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 _____	04/02/2020

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 -** 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 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. Findings include: R1's admission Minimum Data Set ((MDS) dated [DATE], 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. 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. 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 [MEDICATION NAME]. The windows on the unit slid to the side to be opened and the [MEDICATION NAME] were screwed to the top and the bottom of the window frames. The [MEDICATION NAME] were secured from the outside of the frame to approximately four inches from the sliding pane of the window. 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. R1's facility Progress Notes identified the following: 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. 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 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 [MEDICATION NAME] on the window frame and pulled out the screws that held the [MEDICATION NAME] 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 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 [DATE]. 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 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 [MEDICATION NAME] 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 [MEDICATION NAME], 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 [MEDICATION NAME] 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 [MEDICATION NAME] 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 [MEDICATION NAME] 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.

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

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) 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 [MEDICATION NAME] 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 [MEDICATION NAME] 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 [MEDICATION NAME] 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 [MEDICATION NAME] 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 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 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 [MEDICATION NAME] 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 [MEDICATION NAME] 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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings include: 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 [ROOM NUMBER] carrying a broom and a dustpan. -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 [ROOM NUMBER] and mopped the floor. -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 [ROOM NUMBER]. -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 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 [ROOM NUMBER]. -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 [ROOM NUMBER]. 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, cleaning/disinfecting and hand hygiene she stated, I don't understand. On 4/1/20, at 9:30 a.m. HK-B was observed mopping the communal, toilet/tub room with a large mop. -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. -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. 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. 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.