STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **245148**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **06/01/2020**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to provide supervision for a wandering resident and reduce altercations for 1 of 4 residents (R1) reviewed for resident to resident interaction. Findings include: A progress note dated 5/22/20, indicated that a female resident came out of her bathroom and observed R1 in her room. The female resident yelled at R1, who then pushed her in the chest. R1 was placed on every 15 minute checks through the weekend. [DIAGNOSES REDACTED]. R1's annual Minimum Data Set ((MDS) dated [DATE], indicated R1 had severe cognitive impairment. The MDS's Care Area Assessment (CAA) indicated that R1 wandered around the unit and in/out of other's rooms for most of the day and that R1 can get physically aggressive when staff attempted to help in any way. R1's care plan printed on 6/1/2020, indicated that R1 was involved in a resident to resident altercation where R1 pushed another resident on 5/9/2020. R1's care plan further indicated that R1 was involved in another resident to resident altercation on 5/22/2020, where R1 hit another resident when R1 wandered into another resident's room. Interventions included R1 was on every 15 minute checks and was to see the psychiatrist. R1's care plan also focused on utilizing [MEDICAL CONDITION] medications for [MEDICAL CONDITION] Disorder with interventions that included attempting interventions before behaviors began, assist in avoiding situations or people that are upsetting to R1, and to remind R1 of being mindful of actions and behaviors towards others. Furthermore R1's care plan indicated that R1 would lay down and was incontinent in other resident's beds. The interventions included R1 be taken to his room or redirect R1 from going into other resident's beds. On 6/1/2020, at 9:43 a.m. it was observed that R1 walked into a room that was not his and laid down in the bed with the door open. At 9:59 a.m. registered nurse (RN)-A walked into a room directly across the hallway from where R1 was laying. At 10:06 a.m. a therapist walked pass the room and went into a different room further down the hallway. At 10:07 a.m. RN-A walked into the room where R1 was laying. At 10:10 a.m. RN-A identified R1 for surveyor, and indicated she was going to talk to the nurse because she realized that was not R1's room. RN-A further indicated that she was not familiar with the unit. At 10:13 a.m. RN-B and licensed practical nurse (LPN)-A walked into room and stated hi, let's get up. R1 responded no then hollered no God damn it At 10:15 a.m. LPN-A stated to RN-A let's come back. At 10:24 a.m. nursing assistant (NA)-A entered room where R1 was laying in bed. NA-A asked R1 did you get breakfast R1 responded with no NA-A stated well let's go get breakfast, but we have to go to your room, let's go to your room R1 yelled at NA-A no, I don't want to. Record review indicated that R1 was placed on 30 minute checks on 5/22/20, and 5/23/20, following the incident on 5/22/20. During an interview on 6/1/2020, at 10:19 a.m. NA-A indicated that R1 liked to go into other people's room. NA-A then indicated that staff try to keep R1 out of other people's rooms but sometimes R1 needs to be re-approached to get him back into his room. At 10:30 a.m. LPN-A was interviewed and indicated that R1 was noncompliant and did not like to be redirected and at times will become combative. LPN-A further indicated that R1 wandered from bed to bed and did not know how do stop R1 from doing that. When LPN-A was asked about 15 minute checks, LPN-A indicated that 15 minute checks are difficult because R1 moved around the unit so frequently and quickly. During an interview on 6/1/2020, at 10:56 a.m. social worker (SW)-A stated We usually don't have a problem with (R1) because the other resident's are not in their room that often. During an interview on 6/1/2020, at 11:13 a.m. director of nursing (DON) indicated that following the altercation between both residents, R1 was placed on every 15 minute checks and that they thought about moving the female resident that was involved in the altercation to a different unit. Then at 11:49 a.m. the DON indicated that 15 minute checks were never completed, but 30 minute checks were completed and that when a resident is placed on 15 minute checks it is to ensure that the resident or incident had calmed down afterwards. The DON further indicated that the recurrence of another altercation happening between both residents was still a problem and that they needed to come up with a better plan. The policy for Monarch Healthcare Management Abuse Prohibition/Vulnerable Adult Plan dated 7/5/2019, indicated that purpose of the policy was to ensure that residents are not subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self abuse.

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