Electronically delivered
December 28, 2020

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

RE: CCN: 245332
Cycle Start Date: December 8, 2020

Dear Administrator:

On December 8, 2020, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On November 30, 2020, the situation of immediate jeopardy to potential health and safety cited at F880 was removed.

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 listed below to the CMS Region V Office for imposition. 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 $11,160; 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.

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

DEPARTMENT CONTACT

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

Sarah Grebenc, 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: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@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, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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 12/08/2020

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 A COVID-19 Focused Infection Control survey was conducted on 12/08/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility is in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 12/08/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. As a result, a deficiency was cited at F880. The following complaint was found to be SUBSTANTIATED: H5332053C/MN00067647. The COVID-19 Focused Infection Control survey resulted in an Immediate Jeopardy (IJ) at F880 on 11/23/20, when it was identified the facility failed to follow the Centers for Disease Control (CDC) guidelines for co-horting to prevent and/or minimize the transmission of COVID-19. The facility failed to separate roommates, when other rooms were available and when one roommate was COVID-19 positive and the other negative. The facility implemented corrective action on 11/30/20, and F880 is being issued at past non	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/30/2020

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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F 000	Continued From page 1 compliance. There was no finding of substandard quality of care (SQC) therefore an extended survey was not conducted. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000		
F 880 SS=J	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 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,	F 880		12/30/20

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F 880	Continued From page 2 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. (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.	F 880		

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F 880	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 when the facility failed to separate COVID positive residents from COVID negative residents resulting in an immediate jeopardy (IJ) due to the increased risk for transmission of COVID-19 for 2 of 2 residents (R1, R2) reviewed for infection control practices. The deficiency was identified as past noncompliance and issued at Immediate Jeopardy. The past noncompliance IJ began on 11/22/20, was removed and the deficient practice was corrected by 11/30/20, after the facility implemented corrective action to prevent reoccurrence. The administrator and director of nursing (DON) were notified of the IJ past noncompliance on 12/8/20, at 3:28 p.m., as a result of the corrective action taken by the facility. Findings include: Current CDC guidance last updated 11/20/20, indicated nursing home residents are at high risk of being affected by respiratory pathogens like COVID-19 due to older age and underlying chronic medical conditions. Residents with known or suspected COVID-19 should be placed in a private room with their own bathroom. Residents with COVID-19 should be cared for in a dedicated unit or section of the facility with dedicated staff. R1's admission Minimum Data Set (MDS) assessment dated 10/08/20, indicated R1 had	F 880	Past noncompliance: no plan of correction required.	

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F 880	Continued From page 4	F 880		

diagnoses that included urinary tract infection, polyneuropathy, pressure ulcer of sacral region and COVID-19. R1's COVID-19 polymerase chain reaction (PCR) test result dated 11/17/20, indicated R1 was positive for COVID-19.

R2's admission MDS dated 09/03/20, indicated R2 had a Brief Interview of Mental Status (BIMS) score of 13 out of 15 (which indicated intact cognition), had diagnoses that included heart failure and nodular sclerosis Hodgkin lymphoma. R2's COVID-19 PCR test result dated 11/17/20, indicated R2 was negative for COVID-19. These comorbidities placed R2 at significant risk for complications if R2 were to contract COVID-19.

During interview on 12/08/20, at 10:35 a.m. registered nurse (RN)-A stated she cared for R1 and R2. R1 tested positive for the COVID virus on 11/17/20. R2 tested negative for the COVID virus on 11/17/20. R1 was symptomatic and lethargic. RN-A stated that because R1 and R2 were roommates when COVID testing took place, they continued to reside in the same room. R1 and R2 shared commode in their room. R1 needed complete physical care and did not use a commode.

During observation on 12/08/20, at 9:55 a.m. surveyor entered R1 and R2's room. R1's bed was against the wall that faced the window. There was a space of about 6 feet between R1's bed and the door that led to the bathroom. The bathroom door was closed. R2's bed was against the wall that faced the door. The head of the bed was toward the door.

During interview with R2 on 12/08/20, at 10:01 a.m. R2 stated that she was unhappy to be in the

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F 880	Continued From page 5	F 880		

room. She did not like to use the same commode with R1 and did not know why she had to stay with R1 when she was COVID-19 positive. R2 stated that she asked to be moved to different room but none had responded to her request.

During interview with R1 on 12/08/20, at 10:05 a.m. R1 stated that she was tested COVID-19 positive and had headache, coughing. R1 confirmed she and R2 stayed together in the same room the whole time she was sick.

During interview on 12/08/20, at 10:42 a.m. DON stated as far as she knew, R1 and R2 would continue to be roommates since R1 was no longer in quarantine period even though R1 was COVID-19 positive and R2 was COVID-19 negative.

During interview on 12/08/20, at 10:57 a.m. the DON and administrator stated they just overlooked R2. They did not realized she was COVID-19 negative and her roommate was COVID-19 positive.

During interview on 12/08/20, at 10:57 a.m. the administrator confirmed the COVID-19 policy indicated COVID-19 positive residents ideally would be moved to a private room with a private bathroom. However, she admitted that they overlooked and missed R1 and R2's situation. The administrator confirmed at the time of the onsite visit (12/8/20) there were no COVID positive residents.

The CDC People with Certain Medical Conditions, revised November 2, 2020, identified adults with certain underlying medical conditions such as kidney disease, diabetes, or lung disease, are at

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F 880	Continued From page 6	F 880		

increased risk from the virus that causes COVID-19. Severe illness from COVID-19 is defined as hospitalization, admission to the ICU, intubation or mechanical ventilation, or death.

The immediate jeopardy (IJ) that began on 11/22/20, was removed on 11/30/20, when the facility took steps to remove the IJ and correct the deficient practice. The policy entitled Coronavirus COVID-19 updated 11/24/20, was revised to include if a resident was COVID positive, they would be moved to a private room with a private bathroom. On 11/30/20, a quality assurance performance improvement committee (QAPI) met and put a plan of correction in place. Those in attendance of the QAPI meeting included; DON, activity director, social services director, administrator, recreation services director, maintenance director and business office manager. The plan identified if a resident was diagnosed with COVID they would be moved to a private room with a private bathroom and to prevent reoccurrence, weekly audits would also be completed. The plan also identified before new residents were admitted, the facility would reserve 2 empty rooms for new positive residents. The staff who attended the QAPI meeting (administrator, DON, social services, director, activity director, director of maintenance and business office manager) were interviewed on 12/8/20, and all verified they developed a plan and audit tools and identified positive residents should not cohort together and a positive resident should be in private room. Licensed practical nurse (LPN)-B, who works evenings and weekends, was interviewed on 12/8/20, at 1:06 p.m. and verified residents who were COVID positive should not share and room and should be in a private room with a private bathroom.

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F 880	Continued From page 7 Review of the audit tool identified the date a resident were diagnosed as COVID positive and if they were in a private room or not. Review of all resident's polymerase chain reaction (PCR) tests also identified there were no COVID positive residents with COVID negative residents in the same room.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 28, 2020

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

Re: Event ID: RYXX11

Dear Administrator:

The above facility survey was completed on December 8, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

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	00988	A. BUILDING: _____ B. WING _____	C 12/08/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/08/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED: H5332053C/MN00067647.	2 000		

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

Electronically Signed | 12/30/20

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2 000	Continued From page 1 NO licensing orders were issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		