated for a resident to be able to self-administer medications there was to be an order from the provider and a self-administration of (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication assessment was required to be completed to ensure the resident was competent to self-administer the medications. DON reviewed R17's EMR and stated there was an order for self-administer but was unable to locate a self-administer assessment in R17's EMR. DON stated she did not believe R17 had the capability to self-administer and was not comfortable with R17 doing so. Facility Self-Administration of Medication policy dated 2/2024, indicated the interdisciplinary team (IDT) assessed each residents cognitive and physical abilities to determine whether self-administration of medications was safe and clinically appropriate for the resident. Further, the policy indicated the ability to self-administer medications was documented in the medical record and the care plan.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to make choices regarding her living environment and personal possessions was honored by removing items from her room without prior notice and by failing to follow care plan interventions and ACP recommendations for 1 of 1 resident (R22) reviewed for resident rights.Findings include:R22's annual Minimum Data Set (MDS) dated [DATE], identified intact cognition and required assistance with activities of daily living (ADLs). R22's diagnoses included osteoarthritis of the knee (degenerative joint disease causing pain and stiffness in the knee joint), hypertension (high blood pressure), renal insufficiency (reduced kidney function), diabetes mellitus (a condition affecting blood sugar regulation), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), adjustment disorder with anxiety (emotional or behavioral response to stress causing anxiety), and personality disorder (a pattern of thinking and behavior that differs from cultural expectations).R22's comprehensive care plan printed 4/1/26, identified at risk for alterations in behavior related to trauma. The care plan noted R22's hoarding tendencies had escalated following the loss of personal belongings when her brother discarded items previously stored for her. The care plan further identified R22 had a long-standing history of hoarding behaviors, was in contact with the Office of Ombudsman for Long-Term Care (OOLTC) for advocacy and received psychological support services through ACP.The care plan included interventions to support R22's emotional well-being and autonomy, including:Staff would utilize trauma-informed care when working with R22.Staff would provide direct communication and maintain clear boundaries when discussing hoarding behaviors.Staff would avoid involving R22's brother in discussions related to cleaning due to her trauma history.The facility would issue a 30-day notice prior to assisting with cleaning R22's room and would notify the OOLTC when such notice was provided.R22 would be supported in expressing needs and engaging with services.The care plan also reflected ACP recommendations, which included working collaboratively with R22 to gradually remove one to two items per week to minimize distress and support coping.Review of R22's electronic medical record (EMR) revealed no documentation the required 30-day notice was provided to R22 prior to cleaning her room [ROOM NUMBER]/13/25. Further review identified no documentation the OOLTC was notified. Review of R22's progress notes on 4/1/26 indicated the following:Progress note dated 8/13/25 at 4:34 p.m., indicated the administrator, nurse manager (NM), business office manager (BOM), and social services designee (SSD) entered R22's room to clean it out and removed multiple belongings, including magazines, bags, and other items. Documentation indicated R22 became upset and combative when items were removed and verbalized the items were important to her.Progress note, dated 8/13/25 at 9:37 p.m., indicated R22 was so upset following the room clean-out that she called the police at approximately 8:30 p.m. Law enforcement responded and spoke with R22 and the administrator, after which R22 calmed.Regulatory provider visit note dated 8/14/25, indicated R22 remained upset that her room had recently been cleared out due to concerns she was hoarding.During interview on 3/31/26 at 6:22 p.m., R22 stated four facility staff entered her room and removed multiple personal belongings without prior notice. R22 stated this caused her significant distress and reported staff kept violating her room.During interview on 4/2/26 at 2:31 p.m., the ombudsman stated she had no knowledge of R22 and was not notified of any planned room clean-out or intervention.During interview on 4/6/26 at 11:23 a.m., nursing assistant (NA)-C stated R22 had difficulty letting go of items and reported management would occasionally enter her room to clean it. NA-C stated he was not aware of any specific interventions in place to address R22's hoarding behaviors.During interview on 4/6/26 at 2:17 p.m., director of nursing (DON) stated interventions for R22's behaviors should be addressed in the care plan and consistently implemented. The DON stated staff should engage R22 in more in-depth discussions and follow through with interventions so they (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	become routine. The DON further stated if the current approach was not effective, the facility could re-consult ACP to determine alternative interventions.During interview on 4/6/26 at 3:07 p.m., the administrator stated R22 had a long-standing history of accumulating belongings, which he reported was related to childhood trauma, including experiences of having items taken away as punishment. The administrator stated R22 often kept large amounts of items in her room, which at times created safety concerns, including limited space for staff to safely use equipment such as a Hoyer lift and reposition her. The administrator stated staff, including himself, the NM, SSD, and the BOM, entered R22's room to remove items and reduce clutter while attempting to preserve some belongings. He stated R22 was upset during this process and confirmed a formal 30-day notice was not provided prior to the clean-out. The administrator further stated ACP recommendations were received by the facility and typically discussed during meetings for possible incorporation into the care plan, and that non-pharmacological interventions should be included in the care plan and implemented by staff. However, the administrator stated he was not aware of the care plan intervention requiring a 30-day notice prior to cleaning R22's room and was not aware of ACP recommendations to work with R22 to gradually remove one to two items per week.A request was made for the facility's policy regarding resident room cleaning, resident rights, and handling of personal belongings; however, the facility failed to provide the requested policy.

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to revise and update comprehensive care plan for 2 of 5 residents (R7 and R30) reviewed for comprehensive care plans.Findings include: R7's quarterly Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment and required assistance with activities of daily living (ADLs). Diagnoses included hypertension, dementia, anxiety and pressure ulcer of sacral regions stage 3. R7's care plan revised 6/25/25, indicated ecchymotic area (superficial bruise caused by blood leaking from broken blood vessels into skin) to both upper and lower extremities and moisture-associated skin damage (MASD) on gluteal right (right buttock). R7's care plan goal was to remain free from skin breakdown. A skin and wound evaluation dated 9/29/25, indicated R7's right gluteus MASD resolved (healed) 10/8/25. However, R7's care plan was not revised to indicate R7's MASD had resolved. Progress note dated 2/9/26 at 2:22 p.m., indicated new skin issue coccyx pressure ulcer/injury stags 3 - full thickness skin loss, wound acquired in-house. However, R7's care plan was not revised to indicate R7 had developed a stage 3 pressure ulcer to the coccyx. Progress note dated 2/26/26 at 10:49 a.m., indicated new skin issue right lateral midfoot pressure ulcer/injury stage 3 - full thickness skin loss, acquired in-house on 2/23/26. However, R7's care plan was not revised to indicate R7 had developed a stage 3 pressure ulcer/injury to right lateral midfoot. When interviewed on 4/6/26 at 2:12 p.m., nurse manager registered nurse (RN)-B stated she updated wounds on care plans as soon as she was informed there was a new wound. RN-B stated she did not review the progress notes but relied on the nurse to inform her directly of new skin concerns. When interviewed on 4/7/26 at 12:05 p.m., director of nursing (DON) stated the expectation was to customize care plans which included identification of what the skin concern was, where the wound was located, what date the concern was identified and interventions/care of the wound(s). R30's admission MDS dated [DATE], indicated cognitively intact, and dependent on staff with ADLs. MDS section B - hearing, vision and speech ability indicated R30 had minimal hearing difficulty and had no hearing aids. R30's pressure ulcer/injury CAA dated 3/20/26, indicated R30 had a potential for pressure ulcers due to needed assistance with bed mobility. Further the CAA indicated R30's potential for pressure ulcers was further complicated by frequently incontinent of bowel and utilized brief daily to manage. R30 did not currently have a pressure ulcer, R30 was at risk for skin breakdown. R30's communication CAA dated 3/20/26, indicated R30 had minimal hearing loss as evidenced by speaker having to increase volume and speak distinctly. R30 did not wear hearing aids. R30 was at risk for missed messages, isolation, depression, and further hearing loss. R30's care plan dated 3/9/26, indicated R30 had an alteration in communication, used hearing amplifier, with an intervention for staff to assist with communication devices. However, R30 did not have a hearing amplifier. When interviewed on 3/30/26 at 1:58 p.m., R30 stated he had a hard time hearing, requested surveyor to raise voice. During observation on 3/31/26 at 6:20 p.m., R30 was on speaker phone in his room. Writer was able to hear conversation from the hallway; resident was not using a hearing amplifier. During observation on 4/1/26 at 9:25 a.m., R30 was reading the paper with television on, volume up loud, R30 was not utilizing a hearing amplifier. During interview on 4/7/26 at 12:00 p.m., R30 stated he had hearing aids in the past, but they no longer worked. R30 stated he would like some kind of hearing aid or an amplifier but the facility had not offered him a hearing amplifier. When interviewed on 4/6/26 at 1:42 p.m.NA-A stated R30 was a bit hard of hearing, had to speak louder when they talked to R30. R30 did not have any hearing devices. When interviewed on 4/6/26, at 2:12 p.m., RN-B stated care plans were updated quarterly with MDS or if there was a change. RN-B stated R30 did not wear any hearing aids and did not have a hearing amplifier. When interviewed on 4/7/26 at 12:05 p.m., director of nursing stated if the resident was not using or did not have a device that was on the care plan she expected the care (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan to have been updated to reflect the current status of the resident. Facility Care Planning policy revised 11/2024, indicated The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance and/or cueing with activities of daily living, including grooming, dressing and maintaining personal hygiene, for 2 of 2 residents (R13, R16) reviewed for ADL care.Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated cognitively intact and independent with ADLs. Diagnoses included hypertension, sleep apnea, congestive heart failure, diabetes, muscle weakness and unsteadiness on feet. R13's care plan revised 6/25/25, indicated self-care deficit related to diabetes, obesity and hypertension. Care plan interventions included R13 would be accepting assistance with self-care, hair would be washed by nursing staff and cut at beauty shop as needed. Nails would be cut by nursing staff and R13 would receive assistance from one staff for personal hygiene and grooming. R13's order summary printed 3/2/26, indicated an order to apply brace to right knee every morning for pain. On 3/30/26 at 11:17 a.m., R13 was observed to have grey color hairs about an inch long on chin. R13 rubbed her chin, stated this is my goatee isn't it lovely? R13 stated she had asked staff several times to help her with the chin hairs, stated It's gross, don't they know us ladies have issues with chin hairs? R13 stated she was supposed to wear a brace on her knee but had difficulty getting in correctly, although was able to remove it independently. R13 stated they had not been wearing the brace due to staff not assisting with putting it on. R13 stated when the brace was worn she had less pain in the right knee. Knee brace was observed on end of R13's bed. On 3/31/26 at 11:11 a.m., R13 observed in front common area participating in an activity, continued to have long hairs visible on chin. No knee brace observed on R13's right knee. On 4/1/26 at 2:59 p.m., observed R13 laying on the bed watching television, continued with long grey hairs on chin. Knee brace observed on end of R13's bed. On 4/6/26 at 9:51 a.m., R13 participated in an activity in front common area, continued to have grey hair on chin about one inch in length, no knee brace observed on R13's right knee. When interviewed on 4/6/26 at 11:53 a.m., nursing assistant (NA)-B stated R13 needed assistance with grooming. NA-B does not ask R13 about shaving, It might upset her. NA-B stated they had never assisted R13 with a knee brace, nor were they aware there was one. When interviewed on 4/6/26 at 1:42 p.m., NA-A stated R13 needed assistance with incontinent care, help with socks, shoes and pants. NA-A stated there was no knee brace. When interviewed on 4/6/26 at1:52 p.m., registered nurse (RN)-C stated the expectation was for residents to be shaved on shower days or when a need was observed before that. RN-C stated R13 was sensitive about being asked if she wanted assistance with shaving of chin hair so staff would wait until R13 requested assistance with shaving. RN-A stated R13 was able to remove the knee brace, R13 usually had the knee brace on when out of bed. R13 was ablet to take it off independently. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 4/7/26 at 12:05 p.m., director of nursing (DON) stated R13 was able to get up independently. But required assistance of one staff with grooming. DON was not sure if R13 had a knee brace. DON reviewed R13's orders, stated R13 had an order for right knee brace to be applied in the morning. DON stated the expectation was for staff to assist with shaving at least weekly, more often if whiskers were observed for dignity and ordered braces were expected to be applied for safety and pain control R16's quarterly Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment and required assistance with bathing. R16 was independent with all other activities of daily living (ADLs). R16's diagnoses included polyneuropathy (damage to multiple peripheral nerves causing weakness, numbness, or pain, typically in the hands and feet), hypertension (high blood pressure), anxiety disorder (a condition characterized by excessive worry or fear), schizophrenia (a chronic mental disorder affecting thinking, perception, and behavior), muscle weakness (reduced strength in the muscles), adverse effect of unspecified antipsychotics and neuroleptics (negative side effects from medications used to treat mental health conditions), colostomy status (a surgically created opening in the abdomen to divert stool into a bag), and neuroleptic-induced parkinsonism (movement symptoms such as tremors or stiffness caused by antipsychotic medications). Review of R16's electronic medical record (EMR), including nursing notes and ADL documentation, failed to identify evidence staff had offered assistance with changing clothing, provided reminders or cueing to change soiled garments, or addressed concerns related to hygiene and appearance. During observation on 03/31/2026 at 12:02 PM, R16 was sitting in the dining room at a table alone. R16 was wearing a red polo shirt, black sweatpants, and yellow gripper socks. During observation on 4/1/26 at 9:03 a.m., R16 was lying in bed with eyes closed and was wearing the same clothing as the previous day, including a red polo shirt with visible stains, black sweatpants, and yellow gripper socks. During observation on 4/1/26 at 2:54 p.m., R16 was lying in bed with eyes closed and continued to wear the same clothing as the previous day (red polo shirt with visible stains, black sweatpants, and yellow gripper socks). During observation on 4/1/26 at 3:06 p.m., R16 exited the room and ambulated to the common area, wearing the same clothing as the previous day (red polo shirt with visible stains, black sweatpants, and yellow gripper socks), then returned to the room and lay down. During observation on 4/2/26 at 8:50 a.m., R16 was sitting in the dining room eating breakfast and continued to wear the same red polo shirt with visible stains, black sweatpants, and yellow gripper socks. During observation on 4/2/26 at 12:10 p.m., R16 was observed ambulating in the hallway toward the dining room for lunch, wearing the same red polo shirt with visible stains, black sweatpants, and yellow gripper socks. During observation on 4/3/26 at 7:16 p.m., R16 was lying in bed with eyes closed and continued to wear the same red polo shirt with visible stains, black sweatpants, and yellow gripper socks. During observation on 4/6/26 at 9:52 a.m., R16 was lying in bed with eyes closed and continued to (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wear the same clothing observed the previous week, including a red polo shirt with visible stains, black sweatpants, and yellow gripper socks. During interview on 4/6/26 at 11:32 a.m., registered nurse (RN)-A stated staff should ask residents if they had showered and may prompt up to three times. RN-A stated R16 was very independent; however, if staff observed the resident wearing the same clothing, they should approach the resident and offer assistance with changing clothing. RN-A further stated nursing assistants should notify the nurse if the resident refused assistance. During interview on 4/6/26 at 9:59 a.m., nursing assistant (NA)-A stated R16 required assistance with dressing, particularly with lower body clothing, and was independent with upper body dressing. NA-A stated clothing should be changed daily; however, R16 sometimes preferred to wear the same clothing. NA-A further stated if staff observed R16 wearing the same soiled clothing, they should approach and offer assistance with changing; however, NA-A stated he did not document when this occurred. NA-A indicated R16 did not have a history of refusing cares. During interview on 4/6/26 at 11:23 a.m., NA-C stated R16 required assistance with dressing and staff assisted him with changing clothing daily. NA-C stated R16 sometimes refused assistance; however, refusals were not documented. During interview on 4/6/26 at 1:51 p.m., registered nurse case manager (RN)-B stated staff were expected to assist residents with changing clothing daily. RN-B stated if a resident refused, staff could not force care, as it was the resident's preference; however, staff should encourage the resident and re-offer assistance, particularly if the same clothing was observed. RN-B further stated R16 did not require assistance with most ADLs, except for changing the colostomy bag, and indicated staff should have ensured R16's clothing was changed. During interview on 4/7/26 at 1:01 p.m., director of nursing (DON) stated the expectation was that if a nursing assistant observed a resident wearing the same clothing for multiple consecutive days, the nursing assistant should notify the nurse, who would assess the resident and follow up. The DON stated if the resident adamantly refused assistance, this should be reported to the DON. The DON further stated residents with self-care deficits should be set up with assistance for dressing, and documentation should clearly reflect the reason for the deficit and the need for assistance. DON was unable to provide evidence these interventions were implemented for R16. The facility's Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/31/23, indicated the facility was responsible for providing person-centered care that supported each resident's preferences, choices, and quality of life. The policy required staff to provide necessary care and services based on the resident's assessment to maintain or improve ADL abilities, unless decline was clinically unavoidable. The policy identified ADLs to include hygiene (bathing, dressing, grooming, oral care), mobility, toileting, dining, and communication, and required staff to assist residents who were unable to perform these tasks to ensure proper hygiene, nutrition, and overall well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe mobility and transportation of a resident by staff, resulting in the risk for injury, for 1 of 1 residents (R26) reviewed for quality of care.Findings include:R26's 5-day Minimum Data Set (MDS) dated [DATE], identified R26 had intact cognition and required assistance with activities of daily living (ADLs). R26's diagnoses included heart failure (a condition where the heart cannot pump blood effectively), hypertension (high blood pressure), seizure disorder (a condition causing recurrent seizures), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), chronic obstructive pulmonary disease (COPD; a lung disease that makes it hard to breathe), paroxysmal atrial fibrillation (an irregular heart rhythm that starts and stops suddenly), paresthesia of the skin (abnormal sensations such as tingling or numbness), and long-term use of systemic steroids (ongoing use of medications that reduce inflammation but can have side effects).Review of R26's electronic medical record (EMR) on 4/1/26, including the comprehensive care plan, failed to identify interventions addressing safe wheelchair positioning or the use of foot pedals during transport.During observation on 3/31/26 at 12:32 p.m., R26 was assisted from his room to the dining room in a wheelchair without foot pedals; his feet were observed bouncing on the floor.During observation on 4/1/26 at 2:50 p.m., R26 was assisted from his room to the therapy room in a wheelchair without foot pedals; his feet were observed bouncing on the floor during transport.During observation on 4/2/26 at 8:57 a.m., R26 was assisted from the dining room to the common room in a wheelchair without foot pedals; his left foot bounced off the floor twice.During observation on 4/2/26 at 1:22 p.m., R26 was assisted from his room to the common area in a wheelchair without foot pedals; his left foot was observed sliding on the floor.During observation on 4/3/26 at 8:10 a.m., R26 was assisted from his room to the dining room in a wheelchair without foot pedals; his feet were observed sliding on the floor during transport.During interview on 4/6/26 at 11:32 a.m., registered nurse (RN)-A stated if a resident's feet were observed sliding on the floor during wheelchair transport, the resident should be assessed and foot pedals should be in place. RN-A confirmed R26 did not have foot pedals on the wheelchair or in the room.During interview on 4/6/26 at 9:59 a.m., nursing assistant (NA)-A stated staff offered foot pedals to all residents; however, some residents refused due to preferring to self-propel. NA-A stated R26 did not refuse use of foot pedals but did not use them. NA-A stated R26's feet would slide on the floor during transport and staff had to repeatedly remind him to lift his legs.During interview on 4/6/26 at 11:23 a.m., NA-C stated R26 did not use foot pedals and his feet would slide on the floor during transport, requiring staff to repeatedly remind him to lift his feet. NA-C further stated staff assisted R26 with mobility to and from different areas of the facility.During interview on 4/6/26 at 1:51 p.m., registered nurse case manager (RN)-B stated residents who independently mobilized with their feet may not use foot pedals; however, foot pedals should be in place when a resident was being pushed down the hallway by staff.During interview on 4/6/26 at 2:17 p.m., director of nursing (DON) stated when a resident was not independently self-propelling, foot pedals should be in place during wheelchair transport. The DON stated if staff were pushing the resident, they should ensure foot pedals were applied, as the resident's feet could become caught or injured. The DON further stated if staff offered to assist with transport, they were expected to obtain and apply the foot pedals prior to moving the resident. The DON acknowledged transporting a resident without foot pedals could place the resident at risk for harm.A facility policy regarding wheelchair use and foot pedals was requested but was not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a functional maintenance program (FMP) was implemented to maintain the resident's highest practicable level of functioning, as recommended by therapy services, for 1 of 1 resident (R28) reviewed for rehabilitation and restorative nursing services.Findings include:R28's quarterly Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment and required assistance with activities of daily living (ADLs). R28's diagnoses included progressive neurological conditions (disorders that worsen over time and affect the brain or nervous system), cerebral palsy (a group of disorders affecting movement and muscle coordination due to brain injury or abnormal development), hemiplegia (paralysis affecting one side of the body), malnutrition (a condition resulting from inadequate intake of nutrients), other abnormalities of gait and mobility (difficulty walking or moving normally), thyrotoxicosis (a condition caused by excessive thyroid hormone in the body), contracture of right and left lower leg muscle (permanent tightening of muscles that limits movement), muscle weakness (reduced strength in the muscles), and dysphagia (difficulty swallowing). The MDS did not indicate any range of motion exercises.R28's physical therapy Discharge summary dated [DATE], indicated a functional maintenance program (FMP) was established and staff were trained to provide a range of motion (ROM) program. The discharge summary specified R28 was to receive complete range of motion exercises to bilateral lower extremities (BLE) three times daily to reduce the risk of contractures. The summary further indicated R28's prognosis to maintain current level of function (CLOF) was excellent with consistent staff support and participation in the FMP.Review of R28's electronic medical record (EMR) on 4/2/26, revealed no evidence a functional maintenance program was implemented following discharge from therapy. There was no documentation to indicate ROM exercises were initiated, scheduled, or routinely completed as recommended.Review of the CNA (certified nursing assistant) report sheet for Group 2, undated, identified MUST DO ROM EXERCISES ON LOWER EXTREMITIES under the resident's other information section, which was bolded and in all capital letters. However, there was no supporting documentation in the EMR to confirm these interventions were carried out.During observation on 3/31/26 at 3:55 p.m., R28 was lying in bed with his left arm and both legs elevated in the air due to contractures.During observation on 4/2/26 at 8:56 a.m., R28 was assisted to the common area to watch television. R28's left wrist was observed to be contracted at approximately a 90-degree angle. The R28's lower extremities were also contracted and leaned to the left; pillows were in place to provide appropriate support.During interview on 4/6/26 at 9:59 a.m., nursing assistant (NA)-A stated no ROM exercises were being performed.During interview on 4/6/26 at 11:23 a.m., NA-C stated staff turned and repositioned R28, as he was unable to do so independently. NA-C further stated there were currently no range of motion (ROM) exercises being performed for any residents.During interview on 4/6/26 at 1:51 p.m., registered nurse case manager (RN)-B stated physical therapy (PT) establishes range of motion (ROM) programs, and staff should complete them if they are included on the Treatment Administration Record (TAR). RN-B confirmed a ROM program was not in place for R28.During interview on 4/6/26 at 2:17 p.m., the director of nursing (DON) stated ROM exercises would be expected to be completed unless otherwise directed by hospice. The DON stated if ROM exercises were ordered, they should have been care planned and entered into the Medication Administration Record (MAR) so staff were aware they were required to perform them. The DON acknowledged ROM exercises were noted on the CNA group sheets, indicating staff were expected to perform them.The facility policy regarding range of motion (ROM) and functional maintenance programs was requested but was not received.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a thorough post-fall assessment, including root cause analysis, was completed and appropriate interventions were implemented and reflected in the care plan following repeated falls, for 1 of 2 resident (R2) reviewed for accidents.Findings include:R2's quarterly Minimum Data Set (MDS), dated [DATE], identified R2 had intact cognition and required assistance with activities of daily living (ADLs). R2's diagnoses included nontraumatic subdural hemorrhage (bleeding between the brain and its outer covering not caused by injury), anemia (a condition with a decreased number of red blood cells, leading to fatigue and weakness), coronary artery disease (narrowing or blockage of the heart's blood vessels), heart failure (a condition where the heart cannot pump blood effectively), hypertension (high blood pressure), end-stage renal disease [ESRD] (advanced kidney failure requiring dialysis or transplant), diabetes mellitus (a condition affecting blood sugar regulation), cerebrovascular accident [CVA] (stroke; interruption of blood flow to the brain), traumatic brain injury [TBI] (damage to the brain caused by an external force), anxiety disorder (a condition involving excessive worry or fear), depression (persistent sadness or loss of interest), respiratory failure (a condition where the lungs cannot provide enough oxygen or remove carbon dioxide), unspecified atrial fibrillation (an irregular and often rapid heart rhythm), acute respiratory failure with hypoxia (sudden inability to get enough oxygen into the blood), hypoglycemia (low blood sugar), hypokalemia (low potassium levels in the blood), and cardiomyopathy (disease of the heart muscle that affects its ability to pump effectively).Review of R2's electronic medical record (EMR) identified R2 experienced four falls on 6/30/25, 10/14/25, 2/17/26, and 3/6/26.Review of the Incident Review and Analysis dated 6/30/25, identified R2 was found on the bathroom floor after yelling for assistance. Although contributing factors such as end-stage renal disease and muscle weakness were identified, the facility failed to select or implement any new interventions following the fall. Documentation reflected only existing measures, including the bed in a low position, call light within reach, and gripper socks. There was no evidence of a comprehensive root cause analysis or development of individualized interventions to address fall risk following this incident.Review of the Incident Review and Analysis, dated 10/14/25, identified contributing factors including muscle weakness, unlocked wheelchair brakes, and refusal to call for assistance. Although potential interventions such as auto-lock wheelchair brakes and use of a night light were identified, there was no evidence these interventions were implemented. The facility failed to address R2's known behavior of refusing assistance with individualized or alternative interventions. There was no evidence of a comprehensive root cause analysis or effective intervention development following this fall, resulting in continued risk for subsequent falls.Review of the Incident Review and Analysis, dated 2/17/26, indicated R2 was found on the floor at approximately 1800 hours, yelling for help after falling while ambulating to the bathroom. Documentation identified contributing factors included end-stage renal disease and fatigue following dialysis treatment earlier that day. The report indicated R2 struck his head and was transferred to the emergency room for evaluation. Further review of the incident analysis revealed the facility identified contributing factors; however, no additional or individualized interventions were developed or implemented following the fall. The only interventions noted included the bed in a low position, call light within reach, and use of gripper socks. The section for possible interventions was left blank.Review of the Incident Review and Analysis, dated 3/6/26, identified R2 sustained a head injury with active bleeding after attempting to ambulate independently to the bathroom. Although contributing factors such as weakness and dialysis-related needs were identified, the facility failed to develop and implement new or individualized interventions. Documentation reflected only existing interventions, including the bed in a low position, call light within reach, gripper socks, and signage to call for assistance. There was no evidence the facility conducted a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. Building B. Wing	04/07/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive root cause analysis or implemented effective interventions following this fall, resulting in continued risk for injury, as evidenced by repeated falls.Review of R2's care plan, with a print date of 3/30/26, identified a problem of fall risk related to traumatic subdural hemorrhage without loss of consciousness, initiated on 11/10/2023, with a goal for R2 to remain safe and free from falls.Interventions included: Physical therapy (PT) per physician orders, initiated on 11/10/2023 Follow PT and occupational therapy (OT) instructions for mobility function, initiated on 11/10/2023 Keep R2's room clean and free of clutter, initiated on 11/10/2023 Ensure the call light was within reach, initiated on 11/10/2023 Follow facility fall protocol, initiated on 11/10/2023During interview on 4/6/26 at 9:59 a.m., nursing assistant (NA)-A stated when a resident fell, staff were expected to notify the nurse and assist the resident as needed. NA-A stated R2 had previously been independent; however, in the two months prior to his death, he had become weak, required assistance, and used his call light to request help.During interview on 4/6/26 at 11:23 a.m., nursing assistant (NA)-C stated when a resident fell, staff were expected to notify the nurse. NA-C stated R2 had required assistance with transfers for several months due to weakness.During interview on 4/6/26 at 11:32 a.m., registered nurse (RN)-A stated the facility's process following a fall included completing an assessment, conducting neurological checks when indicated, implementing interventions, and updating the care plan. There was no evidence this process was consistently followed for R2, as new interventions were not implemented and the care plan was not updated following repeated falls.During interview on 4/6/26 at 12:05 p.m., registered nurse case manager (RN)-B confirmed the facility's process included identifying root cause and updating interventions and care plans following falls; however, RN-B acknowledged there was no follow-up and no implementation of new interventions after R2's repeated falls. RN-B further stated R2 had a history of self-transferring, which was a known risk factor. RN-B confirmed the facility failed to analyze known behaviors and implement effective, individualized interventions to prevent recurrence of falls.During interview on 4/6/26 at 2:17 p.m., the director of nursing (DON) stated a root cause analysis should be completed after each fall to identify contributing factors and guide the development of interventions. The DON further stated care plans should be updated to reflect changes in condition and interventions following a fall. The DON confirmed there was no evidence consistent root cause analyses were completed for R2 and acknowledged the care plan was not updated to reflect interventions following the repeated falls.Review of the facility's Fall Prevention and Management policy, dated 11/25, indicated staff were responsible for completing a post-fall assessment, conducting an incident review and analysis to identify root causes and contributing factors, and implementing individualized interventions to prevent recurrence. The policy further required staff to revise or add interventions when falls continued, monitor the effectiveness of interventions, and update the resident's care plan to reflect changes. The facility failed to follow its policy, as evidenced by the lack of consistent root cause analyses, failure to implement new or individualized interventions following repeated falls, and failure to update R2's care plan to address identified risk factors, placing the resident at continued risk for injury.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, the facility failed to ensure pneumococcal immunization was offered and/or administered in accordance with current standards of practice for 1 of 5 residents (R27) reviewed for immunizations.Findings include:A pneumococcal vaccine timing resource from the Centers for Disease Control and Prevention (CDC) dated 3/2025, identified recommended vaccination schedules for adults. The guidance indicated adults aged 50 years and older with no prior pneumococcal vaccination should receive either Pneumococcal 20-valent Conjugate Vaccine (PCV20) or Pneumococcal 21-valent Conjugate Vaccine (PCV21). For those who previously received Pneumococcal 13-valent Conjugate Vaccine (PCV13) and Pneumococcal Polysaccharide Vaccine (PPSV23), additional vaccination with PCV20 may be considered based on shared clinical decision-making between the patient and provider.R27's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition and able to make needs known. R27's diagnoses included atrial fibrillation (an irregular and often rapid heart rhythm), heart failure (a condition where the heart cannot pump blood effectively), hypertension (high blood pressure), renal failure (decreased kidney function or kidney failure), diabetes mellitus (a condition affecting blood sugar control), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), and schizophrenia (a chronic mental disorder affecting thinking, perception, and behavior). The MDS and immunization section did not indicate R27 was up to date on the pneumococcal vaccination.Review of R27's electronic medical record (EMR) lacked documentation a pneumococcal immunization had been offered or administered. There was no evidence of prior vaccination, medical contraindication, or refusal documented in the medical record.During an interview on 4/6/26 at 11:34 a.m., R27 stated she would have been interested in receiving any vaccinations for which she was eligible.During an interview on 4/6/26 at 2:17 p.m., the director of nursing (DON) stated the facility was responsible for ensuring residents were assessed for pneumococcal vaccination status and that the vaccine should be offered unless previously received, medically contraindicated, or refused. The DON confirmed there was no documentation that R27 had been offered or had received the pneumococcal vaccine.The facility Pneumococcal policy dated 2/24, indicated all residents were to be assessed for pneumococcal immunization status within 5 days of admission and offered the vaccine within 30 days, if indicated, unless previously vaccinated or medically contraindicated. If immunization status was unknown, staff were to verify through the resident's physician or the Minnesota Immunization Information Connection (MIIC). The policy required adherence to current CDC guidelines for vaccine recommendations.The policy further indicated residents or their representatives were to receive education regarding the benefits and risks of vaccination, with documentation of education and consent in the medical record. Vaccinations were to be administered per physician order and documented, including the date, administrator, and site. If the vaccine was contraindicated or refused, this was to be documented in the medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview the facility failed to ensure COVID-19 immunization was offered and/or administered in accordance with current standards of practice for 1 of 5 residents (R27) reviewed for immunizations.Findings include:A Centers for Disease Control and Prevention (CDC) COVID-19 Vaccination Guidance, current at the time of survey, indicated individuals should receive recommended COVID-19 vaccinations, including booster doses, when eligible, unless medically contraindicated or refused. Long-term care facilities were responsible for assessing vaccination status and ensuring residents were offered recommended vaccines.R27's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition and able to make needs known. R27's diagnoses included atrial fibrillation (an irregular and often rapid heart rhythm), heart failure (a condition where the heart cannot pump blood effectively), hypertension (high blood pressure), renal failure (decreased kidney function or kidney failure), diabetes mellitus (a condition affecting blood sugar control), anxiety disorder (excessive worry or fear), depression (persistent sadness or loss of interest), and schizophrenia (a chronic mental disorder affecting thinking, perception, and behavior). The MDS immunization section did not indicate R27 was up to date on COVID-19 booster vaccination.Review of R27's electronic medical record (EMR), including immunization records, revealed no documentation a COVID-19 booster had been offered or administered. Further, review of physician orders and progress notes lacked evidence of assessment for booster eligibility, discussion with the resident or representative, or documentation of refusal or contraindication.During an interview on 4/6/26 at 11:34 a.m., R27 stated she would have been interested in receiving any vaccinations for which she was eligible.During an interview on 4/6/26 at 2:17 p.m., the director of nursing (DON) stated the facility was responsible for ensuring residents were assessed for and offered COVID-19 booster vaccinations when eligible. The DON confirmed there was no documentation R27 had been offered or received a COVID-19 booster.The facility's COVID-19 vaccination policy dated 12/6/24, indicated all residents were to be assessed for COVID-19 vaccination status and eligibility upon admission or within 5 days. Residents were to be offered vaccination within 30 days of admission, when indicated, unless already vaccinated or medically contraindicated. If a resident's vaccination status was unknown, staff were to verify it through the physician, medical records, or the state immunization registry (e.g., MIIC). The policy further indicated the facility followed current CDC immunization guidelines for vaccine type, timing, and eligibility. Residents or their representatives were to receive education on the benefits and potential side effects of the vaccine, and informed consent was to be obtained prior to administration. Vaccinations were to be administered per physician order and documented in the medical record. Contraindications or refusals were to be documented, including the date of refusal. Documentation was to include the date of vaccination, lot number, expiration date, administrator, and injection site. The Infection Preventionist or designee was responsible for conducting periodic audits to ensure compliance.