DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: MP7T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00943

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245148**

2.STATE VENDOR OR MEDICAID NO.
(L2) **428658800**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT ST LOUIS PARK LLC**
(L4) **3201 VIRGINIA AVENUE SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **10/01/2017**

6. DATE OF SURVEY **05/16/2019** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **220** (L18)
13.Total Certified Beds **220** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	220			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

Reduction in the number of certified SNF/NF beds from 220 beds to 175 beds, effective July 15, 2019, in accordance with a change in licensure. Due to 45 beds being placed in layaway status (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective July 15, 2019, all 175 facility beds are certified SNF/NF. After this change they will have 45 beds on layaway.

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 06/18/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 06/18/2019 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/01/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/28/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 18, 2019

CMS Certification Number (CCN): 245148

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 31, 2019 the above facility is certified for:

220 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 220 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2019

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

RE: Project Number S5148029, H5148209C, H5148214C

Dear Administrator:

On May 16, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction for project numbers S5148029 and H5148209C and on May 31, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. On June 1, 2019 the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction for project number H5148214C. Based on our reviews, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MP7T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00943

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(L4) **3201 VIRGINIA AVENUE SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **10/01/2017**

6. DATE OF SURVEY **03/28/2019** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

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13.Total Certified Beds **220** (L17)

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	220			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date:
Rebecca Wong, HFE NE II 05/07/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 05/24/2019 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
03/01/1968
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 17, 2019

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

RE: Project Number S5148029, H5148205C, H5148206C, H5148207C, H5148208C, H5148209C, H5148210C, H5148211C

Dear Administrator:

On March 28, 2019, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the March 28, 2019 standard survey the Minnesota Department of Health, completed an investigation of complaint number H5148209 that was substantiated.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the March 28, 2019 standard survey, the Minnesota Department of Health completed an investigation of complaint numbers H5148205C, H5148206C, H5148207C, H5148208C, H5148210C, and H5148211C that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is May 7, 2019.

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.

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 a 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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 June 28, 2019 (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 September 28, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	**3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 3/25/19 through 3/28/19, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least	E 004		5/15/19

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

Electronically Signed | 05/02/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 004	Continued From page 1 annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the facility Emergency Plan was reviewed, and updated at least annually. This had the potential to affect all 150 residents who currently resided in the facility, along with staff who work in the facility. Findings include: During review of emergency action plan, it was revealed the Facility Plan was last reviewed on 1/11/18 by the former facility administrator. On 3/28/19, at 2:26 p.m. the facility administrator confirmed the plan was last reviewed on 1/11/18, and since then the plan had not been reviewed again to ensure it was effective in case there was an emergency. The administrator, stated she had started working at the facility, and this would be something she will have to do this year.	E 004	All residents have the potential to be affected. The facility Emergency Preparedness Plan was reviewed by the Administrator at QAPI on 4/24/19. The facility□s Emergency Preparedness Plan will be reviewed annually and on an as needed basis. The Emergency Preparedness Plan remains updated and current. All staff have been reeducated to the Emergency Preparedness Plan. The Administrator/designee will be responsible for the annual review of the Emergency Preparedness Plan. The facility QAPI will also review the Emergency Preparedness Plan annually for compliance.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]	E 039		5/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 2 (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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E 039	Continued From page 3 (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a full-scale community and/or individual facility based exercise to test their emergency preparedness program. This had the potential to affect all 150 residents who currently resided in the facility, along with staff who work in the facility. Findings include: During review of emergency action plan, last reviewed 1/11/18, it was revealed that the facility had not completed a table top or full scale community based emergency preparedness exercise, since the last survey dated 2/8/18, and the table top exercise completed on 11/13/17. On 3/28/19, at 2:26 p.m. the facility administrator confirmed that the facility had had not conducted any table top or full scale exercises in order to test the plan. The administrator, stated she had started working at the facility and this would be something she will have to do this year.	E 039	All residents have the potential to be affected. On 4/16/19 the facility activated the fire plan listed in the Emergency Preparedness Plan. Facility staff responded accurately and appropriately to a small fire that occurred on facility grounds outside. The facility contacted the Fire Department for this actual activation. A tabletop exercise is scheduled for June 5, 2019, in which the facility will participate in group discussion, using a narrated, clinically-relevant emergency scenario. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The Administrator/Designee will be responsible for compliance.	
F 000	INITIAL COMMENTS On 3/25/19-3/28/19 a standard survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found NOT to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		

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F 000	Continued From page 4 The following complaint was found to be substantiated: H5148209C: Deficiency issued at F tag#s F600 and F609. H5148210C: Not substantiated H5148208C: Not substantiated H5148207C: Not substantiated H5148206C: Not substantiated H5148205C: Not substantiated H5148211C: Not substantiated The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		5/15/19

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F 584	Continued From page 5 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide clean bed linen for 1 of 1 resident (R11) reviewed for concerns with soiled linen. In addition the facility identified environmental concerns in 11 third floor	F 584	All residents have the potential to be affected by this practice. R11□s soiled linens were changed and new linens put on his bed. R11□s linens will be changed on his bath day, during	

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F 584	Continued From page 6 rooms as well as 3rd floor common use areas which had the potential to affect all residents residing on the third floor as well as broken floor tiles and wall gouges in rooms 102 and 111 on the first floor. Findings include: On 3/27/19, at 7:45 a.m. R11 was observed to propel his wheelchair in the hallway to the dining room for breakfast. As R11 approached the surveyor he stated his linen was supposed to be changed the previous day but he did not believe it had been changed because the fitted sheet had a large dried yellow stain from the previous day. R11 stated underneath the half folded sheet in his bed was the yellow stain. -At 7:58 a.m. the fitted sheet was observed to have a large dried stain and on the half folded sheet in the middle of the bed was a brown stain. On 3/27/19, at 9:20 a.m. R11 was observed seated in a wheelchair in his room with the call light on. Licensed practical nurse (LPN)-F entered R11's room and R11 asked about getting his scheduled shower. LPN-F was observed standing right next to R11's bed then stated she was going to find out who was going to help him with that but did not offer to have the linen changed. -At 9:21 a.m. NA-M was observed to enter R11's room then immediately came out carrying a bottle of body shampoo. NA-M did not offer to change the linen or make the bed. On 3/27/19, from 10:00 a.m. to 10:28 a.m. R11 was observed in an activity in the dining room and the bed still remained unmade. On 3/27/19, at 10:28 a.m., R11 was observed to	F 584	room deep cleans by housekeeping, and as needed. For all other residents, audits were completed to ensure that their linens are changed on their bath days and as needed. The Alzheimer□s Care Unit dining room floor was stripped and waxed on 4/30/19. The facility dining rooms with floors that can be stripped and waxed will be stripped and waxed on a quarterly basis. These dining rooms are also deep cleaned per housekeeping□s scheduled deep cleans. All other dining room floors were audited and cleaned. The loose vent on ACU Dining Room was secured. All other vents in dining rooms were audited and any loose vents were secured. Fans on the ACU were dusted and cleaned. All facility fans were audited were cleaned. Room 378□s curtain was hung back up on the hooks and the night stand knobs were secured. R 397 was discharged from the facility on 4/19/19. Wheelchair cushions for all current residents were audited and cushions are cleaned. Wheelchair cushions are deep cleaned on the same day as the deep clean schedule for the individual resident rooms and as needed in between. Room 356□s privacy curtain was replaced. Privacy curtains were audited to ensure that they are clean and intact. Privacy curtains have been ordered through the vendor that supplies the curtains. Any privacy curtains needing replacement will be replaced upon	

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F 584	Continued From page 7 propel his wheelchair back to his room. R11 again approached surveyor and stated he had a shower. R11's bed remained unmade at this time and the brown stain on the sheet was visible from the hallway. On 3/27/19, at 11:11 a.m. R11 approached surveyor by the elevator and stated he had asked his fitted sheet to be changed but it had not happened. On 3/27/19, at 11:32 a.m. NA-M stated because of the staffing concerns on the unit the staff had to sometimes pick who was a priority to be assisted and things such as changing bed linen, emptying bedpans or urinals had to wait until there was time to be done and sometimes there was not time to get to it done because staff had to run the whole day. On 3/27/19, at 2:45 p.m. LPN-F verified the fitted sheet and top sheet were both soiled. LPN-F stated the linen was supposed to be changed as R11 had his shower that morning and the bed was supposed to be made by this time of the day. On 3/27/19, at 3:15 p.m. the director of nursing stated linen was supposed to be changed at least once weekly, more often if dirty, and on shower day the staff were supposed to change it immediately. Environmental observations were made on unit 3, the Alzheimers' Care Unit, (ACU) throughout the survey. A tour of the unit was made with the maintenance director and the environmental concerns were confirmed. The following environmental observations were	F 584	shipment received. Privacy curtains will be checked daily by the housekeeping staff. Room 348□s chair was a facility chair and was disposed of immediately. All other facility furniture was audited and cleaned or disposed of. Room 352□s radiator vent was secured. Radiator vents were audited in resident rooms and any radiator vents that were unsecured were secured. The tub room across from the nurse station on the ACU was cleaned out. A tub cover was implemented to ensure this is not used for storage. Tub cover will be removed when residents use the tub. Room 380□s mattress was replaced. An audit was completed to ensure that resident mattresses are free of stains and odors. Mattresses will be deep cleaned by the housekeeping staff per the deep clean schedule and as needed in between. Mattresses identified that need replacement will be communicated to Maintenance via the TELS work order system Room 382□s 3-drawer cabinet middle handle was secured. Walls in this room that were patched were also painted. Resident night stand drawers were audited for handles to be secured. Resident room walls were also audited to ensure that they are patched and painted. Room 383 walls were cleaned. The electrical outlet was replaced. All other rooms were audited and corrected. Room 381 bathroom door jam was repaired. Door jams were audited and corrected.	

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F 584	Continued From page 8 done on 03/27/19, at 8:33 a.m., the dining room heat vent along the outside wall was dirty the full length of the dining room with numerous gray dirty marks, dirt and debris had built up the full length of the vent between the wall and the vent, and the vent was loose. Both door jams going into the dining room had multiple gouged areas that were rough. The two fans had heavy built up dust on all the fan blades. In room 378, the window curtain was coming off the hooks, the three drawer stand by the bed upon entering the room had 1 of 3 knobs missing, and the wheelchair cushion for R397 was stained with a large round circle of brown dried on substance. In room 356, the privacy curtain had a large hole on the top of the curtain. In rooms 346 and 348, a shared common bathroom had five tiles below the sink in the corner missing. Room 348 had a large over stuffed chair that had a large area of dried on brown substance. In room 352 the radiator behind the bed by window radiator vent was loose. The tub room across from nursing station had used plastic gloves and hand wipes with brown material laying on the bottom of the tub. In room 380, the bed by the window, had the sheet off and the mattress was exposed. The mattress had a large circle area that was stained and had a strong urine odor. Nursing assistant, (NA)-E verified the observation and strong urine smell on 3/27/19, at 09:10 a.m. In room 382, the 3 drawer cabinet, middle handle	F 584	Room 377 wall was repaired. Resident Room walls were audited for necessary repairs and repairs have been completed. Water temperatures in the ACU shower room were checked and meets the regulation. Water temperatures in all shower rooms were audited to ensure compliance. The outdoor area near the ambulance entrance was cleaned on 4/26/19, the facility ordered a dumpster to throw large items away. Facility staff also did a facility grounds clean up. The facility will audit this daily to ensure compliance. The laundry lint receptacle has been replaced on 4/8/19. Room 102 had the tiles repaired. All other floor tiles were audited and corrections were made. Room 111□s wall behind headboard was repaired. A bumper was added to the wall for further wall protection. Resident rooms were audited to ensure walls were repaired. Policies and Procedures related to housekeeping and maintenance protocols were reviewed and remain appropriate. Staff have been reeducated to proper cleaning practices and reporting of maintenance and housekeeping issues. Staff have also been re-educated regarding the reporting of maintenance and housekeeping issues. Audits will be completed weekly to ensure compliance. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The Director of Maintenance and Director	

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F 584	Continued From page 9 was very loose and hanging. The walls by both beds had been patched but not painted. In room 386, the wall near the window had brown dried on stains and the bed sheet had brown stains on numerous areas. In room 383, the wall between the closet and bathroom had numerous marred dirty fray marks and electric outlet was broken. The wall with the clock near hallway had multiple marred and dirty gray areas on wall. Room 381 had a splintered wood door jam going into bathroom with rough edges. In room 377, the wall by door had a piece missing from the of wall board. On 3/27/19, at 9:51 a.m., the maintenance director toured unit 3 ACU and confirmed the above listed areas. During the tour, the maintenance director tried to fix the loose vent in the dining room and confirmed it was very loose and that a screw had popped out. The maintenance director stated that the vent was painted annually. In addition, he confirmed that there were multiple chips on the two door jams leading into the dining room from wheelchairs and stated that last week the walls in the resident's room were patched but they had not gotten around to painting at this time. While checking the water temperature in the shower room on advanced care unit (ACU), due to complaints from the residents of cold water in the shower, the maintence director noted that the toilet was leaking and indicated he needed to fix the toilet now and would get back to surveyor on the water temperature.	F 584	of Housekeeping will be responsible for compliance.	

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F 584	Continued From page 10 On 3/27/19, at 2:06 p.m., R99 was observed having a cigarette outside in the smoking area. There was an area across from the smoking area that had bed frames, book cases, and empty palates. R99 reported, "they just throw things out here and leave it there," and and further indicated staff should clean up the area after they throw things out from the area they are remodeling. On 3/25/19, at 11:45 a.m., an initial tour of the environment were conducted with the assistant director of culinary services. Observations of the dumpster area included two garbage dumpsters; one garbage dumpster had, what appeared to be, hundreds of white plastic used gloves, plastic med cups, broken plastic cups lying on the cement slab around the dumpster. The assistant director of culinary services stated, "this is terrible, it should be cleaned immediately, maintenance is responsible for it." The garbage area around the dumpsters was again observed on 3/27/19, at 2:08 p.m. with the maintenance director and although the area had been somewhat cleaned up there still remained some used plastic white gloves, plastic med cups, and broken plastic glasses. The maintenance director took a broom and started to sweep the debris off the cement slab. Adjacent to the smoking area on the outside of the building, was a black basket with a very large hole it and lint from the laundry dryers was escaping from the basket leaving piles of lint on the payment. The maintenance director said that he needed to replace the basket with a new one so that the dryer lint was contained.	F 584		

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F 584	Continued From page 11 The maintenance director was interviewed after completion of tour of the unit 3, ACU, and the outside of the building to include the smoking area and adjacent area to smoking section, and the dumpster areas. The maintenance director stated the facility used the The Equipment Life Cycle System (TELS) system for staff to report to maintenance issues in the environment that needed to be addressed. The TELS system was a software program that allowed staff to document environmental issues that go directly to the maintenance section for correction. On 3/25/19, 11:53 a.m. during the initial screening it was observed in room 102 there were three tiles broken with pieces missing. - At 4:03 p.m. in room 111 it was observed the wall behind the headboard of the bed had 2 large deep gouges in the sheetrock. The gouges exposed the white plaster. On 3/28/19, 11:53 a.m. the director of maintenance (DM) was shown the broken tiles in room 102 and stated he had a plan to use white epoxy to fill the holes in the tiles, explaining that the tiles could not be removed because they were asbestos tiles. After DM was shown the gouges in the wall in room 111 stated he had a plan to attach a bumper to the head boards of beds to keep them from hitting the wall, but has not had time to get the project started.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or	F 585		5/15/19

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F 585	Continued From page 12	F 585		

reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency,

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F 585	Continued From page 13 Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility	F 585		

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F 585	Continued From page 14 or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow up on resident concerns regarding missing items for 1 of 3 residents (R104) reviewed for grievances. Findings include: R104's Admission Record identified diagnoses that included: schizoaffective disorder and dementia. The quarterly Minimum Data Set (MDS) dated 2/22/19, identified R104 had severely impaired cognition, needed extensive one person staff assistance with activities of daily living and wore glasses. Nursing assistant care guide (undated) identified R104 wore glasses. Care plan with revision date of 8/16/18, indicated R104 had glasses but did not always use them. Family member (FM)-A was interviewed on 3/26/19, at 9:32 a.m. and stated R104's glasses were missing and he told staff but FM-A had not received any follow up. On 3/25/19, 3/26/19, 3/27/19, and 3/28/19, R104 was observed and did not wear her glasses.	F 585	All residents have the potential to be affected by this practice. R104□s glasses were found during the week of survey. R104□s care plan and nursing assistant team sheet was updated to reflect resident□s actions of misplacing her glasses and not keeping her glasses on her face all the time and for staff to look for glasses when she is not wearing them. R104□s responsible party was notified of risk and benefits of this by the Social Worker for 3rd floor and to discuss further preferences of resident□s use of her glasses. The facility has Grievance stations on each floor where grievance forms are available for residents, families, and staff to fill out and turn in to the Grievance Officer. Resident Council will be re-educated about the Grievance/Missing Items procedure at the next meeting in May 2019. The Policy and Procedure for Grievances and Missing Items was reviewed and remains appropriate. All staff were re-educated to the Grievance & Missing Items Policy and Procedure.	

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	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 585	Continued From page 15 Nursing assistant (NA)-K was interviewed on 3/28/19, at 9:08 a.m. and said that R104 wore glasses, did not have them on that day and thought they were in her drawer in her room. NA-L was interviewed on 3/28/19, at 9:12 a.m. and indicated that R104 did not wear glasses any more. Licensed practical nurse (LPN)-E was interviewed on 3/28/19, at 9:20 a.m. and said if a resident was missing an item, staff completed a missing item form and searched the resident's room to look for the item. LPN-E said R104 used to wear glasses and she recently got new glasses in January but they were missing. LPN-E said family and the staff came to the same conclusion that if R104 got another new pair of glasses they would get lost due to R104's dementia and other residents on the unit who have dementia who might take the glasses. LPN-E was not able to find documentation of that conversation. LPN-E said that there was no follow up in regard to R104's missing glasses. Social worker (SW)-A was interviewed on 3/28/19, at 10:05 a.m. and said family came to him a couple months ago about missing items but none of the items included glasses. SW-A explained that he would get involved to look for missing items when he was told by nursing staff or had a missing item form from staff or family. SW-A was not aware of R104's missing glasses until he was told that morning by LPN-E. SW-A said after he was told about the glasses, he went to look in R104's room and found the glasses under her bed. The director of nursing was interviewed on	F 585	The Grievance and Missing Items process will be audited weekly for 4 weeks, monthly for 2 months, QAPI will determine further auditing thereafter. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The Director of Social Services or designee will be responsible for compliance.	

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F 585	Continued From page 16 3/28/19, at 10:34 a.m. and indicated the process for missing items included staff would bring the missing item form to the morning meeting with department managers. Any staff can complete a missing item form and bring it to the nurse or social worker and staff will conduct a search.	F 585		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate and follow up on alleged abuse for 3 residents (R1, R28, R92), of 130 residents interviewed after an allegation of innapropriate touch occurred to R448. Findings include: Review of a facility report identified that on 2/15/19, an allegation was made by R448 that a contracted laundry worker (AP), made contact of	F 600	All residents have the potential to be affected by this practice. R 1, R 28, and R 92 were all interviewed during a facility wide interview with residents and staff regarding this incident. R1, R28, and R92 all identified they had allegations of unwanted inappropriate touch or conversation by the Alleged Perpetrator. The facility then followed up immediately for further support and continued the support ongoing with R1, R28, and R92 as part of the investigation.	5/15/19

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F 600	Continued From page 17 a sexual nature on the 2 North elevator. The incident was reported to the SA by SS-C for R448, on 2/15/19, at 12:45 a.m. and was also reported to the local police department. The report indicated the police interviewed the resident and the staff member. The AP was suspended and would not be allowed in the facility. On 2/19/19, at 3:24 p.m. the police investigator conducted a follow up phone call to the facility, and was informed that after the incident, as part of the investigation, skin inspections were conducted for residents unable to communicate, and an additional 130 residents, who were capable of communicating, were immediately interviewed by nursing and social services and there were similar stories with three additional residents. Residents R1, R28, and R92 were identified as potentially affected by the same AP and had not reported incidents to the facility when the alleged events occurred. Police investigator requested the investigations from the additional residents. R1's Admission Record identified R1 was alert and oriented and able to make her own needs known. Although R1's Care Plan dated 2/22/19, indicated Associated Clinic of Psychology (ACP) support groups surrounding alleged abuse as needed. ACP to remain available on call for consult and face to face meetings. Encourage peer interactions and support, the medical record lacked evidence the facility thoroughly investigated and followed up on the allegation of unwanted sexual touch for R1 after R1 reported this during the investigation for R448. R28's Care Plan dated 2/15/19, and revised	F 600	R1 was visited by the psychologist on 2/28/19 regarding the allegations and she informed the psychologist that she felt safe in the facility and when asked what more the facility could do, she gave a response unrelated to the incident. R1 was also interviewed by her Social Services Designee on 2/18/19 and didn□t report any concerns. Monitoring was in place for staff to document any adverse reactions to this event and were instructed to contact the MD if necessary. Progress notes from the time of the alleged incident until current show that the R1 does not show signs of distress. R1 has seen the psychologist weekly since the alleged incident and continues to see psychology. R1 also regularly interacts with the social services designee and nurse manager for her unit as evidenced by the progress notes in her chart. These notes were in the resident□s medical record at the time of survey. R1□s care plan was updated to include this incident. R28 was in fact followed up by the facility and psychology provider. In progress note dated 2/22/19, the Director of Social Services met and assessed this R28. Progress note stated Met with resident in common area. Resident involved/ affected by recent allegations regarding staff on 2/15/19. Was also in hospital for majority of this week and only returned to facility yesterday evening. W checked-in with resident regarding recent hospital stay and her depressive symptoms following recent allegations. Resident smiled and actively engaged W in casual conversation. W stated that he would like	

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F 600	Continued From page 18 2/22/19, indicated: ACP support groups surrounding alleged abuse as needed. ACP to remain available on call for consult and face to face meetings. Encourage peer interactions and support. When discussing abuse history staff were directed to validate feelings, employ active listening skills, encourage residents self awareness, and accommodate residents requests regarding safety. R28 was alert and oriented, able to make needs known and used a wheelchair for mobility. The medical record lacked evidence the facility thoroughly investigated and followed up on the allegation of unwanted sexual attention for R28 after F28 reported this during the investigation for R448. R92's Admission Record indicated she admitted on 3/28/18, with a history of medical issues, R92 used a wheelchair for mobility, and required one to two staff for assistance with daily needs. R92 had no documented instances of making unsubstantiated claims of abuse/neglect of any type. R92's care plan was not updated after the allegation of unwanted attention. The medical record lacked evidence the facility thoroughly investigated and followed up on an allegation of unwanted sexual attention for R92 after R92 reported this during the investigation for R448. R28 was interviewed during survey, on 3/28/19 at 11:28 a.m. R28 stated, "he (AP) asked me if I wanted to kiss him and I said no". Someone from facility came to talk with me, but never followed up. During interview with SS-C and RN-D on 3/28/19, at 11:37 a. m., stated R448 told a consistent story, from the first telling to SS, repeated to RN-D, repeated to the officer, and then again to	F 600	to complete PHQ-9 to assess resident□s depressive symptoms. Resident stated, "I am not depressed" and answered 0 to each question. Scoring 0/27 indicating minimal depressive symptoms. Resident re-iterated her story from last week and stated that she has felt supported by staff. W engaged resident in conversation and stated that W's door is always open if resident would like to talk. W spoke with resident regarding recent hospital stay and offered further validation and actively listened. Resident confirmed her understanding that she can reach out to W with any further concerns. SS will continue to follow and assist resident with emotional/ social support as appropriate. Will assess resident for on-going depressive symptoms as appropriate. R98 was also seen by psychology weekly after the alleged incident and currently maintains this support in addition to facility support. These notes were in the resident medical record at the time of survey. R28□s care plan was updated by the facility on 2/22/19 regarding this incident. This care plan entry was available and in the medical record during the time of the survey. R92 was seen by psychology providers on 2/18/19 for emotional support. Per interview with psychology regarding this allegation, she denies any concerns about this staff contact. She has no concerns about how staff responded to this incident and states she is fine. This note is currently in the resident□s medical record and was present in the record during the time of survey. R92□s care plan was	

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F 600	Continued From page 19 the officer for the recording. SS-C and RN-D stated they believed the assault occurred. SS-C and RN-D indicated R92 reported the alleged AP kept asking R92 about a boyfriend and that it made R92 uncomfortable. Regarding R28, SS-C and RN-D stated R28 went down by the laundry room to look for clothes, was touched inappropriately by the AP and told the AP to stop. R28 reported that it felt strange the AP had invited her into the laundry room, and asked if he could kiss her. SS-C and RN-D indicated R1 had an incident at the end of the hallway, and that AP made a comment and touched R1's breasts inappropriately. Another resident, R999, overheard R1 tell the AP to stop and when R999 came out of her room the AP was standing there. On 3/28/19, at 1:00 p.m. R92 was interviewed and stated: one of the laundry employees kept asking if she had a boyfriend, he just kept asking, he was persistent, and it made her feel uncomfortable. R92 stated this was an inappropriate setting for any employee to establish that kind of relationship. R92 stated she talked with SS-C who came around and did interviews on it. She stated she had not heard anything back, but did not see the AP anymore. The facility provided a background check for AP which was completed by JDP [national Employment Screening and Background Check Services], however the facility failed to have the required DHS [Department of Human Services} background check completed. 3/29/19, at 12:58 p.m. during a follow-up interview the administrator stated all four residents were included in the one investigation since it was all done by one guy. The administrator stated the	F 600	updated to include this incident. The Alleged Perpetrator was hired by the contracted housekeeping company did have a DHS Background Check completed on May 10, 2018 prior to working at the facility and the DHS background check showed he was cleared to work for this facility. The Alleged Perpetrator was removed from the facility on 2/15/19 and is terminated from employment. The entire investigation was sent to the assigned police investigator at the St. Louis Park Police Department on 2/22/19 by the facility. The investigator informed the facility that he and the MDH would be out to investigate this incident and conduct further interviews with the resident at the facility. The facility did not hear any feedback from the police department until March 2019 in which an investigator informed the facility that the police department was planning on closing the investigation and not further pursue any charges. Facility reports to the state agency per state and federal regulation. All future allegations and incidents will be reported to the state agency per the state and federal regulation. The Abuse Policy and Procedure was reviewed and remains current. Staff were re-educated regarding the Abuse Policy and timely reporting. The reports made to the state agency to ensure timely reporting will be audited weekly for 4 weeks, monthly for 2 months, and then the QAPI will determine the future audit schedule.	

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F 600	Continued From page 20 facility had not reported the events for the 3 additional residents (R1, R28, R92) who had reported alleged abuse by AP. 4/1/19, at 1:38 p.m. a voice mail was left for officer (PD)-2 at St. Louis Park Police Department (SLP-PD). On 4/2/19, at 8:55 a.m. officer PD-3 returned the phone call. He reviewed the investigation notes of SLP-PD and stated that no reports had been made for the three additional residents who alleged inappropriate touch or unwanted attention. Although the facility had conducted an investigation into R448's allegation, they failed to report to the state agency (SA) and conduct investigations for R1, R28, and R92 who also made allegations against the alleged AP. The facility abuse policy dated 12/18, indicated allegations of abuse would be promptly reported and then investigated, not later than 2 hours of alleged abuse. 1. to Ensure that residents are not subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the individual, family members or legal guardians, friends of other individuals or self-abuse. 2. To ensure that all incidents of alleged or suspected abuse/neglect are promptly reported and then investigated 3. To ensure that all incidents involving injures of unknown origin are promptly investigated to determine probable cause of unknown origin, injuries and are reported. 4. To identify and remedy any abusive situations. 5. To prevent injuries 6. To ensure that a complete review of existing	F 600	QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The Administrator or designee will be responsible for compliance.	

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F 600	Continued From page 21 incidents is documented. Suspected abuse shall be reported to the SA online reporting process not later than 2 hours after forming the suspicion of abuse.	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced	F 604		5/15/19

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F 604	Continued From page 22 by: Based on observation, interview and document review the facility failed to ensure 1 of 1 resident (R397) was free from the use of restraints. Findings include: R397's Admission Record indicated he admitted to the facility on 3/20/19, and included diagnosis of dementia and repeated falls. R397's care plan dated 3/21/19, identified a fall risk related to a history of falls and an alteration in mobility related to dementia with behavioral disturbance. During observation on 3/27/19, at 4:04 a.m., R397 was lying in bed. A plastic garbage can had been placed between the mattress and frame on R397's bed causing the mattress to curve upwards. The opposite side of the bed was placed against the wall. During interview on 3/27/19, at 4:09 a.m. nursing assistant (NA)-S stated R397 was new to the facility and stated he was resistive to cares. NA-S stated R397 was at risk for falls and stated he made attempts to stand up out of his wheel chair. When asked about the garbage can placed under the mattress, NA-S stated R397 "liked pulling on things" indicating R397 had placed the garbage can himself. NA-S stated he did not know how the garbage can came to be under the mattress. During interview on 3/27/19, at 1:38 p.m. licensed practical nurse (LPN)- E stated R397 was resistive to cares and tried to get up from his wheelchair. LPN-E stated R397 could bear weight but was weak and had been lowered to the floor by staff recently. LPN-E further stated R397 was not capable of picking up his garbage can and	F 604	All residents in the facility have the potential to be affected. R397 has discharged from the facility. A facility wide audit has been initiated to ensure that all residents are free from any form of physical restraint. The policy and procedure for restraints was reviewed and remains current. All staff with direct care responsibilities have been educated about the policy and procedure regarding restraint use. Audits will be conducted weekly for 4 weeks, then every month for 2 months to ensure residents are free from any type of physical restraint, and then QAPI will determine future auditing schedule thereafter and will provide redirection/recommendations based on existing audits. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The Director of Nursing/Designee will be responsible for compliance.	

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F 604	Continued From page 23 placing it between the mattress and the bed frame. During interview on 3/27/19, at 1:58 p.m. the director of nursing (DON) stated the unit nurse was primarily responsible for the care on each unit. In regards to the garbage can placed under R397's mattress, the DON stated, "I do not like that at all." A facility policy titled Restraints, dated 9/2011, indicated the facility recognized the importance of a resident's dignity and safety. Any form of restraint will not be the first intervention when meeting the needs of the resident and will be used as minimally as possible. The policy identified a physical restraint as any manual method or physical or mechanical device, material or equipment attached to or adjacent to a residents body that can not be removed easily and restricts freedom of movement.	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		5/15/19

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F 609	Continued From page 24 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report to the state agency (SA) and thoroughly investigate allegations of unwanted sexual attention for 3 of 130 residents (R1, R28, R92), failed to report alleged resident to resident abuse to the SA within 2 hours for one incident involving 2 of 3 residents (R98, R18) and failed to report timely an allegation of staff abuse for 1 of 7 residents (R23) reviewed for allegations of abuse. Findings include: Review of a Facility Report Summary identified an allegation of sexual touch had been reported to the SA by social services (SS)-C for an individual resident on 2/15/19, at 12:45 a.m., and also reported to the local police department. As a result, the alleged perpetrator (AP) was suspended and would not be allowed in the facility. In addition, as part of the investigation, nursing and social service staff interviewed 130 residents who were capable of communicating.	F 609	All residents have the potential to be affected by this practice. Investigations regarding the alleged incidents for R1, R28, R92, R98, R18, and R23 were thoroughly investigated by the facility per the state and federal regulation. Facility reports to the state agency per state and federal regulation. All future allegations and incidents will be reported to the state agency per the state and federal regulation. Resident Council was educated on Abuse Policy in the February 2019 Resident Council Meeting. The policy and procedure for Abuse Reporting was reviewed and remains current. Staff were re-educated regarding the Abuse Policy and timely reporting procedures. The reports made to the state agency will be audited weekly for 4 weeks, monthly for 2 months, and then the QAPI will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 609	Continued From page 25 Three additional residents (R1, R28, R92) reported incidents that occurred by the same AP. Although R1, R28 and R92 reported incidents of unwanted sexual attention to facility staff, the facility failed to report the allegations of innapropriate touch and/or innapropriate attention to the SA. R1's Admission Record identified she admitted on 12/12/16, with a history of DM II, bipolar disorder, mood affective disorder, anxiety disorder, PTSD, borderline personality disorder, stroke. R1 was alert and oriented and able to make her own needs known. The Care Plan dated 2/22/19, indicated ACP support groups surrounding alleged abuse as needed. ACP is to remain available on call for consult and face to face meetings. Encourage peer interactions and support. Although facility staff, during an investigation interview with R1, learned of R1's allegation of unwanted sexual touch by AP, the facilty did not contact the SA with the information. R28's Admission Record indicated she admitted on 7/20/18, with a history of respiratory failure, shortness of breath, morbid obesity, bipolar disorder severe with psychotic features, personality disorder. The Care Plan dated 2/15/19, and revised 2/22/19, indicated: Associated Clinic of Psychology (ACP) support groups surrounding alleged abuse as needed. ACP is to remain available on call for consult and face to face meetings. Encourage peer interactions and support. When discussing abuse history staff to: validate resident feelings, employ active listening skills, encourage residents self awareness, and accommodate residents requests regarding safety. R28 was alert and oriented, able to make needs known. During the	F 609	determine the future audit schedule. The Administrator or designee will be responsible for compliance.	

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F 609	Continued From page 26	F 609		

investigation interviews, facility staff interviewed R28 and learned of R28's allegation of unwanted attention by AP, however did not report to the SA.

R92's Admission Record indicated she admitted on 3/28/18, with a history of medical issues, R92 used wheelchair for mobility, and required one to two staff for assistance with daily needs. R92 had no documented instances of making unsubstantiated claims of abuse/neglect of any type. During the investigation interviews, facility staff interviewed R92 and learned of R92's allegation of unwanted attention by AP, however did not report to the SA.

During survey, on 3/28/19, at 11:28 a.m., R28 was interviewed and stated "he (AP) asked me if I wanted to kiss him and I said no". Someone from the facility came to talk with me, but never followed up.

On 3/28/19, at 11:37 a.m. during interview with SS-C and RN-D identified R92 reported the AP kept asking about a boyfriend and that made her uncomfortable. SS-C and RN-D stated R28 reported she went down by the laundry room to look for clothes, was touched inappropriately and told the AP to stop and R28 felt it was strange that the AP invited her into the laundry room, and he asked if he could kiss her. SS-C and RN-D identified R1 had an incident at the end of the hallway, that the AP made a comment and touched R1's breasts inappropriately; the conversation was overheard by another resident who heard R1 tell the AP to stop and saw the AP standing there.

On 3/28/19, at 1:00 p.m., during survey, R92 was interviewed and stated: one of the laundry

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	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 609	Continued From page 27 employees kept asking if she had a boyfriend, he just kept asking, he was persistent, and it made her feel uncomfortable. R92 stated this was an inappropriate setting for any employee to establish that kind of relationship. R92 stated she had not heard anything back from facility staff, but did not see him (AP) anymore. R92 stated she talked with SS-C who came around and did interviews on it. The facility provided a background check for AP which was completed by JDP [national Employment Screening and Background Check Services], however the facility failed to have the required DHS [Department of Human Services} background check completed. On 3/29/19, at 12:58 p.m. during a follow-up interview the administrator stated the facility had not reported the events for the 3 additional residents (R1, R28, R92) who had been allegedly abused by AP because it was the same AP. The facility abuse policy, allegations of abuse would be promptly reported and then investigated, not later than 2 hours of alleged abuse. Abuse Policy dated 12/18 1. to Ensure that residents are not subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the individual, family members or legal guardians, friends of other individuals or self-abuse. 2. To ensure that all incidents of alleged or suspected abuse/neglect are promptly reported and then investigated 3. To ensure that all incidents involving injures of unknown origin are promptly investigated to determine probable cause of unknown origin,	F 609		

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F 609	Continued From page 28	F 609		

injuries and are reported.
4. To identify and remedy any abusive situations.
5. To prevent injuries
6. To ensure that a complete review of existing incidents is documented.

Suspected abuse shall be reported to the SA online reporting process not later than 2 ours after forming the suspicion of abuse.

R98's annual Minimum Data Set (MDS) dated 1/18/19, indicated R98 had intact cognition.

On 3/25/19, at 3:51 p.m. when asked if he had any confrontations with other residents R98 stated, about two months ago R18 had assaulted him. R98 stated "he threatened me, I have told staff that he has threatened me, he said I was going to get you." R98 stated when staff asked him about it R18 had said he was sorry. R98 further stated "I keep out of his way. I am afraid of him. We sit at different tables and I make as much room away from him as possible, I am afraid the staff won't do anything."

During a review of the report submitted to the SA for the incident that occurred on 3/10/19, it was revealed the facility did not report the incident until 3/11/19, which was over the required 2 hours. The report indicated R98 had reported on 3/10/19, at 7:00 p.m. that his roommate, R18 had slapped him in the stomach. R98 stated he had found R18 on his side of their shared closet area and had told R18 to stay out of his side of the closet and R18 responded by slapping him in the stomach.

On 3/26/19, at 1:32 p.m. the administrator stated she had reported the resident to resident incident

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F 609	Continued From page 29 on 3/11/19, and not within 2 hours of being aware because the staff had called her and reported the incident and she had asked them to assess the resident and monitor both residents. The administrator also stated R98 had indicated he felt safe and had no injuries when he was assessed. The administrator further stated on 3/11/19, R98 had asked to be moved to a separate room and was appreciative when he moved from the room shared with R18. On 3/27/19, at 11:35 p.m. the administrator acknowledged the allegation should have been reported within 2 hours however she felt interventions had been put in place to protect R98 and that was why she had waited for the next day to report because R98 was protected. R23 was admitted to the facility 7/17/18, with diagnosis of sepsis, osteomyelitis, pressure ulcers and paraplegia. R23's quarterly MDS dated 1/8/19, indicated R23 was alert and oriented. During an interview on 3/25/19, at 6:49 p.m. R23 stated on 3/23/19, nursing assistant (NA)-D told him to "shut the **** up." R23 stated on 3/24/19, he tried to report it to licensed practical nurse (LPN)-C and was told it was too late. He was told he should have reported it earlier. At 6:51 p.m. R23 stated he felt abused by NA-D. On 3/25/19, at 7:07 p.m. the director of nursing (DON) and administrator were told about about R23's allegation. The administrator stated LPN-C called her on 3/24/19, at approximately 9:15 p.m. or 9:30 p.m. LPN-C reported R23 had told him NA-D had told him to "shut up." The	F 609		

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F 609	Continued From page 30 administrator stated she instructed LPN-C to call NA-D and interview NA-D about the allegation. The administrator added she decided not to report it to the SA, because LPN-C informed her R23 did not seem upset, fearful, or anxious about the incident. The administrator stated she did not think it was an abuse issue so she decided to investigate the allegation first before reporting it to the SA. On 3/26/19, 1:20 p.m. the Facility Reported Incident (FRI) was reviewed. The FRI report indicated the facility did not report the allegation until 8:09 p.m. on 3/25/19, after concern was again brought to the facility attention.	F 609		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		5/15/19

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F 625	Continued From page 31 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide notice of bed hold policy for 3 of 5 residents (R88, R123, R60) reviewed for hospitalization. Findings included: R88's medical record revealed R88 had a discharge return anticipated Minimum Data Set (MDS) dated 1/18/19. The medical record lacked documentation as to why R88 had been transferred. Further review of the interdisciplinary notes revealed a note dated 1/19/19, at 3:00 p.m. R88 had returned from the hospital accompanied by a transportation driver in her wheelchair. The medical record lacked documentation of a bed hold notice being provided to R88 and/or responsible representative. In addition, the medical record lacked documentation of staff calling R88 or the responsible person to discuss the bed hold notice following the transfer. On 3/27/19, at 10:53 a.m. the health unit coordinator (HUC) verified there was no bed hold provided for the hospital stay on 1/18/19. The HUC stated R88 was admitted to the hospital due to elevated creatinine and was taken from an appointment to the Emergency Department (ED). When asked what happened when residents	F 625	All residents who are transferred out of the facility have the potential to be affected. R88, R123, and R60 were all transferred out of the facility for hospitalizations. All residents willingly returned to the facility despite receiving the Bed Hold Policy Form. Bed hold choices will be offered to all residents and/or responsible parties when being transferred to a hospital. Staff will provide appropriate information to all the residents being offered a bed hold and response choice will be documented in the medical record. The Bed Hold Policy and form was reviewed and remains current. Appropriate staff have been educated on the Bed Hold Policy. Audits on this process will be completed weekly for 4 weeks, monthly for 2 months and then the QAPI Committee will determine further auditing schedules as necessary. Director of Social Services, Administrator, and the Admissions Coordinator or designee will be responsible for compliance.	

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F 625	Continued From page 32	F 625		

were directly admitted to the hospital from appointments, the HUC stated that was something out of her scope and she did not know what the supervisor did. The HUC directed surveyor to the director of nursing.

On 3/27/19, at 3:00 p.m. the director of nursing stated every time a resident went on a leave of absence or was transferred to the hospital the nurse(s) were supposed to provide the bed hold notice before the resident left the facility and if unable the staff nurses were supposed to contact the resident and /or representative to discuss it. The director of nursing further stated the nurses were supposed to document the conversation in the medical record as "yes bed hold at this time per this person."

R123's MDS dated 3/4/19, identified R123 had moderately impaired cognition.

On 3/25/19, at 12:14 p.m. when asked if she had been to the hospital R123 stated she had been to the hospital three times since December, thought she had also gone in December, then was sent in again in February and March 2019. When asked if she had been provided a bed hold notice, R123 stated she did not remember anything being provided.

On 3/27/19, at 10:53 a.m. R123's medical record was reviewed with the HUC who verified there was no bed hold provided for the hospital transfers for 2/12/19, and 3/12/19. The HUC stated it was not always her responsibility to make sure these were provided to the resident(s) and their representatives but she did make sure there was enough copies in the drawer for the

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F 625	Continued From page 33 nurses to give them with transfers. Review of R60's Admission Record undated indicated R60 was admitted to the facility on 6/1/2016, with diagnosis of paraplegia (loss of function of the lower parts of the body), tracheostomy (a surgically created hole in the neck that allows a tube to be placed in the windpipe for breathing), and morbid obesity. R60's discharge Minimum Data Set (MDS) dated 8/9/18, indicated R60 was hospitalized. No documentation was found in R60's medical record to indicate that R60 received a bed hold notice. On 3/27/19, at 12:15 p.m. the licensed social worker (SS)-B indicated that R60 was on medical assistance so there is an automatic bed hold. When asked if there was any documentation that indicated R60 was provided a bed hold notification when hospitalized in August 2018. SS-B looked for the bed hold, but was unable to provide documentation that indicated R60 or his responsible representative received the bed hold notification for that hospitalization.	F 625		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming services for 1 of 9 residents (R297) reviewed for	F 677	All residents who are dependent for their grooming, specifically shaving, have the potential to be affected.	5/15/19

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F 677	Continued From page 34 activities of daily living. Findings include: R397's Admission Record indicated he admitted to the facility on 3/20/19, with following diagnoses: dementia without behaviors, repeated falls, pain in lower leg, arteriosclerosis, and paroxysmal atrial fibrillation. R397's care plan, 3/21/19, indicated a self care deficit related to dementia. The care plan directed staff to assist with bathing, personal hygiene, dressing and personal hygiene preferences. On 3/25/19, at 4:32 p.m. R397 was observed to be unshaven while sitting near nurses station. The nursing assistant sheet indicated that R397 required an extensive assist of 2 for transfers and received a weekly bath on Saturdays. On 3/27/19, at 7:28 a.m., nursing assistant, (NA)-E greeted R397 and explained to R397 that NA-E and NA-F would be assisting R397 with morning cares. Staff did not offer to shave R397. On 3/27/19, at 8:00 a.m., R397 was once again noted to have a stubble of beard on face. NA-E was queried and stated R397 received a shower on Saturday and was shaved then. NA-E stated staff would also do touch ups again on Thursday when they had more time because the majority of the baths were done then. NA-E confirmed that R397 could use a shave. On 3/27/19, at 10:50 a.m., R397's family member (FM) -B was interviewed. FM-B stated nurses and staff shaved him when he first came	F 677	R397 is no longer a resident of the facility. A house wide audit has been initiated to identify residents who are dependent on staff for shaving. Each identified resident□s care plan was reviewed and updated to ensure each resident is being shaved per their preference or facility protocol. Residents will continue to be assessed for these specific preferences and needs upon admit/re-admit, care conferences, and as needed with individual care plans being updated accordingly. The policy and procedure regarding resident preferences related to grooming and shaving were reviewed and revised. All nursing staff with direct care responsibilities including nursing assistants and nurses will be educated on their roles in ensuring that residents are shaved according to their care plan. Visual audits will be completed weekly for 4 weeks, monthly for 2 months, and then the QAPI will review for further audits, to ensure specific resident care such as shaving is being completed as outlined in their individual/comprehensive care plan and assessment per the resident□s preference. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process.	

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F 677	Continued From page 35 here and he had two weeks facial hair and was then shaved last Saturday when he got a bath. FM-B stated, " I do wish they would shave him everyday" because that was his pattern at home. FM-B confirmed that R397 had couple days growth of facial hair. On 3/28/19, at 10:35 a.m. LPN-E was interviewed. LPN-E stated the resident's were to be shaved on a daily basis if that was their preference. LPN-E stated because R397's preference to be shaved daily was his life long routine according to his wife that he be shaved daily then staff should shave him daily. LPN-E stated staff should try and accommodate the resident's needs. A job description for Certified Nursing Assistant, revised 8/14, was received and reviewed. The job description identified the responsibility of the NA was to provide quality care, as identified in the care plan while performing daily needs were as follows: - Assists residents in dressing and undressing - Assists with oral hygiene and care of teeth and dentures - Assists with hair care, shaving, shampoo, combing - Assists with bathing (tub, shower, whirlpool) and nail care (for non-diabetic residents) - Provides pericare after incontinence and rises soiled linen - Assists residents with transfers in and out of bed and into wheelchair with correct use of transfer belt - Assists to reposition or provide bed mobility - Provides passive range of motion. - Reports to nurse any changes in resident's condition immediately and as necessary.	F 677	DON or designee will be responsible for compliance.	

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(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 677	Continued From page 36 - Reports off to licensed nurse at the end of the shift.	F 677		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow an intervention to prevent fires on the unit. This had the potential to affect all 42 residents residing at the unit of the 150 residents in the facility. Findings include: On 3/25/19, at 11:54 a.m. R29 reported that on 3/4/19, another resident (R64) had caused a fire on the unit when food was left to cook too long in the microwave. R29 stated he was concerned about the safety of the residents in the units and the ratio of the staff to residents. R29 further explained that after the fire he had noticed the maintenance director had put a lock for the microwave on the wall, however multiple times he had seen the key left on the interlock switch on the wall and the microwave was operable. R29 stated it was scary for staff to leave the key there as R64 was in and out of the dining room where the microwave was located and staff were never around to watch it.	F 689	All residents in the facility have the potential to be affected due to the use of microwave in each of the unit. R64 is discharged from the facility. R29 is discharged from the facility. The administrator and the clinical team reviewed current process of microwave use. Microwaves will be supervised and accessible to residents during mealtime. Outside mealtimes, there will be controlled access by staff of the microwave use. Regarding the incident cited, facility staff did do on the spot follow-up with residents regarding microwave use and the facility fire plan and protocols. Further education will be provided to residents at the May 2019 Resident Council Meeting. Facility has contacted the Fire Department to come and speak to the resident council meeting. Microwave usage protocols for residents were revised. The staff were educated to	5/15/19

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	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 689	Continued From page 37 On 3/25/19, at 4:05 p.m. R140 stated R64 had caused a fire on the unit when he left food in the microwave. R140 stated "That is very scary because there is a lot of residents who need help to get out of the unit compared to the amount of staff we have in the building. I know [R29] my friend also talked to you about this concern." On 3/26/19, at 12:50 p.m. the director of maintenance (DM) stated the incident happened on 3/4/19, and was due to smoke from bread that burned in the microwave. The DM stated after the incident he had installed an interlock key switch for the microwave and nursing had the key to the microwave to make sure this did not happen again. On 3/26/19, at 1:43 p.m. the facility administrator acknowledged after the incident she had not gone back to the unit to check with residents to see if they had any further concerns after the incident. The administrator stated she had reviewed the incident report and felt the staff had followed the fire protocol for the facility accordingly. On 3/27/19, from 9:17 a.m. to 10:14 a.m. a blue padded key holder stick with a key was observed inserted into the interlock switch on the wall to the left of the microwave. Surveyor was able to start the microwave and there was no staff supervising the microwave in the dining area at the time. During the observation, there were multiple residents coming in and out of the dining after breakfast and activities, including R64. On 3/27/19, at 10:12 a.m. LPN-H stated after the fire, the microwave was supposed to be locked and if residents wanted to use it staff were to	F 689	the revisions and practices. Audits will be conducted weekly for 4 weeks, monthly for 2 months, and then QAPI will review for further audits to ensure that policy on microwave use is being followed and will provide redirection/recommendations based on existing audits. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The Director of Nursing/Designee and the Director of Maintenance will be responsible for compliance.	

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F 689	Continued From page 38 open it with the key which was kept at the nursing station and staff were to supervise the resident. On 3/27/19, at 10:14 a.m. nursing assistant (NA)-P stated the key was supposed to be stored at the nursing station on top of the Automated External Defibrillator (AED) or in the drawer. NA-P was observed looking for the key but was not able to find it. Surveyor then went into the dining room with NA-P who verified the key had been left there and the microwave was operable without touching the key. NA-P again stated the key was not supposed to be left there since the fire incident. On 3/27/19, at 2:16 p.m. the microwave was observed operable and the key again was on the interlock key switch. Multiple residents were in the dining room area again at this time, however no staff were around to supervise the microwave, since the key was left on the wall. On 3/27/19, at 2:29 p.m. the director of maintenance (DM) was alerted the key had been left on the wall the second time that day. The DM verified the microwave was operable and stated "that is so frustrating" as he left to let the administrator, director of nursing (DON) and LPN-F know about the incident. On 3/27/19, at 3:22 p.m. the DON stated the key was not supposed to be left on the wall as staff were to supervise the use of the microwave "We will have the key to the microwave on the nurse key ring."	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		5/15/19

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F 692	Continued From page 39 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the diet order for 1 of 2 residents (R121). In addition, failed to monitor the fluid restriction for 1 of 2 residents (R121) reviewed for dialysis. Findings include: R121's diagnosis included end stage renal disease (ESRD), hypertension, and type II diabetes obtained from the 5 day Minimum Data Set (MDS) dated 3/1/19. In addition the MDS indicated R121 had intact cognition and was receiving dialysis. R121's care plan dated 2/23/19, identified R121	F 692	All residents with special diets and fluid restrictions have the potential to be affected by this practice. R121□s meal ticket and diet order were reviewed to ensure accuracy. Resident is receiving diet and fluid restriction per order. R121□s fluid intake is documented every shift and totaled daily. R121□s diet order and fluid restriction were reviewed with the resident. All residents with special diets and fluid restrictions have the potential to be affected by this practice. Residents with fluid restrictions were reviewed and are receiving diet and fluids as ordered.	

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F 692	Continued From page 40 had an alteration in kidney function and directed staff to provide the renal diet as ordered. The care plan did not identify R121 was on a fluid restriction or had been provided risks and benefits for not following the fluid restriction and diet. R121's physician order dated 2/26/19, indicated R121 was on a renal diet, with low phosphorus, low potassium, and was on a fluid restriction of 1500 milliliters (ml) per day. A review of the March medication administration record (MAR) revealed R121 had the following order: Fluid Restriction - 1500 ml per day (Division: nursing to provide 60 ml with med pass (240 ml). Dietary to provide 360 ml every meal (1080 ml). Remaining 180 ml to be used as res chooses. No water pitcher at bedside, every shift. The medical record lacked an accurate system of monitoring R121's daily fluid intake amount. On 3/25/19, at 6:05 p.m. nursing assistant (NA)-L was observed to deliver a plate of food for R121. On the plate was a large portion of fried potatoes, lettuce, tomatoes and a piece of chicken on a bun. Also R121 was served a small container of mandarin oranges and 480 ml of beverages. -At 6:17 p.m. R121 had eaten all the food and fluids served. On 3/25/19, at 6:45 p.m. a water pitcher with approximately 300 ml was observed on top of R121's bedside table. On 3/26/19, at 8:50 a.m. during the morning meal, R121 was observed to eat all the served food which included a bagel, cream cheese and two pieces of bacon. R121 also drank 480 ml of milk.	F 692	The policies and procedures regarding fluid restrictions and specialized diets were reviewed and remain current. Nursing and Dietary Staff were educated on specialized diets and fluid restrictions. Audits will be conducted weekly for 4 weeks, monthly for 2 months, and then QAPI will determine future auditing schedule thereafter and will provide redirection/recommendations based on existing audits. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The Director of Nursing, Director of Culinary Services, and Registered Dietician or their respective designees are responsible for compliance.	

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F 692	Continued From page 41 On 3/26/19, at 9:02 a.m. R121 stated during meals staff served him the food he ate and he thought they knew what he was supposed to eat as he did not know all the foods. R121 stated he had not been provided with risk and benefits for not following the ordered diet and fluid restriction. On 3/27/19, at 8:40 a.m. a plate with four sausage links, one boiled egg and a small piece of coffee cake was observed at the table where R121 sat. R121 came in the dining room and was observed to eat two of the four sausage links, the coffee cake and boiled egg with 240 ml of milk. On 3/27/19, at 8:44 a.m. the registered dietician (RD) stated R121 was on a renal diet and staff were supposed to follow the prescribed diet. RD stated the meal ticket instructed staff to "Avoid bananas, oranges, orange juice, melons, potatoes, tomatoes, tomato products and staff was to limit all dairy foods to half a cup or four ounces per day." RD also stated R121 was supposed to be offered twice the amount of hard boiled eggs instead, on concentrated carbohydrate diet. RD stated R121 was not compliant with the ordered diet and fluid restriction however RD verified R121 had not been provided risks and benefits for being non-complaint. RD verified R121 was on a 1500 ml fluid restriction however the medical record lacked an accurate system of monitoring the fluids consumed. RD stated all foods R121 had been observed to eat were some of the foods that were supposed to be avoided due to the renal diet and fluid restriction. RD stated when she had written the fluid restriction order she thought nursing was going to monitor the amounts using the directions she had outlined. RD also stated	F 692		

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F 692	Continued From page 42 R121's diet was to be followed to avoid elevating Phosphorus and Potassium however, staff was to give small portions of the food of course they were not going to restrict his diet. On 3/27/19, at 9:05 a.m. NA-M stated R121 was on a fluid restriction of 1500 ml and the meal ticket outlined foods that were to be avoided. NA-M stated the dietary staff used the meal ticket when serving the food and the NA's were supposed to double check the ticket as they delivered the food to make sure it was accurate. On 3/27/19, at 9:41 a.m. licensed practical nurse (LPN)-F verified the NA's were not documenting fluid consumed with meals consistently. LPN-F acknowledged the water pitcher was not supposed to be at bedside. LPN-F reviewed the MAR and verified there was no documentation of the amount of fluids provided to R121 by nursing with medication pass and meals. On 3/27/19, at 11:02 a.m., LPN-F stated she had reviewed R121's medical record and had not found a risk and benefit documented. LPN-F stated she had provided risks and benefits to R121 after the concern was brought to her attention. On 3/27/19, at 3:17 p.m. the director of nursing (DON) stated dietary was to serve the ordered diet and that staff were supposed to check the diet/meal to make sure it was correct before bringing it to the resident. The DON further stated if it was a resident's choice to not follow the diet and fluid restriction then the resident was supposed to be given a risks and benefits form and staff was to periodically revisit.	F 692		

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F 693	Continued From page 43	F 693		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide appropriate gastrostomy tube flushing to prevent complications for 1 of 1 residents (R80) observed during gastrostomy tube medication administration. Findings include: R80 was admitted to the facility 8/14/2018, with diagnoses of Parkinson's disease, and R80 had a gastrostomy tube (G-tube) for nutrition. R80's	F 693	All residents with tube feedings have the potential to be affected by this practice. R80□s water flush order has been reviewed and water flush order before and after med administration was changed to match facility□s standard flushing order per the dietician□s direction. Water flush order for all residents with tube feedings were reviewed to match the facility□s standard water flush order	5/15/19

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F 693	Continued From page 44 physical orders dated 3/28/19 indicated on 10/31/18, R60 was to receive 75 milliliters (ml) of water before and after each medication to flush the G-tube. On 3/27/19, at 7:32 a.m. licensed practical nurse (LPN)-A was observed administering medications to R80. It was observed that after each medication mixed with 30 ml of water was poured into the G-tube, LPN-A poured approximately 15 ml of water into each medication cup, swished the water in the cup, and poured it into the G-tube. When LPN-A completed administering the 6 medications LPN-A poured the same amount as after each of the other medications. LPN-A did not flush the G-tube with 75 ml as ordered by the physician. - At 8:06 a.m. R80's orders were reviewed with LPN-A. LPN-A was asked how much water was supposed to be used to flush the G-tube after each medication. LPN-A stated 75 ml. LPN-A stated she did not flush with 75 ml after each medication as ordered. On 3/28/19, at 10:54 a.m. during an interview the director of nursing (DON) stated the facility policy was to flush with 15 ml before and after each medication, but the physician orders superceded the standard in the policy. The DON stated the staff member should have flushed with 75 ml as ordered by the physician. The facility's Standardized PCC [Point Click Care-EHR] Nursing Orders dated 2/2019, indicated the orders were generic and needed to be customized for the resident.	F 693	before and after medication administration. RD reviewed all residents with tube feeding to ensure they are receiving adequate fluid according to their needs. Policies and procedures from the pharmacy, nursing, and the facility□s standing-orders were reviewed as it relates to tube-feeding flushes. The policies and procedures as well as the facility□'s standing-orders remain appropriate. Nursing staff were educated on facility□s policies and procedures related to the standard water flush amount before and after medication administration. Audits will be conducted weekly for 4 weeks, then monthly for 2 months, and then QAPI will determine future auditing schedule thereafter and will provide redirection/recommendations based on existing audits. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The Director of Nursing/Designee will be responsible for compliance.	
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		5/15/19

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F 695 SS=D	Continued From page 45 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure maintenance and cleanliness of a continuous positive airway pressure (CPAP) machine for 1 of 1 resident (R123) reviewed for respiratory care. Findings include: R123's diagnoses included acute and chronic respiratory failure, chronic obstructive pulmonary disease obtained from the quarterly minimum data set (MDS) dated 3/4/19. In addition, the MDS identified R123 had moderately impaired cognition and required extensive physical assistance of one staff with activities of daily living. On 3/25/19, at 7:12 p.m. a CPAP machine was observed on top of the bedside dresser next to R123's bed and the tubing to the CPAP which was attached to the nose piece/mask was observed laying on top of R123's bed. The tubing was observed with pink build up outside the connection area to the nose piece. In addition, inside the soft nose piece was a heavy build up of yellow and pink substances.	F 695	All residents who use a CPAPs or BiPAPs have the potential to be affected. R123□s CPAP was replaced on 3/27/19. Residents with CPAPs or BiPAPs have been checked and cleaned per policy. The policy and procedures for CPAP and BiPAP cleaning was reviewed and remains appropriate. All nursing staff with direct care responsibilities including nursing assistants and nurses were educated on proper cleaning of CPAP and BiPAP machines. CPAP and BiPAP machine cleaning will be audited weekly for 4 weeks, monthly for 2 months, and then the QAPI will review results and provide redirection/recommendations based on existing audits. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The DNS/Designee will be responsible for monitoring compliance.	

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F 695	Continued From page 46 On 3/26/19, at 9:15 a.m. R123 was observed asleep in her bed and was wearing the CPAP which was running. On 3/26/19, at 2:59 p.m. licensed practical nurse (LPN)-F who was the unit nurse manager verified R123's CPAP was not clean. LPN-F stated the machine was supposed to be cleaned weekly. At 3:04 p.m. LPN-F reviewed the medical record and verified there was no documentation in either the Treatment Administration Record (TAR) or the Medication Administration Record (MAR) to prompt the staff nurses to clean it weekly. R123's care plan dated 10/29/18, identified R123 had an alteration in respiratory Status Due to Chronic Obstructive Pulmonary Disease, and used a CPAP. The care plan did not have directions for cleaning the CPAP. On 3/26/19, at 3:11 p.m. R123 stated she used the CPAP all the time and she had never been offered to have it cleaned. R123 stated at times she wiped the soft nose piece because it got so dirty over time but did not do a good job. On 3/27/19, at 3:20 p.m. the director of nursing (DON) stated the nurses were supposed to clean the CPAP per the manufacturer guidelines at least weekly and as needed. The DON further stated after concern was brought to the facility attention, "we audited and there will be an order to prompt the nurse to get it cleaned now moving forward." The undated Northwest Respiratory Services Respiratory Equipment Inservice manual directed the CPAP was to be cleaned daily by wiping the	F 695		

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F 695	Continued From page 47 surface area of the mask with a warm wash cloth. In addition, weekly the mask, tubing and water chamber were supposed to be cleaned in warm soapy water.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure adequate	F 725	All residents have the potential to be affected if the facility does not have	5/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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F 725	Continued From page 48 staffing levels to ensure resident needs were met timely. This affected 15 residents (R11, R63, R59, R93, R123, R142, R93, R88, R131, R120, R15, R298, R130, R397, R29), of 150 residents who resided at the facility. Findings include: Resident interviews: R11, was interviewed on 3/25/19, at 4:43 p.m. When asked if he got the care and assistance he needed when he put his call light on for assistance R11 stated the help was "really bad" and at times he had to wait for about 2 hours before help came to his room. R11 further stated he was not sure if the facility was short handed or if the aides were "just lazy." Staff interviews: On 3/26/19, at 9:37 a.m. LPN-H stated there were only two nurses on the floor during the shifts on the 2 East unit and there were 3 medication carts for the entire unit with 42 residents. LPN-H stated the medication pass was heavy and the nurses were to get all the treatments completed including wound care among other things. LPN-H also stated it was difficult to get it all done timely. LPN-H acknowledged because of being pulled here and there since she came and started the morning medication pass she was behind with medication pass and there were multiple residents she still had not given medications yet and the medication administration screen on the computer was "red" indicating late as they had an hour before and after the scheduled medication pass time. On 3/27/19, at 7:09 a.m. surveyor arrived at the 2 East unit and observed there was no third nurse	F 725	adequate nursing staff. R11 was interviewed about call light responses. Call light audits were completed in the last three months prior to survey entering the facility on R11□s room and no concerns were identified. The facility will review staffing, census, and acuity daily to ensure resident needs are being met. The facility leadership maintains an open door stance on staff discussions and solutions for staffing. Leadership met with facility nursing supervisors for PM and Night Shift on 4/29/19 to further discuss the staffing of the facility. The facility actively participates in recruitment efforts as well as staff retention efforts. The facility meets weekly for retention, and all staff are invited. The facility also actively creates recruitment techniques and strategies for current staff to refer applicants. Call light audits and medication pass audits will be conducted on all shifts. Staff education has been initiated on mandatory staffing requirements to assure that the facility is staffed appropriately daily. Staff education has also been initiated on appropriate staffing levels based on census and acuity within the facility. Three resident/family interviews specific to adequate nursing staffing will be completed weekly for 4 weeks, monthly for 2 months, QAPI will review results and provide redirection/recommendations based on existing audits. Three employee interviews specific to adequate nursing staffing will be completed weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 49 or trained medication aide (TMA) scheduled. When asked about the staffing for the unit, LPN-F stated "if there were 44 people in the unit the nurses get a TMA." LPN-F who was the unit manager stated the nurses had told her about the medication pass challenges and she would help as much as possible with blood sugar checks, doing assessments, make calls, doing orders and if there was a change of condition for a resident. When asked about when she was not in on evenings and weekends she was not able to respond to how the nurses got help. LPN-F also stated she had instructed the nurses to get her to the floor if they need assistance when she was in the building. LPN-F further stated it was not "okay" to have medications given late as the nurses had one hour before and after scheduled times. On 3/27/19, at 7:52 a.m. LPN-G stated the resident(s) acuity was high and they needed a lot of treatments and most residents on the unit took a lot of medications. LPN-G stated concerns about the acuity and work load had been brought to management attention several times however, nothing had been done about it. LPN-G stated some residents on the unit had been admitted to the facility with high acuity but because there were no beds available in the Subacute unit the residents were being brought to the 2E unit and management was not thinking about the increasing resident(s) needs. LPN-G stated the nurses felt rushed to get the work done and this was not good because it left room for medication errors. LPN-G also stated if some of the resident(s) wanted as needed pain medications for example they had to have them wait because there was a lot to be done by the two nurses in the unit. LPN-G stated all the nurses always	F 725	for 4 weeks, monthly for 2 months and then QAPI will review results and provide redirection/recommendations based on existing audits. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The DNS and Administrator will be responsible for compliance.	

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	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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 725	Continued From page 50	F 725		

stayed two to three hours after the shift because they had to get the work done including the charting and treatments. LPN-G stated many times the staff in the unit did not take breaks at all and management was aware of this.

On 3/27/19, at 11:32 a.m. anonymous nursing assistant working on 2 East unit stated staffing was not good at the facility at all and they had talked to management about the workload but nothing had been done. NA stated there were a lot of residents who required two staff assistance, needed bedpans, room trays and repositioning because they did not come out of their rooms. NA stated sometimes they had to pick who was a priority to be assisted and things such was changing bed linen, emptying bedpans or urinals had to just wait until there was time and sometimes there was not time to get to it because they had to run the whole day. NA stated the floor had high need population and residents with demands and it was hard to get everything completed timely and properly. NA further stated staff did not take breaks because they had to try to keep up and management was aware.

Observations:
On 3/27/19, at 9:51 a.m. LPN-I was observed to prepare insulin to administer to R63. LPN-I acknowledged she was behind with the medication pass as she was supposed to have administred the insulin at 8:00 a.m. when it was scheduled.

On 3/27/19, at 9:52 a.m. LPN-H was observed set up medications for R59 which was 51 minutes past the acceptable time frames to give the medication(s). LPN-H stated she was behind with the medication pass. LPN-H further identified

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	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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F 725	Continued From page 51	F 725		

she had not still passed medications for R93 and R123 which were all scheduled for 8:00 a.m. and it was now almost 10:00 a.m.

On 3/28/19, at 10:47 a.m. reviewed the medication administration record with unit manager LPN-F who verified the following resident(s) R59, R142, R93, R88, R131, R120, R15 and R298 had not received their morning medications, almost 2 hours past the one hour before and after scheduled time frames. After concern was brought to LPN-F's attention she was observed to approach the two nurses and offered to assist with completing the morning medication pass.

During interview on 3/25/19, at 5:00 p.m. R130 who currently resided on the 2 east unit, stated he got along with the staff well but stated in the middle of the night the staff don't want to come and they don't answer the light so by the time they show up he has already been incontinent. He stated instead of the call light, the next time he needed help, "I yell and scream and they get mad at me because I yell and I get mad at them because I have crap in my pants." R130 stated there was not enough staff at night and they don't want to do the care.

At 5:37 p.m. R130 stated he was stressed out and sad because he could not leave the facility. R130 stated he escaped out the front door once. R130's family member (FM)-A stated the facility locked R130 in the memory care unit and put a wanderguard on him. FM-A stated she was told at the time there was not enough staff to watch R130 and stated she "cried the whole time." FM-A stated the facility sent R130 to the hospital but the hospital sent him back because nothing was

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	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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 725	Continued From page 52	F 725		

wrong with him and when he came back they had moved him to the locked unit. R130 stated, "they had a bracelet on me, I felt like a chimpanzee."

A Twin Cities Physican's visit note dated 12/13/18, indicated R130 was seen due to frequent falls. The note indicated R130 knew he had impulse behaviors and tried to remind himself to wait for help. R130 had a few falls recently and attributed the falls to him getting impatient after waiting a significant amount of time for help to get up. R130 stated this was especially a problem on the over night shift when staff told him the were going to return and then did not. Discussed this with nurse manager.

During interview on 3/27/19, at 4:24 a.m. licensed practical nurse (LPN)-G stated she was the only nurse on the night shift on the 2 EAST unit. LPN-G stated there used to be two nurses but when the new company took over they took one away. LPN-G stated she covered all three hallways and stated, "it's not good." She stated there were 42 residents, three residents with tube feedings and a lot of scheduled medications in the morning. LPN-G stated she did not usually get out of the facility until three hours after she was scheduled to leave.

At 4:31 a.m. LPN-C stated the facility needed more staff, especially 2 East. LPN-C stated the acuity on the unit was high and stated, "if staffing was better we could meet their needs." LPN-C stated the p.m. shift on 2 East had two nurses and stated, "they struggle every day, it's frustrating." LPN-C stated he didn't take breaks and if he did he would get done an hour and a half late.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 725	Continued From page 53	F 725		

During observation on 3/27/19, at 4:00 a.m. a resident on the secured unit was observed asleep in a Broda chair in front of the nurses station. At 4:04 a.m. a set of double doors used to secure the advanced Alzheimers unit were propped open with chairs. At 4:04 a.m. R397 was lying in bed and a plastic garbage can had been placed between the mattress and frame on R397's bed causing the mattress to curve upwards. The opposite side of the bed was placed against the wall.

During interview on 3/27/19, at 4:00 a.m. LPN- J stated the resident asleep in the Broda chair slept there because he was a fall risk.

At 4:05 a.m. nursing assistant (NA)-T was asked about the staffing levels on the unit. NA-T stated he did not usually work on the unit but had picked up the shift. NA-T stated he usually worked the p.m. shift.

During interview on 3/27/19, at 4:09 a.m. NA-S stated R397 was new to the facility and stated he was resistive to cares. NA-S stated R397 was at risk for falls and stated he made attempts to stand up out of his wheel chair. When asked about the garbage can placed under the mattress, NA-S stated R397 "liked pulling on things" indicating R397 had placed the garbage can himself. NA-S stated he did not know how the garbage can came to be under the mattress.

During interview on 3/27/19, at 1:38 p.m. LPN- E stated R397 was resistive to cares and tried to get up from his wheelchair. LPN-E stated R397 could bear weight but was weak and had been lowered to the floor by staff recently. LPN-E further stated R397 was not capable of picking up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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F 725	Continued From page 54	F 725		

his garbage can and placing it between the mattress and the bed frame.

At 4:22 a.m. LPN-J stated the double doors on the unit were always open at night and closed only during day time hours.

During interview on 3/27/19, at 7:15 a.m. LPN-K, on the 2 North unit stated she did not have a trained medication aide (TMA) on the unit on that day. LPN-K stated she was supposed to have one if there were more than 22 residents and stated there were more than that now but they had to pull the TMA. LPN-K stated many of the TMA's went back to school so they were short.

During interview on 3/28/19, at 11:53 a.m. the staffing coordinator stated she based the staff in the building on a grid developed by the director of nursing (DON) and the administrator. The staffing coordinator stated it was used as a reference and if the acuity was higher or if there was an admission she would talk with the unit manager or the director of nursing to determine if more staff was needed. The staffing coordinator stated the 2 north unit did not always have a TMA depending on the census. She stated if the unit had 24 residents they used a TMA and on the p.m. shift the census had to be 26 for a TMA. The staffing coordinator stated on the 2 east unit a TMA was supposed to be scheduled when the census reached 42 residents. She stated if no TMA was available they scheduled an extra NA but stated it did not really help the nurses much. She stated the PM shift got a TMA when the census reached 43 and on the over night shift there was one nurse and two NA's. The staffing coordinator stated the overnight nurse probably did not get to take breaks or lunches and said the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 725	Continued From page 55	F 725		

nurses had talked to her about it. She stated she went to the DON when the nurses were having trouble getting out on time and stated she went to the morning stand up meeting and talked to the team about staffing. She stated she let the team talk to the staff about their staffing decisions.

During interview on 3/28/19, at 1:00 p.m. the DON stated the starting point for staff was the budget and stated he had developed some grids to use as a starting point for staffing the building. The DON stated they also take into account acuity, behaviors, blood sugar checks and wounds. The DON stated the staff on 2 East was always asking for more staff but he was not aware of them staying late. He stated he looks at the results and stated he had not had any significant reports of things not getting done. The DON stated on the night shift one nurse to 41 patients is what was scheduled and stated he knew most of the staff worked through their breaks and said a lot of them say they don't have time. He stated they tried to get the nurses to delegate more tasks to the NA's.

During a resident council meeting held on 3/27/19, at 10:30 a.m. Concerns were brought up about the night shift staff sleeping at night on the 2 East unit of the facility. R29 provided an example of when he put his call light on at night and a night shift staff came into the room and said, "Hey you woke me up, I was sleeping".

Other concerns from resident council included: residents had to wait 30 minutes to 2 hours for a call light to be answered, staff turn their name tags around so residents don't know staff's names, staff don't knock on resident's doors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 725	Continued From page 56	F 725		

before they enter the room, and night shift staff have gotten upset with residents who don't go to bed at 9:00 p.m. or earlier. Night shift staff have told residents that it is not their job to put residents to bed.

On 3/25/19, at 5:15 p.m., 14 of 25 residents were in the dining room. There were two nursing assistants, NA-R and NA-S setting tables with paper place mats, paper napkins, juice and coffee cups. The two NAs were interviewed and said they had to clean up the tables after dinner after the residents were out of the dining room. NA-S poured coffee and juice for the residents already at the table and NA-R continued to gather residents from their rooms and hallways and brought them in their wheelchairs into the dining room. During the meal service there were 6 residents who needed assistance with eating and there was one nurse and two NA's to assist these 6 residents and to monitor the other 19 residents.

On 3/27/19, at 9:16 a.m. nursing assistant (NA)-E was interviewed about staffing ratios. NA-E stated that there were 25 residents on the unit and she was assigned to 13 residents. NA-F came into the area and confirmed that she had 12 residents assigned to her. Both NAs agreed that most of the residents on the unit required two person assist with cares and use of the lift for transfers. Both of the NAs stated that there was not enough nursing assistants to provide care for all the residents on the unit. Both of the NAs stated that they had been warned not to be vocal about the lack of help to meet the needs of the residents and stated by the time they finish changing residents they had to start changing again. That did not leave much time to feed the 6-8 residents who need assistance with feeding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 57	F 725		

The staff were also required to set up the dining room for meals and stated they had only 2 nursing assistants and one nurse on during the weekdays and weekends. We simply run out of time in the day to meet the needs of the residents. When asked about what needs of the residents were not being completed, the reply was: we do not always have time to shave and groom the residents on Monday, Tuesday, and Wednesday. By Thursday, when most of the baths have been completed then we go back and try to shave residents and do nail care if time remains.

On 3/28/19, at 1:24 p.m. an anonymous staff member was queried about staffing. The staff member indicated that additional nursing assistance had been requested and was denied because the number of residents required for additional staffing was 47. This week alone there had been two nursing assistants on the Alzheimers care unit (ACU) and one NA had 13 residents and another NA had 12 residents. The number of residents currently was 45 for both the ACU and advanced Alzheimer's care unit (AACU). The average number of residents was 45. The NAs were not able to check and change residents every two hours or as needed due to the majority of the residents requiring two NAs. There were nine residents who required assistance with feeding on the ACU and on AACU and four residents who required assistance with feeding. Grooming was not always being accomplished in a timely manner because the needs of all the residents had to be prioritized. The night shift lacked the supervision the residents required and staff on the night shift slacked off. Some mornings when the NA's got to the unit/s there were two chairs facing each other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 725	Continued From page 58	F 725		

where staff had sat during the night with feet up. The NA stated concerns about the night shift and indicated today had smelled something foul down the hall, and saw a female resident up and her diaper was sagging and it could have weighed up to 20 pounds. The night staff were not checking and changing the residents. There were 2 nursing assistants and one nurse on the night shift for 45 residents.

R143 chart was reviewed and identified F143 was admitted 3/1/19, with a history of incomplete paraplegia from spinal fusion. R143 was totally dependent on staff for cares, turning, eating, and changing the channel on the television. R143 was able to use an adaptive call light, was cognitively intact and moderately depressed.

On 6/25/19, at 12:30 p.m. R143 was interviewed and stated it was not unusual to wait 45 minutes for staff to answer a call light and at change of shift time, from 1:30-2:30, it was like living in a ghost town, no one answered the lights. R143 went on to say had waited 2 hours one day, for staff to answer the call light, and it was a good thing she just needed someone to change the channel for her.

On 3/27/19, at 4:00 a.m. surveyors entered the building due to the large number of staffing complaints. nursing assistant (NA)-A was observed asleep on the love seat in the TCU day room, snoring loudly. Registered nurse (RN)-A was interviewed and stated that NA-A was on break and it was okay to sleep on his unpaid 30 minute break. RN-A then got up and went in to wake NA-A because his 30 minutes were over. RN-A stated the TCU unit had 1 RN and 1 NA on the night shift and he would help with the turns

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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 725	Continued From page 59 and repositioning if needed. RN-A stated he could call the nursing supervisor if he needed help. RN-A stated the nursing supervisor did have a unit assigned to them. RN-A stated rarely they would put residents to bed on the night shift, if they had not wanted to go to bed on the evening shift. -At 4:18 NA-A was interviewed, NA-A had worked evenings and picked up the night shift as a double shift, and had done a double the night before as well. NA-A had been on this unit during orientation and was oriented to float all over the facility. NA-A stated it was okay to sleep on your 30 minute break. At 4:25 a.m. RN-B stated it was never okay for staff to sleep on the night shift. RN-B stated that most night shifts she was able to work with 2 of the 3 consistent night NA staff on that unit. RN-B stated they usually have 2-3 residents to put to bed on the night shift, and that several residents got up to go outside to smoke or get fresh air. RN-B stated that the nursing supervisor would come to help if needed, but they would have their own unit and patients to care for. -At 8:30 a.m. the administrator and director of nursing (DON) stated it was not their expectation that staff sleep on the night shift. All NA staff were re-educated before they left the facility that morning, and then all nursing staff were re-educated before they left the building. All staff would be re-educated that all breaks are taken in the break room, if you are in your uniform and wearing your name tag on the unit, you are on the job and the residents perception was that you would be available to help them.	F 725		
F 744	Treatment/Service for Dementia	F 744		5/15/19

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F 744 SS=D	Continued From page 60 CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services for dementia care for 2 of 6 residents (R25 and R129) reviewed with dementia. Findings include: R25's quarterly Minimum Data Set (MDS) dated 1/9/19, identified R25 had severe cognition impairment and a need for extensive assist from staff for all activities of daily living (ADL's). The MDS indicated R25 did not refuse cares or wander and this did not interfere with R25's participation in activities or social interactions. R25's care plan revision date 1/17/19, identified R25 had diagnoses that included Alzheimer's or related dementia. Due to cognitive loss, diminished decision making, safety and security issues, R25 was placed on the secure Alzheimer's unit with programs designed for that population. The care plan directed staff to allow resident to self-propel throughout the unit at will, provide environmental cues throughout the unit to minimize the effects of cognitive deficits and provide normalized programs based on resident assessment and interests. R25 was observed to wander up and down the hallway of the secured Alzheimer's unit during	F 744	All residents with Alzheimer□s and/or Dementia have the potential to be affected. R129 is currently at the hospital however, upon return to the facility the Therapeutic Recreation Staff will conduct activity preference assessment, obtain information from the resident□s responsible party, and update resident□s plan of care accordingly. R25□s guardian has been notified to determine what resident□s activity preference and for further personalization of the R25□s room to create a home-like environment conducive to the R25□s diagnosis of dementia. All other resident plans of care for residents with Alzheimer□s and Dementia diagnoses will be audited and updated to ensure proper therapeutic activities are in place. The facility Alzheimer□s and Dementia training was reviewed and meets the state and federal regulations. The facility has recently hired a new Director of Therapeutic Recreation with an extensive	

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F 744	Continued From page 61 observations on 3/25/19, 3/26/19, and 3/27/19. -On 3/25/19 at 11:51 a.m. R25 was observed in a hospital gown in her wheelchair and self-propelled herself up and down the hall. -at 4:37 p.m. R25 laid her head down on the dining room table, then moved away from the table and self-propelled into the hall. -at 4:56 p.m. R25 self-propelled up to the dining room table and laid her head on the table, then moved away from the table and self-propelled into the hall. -On 3/26/19, at 1:11 p.m. R25 was in the dining room and listened to music and church service. -at 2:03 p.m., R25 had moved herself out of the dining room self-propelled to the end of the hall and looked out the window. -at 2:22 p.m. R25 was at the other end of the hall and pushed on an exit door, R25 sat by the door and then self-propelled into the dining room. The TV was on in the dining room and residents waited for the pet therapy visit. R25 self-propelled into the dining room, went to the corner of the dining room and put her head on the table with her eyes closed. -at 2:27 p.m. R25 had her head on the table, then wheeled across the dining room and leaned her head towards the wall with her hands resting on the table. -at 2:30 p.m., R25 wheeled herself out of the dining room and used the handrail in the hall to self-propel down the hall. -at 2:38 p.m. R25 was at the end of the hall and R129 walked up to R25 and attempted to turn her around. R129 was unsuccessful and turned himself around and walked down the hall, R25 followed R129 into the dining room. -at 2:42 p.m., R25 wheeled herself into the dining	F 744	Alzheimer□s/Dementia Care background and will conduct further specialized training for the facility staff as necessary. All staff were re-educated on proper Alzheimer□s and Dementia Care practices. Staff are all educated upon hire, annually, and as needed for Alzheimer□s and Dementia care. Audits regarding resident plans of care and preferences related to Alzheimer□s and Dementia care will be completed weekly for 4 weeks, monthly for 2 months, and then the QAPI will review for further audits. The Administrator and Director of Therapeutic Recreation or designees will be responsible for compliance. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process.	

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F 744	Continued From page 62	F 744		

room and went straight to the opposite wall and up to the wall. R25 rested her head on a bin for garbage with her head in her hands. Staff turned R25 around and R25 faced the direction to leave the dining room. Staff then brought R25 back to the table and provided her a snack.
-at 2:47 p.m., R25 finished her snack and put her head down on the table.
-at 3:17 p.m., R25 self-propelled to another table, put her head down and rested her head on her hands. R25 had her eyes open and stared to the other side of the dining room.

-On 3/27/19, at 7:19 a.m. R25 was brought into the dining room by staff. R25 self-propelled out of the dining room.
-at 7:23 a.m. R25 was in the hallway in her wheelchair with her head tilted back, R25 then self-propelled into the dining room and moved towards a table where another resident told her she couldn't sit there. Nursing assistant (NA)-L took R25 out of the dining room and said R25 was "a challenge".
-at 8:54 a.m., R25 was in the dining room in her wheel chair with her head tilted back and her eyes closed. Licensed practical nurse (LPN)-E assisted another resident to eat.
-at 9:01 a.m. R25 remained in the dining room with her head down and eyes closed.
-at 9:11 a.m. R25 self-propelled out of the dining room and into the hall and self-propelled in the hall. A linen cart was in R25's way and R25 stayed in front of the cart until NA-L assisted her.
-at 9:19 a.m. R25 was in the hallway in her wheelchair with her head back and eyes closed.
-at 9:25 a.m., NA-L and NA-U assisted R25 to bed. NA-L said R25 only sleeps a couple hours at night and then is up in the wheelchair and self-propels up and down the hall.

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F 744	Continued From page 63	F 744		

R129's quarterly MDS dated 3/5/19, identified R129 had severe cognition impairment and needed extensive assist from staff for all ADL's. R129 was able to walk independently. The MDS indicated R129 did not refuse cares or wander and this did not interfere with R25's participation in activities or social interactions. R129 had one to three days within the MDS assessment period when he had physical behaviors directed towards others.

R129's care plan revision date 3/4/19, identified R129 had diagnoses that included unspecified dementia with behavioral disturbances. Due to cognitive loss, diminished decision making, safety and security issues, R129 was placed on the secure Alzheimer's unit with programs designed for that population. Staff were directed to keep R129 busy with activities where he used his hands. The care plan identified R129 preferred to wander in and out of activities and was unable to participate in most activities but enjoyed music. R129 liked to stay busy and wandered around the unit. R129 was identified as an elopement risk and wandered, was disorientated to place and wandered aimlessly. Staff were directed to distract R129 to not wander and offer pleasant diversions, structured activities, food, conversation or television.

R129 was observed to wander up and down the hallway of the secured Alzheimer's unit during observations on 3/25/19, 3/26/19, and 3/27/19.

On 3/25/19, at 11:51 a.m. R129 walked independently in the hall, paced back and forth, stared straight ahead and did not engage in conversation.

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F 744	Continued From page 64 On 3/26/19, at 7:52 a.m., R129 pushed a housekeeping cart down the hall and then R129 tried to open a locked door. -8:54 a.m. R129 wandered the hall and attempted to open doors. -1:20 p.m. R129 wandered in and out of a church/music activity. -1:31 p.m. staff attempted to lay R129 down in his room, R129 was back in the dining room at 1:40 p.m. -1:44 p.m. R129 wandered out of the dining room and walked to the end of the hallway. R129 stood and stared out the window. -2:34 p.m. R129 was in the hallway and R25 came up behind R129, neither resident moved, NA-V intervened and walked R129 away from R25 and said that R129, "will sleep well tonight". -at 3:03 p.m. R129 was in the dining room and pushed chair across the floor towards R25, R129 said nothing and stared straight ahead, R25 had her head on the table. On 3/27/19, at 7:15 a.m., R129 walked up and down the hall, R129 and R25 were at the end of the hall by the exit door, R129 pushed on the exit door. NA-L offered R129 something to drink and brought him to the dining room. -at 7:26 a.m., R129 pushed a chair around the housekeeping cart. The housekeeper came out and took the chair away from R129. -at 7:37 a.m. R129 walked to the end of the hall and looked out the window, R129 walked passed the housekeeping cart, the housekeeper asked R129 to leave things alone and "please, please please, go straight ahead and go eat your breakfast". NA-K was interviewed on 3/28/19, at 9:08 a.m.	F 744		

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F 744	Continued From page 65	F 744		

and indicated all staff received Alzheimer's training monthly. NA-K indicated R25 didn't always like to lay down and R25 liked to talk about where she lived when she was young and look at her personal photos (These interventions where not noted on the care plan or nursing care guide). NA-K said if she saw R25 and R129 in the hall, NA-K would watch to make sure R129 didn't run into R25. R25's room lacked personal items or photos for staff to show resident to engage in conversation.

NA-K indicated staff needed to watch R129 because he would run into R25. NA-K said R129 liked to arrange things. (These interventions where not noted on the care plan or nursing care guide). R129's room lacked personal items or photos for staff to show resident to engage in conversation or items that R129 could arrange.

NA-L was interviewed on 3/28/19, at 9:12 a.m. and said that R25 liked to joke and laugh once she got to know staff (These interventions where not noted on the care plan or nursing care guide).

NA-L said R129 would talk with NA-L, NA-L indicated if R129 was safe, he would let him push things around the unit. (These interventions where not noted on the care plan or nursing care guide).

LPN-E, identified as the nurse manager for the secured dementia unit, was interviewed on 3/28/19, at 9:26 a.m. and said she would love to provide education to staff about the special population on the unit. She wanted to educate staff on how to approach residents with Alzheimer's dementia ,for example, how to talk with the resident, explain cares that staff provide

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F 744	Continued From page 66	F 744		

to the resident, and not come up behind a resident and push them in the wheelchair. LPN-E said because there was a changeover of new staff and the state agency had been in the facility often that LPN-E had not had the time that she would like to train staff. LPN-E felt staff needed more education on dementia care. LPN-E acknowledged interventions that included likes/dislikes for residents were not included on the NA care guide or updated in the care plan. LPN-E said there used to be mandatory meetings for staff to discuss person-centered preferences for all residents on the unit. Likes and dislikes should be on the nursing assistant care sheets and or care plan and LPN-E acknowledged she would like include these but they were not on the care sheets or care plan.
LPN-E indicated R25 had highly advanced dementia and there were no specialized activities for R25 and there was not a lot that could be done for residents like R25 who had advanced dementia. LPN-E said R129 had no attention span and there were no attempts of any one to one activities with him while he walked in the hall. LPN-E said staff attempted to assist R129 sit or lie down when he was tired, however he walked around and did his own thing. LPN-E thought she had talked to recreational therapy to step in and visit with him.

Activity assistant (AA)-A was interviewed on 3/28/19, at 9:45 a.m. and said she tried to provide person centered activities. AA-A said a lot of the residents on the Alzheimer's unit wanted to stay in their rooms and sleep and a lot and residents fell asleep during activities. AA-A stated she tried to incorporate a hand massage or exercise to keep the resident's awake. AA-A said R25 liked sing along's and hand massages. AA-A said R129 had

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	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 744	Continued From page 67	F 744		

a short attention span and roamed the halls all day. When able, AA-A would get R129 to sit down and give him a hand massage and take R129's hand over hand to manipulate play dough. AA-A invited everyone to activity groups and did not have groups specifically for residents with severe cognitive impairment, if there was a resident that needed extra engagement, AA-A would do more one on one visits with that resident. Activity attendance records indicated R129 received one on one visits 1 x a week.

Social services (SS)-A was interviewed on 3/28/19, at 10:07 a.m. SS-A said he talked to R129 when he walked down the hall about the weather and other general topics and if R129 seemed tired, SS-A would let staff know so R129 could lay down. SS-A and nurse manager, LPN-E, had talked with R129's wife about suggestions and interventions for R129 when he wandered and there were no suggestions at this time. SS-A said that he worked with families and residents to provide person centered care. When asked why resident rooms on the unit were sparse of personal items and the nursing unit lacked homelike features, SS-A said he talked to families to not bring in expensive things in case they get lost and agreed the nursing unit was stark and lacked homelike features. SS-A said himself, LPN-E and AA-A were going to start to work on shadow boxes outside resident rooms to personalize the room for the residents.

The director of nursing (DON) was interviewed on 3/28/19, at 10:37 a.m. and indicated staff were trained yearly on dementia care and Alzheimer's. The DON said staff learn about the residents and what they like to do. The DON said there were various busy boxes on the unit, and the activity

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F 744	Continued From page 68 staff had done some videos on television with You Tube and visual things. Staff have found past interests of residents and created busy boxes for those interests. The DON said he would expect to staff to keep R129 engaged and try to get into activities and specific activities geared towards the individual person.	F 744		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		5/15/19

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 758	Continued From page 69 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure pharmacy recommendations were followed for 1 of 5 residents (R130) reviewed for unnecessary medications, Findings include: R130's quarterly minimum data set (MDS) dated 3/5/19, indicated he was moderately cognitively impaired, required one staff assistance for activities of daily living and was incontinent of bowel and bladder. The MDS indicated R130 displayed verbal behaviors during the assessment period but did not display physical behaviors. The MDS further indicated R130's behaviors did not place himself or others at risk for injury. R130's care plan dated 3/8/19, identified an alteration in mood and behavior	F 758	All residents in the facility who are on psychotropic medication have the potential to be affected. R130 has discharged from the facility. The pharmacy will continue to conduct their monthly review of psychotropic medications and send to the facility. The facility nurse managers and social services staff will address the recommendations in the resident medical record. The facility has implemented a monthly medication review meeting as part of the QAPI process with the Medical Director and pharmacist. Pharmacy recommendation implementation will be audited monthly and the QAPI will provide redirection/recommendations based on	

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F 758	Continued From page 70 related to a diagnosis of intermittent explosive disorder and vascular dementia. The care plan indicated R130 met regularly with Associated Clinic of Psychology (ACP). The care plan further directed staff to be alert to mood and behavior changes, offer food and fluid frequently encourage him to verbalize his feelings. R130's Order Summary Report was reviewed and identified the following orders: 12/21/19. Keppra (used to treat seizures) 500 milligrams (mg) every twelve hours. 12/21/19, Valproic Acid (used to treat seizures and bipolar disorder) 10mg twice daily. 1/21/19, Seroquel (antipsychotic medication used to treat certain mental/mood conditions (such as schizophrenia, bipolar disorder, sudden episodes of mania or depression associated with bipolar disorder) 25 mg daily for agitation. 12/26/18, Seroquel 600 mg in the evening, increased from 400 mg. Review of facility Progress Notes, Twin Cities Physicians visit notes and ACP progress notes identified the following: 12/13/18, A Twin Cities Physicans visit note indicated R130 was seen due to frequent falls. The note indicated R130 knew he had impulse behaviors and tried to remind himself to wait for help. R130 has had a few falls recently and attributed the falls to him getting impatient after waiting a significant amount of time for help to get up. R130 stated this was especially a problem on the over night shift when staff told him they were going to return and then did not. Discussed this with nurse manager. Question such a high dose of Seroquel at night, please address with psych	F 758	existing audits. The DNS/Designee will be responsible for compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 71	F 758		

regarding reducing this dose.

1/1/19, Twin Cities Physician visit note indicated R130 was seen to follow up after being moved to a locked unit. R130 lying in bed, calm and cooperative. Stable, continue with current medications.

1/2/19, facility Progress Notes indicated R130 was upset about being in room with a room mate and refused to go to bed. 1/3/19, R130 agitated and yelling about wanting to go out and smoke has been pounding on the doors. Currently downstairs with family. 1/4/19, R130 found on the floor between the toilet and the wall. 1/5/19, R130 up in wheel chair, family here to encourage him to use smoking room instead of going outside. R130 was agreeable. 1/7/19, no behavior noted. 1/8/19, R130 was observed outside the building smoking independently on 1/7/19, three separate times. Staff was able to redirect him after much encouragement not to go outside. R130 was loud and swearing about this. 1/9/19, daughter was updated on R130 wanting to go outside to smoke. Daughter would like R130 to be re-evaluated for removal of the wanderguard and for safety while smoking. 1/10/19, R130 found sitting next to his bed. R130 stated he missed the bed and sat on the floor. 1/14/19, R130 found sitting on the floor and stated he was sitting on the bed and slid to the floor.

1/14/19, R130 seen by ACP social worker. R130 was sent to the hospital and was admitted back to the facility on the secured unit. He was adamantly opposed to being on the unit where he did not have any access to smoke and subsequently acted out by yelling and banging on the wall and furniture. He was recently moved to a private

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	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 758	Continued From page 72	F 758		

room following a care conference. His behavior has improved now that he is able to smoke. R130 presented in a fair mood with a calm affect. He was appreciative of the move to second floor where he had the ability to smoke. It appears that his behavior improves when he is allowed to do what he wants such as smoking outside the building.

1/15/19, facility Progress Notes indicated R130 seen by the back door several times allowing the alarm to sound. Several staff attempted to re-direct him. R130 stated "I'm just doing it to bug you." After 10 minutes R130 returned to his floor. 1/16/19, R130 was found on the floor next to his bed following a loud noise. Stated he was transferring himself to bed and fell.

1/16/19, R130 seen by ACP psychiatrist. R130 alert and awake and reported doing well. Suggest discontinuing morning dose of Seroquel today.

1/17/19, Facility Progress notes indicated R130 was found on the floor in his room and stated he missed the bed. 1/20/19, R130 was found on the floor with his back against the wheel chair. 1/21/19, R130 again found lying on the floor two separate times. 1/21/19, 1/21/19, R130 was again found on the floor. Progress Notes indicated R130 was intentionally placing himself on the floor. A medication review was sent to pharmacy midday which was returned recently. Results relayed to Twin Cities Physican's along with an update on behaviors. Doctor decided R130 should be sent to the hospital since R130 had been trying and threatening to throw himself on the floor. 1/21/19 at 5:30 p.m. police officers arrived and calmed resident down and R130 refused to go to the hospital. Medics told staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 758	Continued From page 73	F 758		

they would not take R130 without a hold order.

A Polaris pharmacy Note To Attending Physician/Prescriber dated 1/21/19, indicated a medication review was requested for R130 due to behavior changes, falls, self transfers and sedation. The following medications can cause dizziness, lethargy, behavioral changes/agitation, central nervous system depression or confusion and may increase fall risk: Seroquel, Valproc Acid, keppra. Recommendations included: Consider dose reduction of any of the above medications, as appropriate. The medical record lacked evidence of follow up to the pharmacy recommendation,

1/22/19, R130 was observed lying on the floor on his back. 1/23/19, R130 was asleep until 3:00 a.m. when he yelled for help, he was found on the floor and assisted back to his wheel chair. At 5:10 a.m. R130 was witnessed throwing himself on the floor. 1/24/19, R130 was again found on the floor and stated he put himself there. 1/23/19, R130 found on the floor next to his bed with head on a pillow and covers wrapped around him. R130 stated he had been asleep. 2/3/19, R130 slid to the floor from the edge of his bed and called out for help. 2/21/19, R130 was found on floor yelling for help. He stated he was self transferring and missed. The Progress Notes identified falls on 3/4/19, 3/8/19, 3/13/19, 3/19/19 and 3/26/19.

During interview on 3/25/19, at 5:37 p.m R130 stated he was stressed out and sad because he could not leave the facility. R130 stated he escaped out the front door once. R130's family member (FM)-A stated the facility locked R130 in the memory care unit and put a wanderguard on him. FM-A stated she was told at the time there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 758	Continued From page 74	F 758		

was not enough staff to watch R130 and stated she "cried the whole time." FM-A stated the facility sent R130 to the hospital but the hospital sent him back because nothing was wrong with him and when he came back they had moved him to the locked unit. R130 stated, "they had a bracelt on me, I felt like a chimpanzee."

During an interview on 3/28/19, at 8:54 a.m. the social service director (SSD) stated R130 was scheduled to discharge to a group home soon. He stated the county had called him to discuss R130's assessment, transfer needs and behaviors and he told them R130 had "really cleared up" in the recent months. The SSD stated initially R130 admitted to the first floor transitional care unit but after the elopement concern in December he had been moved to the secure unit. The SSD stated family was very upset and R130 was moved to the second floor and gradually got better. He stated since R130 had been moved to the second floor he has had some hope and something to look forward to and had only had a few outbursts of anger. The SSD explained if staff gave R130 a few minutes of their time and reassured him he became much easier to re-direct. He stated R130 was still anxious, but not angry and stated he had gotten comfortable on the second floor and was not as isolated anymore. The SSD stated, "I do think he is doing better."

During interview on 3/28/19, at 9:42 a.m. registered nurse (RN)-E stated R130's behaviors had decreased since moving to the second floor. RN-E stated there was a 5 day stretch where staff felt R130 had been putting himself on the floor in late January but stated he was doing much better. RN-E stated the behaviors stopped

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	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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F 758	Continued From page 75 abruptly and staff had not been able to determine the cause. RN-E stated R130's behaviors had really improved. During interview on 3/28/19, at 1:52 p.m. the director of nursing stated around January 20th or 21st R130 was having a shift in behavior, placing himself on the floor and yelling out a lot. He stated RN-E felt it could have led to an injury. The SSD, also present stated staff felt the behaviors may have been medication related. The DON stated since January 21st none of R130's medications had been decreased despite the recommendation from the pharmacy. When asked about the facilities process for following up on pharmacy recommendations, the DON stated the facility did not have a process on their end and relied on the pharmacist to follow up on whether the recommendations had been implemented.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		5/15/19

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F 812	Continued From page 76 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to store and prepare food under sanitary conditions. This practice had the potential to affect residents who ate food prepared from the kitchen and/or kitchenettes. Findings include: An initial tour of the kitchen was conducted on 3/25/19, at 11:45 a.m. with the assistant director of culinary services. Upon entering the kitchen and washing of hands there were no paper towels in the dispenser to wipe hands. The assistant director of culinary services refilled the towel dispenser once it was pointed out. The dry storage area housed paper products and chemicals in a separate white cabinet. The floor in the dry storage area had debris under the food storage shelves of dirt and other plastic materials such as white plastic spoons, and broken glass. The assistant director of culinary services stated the staff swept the floor but did not sweep under the shelves as evidenced by the dirt and other materials found under the shelves on the floor during the tour. The walk in freezer had three large ice chunks side by side on the floor. the assistant director of culinary services stated the stand up freezer "went out last week" and was showing a minus 20 degrees and a work order had been placed.	F 812	All residents have the potential to be affected. The culinary staff have restocked the paper towels in the dispenser for the handwashing sink in the kitchen. The dry storage was cleaned out the week of April 8, 2019 and will be cleaned weekly. Ice build-up has been removed from the walk-in freezer and will continue to be monitored for further build-up. A thermometer has been placed in all freezers and refrigerators cited as having lacked a thermometer. The pans that were stacked and still wet have been dried appropriately. The oven with an out of order sign has had parts ordered to be repaired, however, the kitchen also has 3 other operable ovens for staff to complete meal service appropriately. The meat slicer has been cleaned and stored away as the facility does not use it on a regular basis. All other equipment that are not used regularly have been cleaned and stored away.	

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F 812	Continued From page 77 The dairy refrigerator (white 2 doors) had no thermometer. The pantry which housed the stored dishes and pans had three wet stacked pans used on the serving cart. One oven had an out of order sign on it and it was confirmed the oven did not work. The meat slicer was found to have some grease on it and the assistant director of culinary services indicated that the facility buys meat already sliced and they did not use the food slicer The assistant director of culinary services stated the facility had six dinette areas and the kitchen staff were responsible for cleaning the kitchenettes and reviewing the food for expired dates. The six kitchenettes were located as follows: first floor, TCU and 1 North, second floor 2 E and 2 N, and third floor Alzheimers' care unit (ACU) and the advanced (ACU), secured unit. The transitional care unit (TCU) on 1st floor had a refrigerator/freezer combination and there was no thermometer in the freezer. On 1 North, the kitchenette had a refrigerator/freezer combination and there was no thermometer in the freezer. The 4 slice toaster had a heavy layer of bread crumbs on the bottom. The cabinet door on the lower level had a door coming off the hinges. On 2 North, the kitchen had a 4 slice toaster that had a heavy layer of crumbs on the bottom of the toaster. The refrigerator/freezer combination had no thermometer in the freezer or the refrigerator. On 2 East, the kitchenette had a	F 812	All toasters cited as having bread crumb build up have been cleaned. All other toasters have been audited and cleaned as necessary. The microwave that has been cited as having discoloration was cleaned thoroughly however the facility has replaced this. All other microwaves were audited for cleanliness. All staff have been re-educated to the proper practices as it relates to the issues cited. Audits will be conducted weekly for 4 weeks, monthly for 2 months, and then the QAPI will determine the future monitoring schedule. The Director of Culinary Services/designee will be responsible for compliance.	

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 ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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F 812	Continued From page 78	F 812		

refrigerator/freezer combination and the freezer had no thermometer. The 4 slice toaster had heavy build up of bread crumbs.

On 3rd floor, the ACU kitchenette had a microwave and inside the microwave the plate had dried on white spills. There was a refrigerator/freezer combination and the freezer had no thermometer.

The advanced ACU, secured unit had a refrigerator/freezer combination and there was no thermometer in the freezer. There was a small white microwave inside the cupboard that had a medium gray color on the sides and top of the microwave.

At the end of the tour of the kitchenettes, the assistant director of culinary services confirmed the lack of thermometers in the refrigerator/freezer combinations and questioned who was taking all the thermometers. On all six kitchenettes there were no thermometers in the freezer. The assistant director of culinary services said this had been an ongoing problem and that he goes through a box of thermometers every month. At the start of the kitchenette tour, the assistant culinary director took a handful of thermometers with him and replaced the thermometers.

The dumpsters outside were then observed. There were two garbage dumpsters, both dumpsters had a lid on, around one of the garbage dumpsters were hundreds of white plastic used gloves, plastic med cups and broken plastic cups. The assistant director of culinary services commented,
"this is terrible, it should be cleaned immediately,

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	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 812	Continued From page 79 maintenance is responsible for it." On 03/27/19, at 1:00 p.m. a second tour of the kitchen was done with the assistant director of culinary services. The bread room had a fan sitting on the floor that had a heavy layer of gray dust on all its blades. The milk cooler contained a staff member's personal lunch. The microwave on the advanced ACU was checked. Although it had been cleaned, there was a gray discoloration on the sides and top of the microwave. The findings were confirmed with the assistant director of culinary services.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the facility's garbage and refuse was disposed of properly. This practice had the potential to affect residents and staff who accessed the area. Findings include: On 3/25/19, at 11:45 a.m., a tour was conducted outside the building by the dumpsters with the director of culinary services. There were two dumpsters with closed lids. On the ground, around one garbage dumpster there appeared to be hundreds of white plastic used gloves piled up, plastic med cups, broken plastic cups, and	F 814	All residents have the potential to be affected. The outdoor area near the ambulance entrance was cleaned on 4/26/19, the facility ordered a dumpster to throw large items away. Facility staff also did a facility grounds clean up. The facility will audit this daily to ensure compliance. The laundry lint receptacle has been replaced on 4/8/19. Facility protocols and procedures related refuse removal/disposal have been revised. All staff have been re-educated on proper garbage/refuse disposal practices.	5/15/19

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 814	Continued From page 80 various other garbage. The director of culinary services stated, "this is terrible, it should be cleaned immediately, maintenance is responsible for it." In addition, the side of the building near the area designated for resident smoking a structure that had an appearance of a smoke stack. At the bottom of this structure was a big hole in a black plastic basket that was supposed to catch the dryer lint. The lint was observed in multiple piles around the stack and some of the lint was being blown around by the wind. The smoking area had numerous cigarette butts that had accumulated throughout the winter months on the ground. The director of culinary services stated that these areas were the responsibility of maintenance. On 3/27/19, at 2:06 p.m. R99 was observed out in the smoking area having a cigarette. R99 stated the smoking area had been cleaned up on Monday. R99 pointed to an area across from the smoking area that had bed frames, book cases, desks, and multiple flat palates. R99 stated that the construction workers just threw things out there from the second floor area that was being remolded, and emphasized how disgusting the area looked. On 3/27/19, at 2:08 p.m. the outside area near the dumpsters, smoking area, lint smoke stack, and area of construction, was revisited and observed with the director of maintenance. In the dumpster/garbage area, the majority of the gloves and some garbage had been cleaned up. Remaining on the cement slab were used gloves, plastic med cups, and broken plastic glasses. The broken lint basket had lint flying out of it into	F 814	Audits will be completed weekly for 4 weeks, monthly for 2 months and the QAPI will review for further recommendations thereafter. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The Director of Maintenance, Director of Housekeeping, Director of Culinary, and Director Nursing will be responsible for compliance.	

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F 814	Continued From page 81 the sitting area near the smoking area. The maintenance director said he needed to replace the torn basket with a new basket. The maintenance director obtained a broom to sweep the area.	F 814		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, 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;	F 880		5/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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F 880	Continued From page 82 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate hand hygiene for resident cares and wound cares for 3 of 3 residents (R134, R114, R5). In addition	F 880	All residents in the facility have the potential to be affected. R134 is discharged from the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 880	Continued From page 83 the facility failed to ensure all room tray items were covered while transported through the hallways. Findings include: R134 was observed on 3/25/19, at 6:30 p.m. during wound cares. Registered nurse (RN)-F and licensed practical nurse (LPN)-H provided wound cares to R134's stage IV left buttock wound (Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures). Although RN-F changed her gloves at appropriate times, she did not perform hand hygiene after the gloves were removed. RN-F verified that she had not performed hand hygiene between glove changes. R114 was observed on 3/26/19, at 6:30 a.m. during perineal cares (incontinent of urine and stool and change of incontinence product). Nursing assistant (NA)-B and NA-C prepared supplies, rolled R114 toward her left side, NA-B undid incontinence product and then began to use the wipes to remove the stool on R114 buttocks and legs, several wipes (7-8) needed to be used to remove the incontinent stool. After cleaning skin, NA-A used the same gloves to put a clean incontinence pad under R114, and tucked it partially under. Without removing gloves or performing hand hygiene NA-B had NA-C roll R114 toward the right side. NA-B used her unchanged/considered soiled gloves to pull R114 toward her right side. NA-C then continued to remove incontinent stool from R114's skin. Without changing gloves NA-C then attempted to pull the clean incontinent product from under R114, however the incontinence product ripped when NA-C attempted to place it correctly under	F 880	R114 is discharged from the facility. R5 is discharged from the facility. Immediate staff education was completed during the survey regarding appropriate glove usage and hand hygiene. Policies and procedures regarding peri-care, wound care, and infection control were reviewed and remain appropriate. Nursing staff were re-educated on policies and procedures regarding infection control as it relates to glove usage and hand hygiene for peri-care and wound care. The policy and procedure related to room trays was revised. Food and drinks will be covered for all room trays. Culinary and Nursing staff were re-educated on infection practices related to room trays. Audits of direct care staff will occur weekly for 4 weeks, then every month for 2 months to ensure that standard for proper glove usage are being met including hand hygiene. Audits of meal services will occur weekly for 4 weeks, then every month for 2 months, then QAPI will review for further audits and monitoring. The Director of Nursing and Director of Culinary Services or their respective designees will be responsible for compliance.	

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F 880	Continued From page 84	F 880		

R114. The NA's then rolled R114 back to her left side. NA-B without removing her gloves, went to the clean supplies and reached for a clean incontinence product, returned to R114 and put the clean incontinence product under R114. NA-B and NA-C verified they had not changed gloves or performed hand hygiene.

On 3/27/19 at 8:30 a.m. the director of nursing (DON) stated it was his expectation that staff glove and perform hand hygiene when entering the room and change gloves and do hand hygiene after incontinence cares. The DON explained that before touching any linens or going to clean area, remove gloves, perform hand hygiene and then put on clean gloves.

R5's Admission Record indicated R5 was admitted to the facility on with 5/13/16, with diagnoses of lymphedema, morbid obesity, and open wounds on left lower leg. R5 was alert and oriented to person, place and time. R5 had two open wounds on her left lower leg.

On 3/25/19, at 4:47 p.m. registered nurse (RN)-C entered R5's room to complete dressing changes on open wounds on R5's left lower leg. RN-C washed his hands and put on gloves after preparing the supplies. RN-C removed the dressing from R5's left lower leg and picked up the wound cleaner and cleansed the two wounds. Without changing gloves or washing hands, RN-C picked up the Xeroform (dressing) and placed it in the wound on R5's inner left leg fold. RN-C was stopped and asked to step out of the room. Outside the room RN-C was asked about when changing gloves and handwashing should occur. RN-C stated he should have removed his

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	245148	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 880	Continued From page 85	F 880		

gloves and washed his hands before putting the clean dressings on. RN-C reentered the R5's room. RN-C washed his hands put on clean gloves, removed the Xeroform from the wound, removed his gloves, washed his hands, put on clean gloves and applied clean dressings to both of the wounds on R5's leg.

On 3/28/19, at 10:54 a.m., the director of nursing stated that the expectation was gloves should be removed and hands washed between dirty and clean, on all dressing changes.

On 3/25/19, at 12:14 p.m. it was observed during the lunch meal services on 1 North Rose that 3 of the 4 room trays did not have the salad, desserts, or beverages covered as the trays were carried down the hall from the dining room.

- At 12:45 p.m. dietary aide (DA)-A stated all the food and beverages on the room trays should be covered when the tray is transported to the resident rooms.

On 3/25/19, at 6:33 p.m. during the supper meal services on 1 North, 6 of 6 meal trays were observed being delivered to resident rooms without covers on the salads and beverages.

On 3/27/19, at 8:37 a.m. during dining observation it was noted nursing assistant (NA)-H was preparing room trays on a 3 shelf cart. Three of the nine trays were covered with a full tray cover and taken to resident rooms on 1 North.

- At 8:48 a.m. NA-H pushed the 3 wheeled cart down the hall with the remaining 6 trays on it. None of the beverage glasses or brown sugar

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F 880	Continued From page 86 cups were covered. Full tray covers were available, but not used. On 3/27/19, at 11:28 a.m. the corporate culinary director stated that all food and beverages should be covered with a full tray cover or each item covered individually prior to going down the hall from the dining room.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		5/15/19

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F 883	Continued From page 87 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the influenza and the appropriate pneumonia vaccine Pneumococcal polysaccharide vaccine (PPSV23) was offered and provided for 3 of 5 residents (R122, R63, R34) reviewed for immunizations. Findings include: The Center for Disease Control (CDC) and Prevention identified, PPSV-23 vaccine was for all adults older than 65 years and for those	F 883	All residents have the potential to be affected. R122 is discharged from the facility R63□s responsible party was called and offered to provide the flu vaccine. R34's responsible party was called and offered to provide the pneumococcal vaccine. A house wide audit was performed to identify residents who are eligible for the	

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F 883	Continued From page 88 younger than 65 who are at high risk for Pneumococcal disease or complications from Pneumococcal disease. In addition, Pneumococcal conjugate vaccine (PCV13) was for use in infants and young children and adults 65 years or older. Older children and adults younger than 65 years old who were at increased risk. R122's Admission Record dated 3/26/19, indicated R122 was admitted to the facility on 2/22/19, and was 46 years old. During a review of the medical record, it was revealed on 2/25/19, R122 had signed a consent for the facility to give the PPSV23 and influenza, however no orders had been obtained from the physician to administred the immunization. R63's Admission Record dated 3/26/19, indicated R63 was admitted on 10/15/15, and was 67 years old. The facility Immunization Report dated 3/26/19, lacked evidence influenza vaccine had been offered during the recommended timeframe's October 1st through March 31 for the 2018-2019 Influenza session. The medical record also revealed a consent was required in the immunization record, however no attempts had been made to obtain it from R63's responsible representative. R34's diagnoses included quadriplegia, anoxic brain and dysphagia obtained from the Admission Record dated 3/26/19. During a review of R34's Resident Vaccine Administration Consent Form dated 2/19/19, it was revealed R34's responsible party had provided a telephone consent for R34 to receive the PCV-13 vaccine. The medical record lacked documentation of staff obtaining an order from the physician to administer the	F 883	pneumococcal vaccine. Pneumococcal vaccine will be offered to all new admissions as appropriate. Influenza vaccine will be offered to all eligible residents between October 1st and March 31st of each year. Policies and procedures regarding immunization for influenza and pneumococcal were reviewed and remain appropriate. Nursing staff was re-educated on immunization guidelines for Influenza and Pneumococcal Vaccine. Audits will be conducted weekly for 4 weeks, monthly for 2 months and then QAPI will determine future auditing schedule thereafter and will provide redirection/recommendations based on existing audits. The Director of Nursing or designee will be responsible for compliance.	

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F 883	Continued From page 89 immunization. On 3/27/19, at 2:37 p.m. licensed practical nurse (LPN)-F verified the missing immunizations. She stated for R34 and R122 since consents had been signed the immunizations should have been administred after getting orders from the physician. LPN-F stated R63's Influenza consent should have been obtained so R63 could receive the vaccination. LPN-F stated she was going to follow up with the concerns to make sure residents received the immunizations. The Influenza policy dated 11/2017, directed Influenza vaccination would be administered in accordance with current Center for Disease Control (CDC) recommendations at the time of the vaccination and would be documented in the resident's medical record. The policy also indicated between October 1st and March 31st each year the Influenza vaccine would be offered to the resident's and staff unless medically contraindicated or had already been vaccinated. The Pneumococcal policy dated 9/08, directed upon admission to the facility (within 5 days) all residents would be assessed for current immunization status and eligibility to receive the pneumococcal vaccine and with 30 days of admission would be offered the vaccine when indicated unless the resident had already received the vaccine or was medically contraindicated.	F 883		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,	F 921		5/15/19

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F 921	Continued From page 90 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents environment specific to resident rooms 263, 282, 284, 286, 271, 273, and shared bathroom/shower, were maintained in good repair and in a clean manner in multiple units of the facility reviewed for environmental concerns, potentially affecting 4 residents (R88, R64, R120, R11) and others that use the shared bathroom/shower. Finding include: 2 East Environment issues: On 3/25/19, at 12:00 p.m. during the initial tour of the facility the floors in room 263 where R88 resided were noted to be sticky. R88 was observed lying in bed at the time and under and around the bed there was thick buildup layer of dust and bread crumb debris on the floor. In addition, the privacy curtains were observed soiled with large visible brown and yellow stains which were noticeable from standing outside the room in the hallway. When approached R88 was not able to speak English and just smiled at surveyor when asked questions. On 3/26/19, at 8:57 a.m. to 9:11 a.m. privacy curtains remained dirty and the dust buildup, bread crumb debris and the floor remained sticky when walking on it. R88 was observed to use a large towel to sweep the bread crumbs under the bed. On 3/26/19, at 9:00 a.m. housekeeping staff	F 921	All residents have the potential to be affected. R120 has discharged from the facility. R64 is discharged from the facility. R88□s floors have been cleaned and privacy curtain replaced. Resident rooms have been audited for floor cleanliness and privacy curtain cleanliness and corrections have been made as necessary. Privacy curtains and floor tiles for the resident rooms and bathrooms listed have been repaired or replaced. Privacy curtains have been replaced for all other rooms that are needed. Deep cleans and dusting have been completed for all rooms listed. Deep cleans and dusting has been completed for all other resident rooms. Toilets have been re-caulked for the toilet listed. All other resident toilets that required re-caulking have been re-caulked. The communal shower room listed was deep cleaned and all other shower rooms in the facility have been deep cleaned. Caulking around the toilet for the bathroom between room 282 and 284 has been completed. Resident bathrooms	

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F 921	Continued From page 91 verified the floor was sticky and there was a lot of debris of dust and bread crumbs under the bed and on the floor by R88's bed. The housekeeping staff stated going by the state of the room at the time she did not believe the floors had been cleaned the previous day. The housekeeping staff stated R88 would refuse the room to be cleaned at times and she would report to nursing. On 3/26/19, at 9:15 a.m. went to the room 263 with the director of house keeping and the housekeeping manager in training who verified the privacy curtain was not clean and floor were not clean. The director of house keeping stated she would have the room cleaned right away and she was not aware R88 would refuse to have the room cleaned. On 3/27/19, at 1:42 p.m. to 1:52 p.m. the environmental tour was conducted with the director of housekeeping and the maintenance director. On 3/25/19, at 12:45 p.m. room 282 was observed cluttered, had multiple balls of paper on the floor and heavy food debris was lying on the floor from the entrance. The heat register was observed to be heavily soiled with smears of brown and yellow substance which was noticeable from standing in the hallway. In addition, the air conditioner on the wall next to R64's bed was observed to be covered with heavy fluffy grey substance and dust on the vents and on top and next to R64's bed was a broken tile and had missing piece. On 3/26/19, at 9:00 a.m. the room remained the same even though the housekeeping staff was observed go from room to room in the hallway	F 921	have been audited for caulking around the toilets and recaulking has been completed as necessary. Policies and Procedures related to housekeeping and maintenance protocols were reviewed and remain appropriate. Staff have been reeducated to proper cleaning practices and reporting of maintenance and housekeeping issues. Staff have also been re-educated regarding the reporting of maintenance and housekeeping issues. Audits will be completed weekly for 4 weeks, monthly for 2 months, and then the QAPI will determine further auditing. QAPI committee will review results and provide re-direction or change when necessary and dictate continuation or completion of this monitoring process. The Director of Maintenance and Director of Housekeeping will be responsible for compliance.	

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F 921	Continued From page 92	F 921		

where the room was located but never attempted to clean it.

During the environmental tour the director of housekeeping verified although the floor had been mopped it was sticky to walk on. She verified the heat register and air conditioner had not been cleaned. Also the director of maintenance stated he would fill the hole as the floor would not be ripped off due to asbestos.

On 3/26/19, at 9:00 a.m. during a tour to the shared bathroom for room 284 and 282 the base of the toilet was observed with multiple missing tiles and cocking all around the toilet. In addition, it was observed a broken white tile at shoulder level by the bathroom door from room 286.

During the tour the director of maintenance verified the missing and broken tiles.

On 3/25/19, at 5:15 p.m. the shared toilet for rooms 271 and 273 was observed with multiple missing tiles in front of the toilet along the step to the bathroom floor. During the tour R120 was observed in the room and as surveyor came out of the bathroom he stated "Do you think it's clean and kept well." Also the bathroom door from room 273 was observed with a deep large gouge on the inside of the door at ankle level. In addition, the privacy curtains at the door and between residents in room 271 were observed soiled with brown and black stains which were noticeable when standing outside the hallway.

During the tour both the director's of maintenance and housekeeping verified the concerns.

Shared bathroom/shower:

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F 921	Continued From page 93 On 3/27/19, at 7:15 a.m. to 10:24 a.m. the shared bathroom by the nursing station was observed with a strong smell which was noted from standing outside in the hallway. Inside the toilet bowl was observed stained with stool and there was a strong odor. During the observation multiple staff went past the bathroom and nursing assistant (NA)-M assisted R11 with a shower however never alerted housekeeping to clean the shower/bathroom area. On 3/27/19, at 1:49 p.m. the communal bathroom/shower room remained the same and the director of housekeeping verified the concerns and stated she was going to have it cleaned immediately. On 3/27/19, at 8:04 a.m. anonymous staff approached surveyor and stated "the environment is a mess in 2 East. " The staff further stated a lot of the rooms were in ill repair, the rooms were not deep cleaned regularly and thought residents environment was not kept clean for them.	F 921		

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	245148	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2019**

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THE ESTATES AT ST LOUIS PARK LLC	**3201 VIRGINIA AVENUE SOUTH** **SAINT LOUIS PARK, MN 55426**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 28, 2019. At the time of this survey, The Estates at St. Louis Park was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/02/2019

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
	245148	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/28/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The Estates at St. Louis Park is a 3-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II (222) construction. In 1972 a two- story addition was constructed to the East Wing and determined to be of Type II (222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 220 beds and had a

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K 000	Continued From page 2 census of 149 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 541 SS=D	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not seal the vertical chute with the appropriate fire protective rating in accordance with NFPA 101 (2012), Life Safety Code, section	K 541	All residents have the potential to be affected. The third-floor laundry chute door handle was replaced which allows the door to the	5/15/19

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K 541	Continued From page 3 9.5. This deficient practice could effect all residents in the affected room. Findings include: On a facility tour between the hours of 10:00 AM and 2:00 PM on March 28, 2019, it was revealed that the third floor laundry chute door did not positively latch while self-closing. This deficient practice was verified by the Director of Facility Maintenance at the time of discovery.	K 541	chute to latch while self-closing. Staff were educated on the process of notifying maintenance with environmental concerns. Audits will be conducted weekly for 4 weeks, monthly for 2 months, and then the QAPI will determine further monitoring thereafter. Director of Maintenance or Designee is responsible for compliance.	