Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 31, 2025

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

RE: CCN: 245332
Cycle Start Date: January 29, 2025

Dear Administrator:

On March 31, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 31, 2025

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

Re: Reinspection Results
Event ID: 1VQU12

Dear Administrator:

On March 31, 2025 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 January 29, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 14, 2025

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

RE: CCN: 245332
Cycle Start Date: January 29, 2025

Dear Administrator:

On January 29, 2025, 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 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.

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:

Terri Ament, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 April 29, 2025 (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 July 29, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

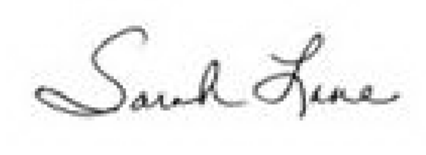
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



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Electronically delivered
February 14, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 1VQU11

Dear Administrator:

The above facility was surveyed on January 27, 2025 through January 29, 2025 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.

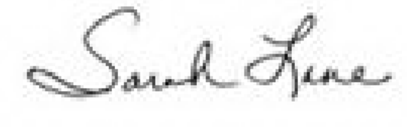
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Terri Ament, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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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 01/29/2025

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 1/27/25, through 1/29/25, 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: H53324702C (MN00109740) H53325300C (MN00109825) with a deficiency issued at F684. Deficient practice was identified related to incidental findings at F880. 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 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.	F 689		2/28/25

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

Electronically Signed | 02/18/2025

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 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the use of an air pressure redistribution mattress to aid in providing pressure ulcer relief for 1 of 3 residents (R1) reviewed for pain management. Findings include: R1's Face Sheet undated indicated R1 had the following diagnoses: hospice, history of cerebral infarction (stroke), peripheral vascular disease, adult failure to thrive and abnormal weight loss. R1's admission Minimum Data Set (MDS) dated 11/29/24 indicated R1 had moderate cognitive impairment, was dependent on staff for all activities of daily living (ADLs), required ongoing pain management and received hospice services. R1's care plan initiated 12/9/24 indicated R2 had an alteration in skin integrity related to peripheral vascular disease, adult failure to thrive, anorexia, and cerebral infarction (stroke). Interventions included pressure redistribution mattress to bed. R1's Wound Care note dated 12/3/24 indicated R1 was being seen for the evaluation and treatment recommendation of a Stage 3 pressure ulcer (a full-thickness tissue loss where subcutaneous fat is visible within the wound, but bone, tendon, or muscle are not exposed) to sacrum. R1 had complaints of pain with increased pressure. R1 reported relief with offloading (relieving pressure from the area). R1's wound orders included use of a pressure redistribution mattress.	F 689	The process for ensuring compliance with Accident Hazards/Supervision/Devices has been reviewed and revised to ensure staff properly implement the use of necessary supervision and assistance, including but not limited to pressure redistribution mattresses. R1 has since been discharged from the facility All residents with air mattresses have the risk of being impacted All necessary EAE staff have been educated on air mattresses. Audits will be completed two (2) times per week for two (2) weeks; one (1) time 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.¿¿	

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F 689	Continued From page 2 On 12/15/24 a progress note indicated R1 had a pre-existing wound to coccyx (sacral area). The area was cleansed and a dressing was applied. The pressure ulcer was noted to be bigger in size, and had more drainage compared to a few days ago. R1's heels were noted to be spongy, and protective boots were applied to both heels. On 12/20/24 a progress note indicated R1's sacral pressure ulcer was not improving, and there was black scab noted in the center of the pressure ulcer. The hospice case manager was called and reminded about the need for air mattress. On 12/21/24 a progress note indicated registered nurse (RN)-A had called hospice regarding R1's pressure ulcer, and the need to follow up with the delivery of the air mattress. On 1/29/25 at 7:10 a.m., RN-A stated R1's physician orders had included a air pressure redistribution mattress. He had called hospice on 12/20/24, and 12/21/24, because the facility had not received the air pressure redistribution mattress from hospice. It was not until a few days after 12/21/24, when the facility had found the air pressure redistribution mattress in R1's room. On 1/29/25 at 8:55 a.m., RN-B stated she was the nurse manager for the unit R1 was on throughout her stay. She was unaware the air pressure redistribution mattress was not on R1's bed. When the order was placed on 12/3/24 the air pressure relieving mattress should have been immediately implemented. An air pressure redistribution mattress was important for not only slowing the progression of a pressure ulcer, but also for comfort and pain relief.	F 689		

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F 689	Continued From page 3 On 1/29/25 at 10:33 a.m., the director of nursing (DON) stated her expectation was all medical provider orders were implemented immediately. She had been made aware of the order for the air pressure redistribution mattress on 12/9/24; however, she had not been updated by nursing staff it had not been implemented until after 12/21/24. The importance of implementing R1's air pressure redistribution mattress was for preventing worsening of R1's pressure ulcer. On 1/30/25, at 9:19 a.m., nurse practitioner (NP)-A verified she had ordered an air pressure redistribution mattress for R1 on 12/3/24. R1 was admitted to the facility with a non-healing pressure ulcer; however, the air pressure redistribution mattress was ordered for comfort and to aid with pain management. She had not been made aware of the delay in implementing the mattress. The facility policy Skin Assessment & Wound Management dated 3/19 directed the purpose of the policy was to provide guidelines for assessing and managing wounds. The policy's guidance for prevention included staff were to implement appropriate preventative skin measures. Examples include, but are not limited to-nutritional interventions, mobility and repositioning plan, pressure redistribution plan.	F 689		
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	F 880		2/28/25

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F 880	Continued From page 4 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 §483.71 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	F 880		

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F 880	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement appropriate personal protective equipment (PPE) to prevent the spread of infection for 1 of 1 residents (R2) observed for enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multi drug-resistant organisms that employs targeted masks, gown and glove use during high contact resident care activities). Findings include: Review of Centers for Disease Control and Prevention(CDC) guidance dated 4/2/24 Implementation of PPE Use in Nursing Homes to	F 880	The process for ensuring compliance with Enhanced Barrier Precautions (EBP) has been reviewed and revised to ensure staff properly implement Personal Protective Equipment (PPE) when caring for residents on EBP or other types of precautions. R2s EBP needs were evaluated by the clinical leadership and implemented as required. Residents residing in this facility who are on Precautions have the potential to be affected if this regulation is not met. Residents requiring EBP have appropriate signage posted on the door to their room indicating required precautions.	

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

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F 880	Continued From page 6 Prevent Spread of Multi drug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for EBP included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. Guidance also included EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status and an infection or colonization with an MDRO. R2's Face Sheet printed on 1/29/25, identified R2 had diagnosis including Clostridioides difficile (C.diff, a bacterium that causes an infection of the colon and large intestine), nephrostomy tube (a tube inserted through the skin to the kidney to drain urine), sputum culture positive for methicillin-susceptible Staphylococcus aureus (MSSA), human immunodeficiency virus (HIV) and septic shock. R2's Order Summary Report dated 1/29/25 identified R2 required wound care to coccyx region and left foot, nephrostomy flush and tube change every three days, and Daptomycin (antibiotic) administered via peripherally inserted central catheter (PICC) and PICC line dressing changes. The order summary report identified the following: staff to follow contact enteric precautions. R2's hospital Discharge Summary for 1/12/25 through 1/27/25, indicated R2 was admitted and treated for septic shock, influenza, MSAA, C-diff	F 880	All necessary EAE staff have received re-education on Enhanced Barrier Precautions using Monarch Healthcare Managements policy. Audits will be completed two (2) times per week for two (2) weeks; one (1) time 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.¿¿	

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 01/29/2025

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F 880	Continued From page 7 infection, and required ongoing antibiotic treatment via PICC line at the time of R2's discharge and readmission to the NH facility. On 1/29/25 at 10:02 a.m., nursing assistant (NA)-A and NA-B were observed in R2's room performing peri care. NA-A and NA-B both were observed to be wearing face masks and gloves. Neither NA-A nor NA-B were wearing gowns. NA-A verified R2 was on EBP per signage on door. NA-A further stated he knew he was required to wear a gown, gloves, and face mask; however, he did not have enough time to don all the required PPE at times. NA-A verified he had training related to proper donning and doffing of required PPE. On 1/29/25, at 10:05 a.m. registered nurse (RN)-A verified R2 required EBP per signage on door. R2 recently returned from a hospital stay for an infection, had a PICC line, and open wounds. When performing peri care, staff should wear a face mask, a gown and gloves. On 1/29/25 at 2:25 p.m., director of nursing (DON) verified R2 required EBP due to having a current infection, PICC line and open wounds. Signage was posted with instructions on the required PPE for those residents who were on EBP. All staff were to follow proper infection prevention which included wearing proper PPE to prevent the spread of infection to other residents as well as staff. The facility policy Enhanced Barrier Precautions revised 4/1/24, identified the facility would implement enhanced barrier precautions for prevention of transmission of multi drug-resistant organisms. Indicated EBP employed targeted	F 880		

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F 880	Continued From page 8 gown and glove use during high contact resident care activities which included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, wound care: any skin opening requiring a dressing. The policy further directed the facility to have gowns and gloves available near or outside of the resident's room; Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions and EBP would be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device was removed.	F 880		

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	00988	A. BUILDING: _____ B. WING _____	C 01/29/2025

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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 1/27/25, thru 1/29/25, a complaint survey was conducted at your facility by surveyors 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: H53324702C (MN00109740) H53325300C (MN00109825), with a licensing orders issued at 4658.0800 Subp. 1. 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 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 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		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement appropriate personal protective equipment (PPE) to prevent the spread of infection for 1 of 1 residents (R2) observed for enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multi drug-resistant organisms that employs targeted masks, gown and glove use during high contact resident care activities). Findings include: Review of Centers for Disease Control and Prevention(CDC) guidance dated 4/2/24 Implementation of PPE Use in Nursing Homes to Prevent Spread of Multi drug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove	21375	Corrected.	2/28/25

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21375	Continued From page 3 use for EBP included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. Guidance also included EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status and an infection or colonization with an MDRO. R2's Face Sheet printed on 1/29/25, identified R2 had diagnosis including Clostridioides difficile (C.diff, a bacterium that causes an infection of the colon and large intestine), nephrostomy tube (a tube inserted through the skin to the kidney to drain urine), sputum culture positive for methicillin-susceptible Staphylococcus aureus (MSSA), human immunodeficiency virus (HIV) and septic shock. R2's Order Summary Report dated 1/29/25 identified R2 required wound care to coccyx region and left foot, nephrostomy flush and tube change every three days, and Daptomycin (antibiotic) administered via peripherally inserted central catheter (PICC) and PICC line dressing changes. The order summary report identified the following: staff to follow contact enteric precautions. R2's hospital Discharge Summary for 1/12/25 through 1/27/25, indicated R2 was admitted and treated for septic shock, influenza, MSAA, C-diff infection, and required ongoing antibiotic treatment via PICC line at the time of R2's discharge and readmission to the NH facility.	21375		

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21375	Continued From page 4 On 1/29/25 at 10:02 a.m., nursing assistant (NA)-A and NA-B were observed in R2's room performing peri care. NA-A and NA-B both were observed to be wearing face masks and gloves. Neither NA-A nor NA-B were wearing gowns. NA-A verified R2 was on EBP per signage on door. NA-A further stated he knew he was required to wear a gown, gloves, and face mask; however, he did not have enough time to don all the required PPE at times. NA-A verified he had training related to proper donning and doffing of required PPE. On 1/29/25, at 10:05 a.m. registered nurse (RN)-A verified R2 required EBP per signage on door. R2 recently returned from a hospital stay for an infection, had a PICC line, and open wounds. When performing peri care, staff should wear a face mask, a gown and gloves. On 1/29/25 at 2:25 p.m., director of nursing (DON) verified R2 required EBP due to having a current infection, PICC line and open wounds. Signage was posted with instructions on the required PPE for those residents who were on EBP. All staff were to follow proper infection prevention which included wearing proper PPE to prevent the spread of infection to other residents as well as staff. The facility policy Enhanced Barrier Precautions revised 4/1/24, identified the facility would implement enhanced barrier precautions for prevention of transmission of multi drug-resistant organisms. Indicated EBP employed targeted gown and glove use during high contact resident care activities which included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters,	21375		

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21375	Continued From page 5 feeding tubes, tracheostomy/ventilator tubes, wound care: any skin opening requiring a dressing. The policy further directed the facility to have gowns and gloves available near or outside of the resident's room; Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions and EBP would be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device was removed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement measure to ensure infection control procedures, including enhanced barrier precautions are implented. The DON or designee could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		