STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	**08/18/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to protect 1 of 3 residents (R1) from abuse. Physical abuse occurred when three staff members held R1 down against her will while they administered a medication rectally on [DATE], which resulted in an immediate jeopardy (IJ) situation. The IJ began on [DATE], when the facility staff failed to protect, prevent, and report a witnessed observation of R1's physical abuse. The IJ was identified on [DATE], and the director of nursing (DON) and administrator were notified at 1:56 p.m. of the IJ. The IJ was cited at past non-compliance because the facility had implemented a thorough investigation, facility wide training of staff, and showed evidence of compliance as of [DATE]. Findings include R1's [DIAGNOSES REDACTED]. R1's Minimum Data Set ((MDS) dated [DATE], indicated R1 had a severely impaired cognition and did not display physical or verbal behaviors towards others. R1's care plan dated [DATE], indicated R1 had altered cognition due to alcohol liver failure and needed time to communicate her needs/wants. The care plan directed staff to provide cues, reorientation and supervision as needed. The care plan also indicated on [DATE], R1 started to become more lucid, aware, and required assist of one from staff. A review of physician orders [REDACTED]. During further review of R1's July Medication Administration Record, [REDACTED]. A nursing note dated [DATE], by RN-A indicated R1 adamantly refused to have [MEDICATION NAME] solution given rectally and that risks and benefits were explained, but R1 continued to refuse. During interview on [DATE], at 8:43 a.m. nursing assistant (NA)-A identified that an incident involving two nurses and R1 had occurred on the evening of [DATE], where two nurses held R1 down while they administered R1's enema. NA-A then indicated that RN-A had approached R1 to administer the enema but R1 refused it, but then after a few minutes RN-A returned with RN-B and NA-A, to administer the enema. NA-A further indicated that upon entering the room, R1 again refused the enema. NA-A also indicated R1 was yelling and screaming, and that RN-B held R1's hands, and mouth and while holding her down in bed, RN-A administered the enema. NA-A then indicated the incident was never reported to the facility. NA-A further indicated that the incident was reported when R1 had died and that the incident had occurred a week or two prior to being reported to the State Agency by NA-A, on [DATE]. On [DATE], at 8:13 a.m., during interview, the facility administrator and DON notified surveyor that after learning about the incident from the surveyor on [DATE], both RNs and NA were suspended and the SA was notified immediately. The DON indicated phone interviews were conducted with both RNs and NA, where it was learned that the incident happened on [DATE]. The incident had not been reported to the facility immediately per the Abuse Policy and was not reported to the SA until [DATE], by NA-A. The DON also identified that both nurses admitted that the incident, as described by NA-A, had occurred. The DON then indicated that RN-A made a statement that she went to give R1 the medication but R1 refused it, then RN-B and NA-A, came in the room, they put a mask over R1's face because R1 was spitting at them. RN-B then held R1's hands down while RN-A administered the enema. The DON also explained that RN-A was asked why she felt that RN-A and other staff felt there was such an importance of R1 getting this medication, and RN-A indicated it was in the best interest of R1. The DON then stated I asked if the order told her (RN-A) to hold her (R1) down and force her, (RN-A) stated no. The DON indicated other nurses were interviewed on the floor where R1 resided at that time, all the nurses indicated R1 would refuse her medication but R1 needed to be re-approached. The DON also indicated the nurse practitioner (NP) was interviewed and asked if the intent of the order was for staff to force R1 into getting the medication and NP indicated the order was never meant to force anything on R1. The DON further identified the NP indicated the order for R1 was changed on [DATE], due to R1's unresponsive state to receive the medication rectally, but later the order was changed again on [DATE], for staff to either give orally or rectally due to R1 becoming more alert and responsive. On [DATE], at 11:35 a.m. during a follow up interview the DON stated, When the staff involved were interviewed, they all acknowledged they performed a medication administration against R1's will. The DON also stated, (RN-A) did say 'we made her (R1) do it,' and that (RN-B) said 'we put a mask on her because she was screaming and spitting.' Although the facility staff failed to report the allegation of resident abuse to facility management on [DATE]; upon learning of the incident of [DATE] when brought to the attention by the surveyor, immediate action took place. The incident was reported immediately to the SA, and RN-A, RN-B, NA-A, were suspended pending investigation. A thorough investigation took place and the facility was able to verify corrective action had been implemented, including RN-A, RN-B and NA-A being terminated. The facility continued with a plan to educate all staff on the importance of reporting, protecting and preventing abuse, which began [DATE], and continued to [DATE]. In addition, the facility planned to have staff take a competency quiz at a later date regarding the information taught about abuse and reporting. It was determined that the majority of staff had been trained by [DATE], and therefore, this deficient practice is being cited at Past Noncompliance. Review of Monarch Health Management policy, Abuse Prohibition/Vulnerable Adult Plan revised [DATE], indicated that the purpose is to ensure that residents are not subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, or volunteers, staff or other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse. The policy further indicated that all staff are responsible for reporting any situation that is considered abuse or neglect along with injuries of unknown origin. Also that reporting must occur immediately to a supervisor and that reporting to the state agency must be reported no later than 2 hours after forming the suspicion of abuse.

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