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

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June 23, 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 May 19, 2023, we informed you that we may impose enforcement remedies.

On June 2, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On June 2, 2023, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 8, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 8, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 8, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction.

The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Estates At St Louis Park Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 2, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 4, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at

(312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

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Electronically delivered

June 23, 2023

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

Re: Event ID: X7ZT11

Dear Administrator:

The above facility survey was completed on June 2, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00943	A. BUILDING: _____ B. WING _____	06/02/2023

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/30/23 through 6/2/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The facility is enrolled in ePOC and therefore a	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction in required, it is required that you acknowledge receipt of the electronic documents.	2 000		

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 06/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS On 05/30/23 through 6/2/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility allowed a nursing assistant (NA)-A to return to work after an allegation of abuse, that resulted in ongoing resident complaints of aggressive rough handling, deprivation of services, and ongoing resident expressions of fear, demoralization, humiliation, shame, and degradation. The immediate jeopardy began on 5/12/23 and the immediacy was removed on 6/2/23. The following complaints were reviewed. H51482292C (MN00093584) with a deficiency issued at F600 The above findings constituted substandard quality of care, and an extended survey was conducted on 6/2/23 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/30/2023

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 600 SS=K	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 ensure residents were free and protected from ongoing verbal, physical abuse, and deprivation of goods by nursing assistant (NA)-A for 11 of 13 residents (R1, R2, R3, R4, R5, R9, R10, R11, R12, R13, R14) who identified abuse by NA-A and were dependent on staff for daily living needs. The facility's failures resulted in an immediate jeopardy (IJ). The IJ began on 5/12/23 when NA-A returned to work after an allegation of sexual and physical abuse. This resulted in ongoing resident complaints of aggressive rough handling, deprivation of services, and ongoing resident expressions of fear, demoralization, humiliation, shame, and degradation. The immediate jeopardy was identified on 6/2/23 and the administrator, assistant administrator, and the director of nursing (DON), was informed of the IJ	F 600	The facility conducted a thorough investigation regarding the allegation reported on 5/12/23. Abuse/neglect was unsubstantiated. The facility immediately suspended NA-A when made aware of the new allegation on 5/30/23. NA-A is no longer employed at the facility. R1, R2, R3, R4, R5, R9, R10, R11, R 12, R13 and R14 have all received thorough investigations related to allegations and reported to the appropriate entity. Identified residents did not exhibit any emotional distress. All were offered ACP services. Trauma informed care plan, BIMs, and PHQ-9 have been completed and updated as appropriate.	7/4/23

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F 600	Continued From page 2 on 6/2/23 at 9:37 a.m. The immediate jeopardy was removed on 6/2/23 at 4:27 p.m., but noncompliance remained at the lower scope and severity of level 2 E- pattern which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings Include: Review of the facility reported incident dated 5/12/23, indicated employee (later identified as nursing assistant (NA)-A) and a resident (later identified as R1) was masturbating in R1's room, grabbing R1's ankles causing pain, and threatening to cause harm with a gun. The facility internal investigation for allegations submitted to the state agency (SA) on 5/18/23, identified NA-A was suspended immediately pending investigation and the allegations were unsubstantiated. Interventions included, R1 would see Associated Clinic of Psychology (ACP), the facility would attempt to keep NA-A off R1's unit, not work with her for as long as possible and only in the event of a staffing crisis. The facility's investigation did not identify NA-A was interviewed nor other staff interviewed regarding the allegations. NA-A's personnel file included a form titled Notice of Suspension Pending Investigation dated 5/12/23, that identified NA-A was suspended on 5/12/23 at 11:53 a.m. related to allegation of physical and sexual abuse. Further indicated, on 5/12/23 at 2:48 p.m., two hours and 55 minutes later, the facility had unsubstantiated the allegation, and NA-A's suspension was rescinded. The form was signed by NA-A, director	F 600	Residents who are dependent on staff for daily living needs have the potential to be affected by this practice. Residents who were interviewed with concerns have been reported, investigated, and followed up on. Facility leadership has implemented weekly questionnaires to address grievances and customer service concerns. Corporate Compliance hotline information, Ombudsman contact information, and MDH reporting line have been shared with residents and distributed throughout the facility. Staff were educated on abuse reporting, concern process, emotional abuse signs and what constitutes emotional abuse. Administrator/Designee to complete at least 3 resident audits weekly x 3 months to ensure residents are free of abuse/neglect and customer service concerns are being addressed. Administrator/designee to complete at least 3 employee audits weekly x 3 months to ensure understanding of resident abuse and neglect and reporting requirements. All audits will be reviewed by LNHA or designee and brought to QAPI for continued quality assurance review.	

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F 600	Continued From page 3 of nursing (DON), human resource (HR) director, and administrator. In review of the facility's investigative file and NA-A personnel file did not identify any education was provided after the 5/12/23 allegations were made, NA-A returned to work the same day. NA-A's employees file contained the following documents titled "teachable moments" with relatable instances of reported concerns that did identify what had occurred; the file lacked details and/or investigation or education provided. -Document dated 10/6/17, indicated NA-A was suspended pending investigation of allegation related to "joking" that made a resident feel threatened. -Document dated 12/13/19, indicated NA-A had allegations of assault and refusal of cares resulting in education provided by facility as well as support of associated clinic of psychology (ACP). -ACP note dated 12/13/19, indicated NA-A was provided individualized education on dealing with resident with behaviors. Education including supporting and validating the resident and offering alternative approaches and responses to negative resident behaviors. NA-A provided personalized sample of appropriate statements to use in difficult situations. -Document dated 3/10/20, indicated NA-A had a reportable event and was investigated and unsubstantiated due to resident mental illness. During interview on 5/30/23 at 5:30 p.m., administrator stated she started with the facility on 3/13/23. Administrator indicated the facility completed a thorough investigation was completed and R1's allegations were not substantiated. NA-A was removed from R1's care	F 600		

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F 600	Continued From page 4 team unless there was a staffing crisis. The facility could not guarantee he would never work with R1. Administrator indicated the investigation did not identify any other concerns about NA-A from other residents that were interviewed. Administrator stated she was not aware, and there was no indication of other resident abuse allegations currently that involved NA-A and/or other staff. Administrator indicated that full investigation was in file. R1's current face sheet identified R1's diagnoses included schizoaffective disorder-bipolar type, and obesity. R1's quarterly Minimum Data Set (MDS) dated 4/20/23, indicated R1 did not have cognitive impairment, did not have sign/symptoms of delirium, and did not have behaviors. The MDS further indicated R1 required extensive assistance of two staff for transfers, toileting, dressing. R1 was always incontinent of bowel and bladder. R1's care plan dated 9/24/21, indicated R1 was at risk for abuse and or neglect. Interventions directed staff to be aware of statements or signs/symptoms of abuse. If they are present, update physician, director of nursing, and administrator immediately. Monitor for signs of emotional distress or mood/behavior changes and notify associated clinic of psychology (ACP) therapist of any allegations of abuse and/or neglect that involves resident. The ACP therapist will follow up with resident as needed. Safety monitoring will be implemented as needed to ensure residents safety (i.e. 15 min checks, 1:1, etc.) Staff will continue to follow the facility vulnerable adult & abuse reporting policy. The	F 600		

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F 600	Continued From page 5	F 600		

local Ombudsman, Adult Protection, Police, and/or state/financial agencies will be notified of any suspected abuse or financial exploitation as needed.

During interview on 5/31/23 at 10:05 a.m., R1 was able to verbally recall NA-A by name and provided details of allegation she reported on 5/12/23. R1 was visibly upset during the interview as she described details, she looked down when speaking not making eye contact, clenched her jaw, displayed facial grimaces, and was wringing her hands or fidgeting. R1 described NA-A's behaviors as mocking, degrading, mean, stern, and yelled when he got angry. R1 stated NA-A would sometimes refuse to provide her personal cares. At times when NA-A had to provide cares, he would be physically aggressive and/or would mock her ability to care for herself. R1 explained she could not complete her own peri care, when she asked NA-A for help he would say things like "you do it yourself, I am not going to do that". R1 reported NA-A had grabbed her left hand and ankle to pull her over onto her stomach in a quick motion that caused her to be in pain, when she asked NA-A what he was doing, NA-A responded in a sarcastic tone "you know what I am doing". R1 stated she had recently informed NA-A of a family members funeral and NA-A responded by making insensitive sarcastic "jokes" about her attending. NA-A's "joking" comments were very degrading and made her feel ashamed. R1 indicated she has reported her concerns to the facility but felt the facility was not doing anything because NA-A's treatment and behavior towards her was ongoing. R1 stated she did not want NA-A to take care of her; she not only feared him taking care of her but also scared he would not provide cares. R1 stated since NA-A continued to

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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 600	Continued From page 6 care for her, she did not want to keep reporting her concerns in fear of further retaliation, and it would make things worse for her. R1 explained she tries to protect herself by staying in her room or leave the facility to avoid NA-A. During an interview on 6/2/23, at 10:40 a.m. family member (FM)-A stated she has been to the facility. FM-A explained had been a video camera in R1's room and had witnessed staff being rough with cares and "verbally curt." FM-A indicated the camera kept getting unplugged. FM-A stated she did not report to administration, she was afraid R1 would be retaliated against by facility staff. FM-A reported this past Mother's Day she had come to the facility to give R1 a framed picture as a gift. Staff yelled at FM-A and made her feel as though she was a burden to the staff, although was unable to recall the names of staff members. FM-A indicated the video was not available for review. During interview on 5/30/23 at 4:38 p.m. NA-A stated he has had residents complain to him that he spoke meanly, "but it was just the way he speaks". He has also had residents complain to him he was too rough when he provided care and when that happened, he would "just apologize" to the resident. NA-A stated he said things to residents in a joking manner that have been taken out of context, however, did not identify how his "joking" could be interpreted to some residents as offensive and demeaning. NA-A explained he was aware R1 had made allegations he grabbed her and threw her into bed with her clothes on. NA-A indicated he could not physically lift R1 on his own, so that allegation was not true. The day that R1 made the allegations (5/12/23), he was not placed on administrative leave, he	F 600		

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F 600	Continued From page 7 gave a statement to administration, did not work with R1 directly, and was moved from R1's unit to another unit. NA-A further explained if R1 would be in the dining room and wanted food heated or wanted water, he could assist with those tasks. NA-A stated he did not receive any education/training. NA-A reported historically there have been residents that filed reports alleging he abused them but through the investigation it was determined to be untrue. NA-A stated he was not sure why residents kept on alleging he was abusing them. During a subsequent interview with NA-A on 6/2/23 at 8:07 a.m., NA-A gave an example of his joking around with residents would be; he would walk up to a resident and say, "what's up man, he has a girlfriend call him all the time, is your girlfriend calling you, why doesn't she call you anymore. Ohhh does she not talk to you anymore" NA-A indicated that because of R1's delusions "you never know where she is going to stand when you are joking with her." NA-A indicated what R1 hears "sticks", she keeps thinking about it. During interview on 6/1/23 at 7:11 a.m., licensed practical nurse (LPN)-A indicated NA-A "jokes" a lot and at times it may be too much, pushing the point of humor. LPN-A stated NA-A's "jokes" were not appropriate because they could be demeaning or offensive. One example is when NA-A went into the dining room, abruptly hit his palm on the table and say, "okay residents I am here", which could frighten residents or be taken the wrong way. LPN-A has personally provided education/counseling to NA-A. NA-A seemed to understand the discussion in the moment, however, had not noticed any on-going changes. LPN-A did not document education/counseling provided to NA-A. LPN-A indicated she would	F 600		

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F 600	Continued From page 8 report allegations of verbal abuse, however did not report NA-A's demanding and offensive jokes to administration or other team members. LPN-A indicated all staff were aware R1 repetitively made and reported allegations against NA-A and aware of the allegation R1 made on 5/12/23. LPN-A indicated R1 was not reliable; NA-A could not possibly pick up R1 and throw her as per the allegation. When R1 made that allegation to LPN-A, LPN-A told R1 "oh you know he didn't do that". During an interview on 6/2/23, at 8:23 a.m. DON stated NA-A has a big personality, he would get excited and loud, and at times could be hard to understand. DON stated she was not able to give an example of NA-A's humor and had not worked with him or seen many of his interactions with the residents. DON stated she was aware of two reports against NA-A; the administrator and assistant administrator investigated them. DON indicated the administrator directed to have NA-A avoid R1, DON was not able to provide details of the facility's investigation. During an interview on 6/1/23, at 8:31 a.m. with RN-E nurse manager for 2nd floor stated he had done a verbal coaching with NA-A in February (2023) related to report of call lights not being answered and for not providing incontinence cares to residents or following up with the call lights. RN-E was aware of the investigation related to R1 and NA-A being suspended pending the investigation. RN-E stated he has never talked to R1 or her family about any care concerns. R2's current face sheet identified R2 had diagnoses that included morbid obesity and	F 600		

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F 600	Continued From page 9 schizoaffective disorder, bipolar type. R2's quarterly Minimum Data Set (MDS) dated 4/19/23, identified R2 did not have cognitive impairment, did not have signs/symptoms of delirium, and did not have behaviors. R2 required extensive to total assistance from two staff for transfers, toileting, and dressing and was frequently incontinent of bowel and bladder. R2's care plan dated 4/22/21, indicated R2 was risk for alterations in behavior related to being a veteran in active combat during the Vietnam war. Behaviors included yelling, being "jumpy", nightmares/night terrors, and depressive like symptoms. R2's care plan dated 11/10/22, identified a goal for R2 to remain free from abuse and/or neglect. Interventions included be aware of statements or signs/symptoms of abuse and update the physician, DON, and administrator immediately. During an interview on 5/31/23 at 8:13 a.m. R2 stated when NA-A worked it took a few hours to all day to get changed after having an incontinent accident. NA-A usually started his shift between 2:00 p.m. and 2:30 p.m., he (R2) would put on his call light for help, NA-A would come into his room and shut off the call light without providing care. That was a common practice of NA-A's. R2 indicated he took bowel medications and was sometimes incontinent of bowel that had a really foul odor that could not go unnoticed; NA-A still would shut off the call light and not clean him up. Instead, NA-A would respond by rudely and abrasively telling R2 "I don't have time for you or this mess right now, we have other patients to take care of!" R2 stated this made him feel embarrassed and ashamed for having accidents	F 600		

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F 600	Continued From page 10 and sitting in urine and feces caused pain and sores on his butt. One time after R2 was told by NA-A he did not have time, R2 saw NA-A go sit down at a table in the dining room from 3:30 p.m. to 4:00 p.m. There was another time, when R2 was assisted to bed by NA-A, NA-A told R2 "You get in that bed, you stay in that bed!". R2 indicated when asking for NA-A's help with personal cares NA-A would get "sassy" thinking he was funny, or it was a show of power over him. R2 thought NA-A's actions were willful and hurtful. R2 stated he has requested for NA-A to not provide him care anymore because of NA-A behaviors that made him feel worthless and undignified, however NA-A still provided care. R2 indicated he filed a grievance and reported it to the social worker, but no one has followed up with him and seemingly nothing done to correct R2's concerns. During a subsequent interview on 6/2/23, at 1:27 p.m. R2 stated when NA-A completed incontinent cares a while ago, he had scrubbed his scrotum so hard to the point of R2 had to say stop, it did cause a sore spot that got better. R2 stated his experiences with NA-A have made him feel withdrawn "I just don't care anymore, I just want to quit dealing with being treated this way." R2 stated he wanted to move to another facility because of how NA-A treated him and the pain NA-A caused when he provided care to him. Facility grievance dated 4/6/23, indicated R2 turned on call light at 1:30 p.m. NA-A came into room at 2:00 p.m. NA-A turned off the call light and left the room. It was not until 6:30 P.M. that night when he received assistance to change his incontinence pad. The form did not identify any actions taken, there was no indication the grievance was investigated or resolved.	F 600		

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F 600	Continued From page 11 During interview on 6/2/23 at 8:49 a.m., FM-B stated she has had to call the facility to have staff provide incontinence care to R2 on multiple occasions. She was upset regarding the lack of care R2 received and has tried to report concerns to different facility staff. FM-B indicated that she has reported concerns several times to the DON and felt she was being ignored. When she reports concerns it was a temporary fix, as in someone will go up to the floor to address it at that time, but there has been no permanent solution or resolution of ongoing issues. FM-B explained she lived out of state, because of the unaddressed concerns she needed to purchase a video phone. FM-B has witnessed via video call on different occasions (could not recall dates), waiting for hours at a time to be changed after incontinent episodes.FM-B was unable to provide video. FM-B heard NA-A say to R2 "If I change you, you know you have to stay in bed". Some days R2 was not able to get out of bed even if he asked staff and R2 would tell her after he was cleaned, he still smelled of feces. FM-B indicated she thought R2 was being bullied in the facility and should not need to beg to go to the bathroom or get out of bed and receive basic needs. FM-B stated R2 has told her he had depressed feelings and sadness regarding his care at the facility. FM-B reported she has noticed R2 was more and more withdrawn since admitting to the facility. He did not engage in the typical things because of the lack of opportunity to have been provided basic activities such as sitting on a toilet. During an interview on 6/1/23 at 2:46 p.m. RN-A indicated he worked on the overnight shift with NA-A. RN-A indicated that nurses should know and be involved in the grievance process. RN-A	F 600		

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F 600	Continued From page 12	F 600		

stated he was not aware of any grievances filed by R2. RN-A reviewed R2's grievance dated 4/6/23, he acknowledged it was not completed and stated something should have been done to resolve it. RN-A indicated since there was an allegation of neglect, it was a reportable incident to the State Agency.

During an interview on 5/31/23 at 11:08, DON indicated an awareness R2 would prefer NA-A did not provide cares. Typically if a resident did not want to work with a certain staff, the resident would be interviewed to find out the reason why. Sometime customer service education needed to be provided to the staff member. DON stated the facility could not guarantee the staff member would not work with the resident or the resident would not see the staff member.

R3's current face sheet identified R3 had diagnoses of morbid obesity, bipolar disorder, moderate intellectual disabilities.

R3's quarterly MDS dated 3/16/23, R3's cognition was not assessed. Prior MDS dated 12/20/22, identified R3 did not have cognitive impairment. The MDS dated 3/16/23, indicated R3 did not have sign/symptoms of delirium and did not have behaviors. R3 required extensive to total assist of two staff for transfers, toileting, and dressing tasks and R3 was always incontinent of bowel and bladder.

R3's vulnerable adult care plan dated 4/22/21, identified R3 was vulnerable due to residing in long term care facility with diagnosis of bipolar disorder that increases resident vulnerability. Interventions included minimize risk for abuse to remain safe and be treated with respect. R3's

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F 600	Continued From page 13 communication care plan intervention directed staff to provide resident adequate time to communicate needs and process information. During an interview on 5/30/23 at 5:09 p.m., R3 stated he had concerns with his care and had been hit in the mouth by a staff member. R3 would not say which staff member. R3 stated NA-A has yelled at him and he would get frustrated when providing cares because he (R3) was slow; getting yelled at made him feel bad. R3 explained he was scared to talk about it and did not tell anyone about the incident. During a subsequent interview on 6/1/23, R3 further disclosed it was NA-A who hit him in the mouth when he was on a different unit. R3 liked to have his teeth brushed however, NA-A would not brush his teeth. NA-A has refused to give him water because then he (R3) would need to go to the bathroom. NA-A treated him roughly when providing cares, he has yelled and raised his voice, and NA-A has told him he does not have time for him. R3 stated he was sad, angry, and uncomfortable living in the facility. R3 has told his family about these situations but has not told anyone at the facility because he was scared of retaliation. FM-D was contacted but did not respond R3's family member was contacted but did no respond. R4's current face sheet identified an admit date of 7/6/22, and included diagnoses of Schizophrenia, morbid obesity, anxiety disorder, urge incontinence and insomnia. R4's annual MDS dated 4/12/23, identified R4 did not have cognitive impairment, no signs/symptoms of delirium and did not have behaviors. R4 required extensive assist of one	F 600		

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F 600	Continued From page 14 staff for bed mobility, transfers and dressing and was always incontinent with bowel and bladder. R4's mood/behavior care plan dated 6/8/12, indicated R4 had behaviors of yelling during cares and swearing when frustrated, irritated, or anxious and had difficulty regulating emotions. Vulnerable adult care plan intervention dated 8/26/21, directed for staff to avoid the use of sarcastic humor. Incontinence care plan interventions included, R4 needs to return to her unit by 12-1 a.m. to get ready for bed (dated 10/21/14.), Met with resident to discuss incontinence voiding on floor in common areas on 1st floor reviewed plan to decrease and prevent voiding on floors (dated 7/20/20). 1. toilet before going to first floor. 2. Return to floor every two hours to toilet during day/evening 3. XL pull up brief; this has helped with independence and ease of toileting for resident. Toilet upon arising, after meals and before bedtime (dated 7/21/20). During an interview on 5/31/23, at 12:58 p.m. R4 stated staff were nasty to residents sometimes. NA-A was mean to her and has physically pushed her back into her wheelchair when she was attempting to stand up. R4 explained when she has told NA-A he was mean to her, he responded by telling her she was lying. When she (R4) asked NA-A for help he would tell her, "No." NA-A has accused her (R4) of deliberately having incontinent episodes, he would "call me lazy and make me feel bad." R4 stated some of her friends really like NA-A, they would take his side. R4's friends have warned her she would have "consequences" like not getting her makeup put on or not go to the country store if she continued to have incontinent episodes. R4 reported she has seen NA-A being rough with other residents	F 600		

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F 600	Continued From page 15 in the facility. Several months ago, NA-A told her (R4) he was not going to change her and she had to wait for the next shift to be changed; R4 became upset and called NA-A a name, then told NA-B. NA-B then told the overnight charge nurse RN-A who then blamed R4, RN-A told R4 "it was my fault I did not get changed because I stayed up until 2:00 a.m. so they did not change me." R4 stated she was called a liar by RN-A so she became angry and replied, "thanks a lot." RN-A replied "you're welcome". R4 stated she became so flustered she dropped a book, she asked RN-A to help to pick it up, RN-A said "no" When R4 asked another resident to help pick the book up, RN-A told the resident not to help R4. "I [R4] told him [RN-A] I hated him and he responded by saying "good."" RN-A then said, "hey [R4] you're supposed to be in bed, get in bed." R4 stated she had not reported the incident to anyone else aside from NA-B and RN-A because she "was afraid things would only get worse" R4 reported at night she did get afraid because staff would tell her to not turn the call light on because they were too busy for her. The staff always complained to her they have to clean her up after she has accidents. Review of R4's medical records and facility incident reports dated 3/1/23-6/1/23, did not identify the allegations or documentation related to R4's reported concerns to NA-B and RN-A. During an interview on 6/1/23 at 9:33 a.m. LPN-A stated it would not surprise her if NA-A told a resident "not to lie" after a resident reported concerns because that was how NA-A talked to residents. LPN-A witnessed NA-A say to R4 he could not help, or he would not help. LPN-A indicated NA-A was dishonest. One morning she	F 600		

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F 600	Continued From page 16 saw R4's call light on, NA-A entered the room, turned it off, and came back out. NA-A told her that R4 did not need anything, she was sleeping. LPN-A stated she immediately went to R4's room and found R4 wide awake and R4 stating "Darn him!" LPN-A explained R4 would often go tell the health unit coordinator (HUC) no one was helping her; the HUC would have to call the nurse's station to get help for R4. During an interview on 6/1/23, at 8:31 a.m. RN-E indicated R4 was very particular about how she looks, but has not heard any concerns related to NA-A refusing to help R4. RN-E stated R4's care plan showed she should be encouraged to toilet every 2 to 3 hours at night and as needed without her putting her call light on. If R4 reported call light concerns at night, the facility would try to solve the problem internally, and would ask the overnight supervisor to do an audit. RN-E stated he did not work overnights so it would not be him doing the audits and he was unaware who would complete the audits if they were needed.. RN-E stated if someone had a complaint about an overnight supervisor that complaint would come to him. RN-E stated that if R4 stated no one was checking on her at night she was alert and oriented she would know if someone checked on her or not. RN-E stated he was not aware of any other complaints related to NA-A. During an interview on 6/1/23, at 11:38 a.m. with HUC stated she has talked to R4 almost every day. HUC stated R4 has said NA-A told R4 "I am too slow and tell me, Move it, Move it". R4 has told HUC, NA-A has refused to provide care and told her "I shouldn't have gone in my diaper, I shouldn't be too lazy, I should take myself to toilet, she shouldn't have to go to the bathroom	F 600		

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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 600	Continued From page 17 because she had just gone not too long ago, he's [NA-A] is too busy and other people to take care of." HUC stated R4 has never reported physical abuse abuse, only verbal. HUC explained R4 would get really down on herself because of the things NA-A has said to her. R4 would say things like, "I know I am too slow". HUC stated she had reported her concerns about NA-A to the assistant administrator about a month ago. During an interview on 6/1/23 at 9:33 a.m. with LPN-A indicated she has worked when HUC has called after R4 reported complaints to the HUC she was not getting assistance from NA-A. LPN-A stated recently she came to work in the morning and R4 was still awake in her chair stating she had been sitting up all night. LPN-A asked R4 why she had not asked staff to lay down, R4 reported she did not ask "them" to lay her down because she didn't want to make "them" mad. R4 was afraid to get others made and would not name any names because her friends like NA-A. LPN-A stated the night staff that would have included NA-A and RN-A have told her if R4 did not ask them they did not offer to lay her down. LPN-A stated R4's care plan indicated that the staff are to ask R4 to toilet every 2-3 hours and offer to lay her down. LPN-A stated R4 told her no one was asking her and she was afraid to get others mad. R4 would not name any names out of fear of upsetting her friends and retaliation of staff. LPN-A indicated even though R4 had sat up in her chair without being toileted according to the care plan and R4 reported she was fearful of staff, she did not report it administration. During an interview on 6/1/23 at 2:46 p.m. RN-A indicated he worked on the overnight shift with NA-A. RN-A denied having any awareness of	F 600		

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F 600	Continued From page 18 NA's loud tone, aggressiveness, and refusing cares. Further denied awareness of any residents complaints about NA-A and/or residents not being provided with incontinence care. RN-A stated "I am surprised of complaints at all at night!" RN-A indicated that nurses should know and be involved in the grievance process. RN-A stated he was not aware of any grievances filed by R2. RN-A reviewed R2's grievance dated 4/6/23, he acknowledged it was not completed and stated something should have been done to resolve it. RN-A indicated since there was an allegation of neglect, it was a reportable incident. During an interview on 6/2/23, at 8:23 a.m. DON stated she was unaware of any allegations of abuse related to R4 but stated she can be obsessive, to the extent one male staff member requested a different work location. R4 had a hard time regulating her emotions and would have explosions. DON stated R4 also had a history of inappropriate incontinence in public areas and can be reluctant with cares. R5's current face sheet identified R5 had diagnoses that included hemiplegia, hemiparesis following cerebral infarction (stroke) affecting dominant side, major depressive disorder with severe psychotic symptoms, psychotic disorder with delusions due to known physiological condition.. R5's Quarterly MDS dated 3/1/23, identified R5 did not have cognitive impairment, did not have signs/symptoms of delirium or behaviors. R5 required extensive assistance of one staff for bed mobility, transfers, dressing, hygiene, toilet use and was always incontinent with bowel and bladder.	F 600		

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F 600	Continued From page 19 R5's care plan dated 3/23/21, identified R5 was at risk for abuse and or neglect as resident resides in a LCT facility. R5 is at risk for cognitive and physical decline related to her diagnosis of adjustment disorder with delusions due to known condition and major depressive disorder with psychotic symptoms including catatonic disorder. Interventions included be aware of statements or signs or symptoms of abuse. If present, update physician, DON and administrator immediately. R5's care plan further indicated R5 was under a psychiatric commitment order related to history of suicidal ideation, refusal of cares and physical aggression to staff. An intervention directed staff to notify ACP therapist and mental health therapist (MHT) of any allegations of abuse and or neglect that involves the resident and ACP therapist will follow up with resident as needed (start date 12/14/21). Review of R5's progress notes dated 3/1/23-6/1/23, did not identify any reported allegations of abuse/neglect. During an interview on 6/1/23, at 12:16 p.m. R5 stated "NA-A is not my favorite". When R5 was asked "why?" R5 responded, "It's the whole thing! Changing me, turning me over; he is rough, it just hurts!" R5 stated she had told someone but could not remember who. R5 explained she did not like NA-A coming into her room and would just ignore him. R5 did not feel educating NA-A would do any good "because he is naturally rough". R5 indicated NA-A had hurt her head; R5 demonstrated on herself striking herself in the head with her hand. During the interview when discussing NA-A with R5 she became increasingly visibly distraught; R5 was tearful,	F 600		

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F 600	Continued From page 20 displayed facial grimacing, and wincing as she recalled details of her encounters with NA-A. R5 stated she was scared of NA-A tearful and stated she was fearful of NA-A. During this interview NA-E entered room, NA-E stated she has never witnessed R5 cry or grimace and is normally just flat or calm. During an interview on 6/2/23, at 1:21 p.m. FM-C stated she visited R5 between 5/25/23 and 5/30/23. During the visit, R5 looked really upset, kind of hurt, "just shut down" and would not express anything. FM-C stated she questioned R5 about her mood because it was out of character, she was not acting at all like herself; R5 did not say anything. FM-C stated they had brought R5 a lazy boy, a couple of weeks ago and came to visit R5 a couple of days after she had brought it and it was gone. When FM asked R5's nurse where her chair went, FM-C was told they didn't know and she could go look for it. During an interview on 6/1/23 at 9:33 a.m. LPN-A stated she was aware of residents who did not want NA-A to provide cares to them or want him in their rooms; R5 was one of those residents. LPN-A did not know why and was unable to determine why R5 did not want NA-A in her room. LPN-A has had to encourage R5 to allow NA-A to assist her in providing cares but had to promise R5 she would not leave her alone with NA-A. R9's quarterly Minimum Data Set (MDS) dated 4/21/23, identified R9 had diagnoses of muscle weakness and gait abnormalities. R9 had moderate cognitive impairment, did not have sign/symptoms of delirium, and did not have behaviors. R9 required extensive assistance from one staff for dressing, toileting, and personal	F 600		

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F 600	Continued From page 21 hygiene. R9 was always incontinent of bowel and bladder. During interview on 5/30/23 at 3:25 p.m., R9 indicated he had been hurt by staff while in the facility. R9 was able to recall NA-A by name and detailed a situation where he was lying in bed on a towel. NA-A had come in the room to respond to the call light and was upset that R9 had an accident on the towel. R9 indicated the towel was urine soaked with some feces on it. NA-A got frustrated and hit him (R9) with the towel as a punishment for having an incontinent accident. R9 stated he reported the incident to family and staff, the staff told him "Oh yeah that's one of the kings around here, he is the asshole here." R9 further explained NA-A says things such as "If you are getting in that bed, you are staying in it." NA-A yelling at residents was a normal part of everyday he worked. R9 reported today (5/30/23) NA-A would not provide him with a soda or anything to drink when he requested because NA-A did not want him to have any accidents. R9 stated NA-A was currently in the building, was concerned, and afraid. During a subsequent interview on 6/1/23, at 2:10 p.m. R9 requested not to talk about the situation with fear of "getting into trouble" from facility staff for talking to surveyor about his concerns R10's current face sheet identified R10 had diagnoses that included of morbid obesity and congestive heart failure. R10's quarterly Minimum Data Set (MDS) dated 5/2/23, identified R10 did not have cognitive impairment. R10 did not have signs/symptoms of delirium or behaviors. R10 required assistance of two staff for transfers, toileting, dressing and	F 600		

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F 600	Continued From page 22 frequently incontinent of bladder and always incontinent of bowel. R10's elimination care plan dated 10/17/19, identified R10's goal to be continent during waking hours and free from sign/symptoms of urinary tract infection. Associated interventions directed staff to check and offer urinal every three hours and as needed, assist to change incontinent products, and pericare after each incontinent episode. Care plan dated 12/02/21, identified R10 was at risk for abuse and/or neglect related R10 resided in a long-term care facility. Associated interventions informed staff R10 was alert and oriented and would likely recognize/report maltreatment, facility will follow vulnerable adult and abuse reporting policy, and safety monitoring will be implemented as needed to ensure resident safety. During interview on 5/31/23 at 12:51 p.m., R10 was unable to recall staff by names, stating most of the staff did not wear name tags. R10 voiced concerns about a staff member that worked evening shift, when that staff member worked, he would wait up to three hours with a soiled incontinent brief on. R10 stated it was painful to have to wait in a soiled brief that long. Staff member(s) would come into his room and shut off the call light without helping. R10 kept a stack of paper towels by his bed in attempts to clean himself up when the brief became so saturated, they leaked because of the wait times were so long. R10 reported frustration and felt ignored by staff. During a subsequent interview at 4:48 p.m. R10 has reported abusive cares every week since he has been on his current unit, but has not had any follow-up. He has left voicemails for the social workers, administrators, and assistant	F 600		

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F 600	Continued From page 23 administrators without action/response. In addition, R10 stated he was able to recall five floor staff members within the last two weeks who he reported concerns to without a response. R10 has notified family and the family has called the administrator to address concerns. Per grievance log, R10 had reported a grievance on 5/5/23. The grievance summary included "resident left voicemail on writers phone about waiting a long time for someone to come in and change him. Resident was upset about the wait time and stated he called the nurses station and then someone came into his room." There was no evidence the grievance had follow-up or resolved; the investigative findings and action taken sections were left blank. During interview on 6/1/23 at 9:54 a.m., FM-C indicated that she has discussed concerns with the administrator and social worker about R10 having to wait two to three hours to have an incontinent brief changed. FM-C indicated leadership was aware of the concerns because it was being discussed at the care conference however, issues kept repeating. FM-C stated "I don't understand how care like this could be the expectation" and "If they just answered the call light and slid a bed pan under him [R10], there would be no incontinence he knows when he needs to go." FM-C stated it was painful for R10 to hold their bowel and bladder and sitting in his own incontinence was causing more issues such as bladder infections and pain on his bottom. R10's progress note dated 3/4/23 indicated R10's urine culture came back abnormal. R10's care plan dated 3/7/23, identified R10 had a current urinary tract infection.	F 600		

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F 600	Continued From page 24 During interview on 6/1/23 at 10:35 a.m., care coordinator (CC)-A stated R10 has told her about concerns of waiting three hours in a soiled incontinent brief and that she was aware of the complaints. CC-A indicated there was not anything currently in his care plan from prevent this from happening. CC-A explained the appropriate thing to do was educate the staff about timely toileting and update the care plan. CC-A stated she reports concerns to her management team. R11's quarterly MDS dated 5/23/23, identified R11 had diagnoses that included depression, schizophrenia and other psychotic disorder. R11's cognition was not assessed and indicated R11 did not have behaviors. R11 required extensive to total 2 staff assist with bed mobility,transfers, dressing, bathing and personal hygiene. R11 was always incontinent of bowel and bladder. Annual MDS dated 11/29/22, indicated R11 did not have cognitive impairment or signs/symptoms of delirium. During interview on 5/31/23 at 12:23 p.m., R11 indicated NA-A has worked with her, he made her feel uncomfortable, it made her angry that he was so gruff. R11 explained within the last year NA-A used her arm to move her in bed, which caused her ongoing pain and discomfort in her left arm and shoulder. NA-A would tease and mock her (R11) about the incident he (NA-A) would say, "I thought you were gonna report that, it must not have been as bad as you thought" When she did not end up going to the doctors over the shoulder pain, NA-A made comments like, "I thought you [R11] were going to go to the doctors, it must of not been that bad, couldn't have been that bad if	F 600		

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F 600	Continued From page 25 you didn't go." R11 stated NA-A made fun of her, minimized her concerns, and refused to provide peri cares when she asked him to be changed out of an incontinent brief. R11 explained she felt uncomfortable when NA-A made comments "ohhhh we go way way back, remember in Wisconsin". R11 denied being in Wisconsin or knowing NA-A outside of the facility. R11 referred to NA-A as "brutal" and was the reason she had cameras put in her room. R11 stated her family member was aware of the poor care she was receiving. During interview on 5/31/23 at 1:56 p.m. FM-D reported she had concerns of abuse and neglect was happening within the facility for (R11). FM-D stated she had reported it multiple times to the previous administrator and state agency, but there have not been any changes made. FM-D stated there was a need to install cameras in R11's room for her safety, however, they kept getting unplugged and data was lost. FM-D indicated since admission to the facility R11's health has been deteriorating. R11 has not received any help to protect or keep R11 safe. FM-D expressed worry of R11's wellbeing. R12's quarterly MDS dated 4/6/23, identified R12 had diagnoses that included major depressive disorder, hemiplegia, and anxiety disorder. R12 did not have cognitive impairment, signs/symptoms of delirium and did not have behaviors. R12 required, extensive from one staff to assist with bathing, dressing toilet use, transfers and bed mobility. R12 was always incontinent of bowel. During interview on 5/31/23 at 12:13 R12 stated he felt ignored by NA-A because NA-A would walk	F 600		

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F 600	Continued From page 26 past his room when he had his call light on and he would not provide cares when requested. R12 stated when he asked NA-A to knock before entering his room, NA-A responded, "You take that complaint any higher we will go out in the parking lot". R12 explained that he was a paraplegic, he would not be able to fight someone, and felt uncomfortable and threatened. R12 explained he has reported his concerns and kept making grievances, but nothing was done. R12 stated he did not feel safe in the facility. R13's annual MDS dated 3/29/23, identified R13 had diagnoses that included cerebral palsy, anxiety disorder, depression, and psychotic disorder other than schizophrenia. R13 required extensive to total assist from two staff for bed mobility, transfers, dressing, toilet use, hygiene and bathing. The MDS did not include a cognitive assessment; quarterly MDS dated 12/28/22, indicated R13 did not have cognitive impairment, signs/symptoms of delirium, and did not have behaviors. During interview on 5/31/23 at 12:31 p.m., R13 explained NA-A refused to provide incontinence care to her and would leave her in a wet brief. R13 would put her call light on and NA-A would come into her room, turn off the call light, and leave the room without assisting her with her needs. R13 stated NA-A would get upset when she asked for help changing/washing her, he would yell and raise his voice. R13 indicated when she was in bed and dropped something on the floor, NA-A would laugh, he thought it is funny, and refused to pick it up. "It's not funny when you're the one needing help." R14's annual MDS dated 5/16/23, identified R14	F 600		

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F 600	Continued From page 27 had diagnoses that included non-traumatic brain dysfunction, and schizophrenia. R14 did not have cognitive impairment, signs/symptoms of delirium, and did not have behaviors. R14 was independent with setup help only from staff for personal hygiene, bed mobility, and transfers, extensive assist of one staff with dressing, and toilet use. R12 frequently incontinent of bowel and bladder. During interview on 5/31/23 at 1:06 p.m. R14 indicated when she requested NA-A to help her with peri care, NA-A would make her do it even though she needed assistance. R14 stated she was afraid to go to sleep at night because of NA-A and was frightened that NA-A would train new staff to do things "his way". On 5/31/23, at 12:10 p.m. R6 who did not have cognitive impairment according to quarterly MDS dated 3/7/23 was interviewed. R6 stated NA-A was "bossy and did not want to do his job". R6 stated she has seen NA-A ignore resident's calls at night and said things to residents that would make you feel bad about yourself. R6 stated R4 would yell for help at night and staff would not help her. R6 explained she tried to do as much as she could independently, so she doesn't have to deal with NA-A or the other overnight staff. During an interview (date/time/staff identifier intentionally omitted; staff feared retaliation) unidentified staff member (USM)-2 stated they have seen long call light wait times throughout the day. USM-2 stated an awareness of NA-A. USM-2 has heard yelling and staff saying "oh be quiet, I'll get to you in a minute". When USM-2 hears remarks, stated "it doesn't make me feel good...I can't do anything about it, but I wouldn't	F 600		

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F 600	Continued From page 28 want to be talked to like that". R2 has told USM-2, he has to wait a long time after he has a bowel movement for staff to help him, USM-2 would turn on R2's call light for him and noticed that the call light remains on for an extended period of time. Residents have reported to USM-2 concerns like "they [facility staff] won't get me up" USM-2 has witnessed staff in common areas such as hallways/nursing station, while resident call lights "just stay on", despite USM-2 notifying nursing staff of the residents needs. USM-2 explained the feeling that if residents complain to certain staff members their complaints were not heard or taken seriously. USM-2 stated if a resident would sit in urine for a long period of time it would be considered neglect and would report to human resources (HR) for allegation of abuse and neglect. However, USM-2 stated they had never reported these concerns to HR or supervisor because USM-2 assumed "it will eventually be taken care of". USM-2 has reported concerns to LPN-A. USM-2 felt comfortable reporting concerns to a supervisor, however felt they would get into trouble, and USM-2 did not want to be reprimanded and did not know exactly what else they could do. USM-2 would not identify specific staff members but had an ongoing concern of how residents were being treated. During an interview 6/1/23 at 12:24 p.m. unidentified staff member (USM)-1 stated they used to be a past employee at the facility, USM-1 was concerned over the lack of care at the facility. USM-1 stated there were residents that would be left in urine soaked briefs for up to three hours; which would be considered neglect. USM-1 stated she was very familiar with NA-A because USM-1 used to supervise him on the evening shift. USM-1 explained she was aware of	F 600		

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F 600	Continued From page 29 a few residents who did not want NA-A in their room or to take care of them, R2, R4, R15, they did not like his tone or his sense of humor. NA-A had a loud voice and his overall demeanor towards the residents was aggressive. USM-1 indicated NA-A also had a different sense of humor; his humor was mentally abusive and could cause psychosocial harm whether it was intended or not. USM-1 did not write NA-A up or provide education, nor report NA-A to administration for being loud, aggressive, or his humor, rather USM-1 had conversations with NA-A (could not recall dates). USM-1 stated NA-A always had a reasoning behind the joke. USM-1 stated there had been times they (USM-1) had reported abuse/neglect to the previous administrator that they witnessed or heard from residents, but little changed. USM-1 indicated it was not a comfortable reporting environment, the previous DON was feared. If you reported or complained you would be deemed a trouble maker or it was thought that previous administrator and/or DON would retaliate and do things intentionally that would make things unpleasant, scheduling only one person to a unit. During interview on 5/31/23 at 9:00 a.m., NA-C stated residents often make staff preferences or request not to have certain aids in their rooms but there was no direction or protocols given. Because there was no protocols NA's would still provide care regardless of preference because care needs must be met. During interview on 5/31/23 at 3:08 p.m., NA-D indicated he did not know NA-A. NA-D stated mocking or making fun of a resident could be a form of abuse and it was reportable. NA-D stated if a resident notified her that a staff member	F 600		

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	245148	A. BUILDING _____ B. WING _____	C 06/02/2023

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F 600	Continued From page 30 made fun of them, she would report it. During an interview on 5/31/23 at 3:12 p.m. NA-E stated an awareness of NA-A and indicated she has had complaints about him in the past. NA-E had heard the residents say that NA-A's tone came across as loud but NA-E felt it is just his tone. NA-E stated NA-A does not know how to talk lower. The first time she (NA-E) worked with NA-A she even thought he was yelling at her. After NA-E worked with him awhile, NA-E realized that was just how NA-A was. NA-E stated that the residents may misinterpret NA-A as demeaning. For example, NA-A answering a call light and saying to the resident, "Hey I saw your call light on, what do you want!?" NA-E indicated NA-E's demeaning tone towards residents was not reportable as verbal abuse. During an interview on 5/31/23, at 4:06 p.m. NA-C stated he has had residents complain about NA-A's voice and tone, "anyone can be intimidated by him [NA-A]. NA-C indicated NA-A was louder person and "jokes around a lot, it could be lost in translation, it may be taken wrong" NA-C indicated that if he thought abuse had occurred he would report it, and no residents had reported allegations of abuse to him. During interview on 5/31/23 at 1:16 p.m., LPN-A described NA-A's voice to be gruff, had a loud voice, and he tended to talk over people. LPN-A stated that could be scary for some people. LPN-A indicated NA-A's sense of humor could be taken out of context and not funny for residents. LPN-A has had residents not want NA-A work with them because of his mannerisms but she did not consider these actions to be abusive other wise she would have reported.	F 600		

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F 600	Continued From page 31 During interview on 5/31/23 at 2:54 p.m., RN-B stated allowing a resident to lay in urine or feces for hours would be considered abuse. RN-B stated he worked with NA-A and he has a loud voice, and has not had any residents or staff complain about him. RN-B stated mocking would be a form of abuse too. Staff should report abuse 100% of the time as soon as it seen. RN-B stated he has not reported any allegations of abuse. During interview on 5/31/23 at 3:15 p.m., RN-C stated both verbal and physical abuse were reportable and should be reported right away. RN-C explained that a direct tone of voice, talking loudly over a resident or at the resident, name calling, minimalizing, yelling, using swear words, refusal of cares, mocking or making fun of residents were all considered abuse and should be reported immediately. RN-C stated NA-A was a loud talker and has never had to intervene during a joke and has never reported him for joking, and has not had any residents complain about NA-A. During an interview on 5/31/23, at 3:33 p.m. RN-F stated he had worked at the facility for years and worked with NA-A on nights. RN-F stated NA-A is loud and may come off as aggressive, "that is just the way NA-A talks, so it's hard to say anything to him." RN-F indicated he has not had any resident complaints about NA-A. RN-F explained most residents know NA-A because he has worked here a long time, "so they understand that is the way he is." RN-F indicated NA-A's loudness and aggressiveness was not reportable and would report allegations of verbal and physical abuse to the administrator verbally.	F 600		

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F 600	Continued From page 32 During interview on 5/31/23 at 3:45 p.m. RN-D stated that if a resident reported to them that NA-A made them (resident) feel horrible, degraded, yelled at them, talked sternly, got angry, and/or refused to provide care every time NA-A worked. This would not be a reportable incident and not a form of abuse. RN-D stated it would be a teaching moment. During an interview on 6/2/23, at 8:23 a.m. DON stated if NA's heard allegations of abuse or witnessed they would report to the nurse and brought up the chain of command. Depending on the situation and if it was allegation of abuse, the allegation was reported to the state agency (SA), and then investigated by administrator, assistant administrator and DON. During an interview on 6/1/23, at 4:53 p.m. assistant administrator (AA) stated she had heard of allegations from R4 related to NA-A and had reported it to the SA in December of 2022. AA believed the allegations were of NA-A teasing R4 about her weight and NA-A joking with R4. AA stated she could not remember the rest of the allegations but believed they had been unsubstantiated. AA stated she had not heard of any newer allegations from R4. AA stated she was aware of NA-A having a loud voice and joking but was not aware of any complaints from staff or residents. Although 11 residents and family members identified a pattern of on going mistreatment from NA-A, including depriving residents of services, humiliation, mannerisms of "joking", loud voice, and aggressive demeanor towards residents. The facility staff were aware and/or had	F 600		

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F 600	Continued From page 33 witnessed NA's behavior towards residents. The staff did not identify and/or report NA-A's actions/mannerisms as instances of abuse. Also, there was no indication a thorough investigation had been completed for resident allegations of mistreatment/abuse which included, staff and resident interviews. This resulted in leaving residents unprotected from NA-A's ongoing abusive tendencies. Policy titled Abuse Prohibition/Vulnerable adult plan with revision date of 2/2/2023 indicates it is in place to ensure all incidents of alleged or suspected abuse/neglect are promptly reported and then investigated, to remedy any abusive situations, to prevent injury and ensure a complete review of existing incidents is documented. The policy indicates all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin. A completed incident report will be routed per facility procedure That staff will take necessary steps to protect residents from possible subsequent incidents of misconduct while the matter is being investigated . Under section of incidents that must be reported Neglect: the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distressed. Abuse: the willful infliction of injury unreasonable confinement, intimidation, or punishment with resulting physical harm, pain mental anguish. Abuse also includes the deprivation by an individual, including a care taker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted	F 600		

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F 600	Continued From page 34 deliberately, not that the individual must have intended to inflict injury or harm. Under prevention section number three: Residents and families are informed of residents rights and grievance procedure without fear of retribution or reprisal, upon admission to facility and annually though resident council. Complaint and grievance procedure dated 12/2022 indicates the administrator or designee shall issue a verbal summary, unless a written summary is required or requested, to the complainant of proposed action on the grievance no later then five business days after receipt of the grievance. Complaints or grievances are to be freely expressed by the resident , family member or responsible party without threat of discharge form or reprisal by the center. The immediate jeopardy that began on 6/2/23 at 9:37 a.m., was removed on 6/2/23 at 4:37 p.m., when it was verified, the facility implemented the following: -Immediately suspended NA-A -Reviewed/revised abuse prohibition policy and procedures. -Completed a thorough investigation including interviewing all residents who NA-A worked with or could have worked to identify additional abuse allegations. -Completed comprehensive assessment of residents who complained of allegations of abuse by NA-A to ensure if psychological services are needed. -Monitored resident who are unable to speak to ensure there are no additional behaviors or other changes identified. -Educated staff on recognizing verbal abuse, including "joking" and reported allegations of	F 600		

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F 600	Continued From page 35 abuse and identify other resources to report if the person in charge is not implementing the facility policy/procedure.	F 600		