Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 23, 2023

Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

RE: CCN: 245332
Cycle Start Date: June 2, 2023

Dear Administrator:

On June 2, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Nathan Schreier, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 2, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 2, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	C 06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT EXCELSIOR LLC	515 DIVISION STREET EXCELSIOR, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/30/23-6/2/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		7/28/23

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

Electronically Signed | 07/01/2023

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.

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E 037	Continued From page 1 staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 2 *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training	E 037		

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E 037	Continued From page 3 Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program.	E 037		

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E 037	Continued From page 4 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide staff emergency preparedness training at least annually which was based on the facility Emergency Preparedness Plan (EPP). This had the potential to affect all 31	E 037	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of	

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E 037	Continued From page 5 residents, staff, and visitors at the facility. Findings include: Review of facility education over the last year revealed the facility lacked annual staff emergency preparedness training for all staff in the past 12 months. During an interview on 6/1/23 at 3:34 p.m., the associate administrator stated staff received EP training upon hire, and verified the facility had not conducted annual EP training during the past year for all staff. The facility Emergency and Disaster Plans policy dated 11/17, indicated the facility has presented a program of staff education in safety policies, accident prevention, emergency situations and disaster plan during orientation and annually.	E 037	fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. E037 s/s F -The process for satisfying this requirement has been reviewed and revised as needed to ensure all The Estates at Excelsior (EAE) staff are appropriately trained on the Emergency Operations Plan (EOP) per the requirements of both the regulation and contents of the facility EOP. -All occupants of the facility have the potential to be affected if this requirement is not met. -All EAE staff will be provided education on the Emergency Operations Plan -The Human Resource Director will ensure appropriate staff are compliant with education upon hire and in	

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E 037	Continued From page 6	E 037	accordance with the regulation and EOP thereafter. - Audits will be completed weekly for four (4) weeks, and monthly thereafter for two (2) months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator or designee is responsible party. -Corrective action will be completed on or before 7/28/23.	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101	E 041		7/28/23

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E 041	Continued From page 7 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:	E 041		

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E 041	Continued From page 8 http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interview on document review, the facility failed to provide emergency generator testing in accordance with the 2012 Edition of Life Safety Code (NFPA 101), section 9.1.3.1, and the 2010 Edition of NFPA 110, Standard for Emergency and Standby Power Systems.	E 041	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or	

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E 041	Continued From page 9 Findings include: Review of the facility generator and monthly generator testing documentation by the state fire marshall on 5/30/2023 between 12:30 p.m. and 2:30 p.m., revealed the facility lacked evidence the Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months, lacked evidence of weekly inspections of the emergency generator from 6/22 through 1/23, and lacked evidence of monthly testing of the emergency generator during 12/2022, and 1/2023. During interview on 5/30/2023, between 12:30 p.m. and 2:30 p.m., the regional maintenance director, associate administrator, and maintenance director verified the lack of documentation at the time of discovery.	E 041	any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. E041 s/s F -The process for satisfying this requirement has been reviewed and revised as needed to ensure the emergency generator is tested, inspected, and documentation demonstrates compliance with the regulation. -All occupants of the facility have the potential to be affected if this requirement is not met. -The current Maintenance Director has been employed since December, 2022. Documentation in the 2567 indicated, “lacked evidence of weekly inspections of the emergency generator from 6/22 through 1/23, and lacked evidence of monthly testing of the emergency generator during 12/2022, and 1/2023.”	

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	245332	A. BUILDING _____ B. WING _____	C 06/02/2023

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E 041	Continued From page 10	E 041	Since becoming established with the facility and the rules and regulations, the new Maintenance Director has since been compliant with requirements to; 1) inspect the generator each week; 2)complete monthly tests; and 3) stay on pace to monitor the generator for at minimum 4 hours within 36 months. -The Maintenance Director has been re-educated to the requirement and will continue with compliance efforts, as demonstrated over the past 5 months. -The Maintenance Director is documenting both testing and inspections per the regulation electronically and/or on paper. - Audits will be completed weekly for four (4) weeks, and monthly thereafter for two (2) months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Maintenance Director or Designee is responsible party -Corrective action will be completed on or before 7/28/23.	
F 000	INITIAL COMMENTS On 5/30/23 - 6/2/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53322441C (MN93263) with a deficiency cited at F826.	F 000		

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F 000	Continued From page 11 The following complaints were reviewed with no deficiencies cited: H53322439C (MN87166) H53322356C (MN84464) H53322927C (MN84489) H53322413C (MN88927) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess and determine safety for self-administration of medications (SAM) for 3 of 3 residents (R6, R16, R25) who were observed to have medications at bedside. Findings include: R6's significant change Minimum Data Set (MDS) dated 3/11/23, indicated she was cognitively	F 554	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of	7/28/23

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F 554	Continued From page 12 intact, required assist of one staff for locomotion, and supervision for eating, personal hygiene, had no upper extremity limitation in range of motion, and diagnoses of diabetes, arthritis, and psychotic disorder. R6's care plan dated 5/23/23 instructed staff to administer medications as ordered, and indicated R6 was able to move independently in her wheelchair, however lacked evidence R6 was assessed for SAM. R6's MHM Self Administration of Medication Evaluation dated 9/12/2017, indicated R6 was assessed for SAM and was able to keep triamcinolone cream (for skin conditions), Mupirocin (for skin infections), and polyvinyl alcohol eye drops (for dry eyes) at bedside and self-administer. R6's Order Summary Report dated 5/1/23, indicated the following: - Trolamine Salicylate Cream 10%, apply to bilateral knees topically two time per day for arthritis pain starting 5/12/21 - Eucerin cream, apply twice per day for dry itchy legs starting 9/9/2022 - Nystatin Cream 100,000 unit/gram (for fungal infection), apply under both breasts topically two time a day for redness until resolved, then as needed starting 3/24/23 R6's record lacked current orders for eyedrops or eye-related supplements. During observation on 5/31/23 at 8:31 a.m., the following were sitting on top of R6's side table in open view within reach of R6: - One opened, 3/4 full bottle of Ocuvite eye	F 554	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F554 s/s D -The process for satisfying this requirement has been reviewed and revised as needed to ensure residents are assessed and determined to be safe for self-administration of medications. -Residents who reside in the facility and can self-administer medications have the potential to be affected if this regulation is not met. -R6, R16, and R25 have been assessed for self-administration of medications and appropriate physician orders obtained, along with appropriate care plan revisions completed. -All current residents that have been assessed and deemed able to self-administer medications have orders and are care planned. -All residents (new and existing) that request to self-administer medication will be assessed after each request and prior	

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F 554	Continued From page 13 supplement (no expiration date) - One opened, 2/3 full bottle of Allergy Eye Relief eyedrops (expired 9/2017) - One opened, 1/3 full bottle of Dry Eye Relief eyedrops (expired 5/2018) - One opened, nearly empty container of Eucerin cream with "house stock 2/2/23" handwritten on the lid During observation on 6/1/23, at 10:45 a.m. one tube of nystatin and one tube of Trolamine Salicylate Cream were sitting on R6's side table within view from the hallway. R6 was not in the room and there were no staff nearby. At 10:56 a.m. R6 was brought to her room with family by staff and the creams were still on the table. At 10:58 a.m. staff left R6's room leaving R6 and family unsupervised with creams still on the table. At 10:59 a.m. RN-B entered R6's room, removed her tube feeding bag, and left the room. The creams were still on the table. At 11:02 a.m. RN-B entered R6's room, cleaned the tube feeding pump, and left the room. The creams were still on the table within reach of R6 and family. During observation on 5/31/23 at 1:47 p.m., the above medications were in same position on the table, within reach of R6. R16's quarterly MDS dated 4/27/23, indicated she was cognitively intact, ambulatory, had no functional range of motion impairment in her upper or lower extremities, and had diagnoses of diabetes, dementia, anxiety, and depression.	F 554	to being able to self-administer medications -Policies and procedures were reviewed and revised as needed to ensure future instances are avoided. -All EAE nursing staff who have the responsibility and credentials to administer medications received education using Monarch Healthcare self-medication administration policy. -EAE Nursing Leadership received education using Monarch Healthcare Policy and Procedure on care planning self-administration of medications -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 7/28/23.	

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F 554	Continued From page 14 R16's care plan dated 7/1/22, included give medications per physician order. There was no indication R16 was assessed for SAM. R16's Order Summary Report dated 5/1/23, included Eucerin cream, apply to bilateral hands topically two times per day for skin changes starting 3/8/22. R16's record lacked an order for pain relieving cream with lidocaine. During observation on 6/1/23 at 11:48 a.m., R16 was seated in her recliner in her room. There were two open, partially used containers of Eucerin cream on her nightstand labeled with her name on the top in black marker, and one tube of pain-relieving cream with lidocaine on her side table, all within reach of R16. R16 stated staff brought them to her and left them for her to use when she needed it and brought more for her when she ran out. R25's annual MDS dated 5/15/23, indicated she was cognitively intact, required supervision for walking and eating, had no functional range of motion impairment in her upper or lower extremities, and had diagnoses of kidney disease, diabetes, arthritis, anxiety, and depression. R25's care plan dated 5/24/23, and included administer medications as ordered and lacked evidence R25 was assessed for SAM. R25's Order Summary Report dated 5/1/23, included the following:	F 554		

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F 554	Continued From page 15 - Bacitracin ointment, Apply to sebaceous cyst on her back when the dressing in changed in the evening every Monday and Friday starting 2/15/23 - Nystatin Powder 1000,000 unit/gram, Apply to affected area topically three time a day. R25's record lacked orders for Eucerin cream and anti-fungal cream. R25's Care Conference Summary dated 2/13/23, indicated 'Self Administration of Medication Assessment Completed' and 'Self Administration of Medications added to Care Plan' were "N/A". During observation on 6/1/23 at 11:28 a.m., R25 was seated on the side of her bed in front of her bedside table, on which sat a bin containing ½ container of Eucerin Cream and ½ tube of bacitracin (an antibiotic ointment) she used for cellulitis in her lower legs, and a tube of ointment R25 described as a "fungal" medication she bought on her own for under her breasts which she moved to the side out of view. Three half-filled medication cups of white powder were also on the table which R25 stated was also for under her breasts. During interview on 6/1/23 at 11:30 a.m. LPN-B stated R25 kept some medication at bedside but there was not an order for it. She stated staff brough R25 her medications but R25 did not always take them right away and wanted to keep them in her room, so nurses needed to keep coming back to see if she took them. LPN-B stated R25 was hoarding the ordered Nystatin and wanted to apply it herself but did not have an order to keep it at bedside or a SAM assessment and was not sure who was responsible for them.	F 554		

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F 554	Continued From page 16 During interview on 6/1/23 at 7:44 a.m. registered nurse (RN)-B stated staff administered all resident medications, otherwise it would be hard to tell if someone took them or not. He stated there were no residents who were able to self-administer, but they had one resident who preferred to have medication dropped off in the room and staff checked back to see if they were taken. RN-B identified R6 had some medications which she purchased over the counter. He verified the medication on her side table expired several years earlier, and stated he needed to take it because it was expired and R6 did not have an order to keep it at bedside. He verified the medications were sitting in view and staff should have noticed them. On 6/1/23 at 8:01 a.m., director of nursing (DON) stated residents needed an order and an assessment for SAM and there were no residents in the facility who self-administered. DON verified R6 did not have an order, and no medications should have been left in her room. He stated medications should be locked in the medication cart where they could be monitored and to ensure they are properly dated and administered correctly to ensure resident safety. If not monitored, staff would not know what residents were taking or how much and would not know what to watch for regarding interactions and side effects. The Self Administration of Medications policy dated 12/2016, identified residents who wished to self-administer medication required an assessment to determine whether it is clinically appropriate for the resident to do so.	F 554		

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F 561	Continued From page 17	F 561		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food preferences of the resident were honored and implemented for 1 of 4 residents (R184) reviewed for choices.	F 561	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or	7/28/23

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F 561	Continued From page 18 Findings include: R184's nursing progress notes dated 5/22/23 indicated R184 was admitted 5/22/23, and was alert and oriented. R184's Medical Diagnosis form indicated the following diagnoses: end stage renal disease, dysphagia (difficulty swallowing), and type two diabetes mellitus. R184's Clinical Physician Orders form indicated a regular diet, regular texture, and pudding thickened consistency. R184's care plan dated 5/30/23 indicated a nutritional problem related to a history of stroke, had intakes of less than 75% of estimated needs, and the need for modified liquids. Interventions indicated a regular diet with pudding thickened liquids. The care plan indicated R184's diet was liberalized due to inadequate intakes. R184's diet order and communication form provided by the culinary director (CD) dated 5/22/23 indicated R184 did not like applesauce, and included instructions not to give apple juice. R184's fluid preferences indicated orange juice, cranberry juice, and milk. R184's evening meal ticket dated 5/30/23 indicated a regular no added salt diet. Other headings on the meal ticket included: allergies, liquid, beverage preferences, likes, dislikes, instructions, and adaptive equipment, The area under these headings were undocumented. During an interview and observation on 5/30/23 at 5:50 p.m., R184 had one cup of apple juice,	F 561	any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F561 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure resident food preferences are honored and implemented -All residents in the facility have the opportunity to be affected if this regulation is not met -R184 was offered a different drink option and is corrected. The resident has since been discharged from the facility. -R184’s care plan was immediately reviewed and revised as needed. The resident has since been discharged from the facility. -Necessary EAE staff have received education utilization Monarch Healthcare	

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F 561	Continued From page 19 which was verified by the CD. The CD stated R184 drank less than half of the 4 ounces of apple juice. CD verified the diet order communication indicated no apple juice and stated they would make sure R184 received other juices when possible. During an interview and observation on 6/1/23 at 8:07 a.m., R184 was at the dining room table and had a cup of fluid in front of him. R184 stated the cup contained apple juice and could not stand apple juice and was tired of receiving it. The apple juice appeared untouched and R184 stated he had not taken any sips. During an interview on 6/1/23 at 11:03 a.m., the dietician (D)-A stated if a resident did not like something, it was communicated on the tray card and if an item is on their dislikes section, the food item should not be served. During an interview on 6/2/23 at 8:03 a.m., cook-A stated the facility provided apple, orange, cranberry juices, orange twist juice, and lemonade which could be offered to residents. During an interview on 6/2/23 at 9:48 a.m., licensed practical nurse (LPN)-A stated she has seen R184 receive apple juice in the past and stated he should not continue to receive it and should be offered a different option. During an interview on 6/2/23 at 9:52 a.m., CD stated he would talk with staff because it was indicated on R184's card not to give the apple juice. During an interview on 6/2/23 at 9:54 a.m., LPN-A stated R184 received apple juice on 6/2/23 and	F 561	policy and procedure on resident food / drink preferences. -Upon initial admission, each new resident or their representative, will meet with the Culinary Director or designee to ensure a food / drink menu is developed and prepared to meet their preferences. Food / drink preferences will be discussed within the first 72 hours after initial admission and care planned appropriately. -Reasons for which existing residents will meet with the Culinary Director or designee to ensure a food/ drink menu is developed to meet their preferences include, but is not limited to, upon their request, with any change in condition, conversations during care conferences, and/or as ordered by a physician. -Meals / drinks served to all residents will reflect their preferred food / drink preferences, as listed on their culinary meal ticket. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Culinary Director or designee is responsible party. -Corrective action will be completed on or before 7/28/23.	

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F 561	Continued From page 20 informed the CD. During an interview on 6/2/23 at 9:55 a.m., the director of nursing (DON) stated if a resident doesn't like something, they should not be forced to eat or drink the item and expected staff to ask about likes, preferences and substitute the food or drink item for something a resident prefers. A policy, Food and Nutrition Services dated 2017, indicated the multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits. A resident-centered diet and nutrition plan will be based on this assessment. Reasonable efforts would be made to accommodate resident choices and preferences.	F 561		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		7/28/23

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 _____	C 06/02/2023

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THE ESTATES AT EXCELSIOR LLC	515 DIVISION STREET EXCELSIOR, MN 55331

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F 584	Continued From page 21 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure resident floors and equipment were clean for 1 of 1 residents (R6) reviewed for a clean and homelike environment. Findings include: R6's significant change Minimum Data Set (MDS) dated 3/11/23, indicated she was cognitively intact, required extensive assistance with bed mobility, transfers, and toilet use, had coughing, choking and pain with swallowing, and diagnoses of diabetes, arthritis, and psychotic disorder.	F 584	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.	

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F 584	Continued From page 22 R6's care plan dated 5/23/23 indicated R6 had a feeding tube placed 3/21/23. R6's Order Summary Report dated 5/1/23, included Nutren 2.0 (tube feeding supplement) 70 cubic centimeters per hour (cc/hr) to run for 12 hours daily starting at 6:00 p.m. on 4/13/23. Review of the 2nd Floor Housekeeper checklist, undated indicated R6's floor was cleaned on 5/29/23. During observation and interview on 5/30/23 at 4:36 p.m. a light brown dried substance approximately 1 inch (in.) by ½ in. was observed on the right side of R6's tube feeding (TF) pump, along with several other spots on the front and the back. The pole used to secure the pump had numerous small spotted areas below the pump, and the bottom of the pole was crusted with approximately 2 in. by 2 in. medium brown dried matter on each of the four legs, in addition to numerous spots moving outward toward the end of the legs. Underneath the pole was a 5 in. by 5 in. area of dried light brown substance on the floor of R1's room next to her recliner. R6 indicated she was not sure how long it was there and did not like it. During interview on 6/1/23 at 7:07 a.m., nursing assistant (NA)-E stated housekeeping cleaned the floors and was not sure who cleaned the other equipment. During observation on 6/1/23, at 7:19 a.m. the brown matter was still on the TF pump, pole, and floor as previously described. During interview on 6/1/23 at 7:44 a.m.,	F 584	Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F584 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure resident floors and equipment are clean. -All residents who reside in the facility can potentially be affected if this requirement is not met. -R6's floor and equipment were immediately cleaned. This is completed. -All Yona Healthcare employees have been reeducated to the requirement using Yona Healthcare Policy and Procedure. -All EAE staff have been educated to the requirement using Monarch Healthcare policy and procedure. -EAE nursing staff and Yona Healthcare employees are trained and expected to clean equipment and floors per designated cleaning schedule and as necessary, in order to promote a clean and homelike environment for all current and future residents. -EAE Management and Yona Healthcare Manager will complete monthly facility environmental tours with the availability to	

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F 584	Continued From page 23 registered nurse (RN)-B stated housekeeping cleaned the floor in the resident rooms. He stated it was supposed to be done by the day shift staff and documented on the treatment administration report (TAR). Upon viewing the TF pump, pole, and floor, RN-B stated it had been there for some time, and 'certainly' did not just spill that day. He stated it was important to keep things clean for infection control purposes and to ensure the resident had a clean place to live, and he wouldn't want it to look like that that at his home. During interview on 6/1/23 at 8:01 a.m., director of nursing (DON) stated he expected staff to clean equipment and spills as they happen for infection prevention. During interview on 6/1/23 at 8:12 a.m., licensed practical nurse (LPN)-A stated nursing staff was responsible for cleaning the TF pump and pole. During interview on 6/1/23 at 8:30 a.m. environmental services supervisor stated all resident rooms were mopped daily and deep cleaned weekly on a rotating schedule, and nursing cleaned the poles and equipment. He stated TF liquid was hard to remove and R6's floor might have been missed but needed to be cleaned for appearance and to help keep people safe from an infection control perspective. The Daily Cleaning Procedure (DCP) undated instructed staff to dust mop and damp mop the entire floor. The Cleaning and Disinfection Resident-Care Items and Equipment policy dated 10/2021 indicated resident-care equipment will be cleaned and disinfected according to CDC	F 584	increase frequency of walk throughs as deemed necessary based off findings. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing, Environmental Services Director, and/or designee is responsible party. -Corrective action will be completed on or before 7/28/23.	

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F 584	Continued From page 24 recommendations.	F 584		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents (R20 & R184) with repeated falls had implemented interventions to promote safety and reduce the risk of falls. Findings include: R20's admission Minimum Data Set (MDS) dated 3/13/23, indicated R20 had severe cognitive impairment and required total assistance of 2 staff for mobility. Furthermore, R20's MDS indicated R20 had a fall with fracture within 6 months prior to admission, diagnoses of a right femur fracture and dementia. R20's fall care area assessment (CAA) dated 3/13/23, indicated R20 has a risk for potential fall related to a history of falls with a femur fracture and receiving antidepressant medication, and cognitive impairments. R20's fall review evaluation dated 3/16/23, indicated R20 had 1-2 falls within the past 6	F 689	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is	7/28/23

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F 689	Continued From page 25 months, before admission. R20's care plan dated 3/14/23, indicated R20 was a fall risk related to a recent fracture, impaired mobility, impulsiveness, and impaired cognition. R20's interventions included auto lock brakes to wheelchair, bolsters on side of air mattress, remove wheelchair from R20's room when not in use, low bed, and to monitor and document safety related to falls. R20's nursing progress note dated 5/26/23 at 11:14 a.m., indicated R20 was calling out for help. Staff responded and found R20 sitting on the floor between the bathroom door and closet door with the wheelchair behind her. R20 reported when she attempted to sit on her wheelchair, the wheelchair moved backwards, and she fell on her bottom. R20's incident review and analysis form dated 5/26/23, indicated R20 stated she had taken herself to the bathroom and when attempting to transfer back into her wheelchair, she had forgotten to lock the chair. The chair had rolled back causing her to fall. The interdisciplinary team (IDT) will review the incident and staff ensured all interventions are active and in place. During an observation on 5/31/23 at 7:06 a.m., R20 was lying in bed. R20's wheelchair was next to the bed and the bed was not lowered to the floor, as directed in the care plan. During a continuous observation on 6/01/23 at 9:23 a.m., R20 was in bed sleeping and had her wheelchair at the bedside. At 9:34 a.m., R20 was up in her wheelchair and came out of her room. Staff had not entered R20's room to assist with	F 689	submitted as the facility□s credible allegation of compliance. F689 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure residents with repeat falls have implemented interventions to promote safety and reduce the risk of falls. -Residents residing in the facility who fall have the potential to be affected if this requirement is not met. -R20 care plan has been reviewed and revised as necessary. Changes, updates, and interventions include, but are not limited to, auto lock brakes to wheelchair, gripper socks on at all times, medication review(s), raised edge/bolsters to air mattress, get resident up right away in the morning when she wakes, seat out in common area in wheelchair when awake, signs posted in room to alert staff, toilet right away when day shift comes on, low bed, dysem to wheelchair seat, place wheelchair next to bed with brakes locked, etc. -R184 care plan was reviewed and revised as necessary. The resident has since been discharged from the facility. -EAE nursing staff have been re-educated to the requirement and the need to implement appropriate fall interventions following a resident fall. -EAE Nursing Leadership staff have been re-educated to ensure that falls are appropriate investigated and fall interventions are care planned and on group sheets.	

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F 689	Continued From page 26 transfer into the wheelchair. An observation on 6/1/23 at 10:41 a.m. R20's bed did not have a bolstered mattress. At 10:44 a.m. R20 was sitting in her wheelchair near the nurse station. R20 manually locked her breaks to stand momentarily and then sit back down. R20 then unlocked her breaks and self-propelled towards the television area. When interviewed on 6/1/23 at 11:00 a.m., nursing assistant (NA)-E stated R20 did not like asking for help and wanted to be independent. NA-E stated it was important to keep R20's bed low but was not sure about bolsters on the side of her bed. NA-E stated R20's wheelchair was ok to be in her room when not in use, but it had to be away from the bed. Furthermore, NA-E was not aware of R20's recent fall. When interviewed on 6/1/23 at 11:07 a.m., licensed practical nurse (LPN)-B stated R20 needed reminders to ask for help when getting up or using the bathroom. LPN-B verified R20's wheelchair was inside her room this morning and verified it should have been stored outside of the room as R20 will walk to it if it is in sight. LPN-E verified R20's bed was an air mattress and had no bolstered sides in place. LPN-E assisted R20 to stand and tested the auto lock breaks on the chair and verified the auto brakes were not engaging and R20's chair was able to move freely. When interviewed on 6/1/23 at 12:03 p.m. the Director of Nursing (DON) stated R20's fall on 5/26/23, was reviewed by IDT and he had checked R20's wheelchair and they had been working. The DON verified R20's mattress did not	F 689	-Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 7/28/23.	

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F 689	Continued From page 27 have bolsters in place and the correct mattress would be ordered. The DON expected staff to follow the residents care plan to help prevent falls and ensure the safety of residents. R184's nursing progress notes dated 5/22/23 indicated R184 was admitted and alert and oriented. R184's Medical Diagnosis form indicated the following diagnoses: end stage renal disease, chronic obstructive pulmonary disease, muscle weakness, and type two diabetes mellitus. R184's Care Area Assessment (CAA) Worksheet form in progress dated 6/1/23 indicated R184 required extensive assistance for bed mobility, transfer, dressing, toileting, and personal hygiene. The CAA indicated R184 was assessed at risk for falls due to metabolic encephalopathy, end stage renal disease, type two diabetes, and chronic obstructive pulmonary disease. R184 also received antidepressant medication which could increase the risk of falls, required assist for transfers and activities of daily living, was incontinent, staff would follow therapy recommendation for ambulation, transfers, activity of daily living (ADL) status, and update the charge nurse and therapy of any concerns. The goal was for the resident to be free from falls daily through the review date. R184's care plan dated 5/23/23 indicated R184 at risk for falling and interventions included keeping briefs and incontinent products in the drawer out of sight, follow physical therapy and occupational therapy instructions for mobility function, resident to wear gripper socks at night, monitor and document on safety, review information on past	F 689		

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F 689	Continued From page 28	F 689		

falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident, family, caregivers, and interdisciplinary team (IDT) as to causes, and resident will have night light on at night to assist with visibility.

R184's care plan revised 5/30/23 indicated an alteration in mobility due to a history of falls, assist of one with transfers and was revised that included assist with transfers assist of two with a mechanical stand.

R184's care sheet, undated, indicated R184 required assist of two with the EZ stand (mechanical stand lift).

R184's Therapy Transfer Recommendations form dated 5/30/23 indicated EZ stand for transfers with assist of two.

R184's progress notes dated 5/25/23 indicated R184 was found on the floor and was bare footed with the four wheeled walker in front of him. There were bleeding skin tears to left elbow and between second and third fingers. R184 stated he was trying to get his brief.

R184's progress notes dated 5/27/23 indicated a fall in R184's room after trying to sit in his wheelchair and lost his balance and fell.

R184's progress notes dated 5/30/23 indicated R184 was on the floor lying on his left side and was bare footed with the four wheeled walker in front of him and was trying to go to the bathroom.

R184's Fall Review Evaluation form dated 5/23/23, indicated R184, was alert and oriented,

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F 689	Continued From page 29 frequently incontinent, confined to a chair and oriented, could not independently come to a standing position, exhibited loss of balance while standing, required hands on assistance to move from place to place, and was admitted following falls at home. R184's Incident Review and Analysis dated 5/26/23 indicated an incident on 5/25/23 where R184 was found on the floor bare footed and had the four wheeled walker in front of him and was going to get his brief. The note indicated the IDT reviewed the root cause of the fall and determined it was related to the absence of non-slip footwear, confusion, and forgetfulness related to call light usage, poor visibility, resident confusion and curiosity related to visible incontinence products. IDT agreed to implement the following interventions: grip socks on while in bed, incontinence products to be removed from visibility and placed into appropriate cupboard. Night light to be on at bedtime to increase visibility. During an interview on 5/30/23 at 4:56 p.m., R184 stated he had fallen trying to go to the bathroom. He stated he pushed the call button, in which he waited about 20 minutes before he got up to use the bathroom and fell. During an observation on 5/31/23 at 7:54 a.m., nursing assistant (NA)-B assisted resident to sit up in bed. At 7:59 a.m., NA-B applied gait belt and assisted to stand at 8:00 a.m., and transferred R184 to his wheelchair. During an observation on 5/31/23 at 9:10 a.m., NA-C assisted R184 to the bathroom with assist of one and transferred him back to the	F 689		

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F 689	Continued From page 30 wheelchair. During an interview on 5/31/23 at approximately 9:30 a.m., NA-B stated they look at care sheets to determine what kind of cares a resident required. During an interview on 5/31/23 at 12:31 p.m., NA-B stated she looks in the communication binder or in the therapy binder to know how a resident transferred and stated she was not made aware R184 transferred with an EZ stand and verified she transferred R184 with assist of one that morning. During an interview on 5/31/23 at 12:35 p.m., NA-C stated therapy lets them know how a resident transfers and it was normally in the binder on the residents care sheets, and stated she was not made aware that R184's transfer status changed to an EZ stand and verified she transferred R184 with assist of one that morning. During an interview on 5/31/23 at 12:39 p.m. LPN-B stated R184 had three or four falls since admission and a risk management form was completed following falls and stated she only saw one risk management form completed in the medical record. LPN-B stated the form included information about the incident, what injuries were sustained, who was updated, and the action added to the care plan. LPN-B verified R184 was supposed to have a night light in his room but did not and he is an EZ stand with two assist when transferring. During an interview on 5/31/23 at 12:53 p.m., physical therapist (PT)-A stated R184's care plan changed on 5/30/23 and was originally an assist of one and a walker, was unsafe to continue and	F 689		

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F 689	Continued From page 31	F 689		

was downgraded to a mechanical lift. She completed a form and provided it to LPN-A and left a copy of the transfer status in the book, spoke with the nurse on 5/30/23, and put a copy of the instructions in their PT folder.

During an interview on 5/31/23 at 12:55 p.m. LPN-A stated R184 had three falls since admission and a risk management report was supposed to be completed. R184 had two completed, one on 5/25/23, and one on 5/30/23. LPN-A stated there was no risk management report for 5/27/23 and verified no new interventions were added. LPN-A verified R184 was changed to an EZ stand with two assist and stated the instructions was on the team's care sheets, resident care plan and the NA's had the sheet and she expected them to know. LPN-A further stated staff or the resident could get injured if the care sheet wasn't followed.

During an interview on 6/1/23 at 12:03 p.m., the director of nursing (DON) stated when a resident falls, the floor nurse complete an assessment on injuries and notifies the provider, DON, administrator, responsible party, completes a risk management form, along with a progress note, update the care plan if warranted, and is reviewed by the DON or the LPN care coordinator. The DON was working on the incident analysis from 5/30/23, and stated he provided education 5/31/23 regarding transferring resident with assist of one instead of the interventions of the EZ stand transfer and the lack of foot wear from the fall.

A policy Fall Prevention and Management dated February 2021, indicated the purpose of the policy was to identify residents at risk for falls, implement fall prevention interventions, provide

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 _____	C 06/02/2023

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 689	Continued From page 32 guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a therapeutic diet as prescribed for 1 of 2 residents (R184) reviewed who had an altered diet. Findings include: R184's nursing progress notes dated 5/22/23, indicated R184 was alert and oriented.	F 692	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of	7/28/23

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 _____	C 06/02/2023

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F 692	Continued From page 33 R184's Medical Diagnosis form indicated the following diagnoses: end stage renal disease, dysphagia (difficulty swallowing), disarthria (weakened muscles used for speech) following cerebral infarction (stroke), and type two diabetes mellitus. R184's Clinical Physician Orders form dated 5/23/23 indicated a regular diet, regular texture and pudding thickened consistency. R184's care plan dated 5/30/23 indicated a nutritional problem related to a history of stroke, had intakes of less than 75% of estimated needs, and the need for modified liquids. Interventions indicated a regular diet with pudding thickened liquids. The care plan indicated R184's diet was liberalized due to inadequate intakes. R184's care sheet indicated pudding thick liquids. R184's diet order and communication form provided by the culinary director (CD) dated 5/22/23 indicated R184 required thickened liquids, a dysphagia diet, and no straws. R184's diet order and communication form dated 5/23/23 indicated a regular diet with controlled carbohydrates and pudding thickened liquids. R184's evening meal ticket dated 5/30/23 indicated a regular no added salt diet. R184's speech therapy note dated 5/30/23 indicated pudding thickened liquids and regular textures. R184 was provided a handout on recommended compensatory swallow strategies that included small bites, alternating between liquids/solids, slow pacing, upright positioning,	F 692	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F692 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure therapeutic diets are provided as prescribed. -Residents residing in the facility who are prescribed an altered diet have the potential to be affected if this requirement is not met. -R184 care plan was immediately reviewed and revised as necessary, with no evidence of harm or lasting effects. The resident has since been discharged from the facility. -All other residents residing in the facility who are prescribed an altered diet have been reviewed and each care plan has been revised as necessary. -EAE culinary and nursing staff have been re-educated to the requirement and the need to provide appropriate therapeutic diets and textures as prescribed.	

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	245332	A. BUILDING _____ B. WING _____	C 06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 34 and double swallows, R184 verbalized understanding and was agreeable to all recommended strategies. During an observation on 5/30/23 at 4:49 p.m., R184 was in the dining room, had a water glass with a straw in it. R184 picked up his cup of water and observed the water sloshing around inside the cup and did not drink any fluid. During an interview and observation on 5/30/23 at 5:24 p.m., licensed practical nurse (LPN)-A stated R184 was supposed to have pudding thickened liquids and stated the liquids were nectar thick and not thick enough, adding R184 could choke and had been drinking out of the water cup. During an interview on 5/30/23 at 5:39 p.m., dietary aide (DA)-B stated R184's fluids should be thick like pudding so he doesn't choke. During an interview 5/30/23 at 5:40 p.m., the cook (C)-B stated R184 was supposed to have pudding thickened liquids. During interview 5/30/23 at 5:45 p.m., the culinary director stated the diet ticket should have included the pudding consistency diet. The culinary director stated water glasses and straws were provided by nursing. During an interview on 5/31/23 at 10:32 a.m., the director of nursing stated staff should follow the diets listed in Point Click Care and the aide sheets because if the correct thickness was not followed, it could be a choking hazard. Nurse consultant (NC)-D stated staff need to make sure they are following the physician and speech therapy orders.	F 692	-Necessary EAE staff have been re-educated on where to locate current diet orders. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Culinary Director or designee is responsible party. -Corrective action will be completed on or before 7/28/23.	

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	245332	A. BUILDING _____ B. WING _____	C 06/02/2023

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 692	Continued From page 35 During an observation and interview on 6/1/23 at 8:07 a.m., R184 was in the dining room and had apple juice and milk next to his breakfast. The apple juice was a thinner consistency but not pudding thickness, the milk was not a pudding consistency. Resident had not drank either of the fluids. C-A stated the milk was not thick enough and the resident voiced the same concern. C-A left the fluids and would get R184 thickened milk. During an interview on 6/1/23 at 8:11 a.m., LPN-A stated the apple juice was between a nectar and honey thickened consistency and the milk was nectar thickened. LPN-A took the milk and apple juice off R184's tray. A policy Diet Manual and Diet Orders undated indicated it was the policy of Monarch Healthcare Management to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, and may or may not include therapeutic and altered textured diets.	F 692		
F 801 SS=C	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes:	F 801		7/28/23

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 _____	C 06/02/2023

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THE ESTATES AT EXCELSIOR LLC	515 DIVISION STREET EXCELSIOR, MN 55331

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F 801	Continued From page 36 §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following	F 801		

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F 801	Continued From page 37 qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to designate a qualified person to serve as the director of food and nutrition services in the absence of a full-time dietitian. This had the potential to affect all 31 of 31 residents who required clinical nutrition services. Findings include:	F 801	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of	

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	245332	A. BUILDING _____ B. WING _____	C 06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 801	Continued From page 38 During interview 5/30/23 at 11:41 a.m., the culinary director (CD) reported he had not been a director of food and nutrition services in a nursing facility for two or more years. CD stated he had a bachelor's degree in marketing and communications and was trying to complete a certified dietary manager (CDM) program. The dietician comes into the facility once or twice a week to collaborates with him. A copy of an email on 11/17/2021, at 4:22 p.m., indicated CD was enrolled in the Nutrition and Foodservice Professional Training Program through the University of North Dakota, however there was no indication he had completed this course. During interview 6/1/23 at 7:32 a.m., the administrator stated the dietician was at the facility weekly, but not full time and expected CD to have the certification and would look to getting CD certified. A facility Job Description for the Culinary Director dated 11/5/20, indicated the CD was responsible for managing the culinary service department in providing quality food and nutritional services to residents. The description further indicated qualifications must be a graduate of or currently enrolled in an approved Culinary Services Director's course that meets the requirements for State and Federal long term care regulations.	F 801	this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F801 s/s C -The process for satisfying this requirement has been reviewed to ensure EAE staff meet the requirement(s) for ensuring qualified staff oversee the food service program. - At the time of this MDH Survey, the facility Culinary Director was enrolled in a Certified Dietary Manager (CDM) course through the University of North Dakota. -Effective immediately, a Regional CDM employed by Monarch Healthcare Management has been established to oversee Culinary Services and will provide appropriate service to the facility in accordance with all applicable local, state, and federal standards. - The Administrator has been re-educated to the requirement and will ensure that whomever oversees the culinary department is qualified and either enrolled	

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	245332	A. BUILDING _____ B. WING _____	C 06/02/2023

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 801	Continued From page 39	F 801	in an approved CDM course or is certified. -All Residents residing in this facility have the potential to be affected if this requirement is not met. -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator or designee is responsible party. -Corrective action will be completed on or before 7/28/23.	
F 826 SS=E	Rehab Services Physician Order/Qualified Pers CFR(s): 483.65(b) §483.65(b) Qualifications Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a sufficient number of qualified physical therapists (PT) and/or support staff were available to meet the therapy needs of 7 of 10 residents (R9, R13, R14, R20, R25, R183, R184) reviewed for rehabilitation services. Findings include: R9 R9's annual Minimum Data Set (MDS) dated	F 826	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by	7/28/23

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 _____	C 06/02/2023

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F 826	Continued From page 40 4/1/23, indicated intact cognition, did not reject cares, and required extensive assistance for most activities of daily living (ADLs). R9 did not ambulate in the room or corridor, had one fall since the last assessment, started physical therapy on 8/22/22, and the therapy sessions were ongoing. R9's diagnosis included: diabetes mellitus with diabetic neuropathy (nerve damage caused by diabetes), human immunodeficiency virus, idiopathic peripheral autonomic neuropathy (nerve damage of unknown cause), repeated falls. R9's Medical Diagnosis tab in the EMR undated indicated the following additional diagnoses: acquired absence of right leg below knee, and major depressive disorder. R9's order report indicated R9 had an order dated 8/18/22, for physical therapy to evaluate and treat. R9's care plan dated 3/15/23, indicated R9 was at risk for falls and interventions included: follow physical therapy (PT) instructions for mobility function. R9 had major depressive disorder and interventions included R9 enjoyed conversing with others and going out in the community, and engaging in activities, work with therapies, nursing, meds, etc so resident may attend activities of interest, and R9 had a potential for mood and behavior related to adjustment to the facility and major depressive disorder. An intervention recommended by Associated Clinic of Psychology (ACP) indicated to continue to maximize opportunities for autonomy and control around therapies may be helpful in increasing engagement. For example, letting R9 decide between two available therapy times or making a	F 826	the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F826 s/s E -The process for satisfying this requirement has been reviewed and revised as necessary to ensure that a sufficient number of qualified Physical Therapists are available to meet the prescribed health needs of residents receiving therapeutic services. -Residents who are receiving Physical Therapy (PT) as ordered by a physician have the potential to be affected if this requirement is not met. -All current residents receiving PT and/or other support services have been reviewed to ensure that their needs are met as ordered by the physician. -A new Therapy Manager has been hired, with an anticipated start date of mid-July, 2023. -Select Therapy OTR will participate in Interdisciplinary Team (IDT) meetings three (3) times per week to discuss current resident needs and/or staffing.	

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 _____	C 06/02/2023

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F 826	Continued From page 41 schedule so R9 knew what to expect. R9's PT Recert, Progress Report and Updated Therapy Plan forms for 3/14/23, through 4/12/23, 4/12/23 through 5/11/23, and 5/11/23 through 6/9/23, all identified R9's plan of treatment was expected to be provided three times a week for four weeks. However, the Service Log Matrix forms from 3/5/23 through 5/27/23, identified R9 only received therapy 21 out of 36 PT visits. R9 refused a total of three visits: Sunday, April 16, 2023, (All three visits were made that week), Tuesday April 25, 2023, and Thursday April 27, 2023. The form indicated R9 was "out" two visits on Monday, April 10, 2023, and Monday, May 8, 2023. During an interview 5/30/23 at 1:09 p.m., R9 stated she was supposed to have physical therapy in order to increase her ability to walk, however indicated she had not received physical therapy the past couple of weeks and could not expect to be discharged from the facility until she was able to walk with a walker. During a follow-up interview 5/31/23 at 3:09 p.m., R9 stated she did not walk that day and when she inquired about therapy, R9 was informed she was not on the case load list and reported they would have to talk to the supervisor. R13 R13's quarterly Minimum Data Set (MDS) dated 2/23/23, indicated R13 had severe cognitive impairment and required extensive assistance with one person for transfers and limited assistance with one person for walking. R13 had PT twice during the seven day look back period	F 826	-Select Therapy OTR will participate in weekly Medicare Meetings to discuss current needs and/or staffing. -Select Therapy has established relationships with external staffing agencies to potentially assist with coverage options to meet the needs of residents receiving therapeutic services as prescribed. -All new residents with prescribed PT treatment and/or other support services will be evaluated in a timely manner, and treatments completed in accordance with physician recommendations. - Audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator, Director of Nursing, and/or designee is responsible party. -Corrective action will be completed on or before 7/28/23.	

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F 826	Continued From page 42 and had two or more falls since the prior assessment. Furthermore, R13 had diagnoses of Alzheimer's Disease and failure to thrive. R13's provider order dated 3/15/22, directed PT to evaluate and treat as indicated. R13's care plan dated 11/18/23, indicated R13 had an alteration in mobility related to cognition deficits. Interventions included PT per provider order and follow PT instructions. R13's PT recertification, progress report and updated therapy plan for 3/16/23-5/11/23, indicated R13's plan of treatment was three days a week for four weeks. However, the therapy schedule report dated 3/2023-5/2023, indicated PT had seen R13 only twice for the weeks of 3/16/23-3/22/23 and 5/3/23-5/9/23, and had no missed visits documented. R13's PT recertification, progress report and updated therapy plan for 5/12/23-6/10/23, indicated R13's plan of treatment was three days a week for four weeks. However, the therapy schedule report dated 5/2023, indicated PT had seen R13 only once a week for the weeks of 5/12/23- 5/31/23, and there were no missed visits identified. Over the past two certification periods, R13 had only received 13 out of 21 PT visits. R20 R20's admission MDS dated 3/13/23, indicated R20 had severe cognitive impairment and required total assistance of two staff for mobility. Furthermore, R20's MDS indicated R20 had	F 826		

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F 826	Continued From page 43 diagnoses of a right femur fracture related to a fall, and dementia. R20's provider order dated 3/13/23, directed PT to evaluate and treat as indicated. R20's care plan dated 3/14/23, indicated R20 was a fall risk related to a recent fracture, impaired mobility, impulsiveness, and impaired cognition. Interventions included follow PT instructions for mobility. R20's PT evaluation and plan of treatment for 3/14/23-4/12/23, indicated R20's plan of treatment was five days a week for four weeks. However, the therapy schedule report dated 3/2023-5/2023, indicated PT had seen R20 twice a week for the week of 3/14/23-3/20/23, four times a week for the week of 4/4/23-4/10/23, and had no missed visits documented. R20's PT recertification, progress report and updated therapy plan for 4/8/23-5/7/23, indicated R20's plan of treatment was five days a week for four weeks. However, the therapy schedule report dated 4/2023 to 5/2023, indicated PT had seen R20 three times a week for the week of 5/1/23-5/7/23, and had no missed visits documented. R20's PT recertification, progress report and updated therapy plan for 5/8/23-6/6/23, indicated R20's plan of treatment was five days a week for four weeks. However, the therapy schedule report dated 5/2023, indicated PT had seen R20 three times a week for the week of 5/8/23-5/14/23, one time a week for the week of 5/15/23-5/21/23, three times a week for the week of 5/22/23-5/28/23, and had no missed visits	F 826		

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F 826	Continued From page 44 documented. Over the past three certification periods, R20 had received 45/60 PT visits. R14 R14's quarterly Minimum Data Set (MDS) dated 5/26/23, indicated she was cognitively intact, required extensive assistance of two staff for bed mobility, transfers, dressing, and toilet use, was always incontinent of bladder and bowel, and had diagnoses of left below the knee leg amputation, diabetes, paralysis on one side of her body due to stroke, and depression. R14's care plan dated 12/29/22, included follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function. R14's Order Summary Report dated 5/1/23, included: - Compression stocking to left lower extremity should be applied by therapy starting 2/9/23. - Complete MHM Daily Skilled Note under Forms in electronic health record. State why resident was being covered for PT/OT and Nursing every shift which started 3/27/23. - PT/OT for assessment for prosthetic which started 5/1/23. R14's PT Recert, Progress Report and Updated Therapy Plan for certification period 3/28/23 - 4/26/23, indicated PT was ordered three times per week for four weeks, and was signed by R14's medical provider as medically necessary to instruct in home exercise program, assess functional abilities, improve dynamic balance, increase coordination, increase functional activity	F 826		

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F 826	Continued From page 45 tolerance, and increase lower extremity range of motion and strength. R14's Therapy Encounter Notes indicated R14 received PT on 3/28/23, 3/30/23, and 4/3/23, however the medical record lacked evidence of any additional therapy visits during the certification period 3/28/23 - 4/26/23. The therapy Service Matrix Log for March 2023, and April 2023, indicated R14 had three of 12 PT visits during the certification period 3/28/23 - 4/26/23. R14's PT Evaluation and Plan of Treatment for certification period 5/4/23 - 6/2/23, identified PT had been ordered 3 times per week for four weeks, and was signed by R14's medical provider as medically necessary. In addition indicated without therapy R14 was at risk for compromised general health, contracture(s), decrease in level of mobility, decreased participation with functional tasks, further decline in function, immobility, increased dependency on caregivers, limited out-of-bed activity and muscle atrophy. R14's Therapy Encounter Notes indicated R14 received PT on 5/4/23, and lacked evidence of therapy visits again until 5/22/23, in preparation for prosthetist visit scheduled for 5/25/23. The therapy Service Matrix Log for May 2023, indicated R14 had one visit on 5/4/23, and lacked evidence of any further PT visits until 5/22/23. Over the two certification periods, R14 received four of 20 PT visits. R25	F 826		

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F 826	Continued From page 46 R25's annual Minimum Data Set (MDS) dated 5/15/23, indicated she was cognitively intact, required extensive assistance of one staff for bed mobility, transfers, and dressing, and assistance of two staff for toileting. R25 was incontinent of bladder and frequently incontinent of bowel, and had diagnoses of kidney disease, diabetes, arthritis, anxiety, and depression. R25's care plan dated 5/12/22, instructed staff to follow PT and OT instructions for mobility function. R25's Order Summary Report dated 5/1/23, included PT/OT to evaluate for safety in using a power wheelchair starting 2/22/23, and PT to evaluate and treat right shoulder which started on 12/28/22. R25's PT Evaluation and Plan of Treatment for certification period 3/11/23 - 4/9/23, indicated PT was ordered three times per week for four weeks, and was signed by R25's medical provider as medically necessary to address impairments, decrease fall risk, improve level of independence and ability to safely navigate R25's environment independently. R25's Therapy Encounter Notes indicated R25 received PT seven times during the certification period 3/11/23 - 4/9/23. The therapy Service Matrix Log for March 2023 and April 2023, indicated R25 had seven PT visits during the certification period 3/11/23 - 4/9/23. The PT Recert, Progress Report and Updated Therapy Plan for certification period 4/9/23 -	F 826		

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F 826	Continued From page 47 5/8/23, indicated PT was ordered three time per week for four weeks and was signed by R25's medical provider as medically necessary to analyze gait pattern, assess functional abilities, instruct in home exercise program, increase coordination, increase functional activity tolerance, increase independence with gait, increase lower extremity range of motion and strength, and minimize falls. R25's Therapy Encounter Notes indicated R25 received PT nine times during the certification period 4/9/23 - 5/8/23. The therapy Service Matrix Log for April and May 2023, indicated R25 had ten PT visits during the certification period 4/9/23 - 5/8/23. The PT Recert, Progress Report and Updated Therapy Plan for certification period 5/9/23 - 6/7/23, indicated PT was ordered three time per week for four weeks and was signed by R25's medical provider as medically necessary to decrease complaints of pain, enhance rehab potential, facilitate independence with all functional mobility, increase upper and lower extremity range of motion, and increase independence with gait to improve quality of life. R25's Therapy Encounter Notes indicated R25 received PT three times between 5/9/23, and 5/31/23. The Therapy Service Matrix Log May 2023, indicated R25 had three PT visits during the period 5/9/23 - 5/31/23. Over the three certification periods, R25 received 20 of 33 PT visits.	F 826		

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F 826	Continued From page 48 R183 R183's hospital discharge orders dated 4/13/23, indicated R183 had a fall while standing. The orders identified physical therapy (PT) was ordered to evaluate and treat with instructions that included weight bear as tolerated and minimize mobility to room only today. R183's admission nursing progress note dated 4/13/23, indicated R183 was admitted after a fall that resulted in a below the knee fracture and right hip grafting. R183's 48 hour care plan dated 4/14/23, identified an alteration in mobility and a risk for falls with interventions to follow PT instructions. During an interview 6/1/23 at 9:51 a.m., R183 stated she was admitted to the facility to have physical therapy and indicated the director informed her after admission there was no physical therapist on staff at the time and the facility was attempting to recruit one. R183 stated she voiced concerns to staff and believed the staff person she spoke with was the associate administrator. R183 indicated her daughter spoke with a staff member as well regarding the concern. R183 stated she was upset the organization was not providing therapy services and made a decision to discharge from the facility on 4/14/23. R184 R184's nursing progress notes dated 5/22/23, identified R184 was admitted 5/22/23, and was alert and oriented.	F 826		

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F 826	Continued From page 49 R184's Medical Diagnosis tab in the electronic medical record (EMR) undated identified the following diagnoses: end stage renal disease, dysphagia (difficulty swallowing), and type two diabetes mellitus. R184's Clinical Physician Orders dated 5/22/23, in the EMR revealed an order for physical therapy to evaluate and treat. R184's Therapy tab in the EMR indicated R184 had PT which started on 5/23/23, five times a week. R184's care plan dated 5/23/23, indicated a risk for falling and an alteration in mobility and interventions indicated to follow to PT instructions. The Service Log Matrix indicated R184 had PT on 5/23/23, 5/24/23, and 5/25/23. The Service Log Matrix lacked documentation R184 received therapy for the remainder of the week on 5/26/23, or 5/27/23. During an interview 5/31/23 at approximately 2:20 p.m., physical therapist (PT)-A stated there was an order for R9 to receive physical therapy three times per week, however believed R9 had not been receiving therapy since there was no full time physical therapist at the facility. PT-A indicated she believed since R9 had been not receiving the therapy as ordered, could be the reason R9 continued to be on therapy for an extended length of time. PT-A stated R9's goals were to ambulate, increase strength, and decrease the risk of falling so R9 could discharge to an assisted living facility. PT-A stated R9	F 826		

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F 826	Continued From page 50	F 826		

received therapy two to three times a week in April, however confirmed in May she had only received therapy once a week on average.

During an interview 6/2/23 at 8:46 a.m., occupational therapist registered (OTR) regional manager for Select Rehab stated she completed all the staff scheduling and confirmed there was not an on-sight program manager at the facility. OTR stated the facility had not had an on-sight manager since the middle of February, 2023. OTR indicated since they did not have consistent staffing at the facility, they prioritized residents receiving therapy who were short stay to be seen first and long term residents were second priority. OTR stated they did the best they could to find staff to cover visits and when they could not see someone, visits were staggered between physical, occupational or speech therapy. At 9:07 a.m., OTR stated she had been in ongoing communication with the campus administrator and associate administrator regarding the staffing challenges and stated she sent the associate administrator a schedule of therapists who were on site the last 60 days, however the list did not include the residents who had been seen.

During an interview 6/2/23 at 11:52 a.m., the medical director stated he was not aware of any concerns with residents not receiving therapy and added if a resident did not receive therapy it was "not a good thing because that is what they are there for."

During an interview 6/2/23 at 2:44 p.m., director of nursing (DON) and nurse consultant, DON stated he expected physical therapy to be at the facility and provide PT as ordered. Nurse consultant indicated PT wrote the plan of care

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F 826	Continued From page 51 and the number of treatments required and the facility relied on them to complete treatments as specified. During an interview 6/2/23 at 2:51 p.m., the associate administrator stated his expectation was upon admit, residents were evaluated by therapy on the first day and therapy would continue as ordered. Associate administrator confirmed a resident chose to leave against medical advice as they did not receive therapy as ordered. A Therapy Services Agreement contract dated 4/1/18, indicated under the heading Obligations of Contractor, Select Therapy would provide therapists to perform rehabilitation services at the facility five days per weekday per week, during normal business hours as reasonably determined by contractor; upon facility's reasonable request, contractor would use reasonable efforts to provide rehabilitation services on weekends and holidays, based on contractor's ability to staff. Contractor would provide rehabilitation services in accordance with a plan of treatment established by the physician responsible for each patient's care or other qualified healthcare professional, as permitted by law. The contractor would be the exclusive agent under the agreement to furnish rehabilitation services. The Facility Assessment Tool dated 5/26/23, indicated the interdisciplinary team (IDT) ensured they had the proper equipment, resources, and competent staff to properly meet the needs of the residents. If they did not have the equipment or resources, vendors were contracted to ensure that these items could be provided. The assessment further indicated physical therapy	F 826		

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F 826	Continued From page 52 was a service offered based on a patient's needs and under a heading Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies, the facility identified the following staff utilized at the facility: therapy services, director of rehab, physical therapy, and physical therapist assistant.	F 826		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request	F 865		7/28/23

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F 865	Continued From page 53 during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:	F 865		

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F 865	Continued From page 54 §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct ongoing quality assurance and performance improvement (QAPI)	F 865	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of	

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F 865	Continued From page 55 activities and develop and implement action plans to correct quality deficiencies identified during the survey the facility was or should have been aware of. This deficient practice had the potential to affect all 31 residents residing in the facility. Findings include: For additional information, review F826. The facility failed to ensure a sufficient number of qualified physical therapists (PT) and/or support staff were available to meet the needs of seven of 10 residents (R9, R13, R14, R20, R25, R183, R184) reviewed for rehabilitation services. The Facility Assessment Tool dated 5/26/23, indicated the interdisciplinary team (IDT) ensured they had the proper equipment, resources, and competent staff to properly meet the needs of the residents. If they did not have the equipment or resources, vendors were contracted to ensure that these items would be provided. The assessment identified physical therapy was a service offered based on a patient's needs and under a heading Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies, the facility identified the following staff utilized at the facility were: therapy services, director of rehab, physical therapy, and physical therapist assistant. The Estates and Excelsior QAPI Agenda dated 3/21/23, covering January and February 2023, identified "No Trend Identified" under Rehab Services. The Estates and Excelsior QAPI Agenda dated 4/18/23, included a Rehab Services section which	F 865	Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F865 s/s F - The process for satisfying this requirement has been reviewed and revised as needed to ensure the facility is identifying quality concerns through the Quality Assurance and Performance Improvement (QAPI) team meeting; with a goal of ensuring the highest practical quality of life and quality of care are achieved for all those served. -All residents in the facility have the potential to be affected if this requirement is not met. - EAE Leadership staff have been re-educated on the importance of an	

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	245332	A. BUILDING _____ B. WING _____	C 06/02/2023

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F 865	Continued From page 56 was left blank. The Estates and Excelsior QAPI Agenda dated 5/30/23, included "Continue the search for a new Therapy Director". Review of the agendas revealed a lack of documentation the therapy director, or any representative from therapy had attended the March, April, and May 2023, meetings. In addition, the agendas lacked documentation the residents had not been receiving therapy services as ordered and lacked identification of a corrective action plan. During an interview on 6/1/23 at 3:44 p.m., nurse practitioner (NP)-C stated the company that supplied physical therapy staff had sporadic availability and indicated there was a potential for functional decline if residents were not seen on a consistent basis. NP-C indicated without the tools of available therapists, there was always a risk of residents not being successful. During an interview on 6/2/23 at 8:46 a.m., occupational therapist registered (OTR) regional manager for Select Rehab (contracted company for therapy services) stated she completed all the staff scheduling and attended the facility Medicare meetings. OTR confirmed there had not been an on-sight therapy manager present in the facility since the middle of February 2023. She stated she had been in communication with the campus administrator and associate administrator of the facility regarding the therapy staffing challenges. During an interview on 6/2/23 at 10:32 a.m., the regional vice president for Select Rehab stated	F 865	effective QAPI team and the need to identify, develop, and implement plans to correct areas of opportunity. This includes, but is not limited to, the Director of Rehabilitation, employed by Select Therapy. -As indicated in the CMS 2567, Select Therapy has a section dedicated to them in the QAPI minutes. It will be required of them to utilize this section to report on items that include, but are not limited to, staffing and any other challenges with meeting the needs of EAE residents on case load. -EAE will effectively utilize QAPI team meetings to identify areas requiring improvement; develop plans for improvement; monitor results of developed plans; and act accordingly on those results to ensure the highest practicable quality of life and quality of care are maintained for all those served. -EAE will effectively utilize QAPI to address and correct deficient practice areas, which include, but are not limited to, current deficiency F826. -Monitoring to assure compliance will include, but is not limited to, audits completed each week for four (4) weeks; bi-weekly for four (4) weeks; and monthly thereafter for one (1) month. Audit results for the aforementioned deficiency will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator, Director of Nursing and/or designee(s) are responsible party. -Corrective action will be completed on or before 7/28/23.	

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F 865	Continued From page 57 the facility was aware some residents were not receiving therapy and the lack of therapy services had been discussed in care conferences. During an interview 6/2/23 at 11:52 a.m., the medical director stated he was not aware of any concerns with residents not receiving therapy and added when a resident did not receive therapy, "it was not a good thing because that is what they are there for." During an interview on 6/2/23 at 3:20 p.m., associate administrator stated PT, occupational therapy (OT), and speech therapy (ST) were provided exclusively by one contracted company. He indicated he was aware the company was unable to provide therapy services to all residents as ordered beginning in February 2023, after the previous therapy director left. He confirmed a resident left the facility against medical advice due to the lack of therapy services. Associate administrator stated the facility held interdisciplinary meetings daily in the morning and weekly interdisciplinary meetings on Wednesdays, to increase awareness of what was happening in the facility. He stated he informed upper leadership and the medical director of the lack of therapy services as ordered and he was "pushing to correct it." Associate administrator confirmed the facility did not develop or implement an action plan to correct the problem beyond informing corporate executives, nor were there efforts to contract with other companies to ensure services were provided. He confirmed he was aware the facility continued to admit new residents from the hospital who required therapy services. He stated he would have to speak with leadership to determine if the facility should stop taking new admissions who required therapy;	F 865		

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F 865	Continued From page 58 however, indicated he had not yet discussed that option with leadership. He indicated the QAPI committee discussed the lack of therapy services in every QAPI meeting with the medical director, however the therapy services director did not attend QAPI meetings. Associate administrator confirmed the QAPI committee meeting minutes lacked discussions of the lack of therapy services or development of an action plan to correct the problem. The QAPI Plan (undated) included the facility would develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. Included it would help departments, consultants, and ancillary services which provided direct to indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability. The QAPI Program dated February 2020, indicated the QAPI plan included identifying and prioritizing quality deficiencies, developing and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities.	F 865		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		7/28/23

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F 880	Continued From page 59 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 60 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was completed during nursing cares for 1 of 4 residents (R7) reviewed for medication administration and catheter cares. Findings include: R7's quarterly Minimum Data Set (MDS) dated 4/28/23, indicated R7 was cognitively intact, had an indwelling catheter and diagnoses of diabetes and urinary tract infections. An observation on 5/31/23 at 8:08 a.m., trained medication assistant (TMA)-A entered R7's room to obtain a blood glucose and vital signs before administrating R7's medications. Hand hygiene	F 880	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to	

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F 880	Continued From page 61 was performed upon entering R7's room. A blood pressure cuff was placed on R7's left arm and machine started. TMA-A then donned gloves and obtained R7's glucometer to obtain a blood glucose. After obtaining R7's glucose, TMA-A removed gloves and placed in garbage. Without first performing hand hygiene, TMA-A removed the blood pressure cuff from R7's arm and, removed a pen from her pocket to write down the blood pressure result. TMA-A then wrapped the cuff and line around the vital sign machine and obtained a pulse oximeter that was in the vital machine basket to obtain R7's pulse and oxygen saturations. After medications were administered, TMA-A performed hand hygiene upon exiting R7's room. When interviewed on 5/31/23 at 8:22 a.m., TMA-A acknowledged hand hygiene was not completed after obtaining R7's blood glucose and glove removal. TMA-A stated there was no hand sanitizer in R7's room and she forgot. TMA-A acknowledged hand hygiene should be completed after each glove removal. During an observation on 6/1/23 at 6:45 a.m., nursing assistant (NA)-D entered R7's room to assist with morning cares. R7 was sitting on his bed attempting to get shorts on. R7's catheter bag was laying on the floor next to him. NA-D made no attempt to remove R7's catheter bag from the floor. R7 requested lotion to be applied on his bottom and back. NA-D donned gloves and assisted R7 to stand with the walker and applied ointment. R7's catheter was left lying on the floor. R7 pulled the shorts up and sat back down on the bed. NA-D removed gloves, without performing hand hygiene and picked the up catheter bag and hung it from R7's walker. R7	F 880	the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F880 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure EAE staff use proper hand hygiene during nursing cares. -Residents residing in this facility who have care provided by EAE nursing staff have the potential to be affected if proper hand hygiene is not performed. -All EAE staff have received re-education on appropriate hand hygiene practice. -All EAE nursing staff have received re-education on catheter care, which includes, but is not limited to specifically the need to keep catheter tubing and drainage bags off the floor. -Hand hygiene and catheter care education will be provided using Monarch Healthcare Management Policy and Procedure -Monitoring to assure compliance will include, but is not limited to, audits completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice	

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F 880	Continued From page 62 requested catheter to be emptied. Without performing hand hygiene, NA-D donned gloves and unhooked R7's catheter and placed on the floor before obtaining a urinal from R7's bathroom. R7's catheter was emptied into a urinal and some spill was wiped with a resident bathing wipe. R7's catheter was placed in a dignity bag and hung back on the walker. NA-D emptied the urinal and removed gloves without performing hand hygiene. NA-D took some paper towels to wipe sweat from his face and without performing hand hygiene donned new gloves. NA-D assisted R7 to his wheelchair and putting on shoes. NA-D then collected dirty linen and garbage from R7's room before removing gloves and exiting the room without performing hand hygiene. When interviewed on 6/1/23 at 7:09 a.m., NA-D stated catheter bags could be set on the floor if there was no place to hang them. NA-D stated usually the catheter bag would be wiped with an alcohol wipe instead of a skin cleansing wipe, but NA-D did not have any with him and further stated the catheter was still cleaned. NA-D acknowledged not performing hand hygiene in between glove use and further stated it was not necessary as "gloves keep hands clean". When interviewed on 6/1/23 at 12:03 p.m., the Director of Nursing (DON) expected staff to complete hand hygiene between glove changes or after glove removal. The DON also expected resident catheters to be hanging and off the floor during cares. The DON further stated these steps were all important to minimize risk of infection to the residents. A facility policy titled Catheter Care revised	F 880	will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed on or before 7/28/23.	

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F 880	Continued From page 63 9/2014, directed staff to ensure catheter tube and drainage bag are kept off the floor. A facility policy titled Handwashing/Hand Hygiene revised 8/2019, directed staff to use an alcohol-based hand rub or soap and water after glove removal. Furthermore, the policy directed the use of gloves does not replace hand washing/hand hygiene.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/30/2023. At the time of this survey, The Estates At Excelsior was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 07/01/2023

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Estates at Excelsior is a 1-story building with a partial basement that was built in 1962 and was determined to be of Type II(222) construction. The facility is divided into four smoke compartments. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that are monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 56 beds and had a census of 31 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		7/28/23

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THE ESTATES AT EXCELSIOR LLC	**515 DIVISION STREET** **EXCELSIOR, MN 55331**

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K 321	Continued From page 3 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 8.4.3.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 05/30/2023 between 12:30 PM and 02:30 PM, it was revealed by observation that the door to the laundry room in the basement did not fully close or latch when testing the automatic closing device. An interview with the Regional Maintenance Director, Associate Administrator, and Maintenance Director verified this deficient finding at the time of discovery.	K 321	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. K321 s/s D -During the walk-through it was observed that the door to the laundry room did not fully close and latch when tested. -In the event of an emergency, all occupants have the potential to be affected if this regulation is not met. -Maintenance Supervisor has been re-educated to the requirements and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/30/2023**

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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K 321	Continued From page 4	K 321	identified area has been corrected. - Audits will be completed weekly for four (4) weeks, and monthly thereafter for two (2) months. Any deficient practice will be immediately corrected, and results will be reported to QAPI. -Maintenance Director or Designee is responsible party -Corrective action will be completed on or before 7/28/23.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918		7/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/30/2023**

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THE ESTATES AT EXCELSIOR LLC	**515 DIVISION STREET** **EXCELSIOR, MN 55331**

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K 918	Continued From page 5 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.1, 8.4.2.4, 8.4.9, 8.4.9.5.1, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 05/30/2023 between 12:30 PM and 02:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that they have tested their EPSS for 4 hours within the last 36 months. 2. On 05/30/2023 between 12:30 PM and 02:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that they completed any weekly inspections of their emergency generator from June 2022 through January 2023. 3. On 05/30/2023 between 12:30 PM and 02:30 PM, it was revealed by a review of available	K 918	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245332	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/30/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 6 documentation that the facility could not provide documentation showing that they completed the required monthly testing of their emergency generator during December 2022 and January 2023. An interview with the Regional Maintenance Director, Associate Administrator, and Maintenance Director verified this deficient finding at the time of discovery.	K 918	K918 s/s F -The process for satisfying this requirement has been reviewed and revised as needed to ensure the emergency generator is tested, inspected, and documentation demonstrates compliance with the regulation. -The Maintenance Director has been educated to the requirement -The Maintenance Director is documenting both testing and inspections per the regulation. This is corrected. - Audits will be completed weekly for four (4) weeks, and monthly thereafter for two (2) months. Any deficient practice will be immediately corrected and results will be reported to QAPI. -Maintenance Director or Designee is responsible party -Corrective action will be completed on or before 7/28/23.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 14, 2023

Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

RE: CCN: 245332
Cycle Start Date: June 2, 2023

Dear Administrator:

On August 14, 2023, we notified you a remedy was imposed. On September 6, 2023 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 1, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 2, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 23, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 2, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 1, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 14, 2023

Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

RE: CCN: 245332
Cycle Start Date: June 2, 2023

Dear Administrator:

On June 23, 2023, we informed you that we may impose enforcement remedies.

On August 3, 2023, the Minnesota Department(s) of Health and Public Safety completed a revisit/survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

K0321 -- S/S: D -- NFPA 101 -- Hazardous Areas - Enclosure Bld: 01

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 2, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 2, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 2, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial

compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 2, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Excelsior Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 2, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 2, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us