Electronically delivered
April 15, 2020

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

SUBJECT: SURVEY RESULTS
CCN: 245148
Cycle Start Date: Cycle Start Date: April 2, 2020

Dear Administrator:

## SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

## SURVEY RESULTS

On April 2, 2020, a survey was completed at your facility by the Minnesota Department of Health. A complaint investigation and a COVID-19 Focused Survey at The Estates At St Louis Park LLC were completed to determine if your facility was in compliance with Federal requirements related to the complaint and implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

## PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 2, 2020 survey. The Estates At St Louis Park LLC may choose to delay submission of a

POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC 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; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Susanne Reuss, Unit Supervisor
Fax: (651) 215-9697
Email: susanne.reuss@state.mn.us

## INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 2, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Susanne Reuss, Unit Supervisor
Fax: (651) 215-9697
Email: susanne.reuss@state.mn.us

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

The Estates At St Louis Park LLC may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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 |
|---|---|---|---|
| | 245148 | A. BUILDING _____ B. WING _____ | C 04/02/2020 |

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

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| E 000 | Initial Comments<br><br>A COVID-19 Focused Infection Control survey was conducted on 4/1/20, through 4/2/20, using CMS Appendix Z Emergency Preparedness Requirements, the facility is in compliance with the Appendix Z Emergency Preparedness Requirements.<br><br>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents because you are enrolled in ePOC. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 4/1/20, through 4/2/20, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be substantiated:<br>H5148236C. Deficiency issued at F Tag 689.<br><br>In addition, A COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined not to be in compliance.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. | F 000 | | |

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

Electronically Signed | 04/15/2020

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| F 000 | Continued From page 1<br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to implement adequate supervision and safety measures for 1 of 2 residents (R2) reviewed for accidents. This resulted in actual harm for R1 who opened a window on the third floor of the facility and jumped out resulting in multiple fractures.<br><br>Findings include:<br><br>R1's admission Minimum Data Set (MDS) dated 3/10/20, indicated he was severely cognitively impaired and was independent with ambulation and transfers. The MDS indicated R1 displayed wandering behaviors but indicated the wandering did not place him at risk for getting to a dangerous place.<br><br>R1's care plan dated 3/9/2020, identified a risk for elopement related to cognitive impairment. | F 689 | R1 is discharged from the facility.<br><br>A facility wide audit of resident elopement risk assessments and care plans has been initiated to identify all residents as requiring adequate supervision and safety measures.<br>New admissions, readmissions from the hospital, will continue to be assessed upon admission for adequate supervision and safety as it relates to elopement risk. Appropriate interventions will be implemented, and care plans will be updated to reflect interventions.<br><br>For all other residents this may affect they will continue to be assessed quarterly/annually with significant change in condition and as needed with individual care plans being updated accordingly. | 4/21/20 |

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| F 689 | Continued From page 2<br>The care plan indicated R1's elopement assessment indicated he was at risk. The care plan was updated 3/28/20, to include, windows were checked and secured by maintenance and identified R1 had expressed wanting to go to Kwik Trip and staff had brought in food from Kwik Trip to address his wants.<br><br>During observation of the third floor memory care units on 4/1/20, at 8:22 a.m. the windows on the unit were observed to have white plastic stoppers. The windows on the unit slid to the side to be opened and the stoppers were screwed to the top and the bottom of the window frames. The stoppers were secured from the outside of the frame to approximately four inches from the sliding pane of the window.<br><br>R1's Elopement Risk Evaluation dated 3/24/20, indicated he had attempted to elope from the facility one or more time, was disorientated and wore a Wanderguard (a system used to secure, lock and alarm specific doors if a resident attempted to leave) bracelet. The evaluation indicated on 3/24/20, R1 was seen by staff yelling out the window asking for someone to take him to Kwik Trip. The evaluation further indicated R1 had also got on the elevator when staff came to the third floor and the Wanderguard system activated.<br><br>R1's facility Progress Notes identified the following:<br><br>3/24/20, Writer heard alarm go off and met housekeeper who had come from the elevator. Writer asked housekeeper if anyone had entered the elevator and was told R1 had gotten on the | F 689 | The IDT will continue to review safety and supervision interventions as appropriate and monitor residents per facility policy.<br><br>The policies and procedures for Accidents and Supervision and Elopement have been reviewed and remain current. The facility has also changed the protocol to ensure that the doors separated the secured Alzheimer□s Care Unit and the secured Advanced Alzheimer□s Care Unit remain closed during all shifts. Education initiated with staff on ensuring proper intervention and monitoring is in place for residents for safety and supervision. Education will remain ongoing as indicated. The IDT will continue to review interventions and make updates, as necessary.<br><br>Administrator and/or designee will complete audits to ensure compliance weekly for 4 weeks, monthly for 4 months, then QAPI will determine future audit schedules based on existing audit findings. | |

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elevator to go down. Writer went down stairs and brought R1 back up to the unit.

3/24/20, Staff members reported R1 opened the window in the television room on the unit and was screaming out the window. R1's head was half way out the window. Noted screws keeping window in safe position were out and maintenance fixed the problem.

3/24/20, Writer spoke to R1's family member (FM)-A to discuss his behavior. R1 was seen trying to open a window on the unit. R1 was slamming the window back and forth and was able to get the window to slide open and put his head outside the window. R1 was yelling down to some people in the parking lot. Staff witnessed the event. Maintenance checked all the windows on third floor to make sure they were working properly. Writer also informed FM-A that R1 had gotten on the elevator that morning. FM-A was upset about the events that took place, writer assured FM-A that R1 would be kept safe. Plan to move R1 to the "more" secured unit.

3/27/20, during breakfast time staff noted alarm going off. R1 had pulled his call light out of the wall. R1 was observed trying to unscrew the window at the end of the hallway with a spoon. When asked what he was doing, R1 stated he needed to save his baby and said "I will jump from window, maybe I break my leg, but it is OK." A little later R1 was walking into other residents rooms and stating, "I am looking for loose screws to get out of the window."

3/28/20, Writer was approached around 9:00 a.m. by house keeping staff that was coming into

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work that someone was lying on the ground in the employee entrance parking lot. Staff went immediately to check on resident who was later identified as R1 who lived on the third floor of the facility. 911 was called and R1 was taken to the hospital.

3/28/20, R1 was in a pleasant mood this morning. After breakfast R1 was seen seated in the hallway near the end of the corridor. After some time, another resident approached writer and reported that someone broke the window. Writer got up to check and noted a crowd forming outside around R1.

3/28/20, Writer spoke to FM-A regarding incident. Informed FM-A R1 got out the window of another residents room and landed outside on the grass. Informed FM-A that staff had seen him shortly prior to being outside on the grass and he had been pleasantly sitting in a chair. FM-A was informed that it appeared R1 had broken the stopper on the window frame and pulled out the screws that held the stopper in place. At time of call, facility staff were not aware which hospital R1 was sent to, later found out and informed FM-A.

3/28/20, Call made to hospital. Per emergency department nurse, R1 sustained a rib fracture, compression fracture and burst fracture (injury to the spine). No head injury or brain bleed noted on scan. R1 was to be admitted to the intensive care unit for observation.

A nurse practitioner visit note dated 3/27/20, indicated R1 reported he was being kept at the facility and believed he needed to leave. R1 was

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packed, wearing a coat and in constant motion looking for bus stop, airport and constantly walking around the facility checking doors. R1 had recently forced open a window on the third floor, knocked out the screen and with his head out the window was yelling at staff on the ground floor.

An Incident Review and Analysis dated 3/28/20, indicated R1 admitted to the facility on 3/3/20. R1 began displaying exit seeking behaviors a few weeks after admission and had a Wanderguard placed since admission. The incident review indicated maintenance had checked windows on the third floor on 3/24/20, and all were secured and bolted. On 3/28/20, maintenance checked all windows again and fully secured the windows so they could not be opened and on 3/30/20, new window blocks were installed.

A facility investigation file was reviewed and included the following:

A document titled [R1] incident dated 3/28/20, indicated per licensed practical nurse (LPN)-A, R1 had eaten his breakfast later than the other residents. A house keeper coming in for her shift saw R1 on the ground. The house keeper reported it to the nurse supervisor on duty. At the same time, another resident on the unit approached LPN-A, and said someone had broken a window. This was all around 9:30 a.m. The paramedics arrived and took off R1's shoes to see if he could wiggle his toes, which he was able to do and was also able to wiggle his fingers. Staff reported it looked like R1 had dragged himself toward the sidewalk. Prior to the incident staff said R1 was pleasant, ate his

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breakfast and was seated at the end of the hall by the window. The report indicated a nursing assistant (NA) stated he had been helping residents from the dining room and had seen R1 in the hallway. The report indicated no apparent tools were used to break the window stopper off.

During interview on 4/1/20, at 8:29 a.m. social worker (SW)-A stated prior to the installation of the long window stoppers, the windows had a four inch metal block attached to the frame to prevent the windows from opening more than four inches. SW-A stated the blocks were changed on Monday (3/30/20), he believed. SW-A stated the Friday prior to R1 jumping out the window, R1 had been agitated and wanted to go back to, or thought he was in Wisconsin. SW-A stated on Saturday (3/28/20), he received a call that R1 had jumped through a window. SW-A said he found the stopper and stated, "I can't tell you how he got it out because they were all re-checked and tightened by maintenance the previous week." SW-A said he noted the metal stopper was torn and jagged.

At 9:15 a.m. LPN-B stated R1 was a pretty new admit and stated he had his days and nights turned around and was sleeping during the day and awake at night. LPN-B stated R1 kept asking for the Kwik Trip and stated it was reported to her that he was exit seeking at times so a Wanderguard had been placed. LPN-B stated she was not in the facility the first time R1 removed a stopper from the window and said two other staff members alerted her. The two staff members told her at a little before 7:00 a.m. R1 popped the screen off the window and was able to get his head out of the window and was yelling

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for the Kwik Trip. LPN-B stated the maintenance staff was fixing the window when she arrived on the unit and told her R1 must have somehow gotten the bolt off the window. LPN-B stated after the incident, maintenance checked all the windows on the third floor. LPN-B stated after that incident R1 was moved to the "more" secured side of the unit. LPN-B stated she was not aware R1 had jumped out the window on the 28th until she returned to work the following Monday. LPN-B said R1 had gone into another resident's room and jumped out the window on to the grass and on Monday following the incident maintenance went through and replaced all of the blocks on the windows.

At 9:31 a.m. NA-B stated the day R1 jumped out the window he had come in at 6:00 a.m. and R1 was seated on the other side of the door of the secured unit. NA-B said, "At night they keep the doors open" between the two units. NA-B said R1 ate breakfast and went back to bed. In regard to the resident whose window R1 jumped out of, NA-B said he had been in the room and went to throw the garbage away and when he returned he saw the other resident with the nurse in the hallway. NA-B said the nurse told him someone had gone through the window. NA-B said he saw the block and said it was sitting on the ledge with the screws out of it. He said R1 was able to pry it loose somehow. NA-C was also present and stated after breakfast he went on break. He stated he had last seen R1 in the dining room. NA-C stated R1 ate breakfast and went to his room.

At 9:57 a.m. maintenance (M)-A stated on 3/23/20, R1 had managed to take off one of the

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stoppers on the windows. M-A stated he went upstairs and screwed it into different holes and said he had to use a power tool to fix it. M-A stated he had asked if R1 had any tools. M-A stated because of the window and the traffic, the nurse had moved R1 to the other side of the unit and made sure he did not have a window bed. M-A stated he performed an audit of all the windows to make sure all the windows had two screws in them. M-B, also present stated it appeared R1 may have taken the window and kept slamming it until the stopper popped out and stated that was why they decided to use double stops, one at the top of the window and one at the bottom. M-B said it seemed like it would have taken a while and made some noise. M-B further stated the original stoppers had self tapping screws and would not have been able to be removed with a screw driver or a utensil.

At 10:31 a.m. the director of nursing (DON) stated, based on the investigation R1 had been in the dining room at breakfast time, around 8:30 a.m., then was seated at the end of the hallway wearing his jacket. The DON said she had seen the metal stopper and it looked like it had been pried open and two four inch screws had been removed.

At 1:48 p.m. FM-A stated the facility had called her on Saturday morning and told her R1 had been dressed, ate breakfast and then approximately 15 minutes after that he went out the window. FM-A said she was told the previous Tuesday R1 had opened a window and gotten his head out of the window. FM-A said it was really frustrating because that same morning a house keeper had come to the unit and let R1 get into

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| F 689 | Continued From page 9 | F 689 | | |

the elevator. FM-A stated LPN-B had asked her what they (the facility) should do and told her that maintenance had checked all the windows and made sure they were secure. LPN-B then called her back and said she wanted to move R1 to the other unit that's more secure so he couldn't get on the elevator but stated this all happened on the overnight shift when the doors were all open so it wasn't any more secure. FM-A stated when she got the call after R1 went out the window it was around 11:00 a.m. and the facility did not know what hospital R1 had been taken to. FM-A said the hospital told her R1 also had a concussion. FM-A stated R1 told her he wasn't happy at the facility and had called and said he wanted to leave.

At 2:31 p.m. LPN-A stated R1 had breakfast around 8:00 a.m. on the 28th. LPN-A said the last time she had seen him he was seated at the end of the hallway. LPN-A said she was not sure what time it was and stated she was at the nurse's station on the phone when another resident came and told her someone had broken a window. LPN-A stated she looked out the window of the nurses' station and saw everything and went outside. LPN-A said she saw the screen was out of the window. LPN-A stated she was not aware R1 had opened a window a few days prior. LPN- A further stated she did not recall hearing anything unusual the morning before R1 jumped out the window but stated the television was on in the dining room and a radio was on in the room R1 jumped out of.

During interview on 4/2/20, at 8:23 a.m. the administrator stated on March 28th, she received a phone call from the nurse that R1 had jumped

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| F 689 | Continued From page 10<br>out the window on the third floor. The administrator stated after talking to the staff she learned he jumped from another resident's window. The administrator stated it appeared R1 had broken the metal stopper off the window but was unsure how as there was no evidence he used any tools. She said after the first time R1 had broken a stopper off the window, he had maintenance go around the unit and tighten all of them. The administrator further stated R1 was had not been placed on increased monitoring after the first event. | F 689 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; | F 880 | | 4/21/20 |

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| F 880 | Continued From page 11<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | F 880 | | |

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| F 880 | Continued From page 12<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to maintain infection control measures related to hand washing, glove use and environmental cleaning/disinfection for 2 of 4 units reviewed for infection control practices.<br><br>Findings include:<br><br>During continuous observation on 4/1/20, from 8:33 a.m. to 9:00 a.m. the housekeeping staff (HK)-A was observed to come out of room 102 carrying a broom and a dustpan.<br>-At 8:34 a.m. HK-A, without gloves grabbed the adhesive mop stick and reached into a bucket of water with soaked mop pads and tossed the mop pad on the floor in room 102 and mopped the floor.<br>-At 8:35 a.m. HK-A came out of the room and with her bare hands, peeled the brown soiled mop pad, folded it in half and then walked around the cleaning cart and tossed it in a plastic bag. HK-A then, still with her bare hands grabbed another clean mop pad from the bucket, tossed it on the floor and went over the floor. During the observation, two different size boxes of gloves were observed on the wall rack across from room 102.<br>-At 8:39 a.m. HK-A finished mopping in the room and continued to mop outside the hallway in front of the door to the hallway using the same mop. Then with bare hands peeled off the brown soiled mop pad, folded it in half and tossed it into the | F 880 | A facility wide staff competency training was completed to ensure that staff are aware of the proper hand hygiene protocol and glove use. All housekeeping staff completed a competency training on the proper process of changing mop heads in between mopping rooms in the facility.<br><br>The policies and procedures for Hand Hygiene and Cleaning Rooms with Microfiber Mop System were reviewed and remain current.<br><br>The Director of Nursing and Director of Housekeeping and/or their respective designees will complete audits to ensure compliance weekly for 4 weeks, monthly for 4 months, and then the QAPI committee will determine future audit schedules based on existing audit findings. | |

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| F 880 | Continued From page 13 | F 880 | | |

plastic soiled bag on the cart. Then without performing hand hygiene, HK-A wheeled the cleaning supply cart down the hallway as she collected the wet floor signs and put them on the cart.
-At 8:41 a.m. HK-A swept the floors in the hallway then wheeled the cleaning cart into the dining room, applied a pair of gloves without washing her hands then reached into the cleaning cart, removed a spray bottle, sprayed the tables and wiped all the tables in the dining room.
-At 8:44 a.m. HK-A removed the gloves then opened the trash can, pulled the bag of garbage out, tied it and went down the hallway to the soiled utility room and came out without washing her hands.
-At 8:48 a.m. to 8:59 a.m. HK-A again with bare hands reached into the bucket with soaked mop pads, removed a pad and was observed to mop the dining room floor during which time she twice rinsed the pad in the water bucket before she completed.
-At 9:00 a.m. HK-A peeled the mop pad off the mop stick, folded it in half before she tossed the brown soiled pad into the plastic bag. HK-A then wheeled down the hallway and left the cart outside room 111.
-At 9:01 a.m. HK-A was observed, again without washing her hands, to apply gloves, knocked on the door and went into room 111. She introduced herself as housekeeping then came out of the room. At this time surveyor intervened and asked HK-A to remove her gloves and wash her hands. HK-A acknowledged she had been touching soiled linen during cleaning without gloves and had not washed her hands after removing gloves or before continuing with cleaning. When asked what the facility policy was for glove use,

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| F 880 | Continued From page 14<br>cleaning/disinfecting and hand hygiene she stated, "I don't understand."<br><br>On 4/1/20, at 9:30 a.m. HK-B was observed mopping the communal, toilet/tub room with a large mop.<br>-At 9:32 a.m. after HK-B finished mopping the floor and with the same mop she mopped outside the toilet/tub room from the dining room to a room approximately 19 feet away.<br>-At 9:36 a.m. HK-B stated she was supposed to use the same mop to clean three rooms before changing the mop and water but she was supposed to rinse the mop between rooms.<br><br>On 4/1/20, at 10:12 a.m. the director of housekeeping stated she had started to in-service staff and would have expected the staff to use gloves, wash hands, and rinse the mops between rooms.<br><br>The undated Healthcare Services Group, Inc Job Description directed staff to perform housekeeping and cleaning activities within well established guidelines to ensure that quality standards and safety guidelines were met. | F 880 | | |

Electronically delivered
April 15, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: M6K811

Dear Administrator:

The above facility was surveyed on April 1, 2020 through April 2, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 4/1/20, through 4/2/20 a survey was conducted to determine compliance for State licensure. The following correction orders are issued. Please indicate on your electronic plan of correction that you have reviewed the order, and identify the date of correction. | 2 000 | | |

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| 2 000 | Continued From page 1<br>The following complaint H5148236C was found to be substantiated.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review the facility failed to implement adequate supervision and safety measures for 1 of 2 residents (R2) reviewed for accidents. This resulted in actual harm for R1 who opened a window on the third floor of the facility and jumped out resulting in multiple fractures.<br><br>Findings include: | 2 830 | R1 is discharged from the facility.<br><br>A facility wide audit of resident elopement risk assessments and care plans has been initiated to identify all residents as requiring adequate supervision and safety measures.<br>New admissions, readmissions from the hospital, will continue to be assessed upon admission for adequate supervision | 4/21/20 |

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| 2 830 | Continued From page 2<br><br>R1's admission Minimum Data Set (MDS) dated 3/10/20, indicated he was severely cognitively impaired and was independent with ambulation and transfers. The MDS indicated R1 displayed wandering behaviors but indicated the wandering did not place him at risk for getting to a dangerous place.<br><br>R1's care plan dated 3/9/2020, identified a risk for elopement related to cognitive impairment. The care plan indicated R1's elopement assessment indicated he was at risk. The care plan was updated 3/28/20, to include, windows were checked and secured by maintenance and identified R1 had expressed wanting to go to Kwik Trip and staff had brought in food from Kwik Trip to address his wants.<br><br>During observation of the third floor memory care units on 4/1/20, at 8:22 a.m. the windows on the unit were observed to have white plastic stoppers. The windows on the unit slid to the side to be opened and the stoppers were screwed to the top and the bottom of the window frames. The stoppers were secured from the outside of the frame to approximately four inches from the sliding pane of the window.<br><br>R1's Elopement Risk Evaluation dated 3/24/20, indicated he had attempted to elope from the facility one or more time, was disorientated and wore a Wanderguard (a system used to secure, lock and alarm specific doors if a resident attempted to leave) bracelet. The evaluation indicated on 3/24/20, R1 was seen by staff yelling out the window asking for someone to take him to Kwik Trip. The evaluation further indicated R1 had also got on the elevator when staff came to the third floor and the Wanderguard system | 2 830 | and safety as it relates to elopement risk. Appropriate interventions will be implemented, and care plans will be updated to reflect interventions.<br><br>For all other residents this may affect they will continue to be assessed quarterly/annually with significant change in condition and as needed with individual care plans being updated accordingly. The IDT will continue to review safety and supervision interventions as appropriate and monitor residents per facility policy.<br><br>The policies and procedures for Accidents and Supervision and Elopement have been reviewed and remain current. The facility has also changed the protocol to ensure that the doors separated the secured Alzheimer□s Care Unit and the secured Advanced Alzheimer□s Care Unit remain closed during all shifts.<br>Education initiated with staff on ensuring proper intervention and monitoring is in place for residents for safety and supervision. Education will remain ongoing as indicated. The IDT will continue to review interventions and make updates, as necessary.<br><br>Administrator and/or designee will complete audits to ensure compliance weekly for 4 weeks, monthly for 4 months, then QAPI will determine future audit schedules based on existing audit findings. | |

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| 2 830 | Continued From page 3<br>activated.<br><br>R1's facility Progress Notes identified the following:<br><br>3/24/20, Writer heard alarm go off and met housekeeper who had come from the elevator. Writer asked housekeeper if anyone had entered the elevator and was told R1 had gotten on the elevator to go down. Writer went down stairs and brought R1 back up to the unit.<br><br>3/24/20, Staff members reported R1 opened the window in the television room on the unit and was screaming out the window. R1's head was half way out the window. Noted screws keeping window in safe position were out and maintenance fixed the problem.<br><br>3/24/20, Writer spoke to R1's family member (FM)-A to discuss his behavior. R1 was seen trying to open a window on the unit. R1 was slamming the window back and forth and was able to get the window to slide open and put his head outside the window. R1 was yelling down to some people in the parking lot. Staff witnessed the event. Maintenance checked all the windows on third floor to make sure they were working properly. Writer also informed FM-A that R1 had gotten on the elevator that morning. FM-A was upset about the events that took place, writer assured FM-A that R1 would be kept safe. Plan to move R1 to the "more" secured unit.<br><br>3/27/20, during breakfast time staff noted alarm going off. R1 had pulled his call light out of the wall. R1 was observed trying to unscrew the window at the end of the hallway with a spoon. When asked what he was doing, R1 stated he | 2 830 | | |

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| 2 830 | Continued From page 4<br>needed to save his baby and said "I will jump from window, maybe I break my leg, but it is OK." A little later R1 was walking into other residents rooms and stating, "I am looking for loose screws to get out of the window."<br><br>3/28/20, Writer was approached around 9:00 a.m. by house keeping staff that was coming into work that someone was lying on the ground in the employee entrance parking lot. Staff went immediately to check on resident who was later identified as R1 who lived on the third floor of the facility. 911 was called and R1 was taken to the hospital.<br><br>3/28/20, R1 was in a pleasant mood this morning. After breakfast R1 was seen seated in the hallway near the end of the corridor. After some time, another resident approached writer and reported that someone broke the window. Writer got up to check and noted a crowd forming outside around R1.<br><br>3/28/20, Writer spoke to FM-A regarding incident. Informed FM-A R1 got out the window of another residents room and landed outside on the grass. Informed FM-A that staff had seen him shortly prior to being outside on the grass and he had been pleasantly sitting in a chair. FM-A was informed that it appeared R1 had broken the stopper on the window frame and pulled out the screws that held the stopper in place. At time of call, facility staff were not aware which hospital R1 was sent to, later found out and informed FM-A.<br><br>3/28/20, Call made to hospital. Per emergency department nurse, R1 sustained a rib fracture, compression fracture and burst fracture (injury to | 2 830 | | |

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| 2 830 | Continued From page 5<br>the spine). No head injury or brain bleed noted on scan. R1 was to be admitted to the intensive care unit for observation.<br><br>A nurse practitioner visit note dated 3/27/20, indicated R1 reported he was being kept at the facility and believed he needed to leave. R1 was packed, wearing a coat and in constant motion looking for bus stop, airport and constantly walking around the facility checking doors. R1 had recently forced open a window on the third floor, knocked out the screen and with his head out the window was yelling at staff on the ground floor.<br><br>An Incident Review and Analysis dated 3/28/20, indicated R1 admitted to the facility on 3/3/20. R1 began displaying exit seeking behaviors a few weeks after admission and had a Wanderguard placed since admission. The incident review indicated maintenance had checked windows on the third floor on 3/24/20, and all were secured and bolted. On 3/28/20, maintenance checked all windows again and fully secured the windows so they could not be opened and on 3/30/20, new window blocks were installed.<br><br>A facility investigation file was reviewed and included the following:<br><br>A document titled [R1] incident dated 3/28/20, indicated per licensed practical nurse (LPN)-A, R1 had eaten his breakfast later than the other residents. A house keeper coming in for her shift saw R1 on the ground. The house keeper reported it to the nurse supervisor on duty. At the same time, another resident on the unit approached LPN-A, and said someone had broken a window. This was all around 9:30 a.m. | 2 830 | | |

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| 2 830 | Continued From page 6<br><br>The paramedics arrived and took off R1's shoes to see if he could wiggle his toes, which he was able to do and was also able to wiggle his fingers. Staff reported it looked like R1 had dragged himself toward the sidewalk. Prior to the incident staff said R1 was pleasant, ate his breakfast and was seated at the end of the hall by the window. The report indicated a nursing assistant (NA) stated he had been helping residents from the dining room and had seen R1 in the hallway. The report indicated no apparent tools were used to break the window stopper off.<br><br>During interview on 4/1/20, at 8:29 a.m. social worker (SW)-A stated prior to the installation of the long window stoppers, the windows had a four inch metal block attached to the frame to prevent the windows from opening more than four inches. SW-A stated the blocks were changed on Monday (3/30/20), he believed. SW-A stated the Friday prior to R1 jumping out the window, R1 had been agitated and wanted to go back to, or thought he was in Wisconsin. SW-A stated on Saturday (3/28/20), he received a call that R1 had jumped through a window. SW-A said he found the stopper and stated, "I can't tell you how he got it out because they were all re-checked and tightened by maintenance the previous week." SW-A said he noted the metal stopper was torn and jagged.<br><br>At 9:15 a.m. LPN-B stated R1 was a pretty new admit and stated he had his days and nights turned around and was sleeping during the day and awake at night. LPN-B stated R1 kept asking for the Kwik Trip and stated it was reported to her that he was exit seeking at times so a Wanderguard had been placed. LPN-B stated she was not in the facility the first time R1 | 2 830 | | |

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| 2 830 | Continued From page 7<br>removed a stopper from the window and said two other staff members alerted her. The two staff members told her at a little before 7:00 a.m. R1 popped the screen off the window and was able to get his head out of the window and was yelling for the Kwik Trip. LPN-B stated the maintenance staff was fixing the window when she arrived on the unit and told her R1 must have somehow gotten the bolt off the window. LPN-B stated after the incident, maintenance checked all the windows on the third floor. LPN-B stated after that incident R1 was moved to the "more" secured side of the unit. LPN-B stated she was not aware R1 had jumped out the window on the 28th until she returned to work the following Monday. LPN-B said R1 had gone into another resident's room and jumped out the window on to the grass and on Monday following the incident maintenance went through and replaced all of the blocks on the windows.<br><br>At 9:31 a.m. NA-B stated the day R1 jumped out the window he had come in at 6:00 a.m. and R1 was seated on the other side of the door of the secured unit. NA-B said, "At night they keep the doors open" between the two units. NA-B said R1 ate breakfast and went back to bed. In regard to the resident whose window R1 jumped out of, NA-B said he had been in the room and went to throw the garbage away and when he returned he saw the other resident with the nurse in the hallway. NA-B said the nurse told him someone had gone through the window. NA-B said he saw the block and said it was sitting on the ledge with the screws out of it. He said R1 was able to pry it loose somehow. NA-C was also present and stated after breakfast he went on break. He stated he had last seen R1 in the dining room. NA-C stated R1 ate breakfast and went to his | 2 830 | | |

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| 2 830 | Continued From page 8<br>room.<br><br>At 9:57 a.m. maintenance (M)-A stated on 3/23/20, R1 had managed to take off one of the stoppers on the windows. M-A stated he went upstairs and screwed it into different holes and said he had to use a power tool to fix it. M-A stated he had asked if R1 had any tools. M-A stated because of the window and the traffic, the nurse had moved R1 to the other side of the unit and made sure he did not have a window bed. M-A stated he performed an audit of all the windows to make sure all the windows had two screws in them. M-B, also present stated it appeared R1 may have taken the window and kept slamming it until the stopper popped out and stated that was why they decided to use double stops, one at the top of the window and one at the bottom. M-B said it seemed like it would have taken a while and made some noise. M-B further stated the original stoppers had self tapping screws and would not have been able to be removed with a screw driver or a utensil.<br><br>At 10:31 a.m. the director of nursing (DON) stated, based on the investigation R1 had been in the dining room at breakfast time, around 8:30 a.m., then was seated at the end of the hallway wearing his jacket. The DON said she had seen the metal stopper and it looked like it had been pried open and two four inch screws had been removed.<br><br>At 1:48 p.m. FM-A stated the facility had called her on Saturday morning and told her R1 had been dressed, ate breakfast and then approximately 15 minutes after that he went out the window. FM-A said she was told the previous Tuesday R1 had opened a window and gotten his | 2 830 | | |

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| 2 830 | Continued From page 9<br>head out of the window. FM-A said it was really frustrating because that same morning a house keeper had come to the unit and let R1 get into the elevator. FM-A stated LPN-B had asked her what they (the facility) should do and told her that maintenance had checked all the windows and made sure they were secure. LPN-B then called her back and said she wanted to move R1 to the other unit that's more secure so he couldn't get on the elevator but stated this all happened on the overnight shift when the doors were all open so it wasn't any more secure. FM-A stated when she got the call after R1 went out the window it was around 11:00 a.m. and the facility did not know what hospital R1 had been taken to. FM-A said the hospital told her R1 also had a concussion. FM-A stated R1 told her he wasn't happy at the facility and had called and said he wanted to leave.<br><br>At 2:31 p.m. LPN-A stated R1 had breakfast around 8:00 a.m. on the 28th. LPN-A said the last time she had seen him he was seated at the end of the hallway. LPN-A said she was not sure what time it was and stated she was at the nurse's station on the phone when another resident came and told her someone had broken a window. LPN-A stated she looked out the window of the nurses' station and saw everything and went outside. LPN-A said she saw the screen was out of the window. LPN-A stated she was not aware R1 had opened a window a few days prior. LPN- A further stated she did not recall hearing anything unusual the morning before R1 jumped out the window but stated the television was on in the dining room and a radio was on in the room R1 jumped out of.<br><br>During interview on 4/2/20, at 8:23 a.m. the | 2 830 | | |

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| 2 830 | Continued From page 10<br>administrator stated on March 28th, she received a phone call from the nurse that R1 had jumped out the window on the third floor. The administrator stated after talking to the staff she learned he jumped from another resident's window. The administrator stated it appeared R1 had broken the metal stopper off the window but was unsure how as there was no evidence he used any tools. She said after the first time R1 had broken a stopper off the window, he had maintenance go around the unit and tighten all of them. The administrator further stated R1 was had not been placed on increased monitoring after the first event.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 4/1/20, through 4/2/20 a survey was conducted to determine compliance for State licensure. The following correction orders are issued. Please indicate on your electronic plan of correction that you have reviewed the order, and identify the date of correction. | 2 000 | | |

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| 2 000 | Continued From page 1<br>The following complaint H5148236C was found to be substantiated.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review the facility failed to implement adequate supervision and safety measures for 1 of 2 residents (R2) reviewed for accidents. This resulted in actual harm for R1 who opened a window on the third floor of the facility and jumped out resulting in multiple fractures.<br><br>Findings include: | 2 830 | | |

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| 2 830 | Continued From page 2<br><br>R1's admission Minimum Data Set (MDS) dated 3/10/20, indicated he was severely cognitively impaired and was independent with ambulation and transfers. The MDS indicated R1 displayed wandering behaviors but indicated the wandering did not place him at risk for getting to a dangerous place.<br><br>R1's care plan dated 3/9/2020, identified a risk for elopement related to cognitive impairment. The care plan indicated R1's elopement assessment indicated he was at risk. The care plan was updated 3/28/20, to include, windows were checked and secured by maintenance and identified R1 had expressed wanting to go to Kwik Trip and staff had brought in food from Kwik Trip to address his wants.<br><br>During observation of the third floor memory care units on 4/1/20, at 8:22 a.m. the windows on the unit were observed to have white plastic stoppers. The windows on the unit slid to the side to be opened and the stoppers were screwed to the top and the bottom of the window frames. The stoppers were secured from the outside of the frame to approximately four inches from the sliding pane of the window.<br><br>R1's Elopement Risk Evaluation dated 3/24/20, indicated he had attempted to elope from the facility one or more time, was disorientated and wore a Wanderguard (a system used to secure, lock and alarm specific doors if a resident attempted to leave) bracelet. The evaluation indicated on 3/24/20, R1 was seen by staff yelling out the window asking for someone to take him to Kwik Trip. The evaluation further indicated R1 had also got on the elevator when staff came to the third floor and the Wanderguard system | 2 830 | | |

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| 2 830 | Continued From page 3<br>activated.<br><br>R1's facility Progress Notes identified the following:<br><br>3/24/20, Writer heard alarm go off and met housekeeper who had come from the elevator. Writer asked housekeeper if anyone had entered the elevator and was told R1 had gotten on the elevator to go down. Writer went down stairs and brought R1 back up to the unit.<br><br>3/24/20, Staff members reported R1 opened the window in the television room on the unit and was screaming out the window. R1's head was half way out the window. Noted screws keeping window in safe position were out and maintenance fixed the problem.<br><br>3/24/20, Writer spoke to R1's family member (FM)-A to discuss his behavior. R1 was seen trying to open a window on the unit. R1 was slamming the window back and forth and was able to get the window to slide open and put his head outside the window. R1 was yelling down to some people in the parking lot. Staff witnessed the event. Maintenance checked all the windows on third floor to make sure they were working properly. Writer also informed FM-A that R1 had gotten on the elevator that morning. FM-A was upset about the events that took place, writer assured FM-A that R1 would be kept safe. Plan to move R1 to the "more" secured unit.<br><br>3/27/20, during breakfast time staff noted alarm going off. R1 had pulled his call light out of the wall. R1 was observed trying to unscrew the window at the end of the hallway with a spoon. When asked what he was doing, R1 stated he | 2 830 | | |

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| 2 830 | Continued From page 4<br>needed to save his baby and said "I will jump from window, maybe I break my leg, but it is OK." A little later R1 was walking into other residents rooms and stating, "I am looking for loose screws to get out of the window."<br><br>3/28/20, Writer was approached around 9:00 a.m. by house keeping staff that was coming into work that someone was lying on the ground in the employee entrance parking lot. Staff went immediately to check on resident who was later identified as R1 who lived on the third floor of the facility. 911 was called and R1 was taken to the hospital.<br><br>3/28/20, R1 was in a pleasant mood this morning. After breakfast R1 was seen seated in the hallway near the end of the corridor. After some time, another resident approached writer and reported that someone broke the window. Writer got up to check and noted a crowd forming outside around R1.<br><br>3/28/20, Writer spoke to FM-A regarding incident. Informed FM-A R1 got out the window of another residents room and landed outside on the grass. Informed FM-A that staff had seen him shortly prior to being outside on the grass and he had been pleasantly sitting in a chair. FM-A was informed that it appeared R1 had broken the stopper on the window frame and pulled out the screws that held the stopper in place. At time of call, facility staff were not aware which hospital R1 was sent to, later found out and informed FM-A.<br><br>3/28/20, Call made to hospital. Per emergency department nurse, R1 sustained a rib fracture, compression fracture and burst fracture (injury to | 2 830 | | |

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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) COMPLETE DATE |
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| 2 830 | Continued From page 5<br>the spine). No head injury or brain bleed noted on scan. R1 was to be admitted to the intensive care unit for observation.<br><br>A nurse practitioner visit note dated 3/27/20, indicated R1 reported he was being kept at the facility and believed he needed to leave. R1 was packed, wearing a coat and in constant motion looking for bus stop, airport and constantly walking around the facility checking doors. R1 had recently forced open a window on the third floor, knocked out the screen and with his head out the window was yelling at staff on the ground floor.<br><br>An Incident Review and Analysis dated 3/28/20, indicated R1 admitted to the facility on 3/3/20. R1 began displaying exit seeking behaviors a few weeks after admission and had a Wanderguard placed since admission. The incident review indicated maintenance had checked windows on the third floor on 3/24/20, and all were secured and bolted. On 3/28/20, maintenance checked all windows again and fully secured the windows so they could not be opened and on 3/30/20, new window blocks were installed.<br><br>A facility investigation file was reviewed and included the following:<br><br>A document titled [R1] incident dated 3/28/20, indicated per licensed practical nurse (LPN)-A, R1 had eaten his breakfast later than the other residents. A house keeper coming in for her shift saw R1 on the ground. The house keeper reported it to the nurse supervisor on duty. At the same time, another resident on the unit approached LPN-A, and said someone had broken a window. This was all around 9:30 a.m. | 2 830 | | |

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| 2 830 | Continued From page 6<br><br>The paramedics arrived and took off R1's shoes to see if he could wiggle his toes, which he was able to do and was also able to wiggle his fingers. Staff reported it looked like R1 had dragged himself toward the sidewalk. Prior to the incident staff said R1 was pleasant, ate his breakfast and was seated at the end of the hall by the window. The report indicated a nursing assistant (NA) stated he had been helping residents from the dining room and had seen R1 in the hallway. The report indicated no apparent tools were used to break the window stopper off.<br><br>During interview on 4/1/20, at 8:29 a.m. social worker (SW)-A stated prior to the installation of the long window stoppers, the windows had a four inch metal block attached to the frame to prevent the windows from opening more than four inches. SW-A stated the blocks were changed on Monday (3/30/20), he believed. SW-A stated the Friday prior to R1 jumping out the window, R1 had been agitated and wanted to go back to, or thought he was in Wisconsin. SW-A stated on Saturday (3/28/20), he received a call that R1 had jumped through a window. SW-A said he found the stopper and stated, "I can't tell you how he got it out because they were all re-checked and tightened by maintenance the previous week." SW-A said he noted the metal stopper was torn and jagged.<br><br>At 9:15 a.m. LPN-B stated R1 was a pretty new admit and stated he had his days and nights turned around and was sleeping during the day and awake at night. LPN-B stated R1 kept asking for the Kwik Trip and stated it was reported to her that he was exit seeking at times so a Wanderguard had been placed. LPN-B stated she was not in the facility the first time R1 | 2 830 | | |

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| 2 830 | Continued From page 7<br><br>removed a stopper from the window and said two other staff members alerted her. The two staff members told her at a little before 7:00 a.m. R1 popped the screen off the window and was able to get his head out of the window and was yelling for the Kwik Trip. LPN-B stated the maintenance staff was fixing the window when she arrived on the unit and told her R1 must have somehow gotten the bolt off the window. LPN-B stated after the incident, maintenance checked all the windows on the third floor. LPN-B stated after that incident R1 was moved to the "more" secured side of the unit. LPN-B stated she was not aware R1 had jumped out the window on the 28th until she returned to work the following Monday. LPN-B said R1 had gone into another resident's room and jumped out the window on to the grass and on Monday following the incident maintenance went through and replaced all of the blocks on the windows.<br><br>At 9:31 a.m. NA-B stated the day R1 jumped out the window he had come in at 6:00 a.m. and R1 was seated on the other side of the door of the secured unit. NA-B said, "At night they keep the doors open" between the two units. NA-B said R1 ate breakfast and went back to bed. In regard to the resident whose window R1 jumped out of, NA-B said he had been in the room and went to throw the garbage away and when he returned he saw the other resident with the nurse in the hallway. NA-B said the nurse told him someone had gone through the window. NA-B said he saw the block and said it was sitting on the ledge with the screws out of it. He said R1 was able to pry it loose somehow. NA-C was also present and stated after breakfast he went on break. He stated he had last seen R1 in the dining room. NA-C stated R1 ate breakfast and went to his | 2 830 | | |

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| 2 830 | Continued From page 8<br>room.<br><br>At 9:57 a.m. maintenance (M)-A stated on 3/23/20, R1 had managed to take off one of the stoppers on the windows. M-A stated he went upstairs and screwed it into different holes and said he had to use a power tool to fix it. M-A stated he had asked if R1 had any tools. M-A stated because of the window and the traffic, the nurse had moved R1 to the other side of the unit and made sure he did not have a window bed. M-A stated he performed an audit of all the windows to make sure all the windows had two screws in them. M-B, also present stated it appeared R1 may have taken the window and kept slamming it until the stopper popped out and stated that was why they decided to use double stops, one at the top of the window and one at the bottom. M-B said it seemed like it would have taken a while and made some noise. M-B further stated the original stoppers had self tapping screws and would not have been able to be removed with a screw driver or a utensil.<br><br>At 10:31 a.m. the director of nursing (DON) stated, based on the investigation R1 had been in the dining room at breakfast time, around 8:30 a.m., then was seated at the end of the hallway wearing his jacket. The DON said she had seen the metal stopper and it looked like it had been pried open and two four inch screws had been removed.<br><br>At 1:48 p.m. FM-A stated the facility had called her on Saturday morning and told her R1 had been dressed, ate breakfast and then approximately 15 minutes after that he went out the window. FM-A said she was told the previous Tuesday R1 had opened a window and gotten his | 2 830 | | |

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| 2 830 | Continued From page 9<br><br>head out of the window. FM-A said it was really frustrating because that same morning a house keeper had come to the unit and let R1 get into the elevator. FM-A stated LPN-B had asked her what they (the facility) should do and told her that maintenance had checked all the windows and made sure they were secure. LPN-B then called her back and said she wanted to move R1 to the other unit that's more secure so he couldn't get on the elevator but stated this all happened on the overnight shift when the doors were all open so it wasn't any more secure. FM-A stated when she got the call after R1 went out the window it was around 11:00 a.m. and the facility did not know what hospital R1 had been taken to. FM-A said the hospital told her R1 also had a concussion. FM-A stated R1 told her he wasn't happy at the facility and had called and said he wanted to leave.<br><br>At 2:31 p.m. LPN-A stated R1 had breakfast around 8:00 a.m. on the 28th. LPN-A said the last time she had seen him he was seated at the end of the hallway. LPN-A said she was not sure what time it was and stated she was at the nurse's station on the phone when another resident came and told her someone had broken a window. LPN-A stated she looked out the window of the nurses' station and saw everything and went outside. LPN-A said she saw the screen was out of the window. LPN-A stated she was not aware R1 had opened a window a few days prior. LPN- A further stated she did not recall hearing anything unusual the morning before R1 jumped out the window but stated the television was on in the dining room and a radio was on in the room R1 jumped out of.<br><br>During interview on 4/2/20, at 8:23 a.m. the | 2 830 | | |

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| 2 830 | Continued From page 10<br>administrator stated on March 28th, she received a phone call from the nurse that R1 had jumped out the window on the third floor. The administrator stated after talking to the staff she learned he jumped from another resident's window. The administrator stated it appeared R1 had broken the metal stopper off the window but was unsure how as there was no evidence he used any tools. She said after the first time R1 had broken a stopper off the window, he had maintenance go around the unit and tighten all of them. The administrator further stated R1 was had not been placed on increased monitoring after the first event.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |