DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 10, 2023

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

RE: CCN: 245148
Cycle Start Date: May 4, 2023

Dear Administrator:

On June 23, 2023, we notified you a remedy was imposed. On July 5, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 4, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 8, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 23, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 2, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 24, 2023

REVISED LETTER

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

RE: CCN: 245148
Cycle Start Date: May 4, 2023

Dear Administrator:

This letter, sent on May 24, 2023, will replace the letter dated March 19, 2023. I have corrected the Scope and Severity (S/S) from F to E.

On May 4, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 August 4, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 4, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 05/04/2023

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 On 5/1/23 to 5/4/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/1/23 to 5/4/23, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued: H5148406C/MN81979 H5148407C/MN82363 H5148408C/MN82752 H51481880C/MN83578 H51481862C/MN86722 H51481861C/MN88202 H51481713C/MN92377 H51481881C/MN89105 H51481840C/MN89313 H51489022C/MN91577 H51481767C/MN92189 H51481767C/MN92242 H51481767C/MN92205	F 000		

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

Electronically Signed | 05/26/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 H51481860C/MN88490 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		6/9/23

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F 550	Continued From page 2 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified toileting routine for 1 of 1 resident (R19) who expressed feelings of "degradation" over the facility toileting process. Findings include: R19's quarterly Minimum Data Set (MDS) dated 4/19/23, indicated R19 was cognitively intact and received assistance with all activities of daily living (ADL's). R19's care plan revised on 12/13/22, indicated R19 required assistance with toileting, and directed staff to provide staff assistance with peri-care every 3 hours and as needed (PRN) and to provide incontinent products and assist to change as needed. When interviewed on 5/1/23, at 3:07 p.m. R19	F 550	Immediate Corrective Action: Resident will be toileted per preferences, as able. Residents care plan was adjusted quarterly. Corrective Action as it applies to others: A whole house bowel and bladder assessment audit completed and tailored as necessary to resident preference. Recurrence will be prevented by: Education completed with Nursing leadership and educated nursing staff related to resident preference and resident rights. Bowel and bladder assessments will be audited for all new residents going forward, weekly x 4 weeks and results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Any discrepancies will be	

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F 550	Continued From page 3 stated that he had previously (at previous facility) used a bedpan for toileting. R19 stated when he was first admitted to this facility, he had asked for a bed pan and was told they do not use bed pans here and was instructed to have a bowel movement in his incontinent brief. Staff would help him clean up. When interviewed on 5/3/23, at 3:02 p.m. R19 stated that he has not asked staff to use a bedpan since he was told no, as he thought that was the way the facility did things. R19 stated, "makes me feel like you are 80 years old, what the hell, and that you just lay around and you might as well just go in your pants. That is the impression that I got. Still bother me as I know that is not the way it is supposed to be done. It is degrading to go in your pants to begin with and then having staff clean you up." When interviewed on 5/4/23, at 8:55 a.m. nursing assistant (NA-C) stated R19 was always incontinent of bowels and had never requested to use a bedpan. When interviewed on 5/4/23, at 9:31 a.m. licensed practical nurse (LPN-D) stated R19 was incontinent of bowels and needed staff assistance to change him. LPN-D stated that he was not aware R19 would prefer to use a bedpan. When interviewed on 5/4/23, at 9:52 a.m. LPN Care Coordinator (LPN-C) stated R19 would let staff know if he was having bowel issues because, "he knows," he knew when he needed to move his bowels. LPN-C stated the facility had never conducted a bowel assessment on R19 as once incontinent of stool, they would always be incontinent. However, then stated, R19 is aware	F 550	addressed immediately. Corrections will be monitored by: Administrator/DON or designee	

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F 550	Continued From page 4 of when he needs to have a bowel movement, therefore would be able to alert staff to when he needed the bed pan. LPN-C was not aware R19 had a preference to use a bed pan rather than soil himself. LPN-C stated, R19's care plan directed staff to check his pad and change it every 3 hours, therefore, would never offer a bedpan. When interviewed on 5/4/23, at 12:58 p.m. the director of nursing (DON) stated a bowel and bladder assessment was completed on admission and then annually or with a significant change. DON stated nurse managers perform assessments and should be asking the resident their preference as they want to encourage as much independence for the resident as possible. DON stated it was not acceptable for the nurse manager to assume that when a resident is incontinent then they would always be incontinent and a reassessment should be performed. DON was not aware of R19's preference of wanting to use a bed pan. A review of R19's Bowel Evaluation dated 1/16/23, indicated R19 was not continent of bowel and was not appropriate for bowel retaining plan. R19's individualized treatment plan denitrified R19 was a full body lift transfer with assist of 2, toileting plan was to check & change every 3 hours and as needed, incontinent of bladder and bowel. The Activities of Daily Living (ADLs)/Maintain Abilities policy dated 3/31/23 indicated "it is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts	F 550		

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F 550	Continued From page 5 and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility will provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable."	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident was comprehensively assessed for self-administration of medications for 1 of 1 resident (R9), who were observed self-administering medications. R9's quarterly MDS dated 2/1/23, identified R9 was cognitively intact, and required supervision with ADL's. Findings included: R77's quarterly Minimum Data Set (MDS) dated 4/11/23, identified cognitively intact. R9's quarterly MDS dated 2/1/23, identified	F 554	Immediate Corrective Action: Inhaler and nebulizer medication was taken away from the resident immediately. Self-administration assessment completed, and resident is not appropriate for self-administration of inhaler and nebulizer treatment. Corrective Action as it applies to others: Nursing leaders compiled a list of all residents who have self-administration orders and residents who are on nebulizers and inhalers. Whole house audit completed on like residents who are prescribed nebulizers and inhalers completed.	6/9/23

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F 554	Continued From page 6 cognitively intact with diagnosis including lung disorders. During observation and interview on 5/2/23, at 1:30 p.m. R9 was in R77's room and stated a nebulizer machine and multiple vials of medication (budesonide-a steroid inhalation medication) that was on R77's nightstand was his and that he keeps them in R77's room for convenience as he spends time in R77's room frequently. R9 stated he uses the nebulizer machine and medication at least daily. R9 stated, "The nurse knows it's in here, how else do you think I got the stuff [vials of budesonide]." During observation on 5/3/23, at 1:32 p.m. R9 was in R77's room using nebulizer machine and stated he used the vial that was in the room (budesonide). No staff was in the room supervising the administration. During observation on 5/3/23, at 1:43 p.m. R9 was seen going outside, to the smoking area, when he stopped and inhaled six puffs, rapidly, of a yellow handheld inhaler and then proceeded to go outside to smoke. R9 placed the inhaler in his pocket. During interview on 5/4/23, at 9:29 a.m. licensed practical nurse (LPN-D) stated R9 knows how to do everything with the nebulizer. LPN-D stated if a resident has a self-administration order or assessment, it would be in the electronic medical record. R9's electronic medical record failed to include any assessment for self-administration of an inhaler or of the budesonide.	F 554	Recurrence will be prevented by: Education completed with Nursing leadership and educated nursing staff related to self-administration process related to giving residents inhalers and nebulizer medications. Audits will be completed on new residents, if appropriate, x 4 weeks and results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Any discrepancies will be addressed immediately. Corrections will be monitored by: Administrator/DON or designee	

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F 554	Continued From page 7 During interview on 5/4/23, at 10:03 a.m. LPN care coordinator (LPN-C) stated, for a resident to self-administer medication, a self-administration of medications assessment would need to be completed. Assessment consists of reviewing medications with resident, checking to see if resident understands what the medication is prescribed for, demonstration of proper usage of machine (turning it on and off), application of medication to nebulizer cup and ensuring that mask is placed correctly. When assessment is completed, the provider is contacted to receive an order for the resident to self-administration medications. Once order is received, order is processed in the computer under resident's orders. LPN-C stated staff would be updated by herself and the order would also be displayed in the treatment administration record (TAR). LPN-C stated the nebulizer needed to be cleaned after treatments so staff need to monitor usage so that nebulizer and mask was cleaned properly. LPN-C reviewed R9's orders and stated she could not locate an order or assessment for R9 to be able to self-administer nebulizer treatments or inhalers. During interview on 5/4/23, at 12:58 p.m. the director of nursing (DON) indicated for a resident to self-administer medication, the resident needs to be assessed to make sure that they are cognitively intact and able to do so. Provider would then be notified to see about receiving an order for self-administration of medication. The self-administration of medications assessment was reviewed/completed on a quarterly basis. DON stated she was not aware R9's nebulizer machine and medication was in R77's room and that it was not okay for a nebulizer machine to be in a different resident's room due to infection	F 554		

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F 554	Continued From page 8 control concerns (tubing/mask in someone else's person space). DON stated it was not acceptable for the medication to be left in room as there is no self-administration order for it and it was not R77's medication and should be in a locked drawer. DON stated it was not acceptable for R9 to have inhaler and the six puffs R9 took was, "too much" as order is for 2 puffs every 6 hours as needed. DON stated she would be letting the provider know of incident as R9 was taking over the daily ordered amount. DON stated R9 does not have a self-administration of medication order for the nebulizer machine nor inhaler. The Self-Administration of Medications policy dated 12/2016, required the interdisciplinary team to determine that it is clinically appropriate and safe for the resident to do so. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: a. Ability to read and understand medication labels. b. Comprehension of the purpose and proper dosage and administration time for his or her medications. c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and d. Ability to recognize risks and major adverse consequences of his or her medications. 3. If the team determines that a resident cannot	F 554		

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	245148	A. BUILDING _____ B. WING _____	C 05/04/2023

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F 554	Continued From page 9 safely self-administer medications, the nursing staff will administer the resident's medications.	F 554		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure three years of survey results/complaints were readily accessible. This had the potential to affect all 119 residents, their families and any visitors who may have wished to review the information.	F 577	Immediate Corrective Action: Binder was immediately found by Associate administrator and moved from bottom shelf to top of cabinet. The binder was flipped over and was unable to identify what the binder was for, and	6/9/23

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F 577	Continued From page 10 Findings include: During an observation on 5/4/23, at 11:50 a.m. a sign on the table at the facility entrance indicated survey results for past three years were available for review. The administrator and associate administrator were not able to easily locate the binder. With further observation, a binder was noted on the bottom shelf of the table, facing down. There was no label on the back cover or edge of the binder. When the binder was turned over, it was noted to have a label indicating it contained survey results. Contents of the binder included recertification survey results from 10/15/21. The binder did not include complaint survey or revisit survey results from 11/9/21, 1/26/22, 6/1/22, 7/7/22 and 9/28/22. On 5/4/23, at 11:53 a.m. the administrator confirmed the contents of the survey binder. She expected the binder contained all survey results from the past three years and to have the binder easily accessible to those who want to look at it. A policy for posting of survey results was requested but was not received.	F 577	associate administrator flipped the binder over to have the front label visible and moved to the higher shelf. The administrator immediately updated the binder with previous 5 surveys where facility received citations. Corrective Action as it applies to others: Binder now visible for all residents, families staff, and visitors. Recurrence will be prevented by: Administrator and Associate Administrator will audit binder monthly x2 months. Binder will have labels on front, back, and side to be easily identifiable no matter which way it is set down. Facility will obtain designated basket or chain to place on the cabinet to ensure it does not get misplaced. The results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Any discrepancies will be addressed immediately. Corrections will be monitored by: Administrator/Associate Administrator or designee	
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		6/9/23

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F 623	Continued From page 11	F 623		

representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is

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F 623	Continued From page 12 transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide	F 623		

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F 623	Continued From page 13 written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the Long-Term Care (LTC) Ombudsman of a facility-initiated transfer for 1 of 1 resident (R124) reviewed for hospitalization. This had the potential to affect all 119 residents who resided in the facility. Findings include: R124's admission Minimum Data Set (MDS) dated 2/11/23, indicated R124 was cognitively intact. R124's progress note dated 3/3/23, at 1:52 p.m., registered nurse (RN)-D indicated R124 was sent to the emergency room for an evaluation of abdominal pain. R124 was discharged to the hospital on 3/3/23. R124 refused to sign bed hold paperwork. During an interview on 05/03/23 at 1:58 p.m., social service designee, (SSD)-A, stated, she would give the resident ombudsman information. If the resident left against medical advice, (AMA), she would complete a Minnesota Adult Abuse Reporting Center (MAARC) report. SSD-A added if the resident chose to go home, the facility would plan a discharge to a safe place for the resident to go. If SSD-A had a concern, she would call the ombudsman. SSD-A had not	F 623	Immediate Corrective Action: Administrator sent January 1, 2023 through April 30, 2023 to Ombudsman office for all transfers and discharges during this time. Corrective Action as it applies to others: Education is completed with social services department on notice of transfer and discharge requirements to be sent to ombudsman and where to send information. All documents related to the notification will be stored in a shared drive for all to access in the event of turnover. Documents will include Discharge and transfer list, where and when it was sent, and email and/or fax confirmation. Recurrence will be prevented by: Education completed with social services department on notice of transfer and discharge requirements to be sent to ombudsman and where to send information. Audits will be monthly x 2 months and results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Any discrepancies will be addressed immediately. Corrections will be monitored by: Administrator/Social Services Director or designee	

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F 623	Continued From page 14 submitted information to the LTC Ombudsman regarding discharges to the hospital, nor was aware of the requirement. In an email received from the LTC Ombudsman, on 5/3/23 at 4:11 p.m., the Ombudsman indicated they had not received any discharge notices from The Estates at St. Louis Park in recent months. During an interview on 5/4/23 at 8:57 a.m., the administrator stated if a resident stayed in the hospital, they pulled notes from the hospital regarding their care. The facility would get a bed hold signed, asking if they wanted to hold the bed. Discharge summaries are supposed to be sent at the end of the month to the Long Term Care Ombudsman. She was not aware of a log of who had been transferred to the hospital and stated she would investigate it. During a follow-up interview on 5/04/23 at 11:55 a.m., the administrator stated discharge notifications were emailed in past. However, there had been no process for sending the notifications since January 2023. She stated today she sent the admission/discharge to/from report dated January 1, 2023, through April 30, 2023, to the ombudsman. She added, R124 was included in the notification of hospital transfer to the ombudsman today. The Transfer or Discharge Notice policy revised 12/2016, indicated resident would receive a written notification of transfers/discharges including hospital and emergency room. A copy of the notice would be sent to the Office of the State Long-Term Care Ombudsman.	F 623		
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		6/9/23

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F 677	Continued From page 15 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 the necessary services to maintain personal hygiene for 3 of 3 residents (R54, R68, and R59) who were unable to carry out activities of daily living (ADLs) independently. Findings include: R54's annual Minimum Data Set (MDS) dated, 1/19/23, identified severe cognitive impairment, had a diagnosis of Alzheimer's dementia, and required extensive assist of one staff for personal hygiene. R54's care plan dated 3/24/23, indicated a self-care deficit related to decreased cognition and needing assistance with her activities of daily living (ADL's) and directed staff to cut fingernails and assist with personal hygiene. R54's care plan dated 3/24/23, indicated incontinence of bladder and bowel and resident would often dig in her incontinence brief to remove stool. R54's care plan dated 3/24/23, indicated a potential for impaired skin integrity related to scratching and picking at her skin. R54's May 2023 treatment record indicated a task for night shift nursing assistants to get her dressed and complete ADLs and was initialed and documented as completed on 5/1/23, 5/2/23	F 677	Immediate Corrective Action: All identified residents received nail care immediately once made aware. All identified resident care plans were updated appropriately. Corrective Action as it applies to others: House wide nail care will be completed initially to ensure all residents nails are groomed to their preference and then ongoing audits to maintain going forward. Recurrence will be prevented by: Education completed with Nursing leadership and educated nursing staff related to nail care and refusals. Audits will be completed weekly, x 4 weeks based on all resident shower schedule and verify if nail care was completed post shower. Results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Any discrepancies will be addressed immediately. Corrections will be monitored by: Administrator/DON or designee	

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F 677	Continued From page 16 and 5/3/23. During observation on 5/1/23 at 2:43 p.m., R54 was noted to be sitting in a chair in the hallway with her hands on her lap. All R54's fingernails on both hands varied in length from ¼ to ½ inch in length and were packed with a black and/or brown substance. R54 was unable to verbalize information or answer any questions regarding her nail care. During observation on 5/2/23 at 8:26 a.m., 5/3/23 at 12:51 p.m. and 5/4/23 at 10:20 a.m., R54's fingernails were noted to be still untrimmed and packed with a black and/or brown substance. When interviewed on 5/4/23 at 10:22 a.m., nursing assistant (NA)-A stated staff assist residents who need help with dressing, grooming and hygiene in the morning, evening and whenever additional assistance is needed. NA-A stated normally staff will perform routine nail care including trimming and cleaning with a resident's bath or shower or when needed if nails are dirty. NA-A stated if a resident is not allowing nail care staff would reapproach later or ask another staff member to attempt and notify the charge nurse. When interviewed on 5/4/23 at 10:46 A.M., NA-B stated R54 required staff assistance with dressing, grooming, toileting, and personal hygiene. NA-B stated R54 would not be able to complete her own nail care independently. NA-B stated R54 would normally not refuse assistance with cares. NA-B looked at, and verified R54's nails on both hands were dirty and in need of a trim. When asked what could be the black/brown substance under R54's nails be; NA-B stated it could be food or feces. NA-B stated there had been instances R54 had been incontinent of	F 677		

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bowel and had manually removed the feces with her hands from her incontinent brief. NA-B stated in this instance a resident's nails should be cleaned and trimmed right away. NA-B stated R54 had a history of itching and picking at her skin and her dirty nails would put her at higher risk of infection.

When interviewed on 5/4/23 at 1:10 p.m., licensed practical nurse (LPN)-B stated she was responsible for determining a resident's care needs, updating resident care plans, communicating resident needs to staff and ensuring the residents on her unit were cared for according to their care plans. LPN-B stated R54 had a history of removing or digging in her stool and required staff assistance for nail care after episodes of bowel incontinence. LPN-B stated R54 had never had a skin infection related to her itching or picking but the risk was there.

On 5/4/23 at 2:28 p.m., the director of nursing (DON) stated her expectation was that resident nail care was provided whenever needed if dirty and at least weekly. The DON stated R54's compulsion to pick or scratch at her skin with dirty nails put her at a higher risk for infection.

R68's face sheet dated 5/4/23, indicated R68's diagnoses included hemiplegia (paralysis of one side of the body), major depressive disorder and type II diabetes mellitus.

R68's quarterly MDS dated 3/1/23, indicated R68 required extensive to full physical assistance from another person for activities of daily living (ADL) including bathing, grooming and personal hygiene. R68 was independent with eating after

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set up by another person. R68's cognition was intact; her speech was unclear but was usually able to make herself understood.

R68's care plan with a print date 5/4/23, indicated R68 was cooperative with cares and required assistance with nail care. R68 sometimes scratched herself and would break her skin.

Weekly skin inspected dated 5/1/23, indicated R68's nails were trimmed during her bath on 5/1/23. The note failed to indicate if attempts were made to clean under her nails.

On 5/1/23, at 2:33 p.m. R68 was observed with ½ inch to ¾ inch long fingernails on both of her hands with an unknown thick, dark substance under each nail. R68 was not able to identify what the substance was.

On 5/2/23, at 2:00 p.m. R68 was observed with ¼ inch to ½ inch long fingernails on both of her hands with an unknown thick, dark substance under each nail. R68 confirmed she received assistance with a bath the evening before (5/1/23) but did not indicate if attempts were made to clean under her nails.

On 5/3/23, at 8:30 a.m. R68 was observed eating coffee cake from her breakfast tray, using her hands to hold and place the cake into her mouth, with her nails still containing the dark substance under them.

On 5/3/23, at 2:57 p.m. LPN-A indicated nail care, including cleaning under nails was completed on each bath day. Cleaning under nails was completed as needed as well. R68 did occasionally refuse to have her nails trimmed but

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F 677	Continued From page 19 did not typically refuse to have under her nails cleaned. LPN-A confirmed an unknown dark substance under R68's fingernails. On 5/3/23, at 3:28 p.m., DON indicated she expected nails were cleaned when visibly dirty and at least weekly. Dirty fingernails could result in the resident getting sick, especially if they use their hands to eat. DON noted, on R68's care plan indicated she tended to scratch herself when agitated. This placed R68 at risk for a skin infection if her nails were dirty underneath. R59's significant change MDS dated 4/24/2023, indicated R59 required extensive assistance of two persons with personal hygiene. Diagnosis included stroke, hemiplegia (severe or complete loss of strength or paralysis of one side of the body) or hemiparesis (mild or partial weakness or loss of strength on one side of the body), and dementia. R59's face sheet dated 5/4/23, indicated diagnosis of hemiplegia and hemiparesis following stroke affected left non-dominant side. 59's care plan with a printed date 5/4/23, indicated R59 had a self-care deficit and needed assistance of two with personal hygiene. On 5/2/23 at 9:28 a.m., R59's nails were observed to be about an eighth of an inch long. A brown/tan substance was visible under the nails on R59's right hand. A light brown substance was observed on the nail beds of R59's right nails. R59 stated she would like her nails trimmed and	F 677		

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F 677	Continued From page 20	F 677		

her nails are "too dark" for her when referred to the dark substance under her nails. R59 reported staff clean her nails once a month.

During observation on 5/3/23 at 8:22 a.m., R59 was observed eating a banana using right hand with the nails still dirty looking.

During observation on 5/3/23 at 10:05 a.m. and 5/4/23 10:33 a.m., R59's nails were noted to be the same length as 5/2/23 and still had the brown/tan substance under her right-hand nails and light brown substance on cuticle beds.

During an interview on 5/4/23 at 10:29 a.m., NA-E stated nursing assistants trim and clean residents' nails on shower days if the resident is not diabetic. Some residents refuse their nails to be trimmed and need to be reapproached. Sometimes nursing assistants trim one nail at a time as residents allow. Another time to check if nails need to be cleaned is before or after eating. NA-E stated R59's left nails were clean but said her right fingernails do not look clean and were dirty with black crumbs underneath. NA-E said she can only speak for what she had done that day.

During an interview on 5/4/23 at 10:43 a.m., NA-B stated nursing assistants clean nails on the residents' shower days and look at residents' nail after meals. Nursing assistants clean nails when they see the nails are dirty and sometimes the residents refuse.

During an interview on 5/4/23 at 10:53 a.m., LPN-E stated R59's nails looked dirty and her left hand looks better. LPN-E noted R59's nail length should be trimmed. The nursing assistants should

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F 677	Continued From page 21 trim and clean R59's nails on her shower day, and R59 is not diabetic. During an interview on 5/4/23 at 11:01 a.m., LPN-E verified R59's weekly skin check assessment from Monday, 5/1/23, was completed but the nail section had nothing selected. The options noted were to mark if resident had fingernails and toenails trimmed, if refused, or not necessary. The nail section from the weekly skin check assessment on Monday, 4/24/23, did not have any options selected. The nail section on Monday, 4/17/23, was marked as not applicable. During an interview on 5/4/23 at 1:46 p.m., LPN-E stated R59 refuses cares sometimes, such as showers, ADLs, and nail care. Whether R59 accepts cares depends on her mood. Staff reapproach R59 when cares are refused and pass the task to the next shift if R59 refuses the entire shift. During an interview on 5/4/23 at 1:48 p.m., NA-E stated R59 yells in the morning sometimes and refuses cares. During an interview on 5/4/23 at 1:59 p.m., LPN-B stated fingernails are trimmed and cleaned on the resident's shower day and as needed. Staff need to attempt completing resident cares and should let the nurse know and reapproach if cares refused. Clean fingernails are important for hygiene and because residents eat with their hands. The facility policy Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, identified "A resident who is unable to carry out activities of daily living will receive the necessary	F 677		

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F 677	Continued From page 22 services to maintain good nutrition, grooming and personal and oral hygiene".	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to ensure treatment for edema was completed as ordered by the physician for 1 of 1 residents (R59) reviewed for edema. Findings include: R59's significant change minimum data set (MDS) dated 4/24/2023, stated R59 required extensive assistance with two persons for dressing. Dressing included donning/removing compression stockings. R59's activities of daily living (ADLs) care area assessment (CAA) dated 3/30/2023, showed R59 needed extensive assistance for most ADLs, which included dressing. R59's cognitive loss CAA dated 4/5/2023, suggested presence of inattention, disorganized thinking, and altered level of consciousness.	F 684	Immediate Corrective Action: Documented risk and benefit provided to resident and/or resident representatives who refuse. Corrective Action as it applies to others: Nursing leaders compiled a list of all residents who have TED stocking and compression stockings and lymphedema wraps. Whole house audit completed on like residents who have orders for the above. Recurrence will be prevented by: Education completed with Nursing leadership and educated nursing staff related to orders for ted stocking, compressions stocking, and lymphedema wraps and the documenting and educating on refusals. Audits will be completed residents with corresponding orders weekly x 4 weeks and results shared with the facility QAPI Committee for input on the need to increase,	6/9/23

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F 684	Continued From page 23 R59's active orders listed, "compression stockings when up two times a day for edema" which initiated 3/31/23. The medical record for April and May 2023 showed nursing marked the order as, "administered" except for two entries in April which had no response listed (4/17/23 and 4/28/23). R59's orders listed to monitor for slight edema to bilateral lower extremities every shift. The medical record for April and May 2023 showed nursing marked the order as "administered" except for the day shift of 4/3/23. During observation on 5/1/23 at 2:14 p.m., R59 sat in their wheelchair near the nurse's station. R-59 had gripper socks on both feet but no compression stockings. During an interview on 5/1/23 at 5:19 p.m., R59 stated they wear regular socks. Family member (FM)-N stated R59 had edema to their lower legs and the facility had not addressed the edema, R59 did not wear compression stockings. R59 was not wearing compression stockings. During observation on 5/2/23 at 9:24 a.m. and 5/3/23 at 7:20 a.m., R59 had gripper socks on both feet but no compression stockings. During an interview on 5/4/23 at 10:18 a.m., nursing assistant (NA)-E, stated nursing assistants help residents with compression stockings in the morning. Compression stockings are cleaned at night and hung to dry. NA-E stated there were no compression stockings in R59's room when assisting R59 with morning cares. NA-E was not aware if R59 had orders for compression stockings but would have put the	F 684	decrease or discontinue the audits. Any discrepancies will be addressed immediately. Corrections will be monitored by: Administrator/DON or designee	

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F 684	Continued From page 24 stockings on R59 if they were in R59's room. During an interview on 5/4/23 at 11:04 a.m., licensed practical nurse (LPN)-E stated nursing checks each resident to see if orders for compression stockings are followed. LPN-E stated R59 should have compression stockings on according to the medical record. Nurses check a nursing task daily to verify compression stockings were worn. NA-E told LPN-E that R59 did not have compression stockings on, so LPN-E was going to find compression stockings. LPN-E noted compression stockings are important for edema to make sure residents have less water retention. During observation on 5/4/23 at 11:21 a.m., R59 did not have compression stockings on either foot. Edema noted to left lower extremity. There were no compression stockings noted in R59's room. During an interview on 5/4/23 at 2:16 p.m., LPN-B stated compression stockings show up on staff's charting and on the care sheet. The nurse should check that proper interventions are applied because they show up on the online medical administration record or treatment administration record. If compression stockings are not applied as ordered, nurses need to write a note about the resident declining to wear them. LPN-B stated the order for compression stockings said to have compression stockings on R59 every day and off at bedtime. During an interview on 5/4/23 at 5:16 p.m., the interim director of nursing (IDON)-A stated compression stockings should go on in the morning and off at bedtime. Compression	F 684		

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F 684	Continued From page 25 stockings required a doctor's order and documentation if resident refused. The IDON-A stated compression stockings help with edema and skin breakdown and can cause pain and other complications if not worn. The facility policy Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, identified the facility would provide care and services for ADLs such as bathing, dressing, grooming, and oral care.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure recommendations for cataract evaluation were acted upon for 1 of 1 resident (R19) reviewed for vision. Findings include: R19's quarterly Minimum Data Set (MDS) dated 4/19/23, identified R19 was cognitively intact and	F 685	Immediate Corrective Action: Resident cataract surgery followed up on and appointment is Scheduled June 21st, 2023. Corrective Action as it applies to others: Health Information Director will audit all residents to ensure there are no outstanding follow-up appointments for hearing/vision.	6/9/23

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F 685	Continued From page 26 was able to communicate needs and wishes without difficulty. R19's care plan revised 3/24/23, indicated R19 to have alteration in vision and wears glasses due to visual deficit. The care plan directed staff to provide assistance to set up Ophthalmology appointments as needed or requested by resident or family. On 5/1/23, at 3:03 p.m. R19 was in his room watching television with no eyeglasses in place. R19 stated his eyes are a "total mess" and has been trying to get something done with his eyes. R19 stated that he can not see anything clearly and could not make out surveyor face as it was "all blurry." He had been seen by the eye doctor at the facility and was informed by the eye doctor that he had cataracts. R19 stated that he had been having trouble with headaches. R19's On-Site Vision Encounter Details dated 3/1/22, identified R19 expressed "blurred vision" and was educated regarding ocular condition and prognosis, monitor condition and consult for cataract evaluation and possible treatment. The document indicated an appointment should be scheduled to have a consultation for cataract extraction. There were no additional referral notes to reflect a follow up of cataract referral completed. R19's On-Site Vision Encounter Details dated 9/21/22, identified R19 expressed "blurred vision". Provider note stated "Cataract extraction consultation discussed, and patient elects to proceed with consultation in attempt to improve reduced VA. Please schedule consultation. Monitor Condition. Consult for Cataract	F 685	Recurrence will be prevented by: Education completed to HID and HUCs related to timely follow up appointments. Health information director will create an appointment tracking identifying all vision/hearing appointment dates, times, facility received paperwork, and follow up needed. Administrator/Associate Administrator and/or designee will audits this document weekly x 4 weeks and results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Any discrepancies will be addressed immediately. Corrections will be monitored by: Administrator/DON or designee	

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F 685	Continued From page 27 Evaluation and Possible Treatment. Educated Patient regarding ocular condition and prognosis. Patient is proactively requesting cataract consultation. Patient counseled that VA improvement may be minimal due to other ocular conditions." The document indicated an appointment should be scheduled to have a consultation for cataract extraction. There were no additional referral notes to reflect a follow up of cataract referral completed, even though this referral was repeated from over six months ago on 3/1/22. R19's appointment with MN Eye Consultants date 12/27/22, identified, R19 had cataract left eye and to schedule for cataract surgery. There were no additional referral notes to reflect a follow up of cataract referral completed. R19's On-Site Vision Encounter Details dated 3/7/23, identified R19 expressed "blurred vision and patient is awaiting treatment recommended at ophthalmology consult in December 2022." Provider note included, "Patient is proactively requesting cataract consultation. Patient counseled that VA improvement may be minimal due to other ocular conditions. Educated Patient regarding ocular condition and prognosis. Cataract extraction consultation discussed, and patient elects to proceed with consultation in attempt to improve reduced VA. Please schedule consultation. Consult for Cataract Evaluation and Possible Treatment. Patient is encouraged to continue all exams and treatments recommended by ophthalmologist. Monitor Condition." The document indicated an appointment should be scheduled to have a consultation for cataract extraction. There were no additional referral notes to reflect a follow up of cataract referral	F 685		

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F 685	Continued From page 28 completed even though the original referral was a year before on 3/1/22. During interview on 5/4/23, at 8:55 a.m. nursing assistant (NA)-C indicated that R19 has not had any complaints of vision problems. During interview on 5/4/23, at 9:31 a.m. licensed practical nurse (LPN-D) indicated that R19 has not had any complaints of vision problems. During interview on 5/4/23, at 9:52 a.m. care coordinator LPN-C stated R19's cataract surgery was scheduled with resident not being able to fit through the door of the clinic. LPN-C stated the health unit coordinator (HUC) was working on finding transportation for R19 as they stated R19's weight exceeded the weight limit for the hydraulic lift of the van. LPN-C indicated that when a resident goes to an appointment, paperwork is sent with and when they return with orders, the nurses look at it and then will give to the HUC to follow up and schedule further appointments. LPN-C stated that the cataract evaluation was not followed up on due to resident not being able to fit through the door of the clinic or on the table. LPN-C also stated the HUC informed her that one of R19's follow up appointments the doctor had told R19 that he was not a really good candidate and went over the risks and benefits and stated that R19 had to decide if he wanted to pursue cataract surgery. LPN-C stated that no staff from facility has followed up with R19 to see what he had decided. During interview on 5/4/23, at 12:58 p.m. director of nursing (DON) stated that when a resident has an appointment that an envelope with resident's medical information and order form is sent with	F 685		

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F 685	Continued From page 29 resident. When resident returns, envelope is brought back and given to the nurses and then would go to the HUC. The HUC would transcribe the orders and then give them back to the nurses to perform a second check. HUC is responsible to follow up on appointments. DON stated that she was not aware of cataract surgery not being followed up on and/or scheduled for the past year. The DON stated the referral for consultation on cataracts should have been coordinated after the referral had been made. The Visually Impaired Resident, Care of, policy dated 2/18, identified "While it is not required that our facility provide devices to assist with vision, it is our responsibility to assist the resident and representatives in locating available resources (e.g., Medicare, Medicaid or local organizations), scheduling appointments and arranging transportation to obtain needed services."	F 685		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		6/9/23

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F 686	Continued From page 30 by: Based on observation, interview and document review, the facility failed to implement pressure ulcer interventions for 1 of 3 residents (R40) reviewed who were identified as at risk for pressure ulcer development. Finding include: R40's annual Minimum Data Set (MDS) dated 1/31/23, identified resident as dependent on staff for all activities of daily living (ADL's) and at risk for pressure ulcers. R40's diagnoses included, dementia and had a stroke with left sided weakness. R40's care plan dated 2/21/23, identified a risk for skin breakdown due to a stroke, left sided weakness, a history of wounds to feet and ankles that spontaneously re-open. Staff were directed to use an air mattress on the bed, encourage and assist to turn and reposition every 2-3 hours and as needed. R40 was to have a protective dressing on the heel, a pressure reducing wheelchair cushion and Prevalon boots (a boot with a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure) or a pillow for floating heels while in bed, Skin assessment to be completed per Living Center Policy. Encourage resident to be out of bed from approximately 8:00 a.m. to 2:00 p.m. on Monday, Wednesday, and Friday. R40's evaluation on 4/4/23 from his wound care doctor appointment, identified, "Off-load wound, float heels in bed, reposition per facility protocol." On 4/11/23, the evaluation included he had an unstageable deep tissue injury (DTI) of the left, lateral ankle, which was resolved and directed	F 686	Immediate Corrective Action: Documented risk and benefit provided to resident and/or resident representative who refuse. Corrective Action as it applies to others: Nursing leaders compiled a list of all residents who have prevalon boots or orders to float heel. Whole house audit completed on like residents who have orders for the above. Recurrence will be prevented by: Education completed with Nursing leadership and educated nursing staff related to orders for prevalon boots, orders to float heels, and the documenting accurately and educating on refusals. Audits will be completed residents with corresponding orders weekly x 4 weeks and results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Any discrepancies will be addressed immediately. Corrections will be monitored by: Administrator/DON or designee	

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F 686	Continued From page 31 staff, "continue with non-skid socks, pillow or Prevalon boots. R40's weekly skin assessment dated 4/30/23 identified R40 refused a shower/skin check. Had a preexisting wound on the left/right ankle, and his visible skin on hand and face was intact. R40's physician order summary report and the medication administration record active as of 5/4/23 included, Prevalon boots or float heels when in bed every shift. Medication administration records showed nurses charting that the boots were on every shift May 1, 2023 through May 4, 2023. The medical record lacked documentation identifying R40 had refused to wear the boots or float heels. During observation on 5/2/23, at 2:31 p.m. R40 was sleeping in bed on his back. He was not wearing Prevalon boots on his feet, and his heels/ankles rested directly on the surface of the mattress. The blue Prevalon boots were sitting on a shelf across the room that had wound care supplies on it. During observation on 5/2/23, at 3:50 p.m. R40 was lying in bed in the same position as previously noted with no boots on and a pillow was not under his feet/ankles. During observation and interview on 5/2/23, at 4:55 p.m. R40 had quarter size redness noted to both outer ankles and had no Prevalon boots on or a pillow under his feet/ankles. R40 said he got up for lunch today around noon and right after lunch went back to bed. R40 stated, "They haven't gotten me out of bed for a week even when I have asked to get up."	F 686		

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F 686	Continued From page 32 During observation and interview on 5/3/23, at 8:13 a.m. R40 was in bed with a blue boot on his right foot. The left foot was laying on the bed with no boot on or pillow under his feet/legs and continued to have noted redness to his left outer ankle. R40 said they offer the boot at times or a pillow, "sometimes I ask to take them off, because it hurts my feet." During observation and interview on 5/3/23, at 2:28 p.m. R40 was still in bed and stated, "they haven't gotten me up yet, but they did change me once." The boot continued to be on the right foot, no boot or pillow under the left foot/ankle. The left ankle was turned outward with the outer ankle laying directly on the mattress in the exact same position it was in the morning. During observation and interview on 5/4/23, at 8:20 a.m. R40 was in bed eating breakfast. He had a pressure reducing air mattress on the bed with a moisture absorbing pad under his feet. Prevalon boots were on a shelf and no pillow under his feet/ankles. R40 stated he did not get out of bed at all yesterday, but wanted to. During observation on 5/4/23, at 9:34 a.m. R40 was in bed with his left leg/ankle turned out and his outer ankle was lying on the mattress. He had no boots on and no pillow under his feet/ankles. During interview on 5/4/23, at 9:40 a.m. licensed practical nurse (LPN)-D stated nurses do skin checks on shower day or as needed. "If you note something, you document it, report it to the supervisor, family, and doctor, and fill out a risk management form." "We are watching R40's wounds and can-do betadine to the area as	F 686		

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	245148	A. BUILDING _____ B. WING _____	C 05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 33 needed but right now all his wounds are resolved and we do encourage him to wear his boots and get up out of bed. If he refused, we would document his refusal in the medication and treatment record." During interview on 5/4/23, at 10:16 a.m. speech language program director (SLP)-J stated R40 was not currently receiving therapy but had been in therapy thirteen times since 2017. R40 had issues with mental health and was not realistic on his goals or complianed with therapy. R40 used a mechanical full body lift for transfers due to leg weakness. He can be up in a wheelchair, but staff stated he has not gotten out of bed much recently per his choice. During observation on 5/4/23, at 12:32 p.m. R40 was up in his wheel chair in the dining room eating lunch. During observation and interview on 5/4/23, at 1:40 p.m. R40 was lying in bed with no boots on and no pillow under his feet/ankles. Both ankles had quarter size redness. LPN-C applied R40's boots and stated when he was in bed, he should have his boots on. She stated, "I will talk to the aides and re-educate them regarding applying the boots when the resident is in bed." LPN-C then assessed both ankles. They were red, but they blanched when palpated and she stated, both ankles were red, but they were considered healed as of 4/11/23, "I do not have any pictures to compare how they use to look, and I don't believe the wound doctors takes pictures either. We should have weekly skin assessments." During interview on 5/4/23, at 3:38 p.m. director of nursing (DON) stated, "I would expect my staff	F 686		

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F 686	Continued From page 34 to be following doctors' orders and if a resident refused, they should be charting that. When doing skin checks they should be charting exactly what it looks like, redness or any other concerns." The DON stated care planned interventions should be followed, if the resident refused, they should document the refusal and education provided the resident. The facility Skin Assessment & Wound Management policy dated 5/27/23 indicated "Provide guidelines for assessing and managing wounds. 1. A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid. 2. Tissue Tolerance Evaluation is completed on admission, annually, and upon significant change. Implement appropriate preventative skin measures. 3. Staff will perform routine skin assessments (with daily care). 4. Nurses are to be notified if skin changes are identified. 5. A weekly skin inspection will be completed by licensed staff.	F 686		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		6/9/23

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F 761	Continued From page 35 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure safe medication storage for 1 of 1 residents (R77) who was noted to have medications stored in her room without an order for the specific medication. Findings include: On 5/2/23, at 8:32 a.m. a nebulizer machine was noted on R77's nightstand. Next to the nebulizer machine were seven plastic vials of clear liquid labeled, "budesonide" (medication used to treat asthma). R77 indicated the machine and medication did not belong to her but belonged to her male friend. She did not use the machine or the medication. R77's medical record confirmed R77 did not have an order for budesonide. On 5/3/23, at 3:04 p.m. licensed practical nurse (LPN)-A confirmed R77 did not have an order for budesonide. LPN-A was not aware that R77 had the medication in her room.	F 761	Immediate Corrective Action: R9 budesonide and nebulizer machine and medication removed from R77 room immediately. Corrective Action as it applies to others: Nursing leaders will do unit audits on each resident room to ensure unnecessary medication is in residents rooms. Recurrence will be prevented by: Education completed with Nursing leadership and educated nursing staff related to unnecessary medication being in the resident room. Audits weekly x 4 weeks related to unnecessary medication being in residents rooms. and results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Any discrepancies will be addressed immediately. Corrections will be monitored by: Administrator/DON or designee	

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F 761	Continued From page 36 On 5/4/23, at 1:30 p.m. director of nursing (DON) indicated she was not aware that R77 had medication stored in her room. DON expected all medications were stored in the appropriate area, such as a medication cart or medication room, unless they are ordered for the resident and the resident has been assessed for self-administration of medication. Facility policy, Storage of Medications, instructed drugs used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791		6/9/23

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F 791	Continued From page 37 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide or obtain routine dental services for 1 of 1 residents (R114) reviewed for oral/dental health. Findings include: R114's quarterly Minimum Data Set (MDS) dated 2/14/23, identified she was admitted 10/3/2022, had severely impaired cognition and diagnoses of non-traumatic brain dysfunction and dementia. R114's admission paperwork included an undated and unsigned document with resident's name, date of birth, medical record number and primary's name entitled, "HealthDrive Attending	F 791	Immediate Corrective Action: R114 was immediately put on the dental list . Corrective Action as it applies to others: Nursing leaders will do house wide audit on each resident to determine needs for oral/dental need based on oral/dental assessment. Needs will be referred to health information to ensure referral was made. Recurrence will be prevented: Education completed with Nursing leadership and Health information Department on oral/dental assessment audits and needs. A tracking form will be created for oral/dental needs based on	

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F 791	Continued From page 38 Physician Request for Services/Consultation," and indicated under the dental section, "poor oral hygiene" and, "unable to properly care for teeth" as reasons to have a dental provider examine the resident. R114's nursing oral/dental evaluation dated 10/3/22, indicated several missing teeth and a lack of dentures. R114's nursing oral/dental evaluations dated 11/15/22 and 2/14/23 indicated several missing teeth, a lack of dentures and that she would need staff assistance with her oral hygiene and require dental visits every 6 months and as needed. R114's admission care conference form dated 10/6/22, indicated no date or information regarding her last dental exam. R114's care plan dated 2/26/23, instructed staff to assist with setting up dental appointments. When interviewed on 5/1/23 at 2:25 p.m., R114 stated she had several missing teeth and it bothered her, "how that looks." R114 stated, "I think I need teeth. I don't know if I have them or are getting them. I don't know if I have seen a dentist lately, but I should." When interviewed on 5/4/23 at 12:54 p.m., licensed practical nurse (LPN)-B stated when a resident is admitted to the facility admission paperwork completed by the resident and/or resident's families includes consent forms for dental services and is set up by the medical records department. When interviewed on 5/4/23 at 1:33 p.m., the	F 791	notification from nursing department, when referral made to Health information. Then health information will document when consents were filled out, when information was sent to dental, and when resident was seen by dental. Administrative/Associate Administrator or designee will conduct audits on the spreadsheet weekly x 4 weeks related to unnecessary medication being in residents rooms. and results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Any discrepancies will be addressed immediately. Corrections will be monitored by: Administrator/DON or designee	

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F 791	Continued From page 39 health information manager (HIM) stated dental consent forms are a part of the facilities admission paperwork and the resident or resident's family can choose to use the facility provider or be assisted to find a community provider. The HIM stated nursing staff normally fills out the paperwork and obtains signatures on the consent forms or documents refusal of services and then sends to the medical records department where they are scanned into the resident's medical record. The HIM stated if a form is incomplete or a signature is missing the health unit coordinators would follow-up with nursing to obtain consent or to determine if the resident or family wishes to decline dental services through the facility provider. The HIM stated after a resident or resident's family indicates they would like to be set up on facility dental services she would reach out to the facility provider to set that up. The HIM stated this process was missed for R114. When interviewed on 5/4/23 at 2:20 p.m., the director of nursing (DON) stated her expectation is that every newly admitted resident is offered assistance with setting up routine dental services but this was missed for R114. The facility policy Dental Services dated 12/2016, identified "Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care".	F 791		
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		6/9/23

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F 921	Continued From page 40 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 1 of 20 residents rooms (Room 284) was maintained in a way to prevent mold infestation and failed to maintain the ice machine in a sanitary manner which contained a build up of lime and a brown and black substance where 135 residents were identified as potentially receiving ice out of. Findings include: During observation on 5/1/23, at 2:58 p.m. Rm. 284 was observed. The ceiling had a dark brown stain with water stains running down wall to the top of air conditioner. A line of black furry substance extended approximately two to three feet along the top of air conditioner on the wall. During observation on 5/2/23, at 3:14 p.m. Dark brown stain on ceiling, water stains running down wall and black furry substance on the wall along top of air conditioner remain unchanged. On 5/3/23, at 8:21 a.m. housekeeper (HSK)-A was cleaning area and was interviewed and observed Rm. 284 with surveyor. Housekeeper looked at area above air conditioner and stated she thinks that the black substance was from the plastic that was applied around the air conditioner during winter. HSK-A stated she was not sure what the black substance was and attempted to wipe black substance off the wall with a wet blue rag. Once completed, blue rag was covered with black areas from the substance. Several areas of black substance remain on the wall. HSK-A	F 921	Immediate Corrective Action: Mildew was cleaned off by maintenance director Immediately. Lime and dust were cleaned and removed from ice machine by Maintenance Director Immediately. Dust was removed from pipes by Environmental Services Director Immediately. Residue on front of laundry machine removed immediately. Corrective Action as it applies to others: Maintenance Director and Laundry Services were educated on cross contamination and cleanliness of identified areas. Whole house audit completed of AC units to observe for mold or residue. Recurrence will be prevented by: Education completed with Maintenance Director and Environmental Services Director were educated on cross contamination and cleanliness of identified areas. Audits weekly x 4 related to weeks related to AC unit mildew, laundry room dust, grime, and water, and TELs building services schedule in place for ice machine cleaning and de-liming and results shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Any discrepancies will be addressed immediately. Corrections will be monitored by: Administrator/DON or designee	

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F 921	Continued From page 41 stated the black substance was, "mold from the water that was leaking down the wall from the ceiling." HSK-A stated maintenance would need to look and repair it and that she would notify a nurse or "my boss" about concern and that they would update maintenance. On 5/3/23, at 8:41 a.m. Rm. 284 remained in the same condition with the wall in disrepair. At this time, the director of maintenance (DOM) was interviewed and observed Rm. 284 with the surveyor. DOM stated he was not aware of the wall's condition and that they had a leak upstairs that was running down the walls that was fixed. DOM also stated that the covers that were over the air conditioners, during winter, were just removed and the black substance was, "mold due to the moisture that had came in around cover of air conditioner." DOM stated maintenance concerns are entered as a work order that comes directly to his work cell phone. A facility policy on general building repair and maintenance was requested; however, none was provided. During observation of the kitchen on 5/3/23 at 11:15 a.m., The large ice machine in the main kitchen was noted to have a heavy buildup of a thick, unknown white substance on the door jams and running down both side of the machine. The white plastic back splash inside the ice machine had an unknown brown substance as well as peppering of black spots along the entire length of the back splash inside the machine. On 5/3/23 at 2:34 p.m., the assistant culinary director (ACD) confirmed the above findings and indicated maintenance does the chemical	F 921		

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F 921	Continued From page 42 cleaning and wipes down the inside of the machine monthly. The kitchen staff was responsible for cleaning the outside of the machine monthly. ACD stated he was not able to identify the brown and black substances on the back splash but knew they should not be there. On 5/3/23 at 2:37 p.m., the culinary director (CD) confirmed the above findings and indicated maintenance cleaned the machine monthly and kitchen staff was responsible for cleaning the outside of the ice machine. CD stated it was dirty, but it would wipe right off. On 5/4/23 at 12:35 p.m., the maintenance director (MD) stated maintenance cleaned the ice machine monthly. Cleaning included deliming the outside and cleaning the inside coils. The Maintenance work history report on 4/7/23 marked done, indicated check filters (if present), clean coils, sanitize interior, and delime as necessary. Facility policy Ice Machines and Ice Storage Chests indicated our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions. The Infection Preventionist (or designee) maintains a copy of these procedures. Microbiologic sampling of ice, ice machines and ice storage chests/containers will be conducted during epidemiological investigations.	F 921		

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	245148	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY The Minnesota Department of Public Safety conducted an annual Life Safety recertification survey, State Fire Marshal Division, on May 3, 2023. At the time of this survey, The Estates at St. Louis Park was found 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. The Estates at St. Louis Park is a 3-story building with a basement constructed at two different times. The original two-story building was built in 1966 and was determined to be Type II (222) construction. In 1972 a three-story addition with a basement was constructed to the East Wing and determined to be of Type II (222) construction. The building is fully protected throughout by an automatic fire sprinkler system. It 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 175 beds and had a census of 122 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.