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 Therefore, the NATCEP prohibition is rescinded.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

September 14, 2023

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

Re: Reinspection Results
Event ID: 55I512

Dear Administrator:

On September 6, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 11, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 24, 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 informed you of imposed enforcement remedies.

On August 11, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Mandatory denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (b), effective September 2, 2023, will remain in effect. (42 CFR 488.417 (b)

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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.

As we notified you in our letter of June 23, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 2, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 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.

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/ 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 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.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 24, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 55I511

Dear Administrator:

The above facility was surveyed on August 8, 2023 through August 11, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Please feel free to call me with any questions.

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 08/11/2023

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
F 000	INITIAL COMMENTS On 8/8/23 to 8/11/23, a standard abbreviated survey was conducted at your facility. 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. H53324146C (MN00095641) with a deficiency issued at (F553, F550, F692) H53324326C (MN00095730) H53324327C (MN00095382) with a deficiency issued at (F553, F558) H53324505C (MN00095914) 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 that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		9/1/23

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

Electronically Signed | 08/29/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to ensure timely resolution of missing personal property for 3 of 3 residents reviewed (R1, R5, and R7) for resident rights.	F 550	R1's missing personal property has been located/replenished. R1's Lost/Missing/Damage Items form has been completed. R5 has discharged from the facility. R7's missing personal property has been located/replenished. R7's	

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F 550	Continued From page 2 Findings include: R1's admission Minimum Data Set (MDS) dated 7/6/23, showed an admission date of 6/30/23, with diagnoses including stroke, and paralysis on one side of body. The MDS indicated R1's intact cognition. R5's admission MDS dated 6/30/23, showed an admission date of 6/27/23, diagnoses including septicemia, urinary tract infection, and depression. The MDS indicated that R5 has moderate cognitive impairment. R7's annual MDS dated 7/27/23, showed diagnoses including dementia, anxiety disorder, and depression. The MDS indicated R7 has moderate cognitive impairment. During interview on 8/8/23 at 3:15 p.m., R1 stated he was admitted to the facility on 6/30/23 and brought in some clothes that went missing for more than a month now. R1 stated he was told these might be downstairs but that he could not go there to find them himself. The facility's log for residents' missing items showed in a document titled, Lost, Missing, and Damaged Items, which indicate some residents reported the missing items, however, remain unresolved, as follows: 1. R1 had six pairs of long pajama pants (blue and black), two pairs of boxer shorts, a pair of jeans, and socks that were reported missing on 7/8/23. The estimated value of the items were noted to be $200. 2. R5 had plain-colored short-sleeved shirts	F 550	Lost/Missing/Damage Items form has been completed. Other residents have been interviewed/asked about missing personal property, no other residents have identified missing items. Facility reviewed lost/missing/damaged items forms which are all completed in their entirety. The Facilities policy on Lost, Missing and Damaged Items has been reviewed and remains current. Staff education initiated to facilities Lost, Missing and Damaged Items policy. The facility will complete audits of 3 lost, missing and damaged items form weekly for 4 weeks, then monthly for 3 months, then PRN based on audit findings. The facility will complete 3 resident interviews regarding any missing personal items weekly for 4 weeks, then monthly for 3 months, then PRN based on audit findings. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Social Services or designee will be responsible party.	

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F 550	Continued From page 3 (charcoal, black, dusty blue, and white), athletic pants (U of M fleece pants), four pairs of t-shirt material and underwear. Those missing items were reported on 7/24/23. 3. R7 reported two pairs of leggings, several long sleeve and short sleeve shirts missing on 7/12/23. On 8/11/23 at 2:15 p.m., the administrator verified that the residents' missing items had not been located and there was lack of evidence to show that residents had been updated regarding the status of their missing items or reimbursed. The policy titled, Lost, Missing, and Damaged Items, revised on 2/23, noted for its purpose, "Any resident, resident representative, who has items missing or damaged will bring it to the attention of the Center may file missing or damaged report so that it can be investigated and resolved." The policy indicates that the grievance process will be followed to determine appropriate next steps. The policy also indicates the administrator or designee shall investigate to determine the details involved with the missing/damaged item, and the administrator shall respond to the owner/resident representative of the missing item regarding the investigation outcome and the suggested resolution within 5 business days of receiving the reports. The facility also provides that if the identified item was damaged due to the fault of the facility, it can be replaced by the facility. The policy further provides that the resident has the right to receive a written explanation of the investigation.	F 550		
F 553 SS=D	Right to Participate in Planning Care	F 553		9/1/23

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F 553	Continued From page 4 CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on interviews and documents review, the facility did not ensure participation in care planning for 1 of 5 residents (R1) whose input	F 553	R1's bathing preference and frequency has been obtained and is reflected on resident's care plan. R1 and his wife, will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE ESTATES AT EXCELSIOR LLC	515 DIVISION STREET EXCELSIOR, MN 55331

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F 553	Continued From page 5 preferences were not reflected in the care plan. In addition, the facility did not ensure completion of care plan by all members of the interdisciplinary team (IDT) and the facility did not ensure residents understood and acknowledged the care plan for 5 of 5 residents (R1, R2, R3, R4, and R5) reviewed for care plan. Findings include: R1's admission Minimum Data Set (MDS) assessment dated 7/6/23, indicated an admission date of 6/30/23. The MDS listed R1's active diagnoses including stroke, paralysis on one side of the body, depression with intact cognition. The MDS also indicated R1 needed extensive assistance with one-person physical assistance for personal hygiene and dressing, and R1 was totally dependent on staff for bathing. R1's care plan identified focus areas that include the following: - Self-care deficit related to hemiplegia (paralysis on one side of the body). The interventions include providing 1-person assistance with bathing, dressing, and personal hygiene. In addition, the document titled, "X-retiring MHM [Monarch Health Management] IDT [interdisciplinary team] Care Conference Form V-3-Copy" indicated a care conference effective 7/10/23 was completed for R1. The document noted the following: shower, any time of the day, and on a once-a week basis. During interview on 8/8/23 at 3:15 p.m., R1 indicated non-involvement in planning his care. R1 stated he was told he could only have one shower per week, which was scheduled every	F 553	be informed of future care conferences. R1, R2, and R3 have completed care plans and have had their care plans reviewed with them and/or responsible party. R4 and R5 have discharged from the facility. Other residents have been asked their bathing preference and frequency. These preferences have been added to residents care plan. Other residents and/or responsible party will be informed of future care conferences. Other residents have been offered to review and acknowledge their care plan. The facility has reviewed the Minnesota Department of Health (MDH) Combined Federal and State Bill of Rights. Staff education initiated on MDH Combined Federal and State Bill of Rights specific to Planning and Implementing Care and Self-Determination The facility will complete audits of 3 care plans to ensure completion by IDT weekly for 4 weeks, then monthly for 3 months, then PRN based on audit findings. The facility will complete audits of 3 IDT Care Conference Forms to ensure care plan was offered to view/sign the care plan weekly for 4 weeks, then monthly for 3 months, then PRN based on audit findings. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Social Services or designee will be responsible party.	

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 08/11/2023

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F 553	Continued From page 6 Friday. R1 also stated his wife wanted to be physically present during care conference but the facility did not inform him or his wife about a schedule for a care conference. Instead, the facility called his wife during the time and day of the conference and left a voice message. During interview on 8/10/23 at 7:31 a.m., family member (FM)-A stated R1 was a clean person whose routine in the mornings included taking showers. FM-A stated that at the facility, R1 was not groomed well because the facility only provides one shower per week regardless of the weather temperature. FM-A indicated the facility had not asked R1's preference for bathing or offered additional days despite his requests. FM-A confirmed she had "played phone tag" with Care Coordinator (CC) and was not informed in advance regarding the schedule of R1's care conference even though she wanted to attend. During interview on 8/9/23 at 2:35 p.m., nursing assistant (NA)-A stated only two or three residents have more than one shower in a week. NA-A stated that based on the care sheet document, R1 was being given only one shower each week. During interview on 8/11/23 at 12:01 p.m., the CC stated she participates in care plan development for residents. The CC acknowledged that the facility standard was to give residents one shower per week. The CC also acknowledged she did not ask R1 regarding his bathing preferences, thus, R1 did not have an input on how his bathing schedule was set up. R1's admission care conference effective 7/10/23, showed that R1 was not given the	F 553		

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F 553	Continued From page 7 opportunity to review and acknowledge the care plan. The care plan also showed that social services did not complete and acknowledge his/her part of the care plan. R2's quarterly care conference effective 6/14/23, showed that the resident/responsible party were not given the chance to review and sign the care plan. The care plan also showed non-completion of the social services section. R3's R2's quarterly care conference effective 6/13/23, showed that the resident/responsible party were not given the chance to review and sign the care plan. The care plan also showed non-completion of the social services section. R4's admission care conference effective 7/5/23, showed that 5 did not have the opportunity to review and acknowledge the care plan. The care plan also showed that social services did not complete and acknowledge his/her part of the care plan. R5's admission care conference effective 7/3/23, noted that R5 did not have the opportunity to review and acknowledge the care plan. The care plan also showed that social services did not complete and acknowledge his/her part of the care plan. During interview on 8/11/23 at 2:14 p.m., the administrator and the DON acknowledged the importance of involving the resident and family related to assessments and care planning. The policy titled, Residents Rights, revised on 12/16, notes that the facility guarantees the rights of all residents of the facility, which include the	F 553		

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F 553	Continued From page 8 right to be notified of his medical condition, and of any changes in his or her condition, and to be informed of, and participate in his or her care planning and treatment. The policy titled, Care Planning, revised on 1/6/22, indicates that each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The policy's subsections titled, Baseline Care Plan and Comprehensive Care plan, notes that the interdisciplinary team will be involved in the development of the resident's care plan, and the resident and/or the resident representative will be provided with an opportunity to review and sign the care plan.	F 553		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to ensure resident call device was within reach and resident preference was respected for 1 of 3 residents (R2) observed for dignity. R2's quarterly Minimum Data Set (MDS) dated 6/2/23, indicated intact cognition. The MDS also indicated that R2 required extensive assistance	F 558	R2's call light was placed within reach. Other residents call lights are within reach. The facilities Call Light Policy has been reviewed and remains current. Staff education initiated on ensuring call light placement is within reach of resident. The facility will complete audits of 3	9/1/23

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F 558	Continued From page 9 with 2-person physical assistance for bed mobility, transfers, ambulation, and personal hygiene, and total dependence on staff for toilet use. R2's care plan identified self-care deficit related to fracture and schizoaffective disorder. The plan of actions included staff to help with transfers, ambulation, toilet use, bathing, dressing, and personal hygiene. On 8/8/23 from 1:55 p.m. to 2:34 p.m., R2's call button was observed lying on the floor and not within R2's reach. R2 stated she would call staff when she needed to use the bathroom. R2 stated, it takes "a long time" for staff to respond to her calls. R2 was unable to give a specific length of response time for call response, but R2 repeated, "a long time." During interview on 8/8/23 at 2:34 p.m., Nursing Assistant (NA)-B verified that the cord and button of R2's call device was on the floor and not within R2's reach. NA-B indicated that it was not a practice for staff to give or place the call button with in R2's reach, and NA-B said, "she can't use it." However, R2 retorted, "yes I can!" NA-B then stated, "she can but she does not use it." NA-B picked up the call button from the floor and tied it on R2's right bed rail. While surveyor and NA-B were still in R2's room, R2 reached for the call button and pushed it, demonstrating that indeed she knew how to use it. During interview on 8/9/23 at 8:37 a.m., Hospice Staff (HS)-B verified she used to visit and care for R2 at the facility. HS-B described R2 as having the ability to say what she needs.	F 558	residents call lights to ensure appropriate placement weekly for 4 weeks, then monthly for 3 months, then PRN based on audit findings. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Director of Nursing or Designee will be responsible party.	

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F 558	Continued From page 10 During interview on 8/9/23 at 3:00 p.m., NA-A indicated that R2 could communicate her needs. During interview on 8/9/23 at 3:23 p.m., NA-C stated she does not recall R2 asking help for bathroom use but that R2 would indicate if she needed something. The policy titled, Resident Rights, revised in 12/16, indicates that the facility guarantees the rights of all its residents, including the right to a dignified existence, be treated with respect, kindness, and dignity, and be free from abuse, and neglect.	F 558		
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.	F 692		9/1/23

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F 692	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to administer dietary supplements recommenced for 1 of 1 (R1) who was comprehensively assessed upon admission and received a recommendation to received nutritional supplements two times daily. Findings include: R1's admission Minimum Data Set (MDS) assessment dated 7/6/23, indicated an admission date of 6/30/23, with intact cognition. R1's care plan identified focus areas that included the following: - Potential for nutritional problem related to acute ischemic stroke as evidenced by weight loss prior to admission greater than 10 lbs. The interventions include monitoring for signs of malnutrition such as muscle wasting, significant weight loss of 3 pounds (lbs) in 1 week, above 5% in 1 month, above 7.5 % in 3 months, or above 10% in 6 months, obtaining weight per policy/order, and providing nutritional supplements 4 ounces two times a day with breakfast and lunch. Review of progress notes indicated: Progress notes: -8/7/2023, 12:50 p.m. Dietary Writer met with R1 this morning, R1 reports banana and mighty shake not available at b-fast. Staff report items scheduled for delivery this morning. Writer will update orders in PCC to offer ensure if mighty shake not available. Review of R1's Treatment Administration Record	F 692	R1 is receiving dietary supplements per physician order. Other residents assessed for dietary supplements are receiving them per physician order. The facilities Nutritional Supplements policy has been reviewed and remains current. Nursing staff initiated on flowing physician orders for dietary supplements. The facility will complete audits of 3 residents with dietary supplement orders to ensure they were provided per physician orders weekly for 4 weeks, then monthly for 3 months, then PRN based on audit findings. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Facilities current supply of nutrional supplements was reviewed and supply is on hand. The facilities ordering process was reviewed and current to ensure adequate inventory of supplements. Director of Nursing or Designee will be responsible party.	

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F 692	Continued From page 12 8/4/23 through 8/7/23, mighty shake was marked as administered despite the facility not having the supplement in stock. During interview on 8/8/23 at 3:15 p.m., R1 stated he believed he had lost weight since he moved to the nursing home from the hospital. R1 also stated that staff gave his protein supplement "sporadically" as he would not be given any some days but would be given two on other days. During interview on 8/10/23 at 7:31 a.m., family member (FM)-A stated they observed R1 to be "very skinny" and weak, and believed he had lost weight. FM-A stated R1 reported he was not getting his supplements consistently twice a day. During interview on 8/10/23 at 2:14 p.m., Kitchen Manager/Cook - KM-(A) confirmed they ran out of protein shake supplements starting on 8/4/23 through breakfast time on 8/7/23. KM-A stated they did not serve mighty shake supplement during that period.	F 692		

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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 8/8/23 to 8/11/23, a complaint survey was conducted at your facility by surveyor from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed. H53324146C (MN00095641) with a licensing order issued at (0555, 1805) H53324326C (MN00095730) H53324327C (MN00095382) with a licensing order issued at (0555, 1810) H53324505C (MN00095914) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interviews and documents review, the facility did not ensure participation in care planning for 1 of 5 residents (R1) whose input preferences were not reflected in the care plan. In addition, the facility did not ensure completion of care plan by all members of the interdisciplinary	2 555	Corrected.	9/1/23

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2 555	Continued From page 3 team (IDT) and the facility did not ensure residents understood and acknowledged the care plan for 5 of 5 residents (R1, R2, R3, R4, and R5) reviewed for care plan. Findings include: R1's admission Minimum Data Set (MDS) assessment dated 7/6/23, indicated an admission date of 6/30/23. The MDS listed R1's active diagnoses including stroke, paralysis on one side of the body, depression with intact cognition. The MDS also indicated R1 needed extensive assistance with one-person physical assistance for personal hygiene and dressing, and R1 was totally dependent on staff for bathing. R1's care plan identified focus areas that include the following: - Self-care deficit related to hemiplegia (paralysis on one side of the body). The interventions include providing 1-person assistance with bathing, dressing, and personal hygiene. In addition, the document titled, "X-retiring MHM [Monarch Health Management] IDT [interdisciplinary team] Care Conference Form V-3-Copy" indicated a care conference effective 7/10/23 was completed for R1. The document noted the following: shower, any time of the day, and on a once-a week basis. During interview on 8/8/23 at 3:15 p.m., R1 indicated non-involvement in planning his care. R1 stated he was told he could only have one shower per week, which was scheduled every Friday. R1 also stated his wife wanted to be physically present during care conference but the facility did not inform him or his wife about a schedule for a care conference. Instead, the	2 555		

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2 555	Continued From page 4 facility called his wife during the time and day of the conference and left a voice message. During interview on 8/10/23 at 7:31 a.m., family member (FM)-A stated R1 was a clean person whose routine in the mornings included taking showers. FM-A stated that at the facility, R1 was not groomed well because the facility only provides one shower per week regardless of the weather temperature. FM-A indicated the facility had not asked R1's preference for bathing or offered additional days despite his requests. FM-A confirmed she had "played phone tag" with Care Coordinator (CC) and was not informed in advance regarding the schedule of R1's care conference even though she wanted to attend. During interview on 8/9/23 at 2:35 p.m., nursing assistant (NA)-A stated only two or three residents have more than one shower in a week. NA-A stated that based on the care sheet document, R1 was being given only one shower each week. During interview on 8/11/23 at 12:01 p.m., the CC stated she participates in care plan development for residents. The CC acknowledged that the facility standard was to give residents one shower per week. The CC also acknowledged she did not ask R1 regarding his bathing preferences, thus, R1 did not have an input on how his bathing schedule was set up. R1's admission care conference effective 7/10/23, showed that R1 was not given the opportunity to review and acknowledge the care plan. The care plan also showed that social services did not complete and acknowledge his/her part of the care plan.	2 555		

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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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2 555	Continued From page 5 R2's quarterly care conference effective 6/14/23, showed that the resident/responsible party were not given the chance to review and sign the care plan. The care plan also showed non-completion of the social services section. R3's R2's quarterly care conference effective 6/13/23, showed that the resident/responsible party were not given the chance to review and sign the care plan. The care plan also showed non-completion of the social services section. R4's admission care conference effective 7/5/23, showed that 5 did not have the opportunity to review and acknowledge the care plan. The care plan also showed that social services did not complete and acknowledge his/her part of the care plan. R5's admission care conference effective 7/3/23, noted that R5 did not have the opportunity to review and acknowledge the care plan. The care plan also showed that social services did not complete and acknowledge his/her part of the care plan. During interview on 8/11/23 at 2:14 p.m., the administrator and the DON acknowledged the importance of involving the resident and family related to assessments and care planning. The policy titled, Residents Rights, revised on 12/16, notes that the facility guarantees the rights of all residents of the facility, which include the right to be notified of his medical condition, and of any changes in his or her condition, and to be informed of, and participate in his or her care planning and treatment. The policy titled, Care Planning, revised on	2 555		

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2 555	Continued From page 6 1/6/22, indicates that each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The policy's subsections titled, Baseline Care Plan and Comprehensive Care plan, notes that the interdisciplinary team will be involved in the development of the resident's care plan, and the resident and/or the resident representative will be provided with an opportunity to review and sign the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to plan of care. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are comprehensively developed, include resident preferences and ensure resident and designated IDT members are included in the care planning process. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by:	21805		9/1/23

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21805	Continued From page 7 Based on interview, observation and document review, the facility failed to ensure timely resolution of missing personal property for 3 of 3 residents reviewed (R1, R5, and R7) for resident rights. Findings include: R1's admission Minimum Data Set (MDS) dated 7/6/23, showed an admission date of 6/30/23, with diagnoses including stroke, and paralysis on one side of body. The MDS indicated R1's intact cognition. R5's admission MDS dated 6/30/23, showed an admission date of 6/27/23, diagnoses including septicemia, urinary tract infection, and depression. The MDS indicated that R5 has moderate cognitive impairment. R7's annual MDS dated 7/27/23, showed diagnoses including dementia, anxiety disorder, and depression. The MDS indicated R7 has moderate cognitive impairment. During interview on 8/8/23 at 3:15 p.m., R1 stated he was admitted to the facility on 6/30/23 and brought in some clothes that went missing for more than a month now. R1 stated he was told these might be downstairs but that he could not go there to find them himself. The facility's log for residents' missing items showed in a document titled, Lost, Missing, and Damaged Items, which indicate some residents reported the missing items, however, remain unresolved, as follows: 1. R1 had six pairs of long pajama pants (blue and black), two pairs of boxer shorts, a pair of	21805	Corrected.	

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21805	Continued From page 8 jeans, and socks that were reported missing on 7/8/23. The estimated value of the items were noted to be $200. 2. R5 had plain-colored short-sleeved shirts (charcoal, black, dusty blue, and white), athletic pants (U of M fleece pants), four pairs of t-shirt material and underwear. Those missing items were reported on 7/24/23. 3. R7 reported two pairs of leggings, several long sleeve and short sleeve shirts missing on 7/12/23. On 8/11/23 at 2:15 p.m., the administrator verified that the residents' missing items had not been located and there was lack of evidence to show that residents had been updated regarding the status of their missing items or reimbursed. The policy titled, Lost, Missing, and Damaged Items, revised on 2/23, noted for its purpose, "Any resident, resident representative, who has items missing or damaged will bring it to the attention of the Center may file missing or damaged report so that it can be investigated and resolved." The policy indicates that the grievance process will be followed to determine appropriate next steps. The policy also indicates the administrator or designee shall investigate to determine the details involved with the missing/damaged item, and the administrator shall respond to the owner/resident representative of the missing item regarding the investigation outcome and the suggested resolution within 5 business days of receiving the reports. The facility also provides that if the identified item was damaged due to the fault of the facility, it can be replaced by the facility. The policy further provides that the resident has the	21805		

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21805	Continued From page 9 right to receive a written explanation of the investigation. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents grievance and reporting of missing property is being investigated and responded to appropriately. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) property is maintained safely.. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on interview, observation and document review, the facility failed to ensure resident call device was within reach and resident preference was respected for 1 of 3 residents (R2) observed	21810	Corrected.	9/1/23

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21810	Continued From page 10 for dignity. R2's quarterly Minimum Data Set (MDS) dated 6/2/23, indicated intact cognition. The MDS also indicated that R2 required extensive assistance with 2-person physical assistance for bed mobility, transfers, ambulation, and personal hygiene, and total dependence on staff for toilet use. R2's care plan identified self-care deficit related to fracture and schizoaffective disorder. The plan of actions included staff to help with transfers, ambulation, toilet use, bathing, dressing, and personal hygiene. On 8/8/23 from 1:55 p.m. to 2:34 p.m., R2's call button was observed lying on the floor and not within R2's reach. R2 stated she would call staff when she needed to use the bathroom. R2 stated, it takes "a long time" for staff to respond to her calls. R2 was unable to give a specific length of response time for call response, but R2 repeated, "a long time." During interview on 8/8/23 at 2:34 p.m., Nursing Assistant (NA)-B verified that the cord and button of R2's call device was on the floor and not within R2's reach. NA-B indicated that it was not a practice for staff to give or place the call button with in R2's reach, and NA-B said, "she can't use it." However, R2 retorted, "yes I can!" NA-B then stated, "she can but she does not use it." NA-B picked up the call button from the floor and tied it on R2's right bed rail. While surveyor and NA-B were still in R2's room, R2 reached for the call button and pushed it, demonstrating that indeed she knew how to use it. During interview on 8/9/23 at 8:37 a.m., Hospice	21810		

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21810	Continued From page 11 Staff (HS)-B verified she used to visit and care for R2 at the facility. HS-B described R2 as having the ability to say what she needs. During interview on 8/9/23 at 3:00 p.m., NA-A indicated that R2 could communicate her needs. During interview on 8/9/23 at 3:23 p.m., NA-C stated she does not recall R2 asking help for bathroom use but that R2 would indicate if she needed something. The policy titled, Resident Rights, revised in 12/16, indicates that the facility guarantees the rights of all its residents, including the right to a dignified existence, be treated with respect, kindness, and dignity, and be free from abuse, and neglect. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		