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 _____	06/12/2020

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 observations, interview and document review, the facility failed to conduct a comprehensive assessment of aggressive behavior and implement interventions to protect other residents from R1 who was involved in multiple altercations involving other residents on the unit. In addition, failed to provide adequate supervision as R1 continued to wander and sleep/lay in other residents beds, causing other residents distress. R1 subsequently became agitated and was physically aggressive when he threatened and hit other residents. R2, R3, and R4 were identified to be in an immediate jeopardy situation related to risk for serious injury, harm, impairment or death due to the physical aggression by R1. R1's behaviors had the potential to affect all 20 residents residing on the Advanced Alzheimer's Care Unit (AACU) wing. The immediate jeopardy began on 5/9/20, when the facility failed to protect R2 from R1's physical abuse. The IJ was identified on 6/11/20, the director of nursing (DON), administrator, administrator interns, and the assistant director of nursing were notified at 5:05 p.m. The immediate jeopardy was removed on 6/12/20, at 9:30 a.m., after it could be verified the facility had implemented an acceptable removal plan, however, noncompliance remained at the lower scope and severity level of E, a pattern with no actual harm with potential for more than minimal harm. Findings include: R1's face sheet dated 6/12/20, indicated [DIAGNOSES REDACTED]. R1's annual Minimum Data Set ((MDS) dated [DATE], identified a brief interview for mental status (BIMS) of 0, indicating severe cognitive impairment. R1 was ambulatory and wandered throughout the unit. R1 was moved to the locked unit in 12/19 due to elopement. R1's behaviors had escalated since admission to the unit. R1's physician visit notes dated 5/12/20, indicated reports of increased agitation and restlessness. R1's care plan initiated 6/3/19, identified an alteration in cognition related to [DIAGNOSES REDACTED]. It also identified socially inappropriate disruptive behaviors such as laying/sleeping in other residents' beds, yelling, pushing, and hitting other residents. R1's behavioral approach included allowing time to communicate his needs/wants, redirecting him to his bed when he was in others rooms, providing cues, reorientation and supervision as needed. During observations on 6/11/20, at 12:46 p.m. R1 went into R4's room and laid down in her bed. -At 1:05 p.m. the licensed practical nurse (LPN)-A was observed to enter R4's room, however, did not redirect R1 out of the room. LPN-A left the room and R1 continued to lay on R4's bed until 1:18 p.m., when nursing assistant (NA)-A wheeled R4 in her room via wheelchair. At this time R4 observed R1 laying on her bed and yelled, What is he doing there? NA-A called R1's name and attempted to physically remove him from the bed. At this same time social services designee (SSD)-A came into R4's room and was observed to offer R1 a 7-Up and was able to redirect him out of R4's room. Additional altercations, involving R1, were reviewed, and identified the following: A Progress Note (PN), dated 5/9/20, identified R1 had been known to go into other residents' rooms and lay in their beds. It further indicated, R2 had caught R1 in her room again and when R2 was on her way to the dining room, R1 went after her, pushed her against the door to the dining room, and went after her with his fist. R2 said R1 had scratched her arms and grabbed her chest. A PN, dated 5/22/20, indicated R2 was in her room and when she came out of the bathroom, R1 was in her room. R2 yelled at R1 and R1 pushed R2, hitting her in the chest, which resulted in a red mark. R5, identified as having intact cognition, per MDS dated [DATE], witnessed an altercation between R1 and R2: - A PN dated 6/6/20, identified R5 reported, that guy (R1) was in R2's room again and they both screamed at him to leave. R5 witnessed R1 hitting R2 in the right arm/shoulder two times. The intervention identified at this time was to keep R1 on the unit, and to transfer R2 to another room off the unit after securing a Wander Guard on R2's right wrist, due to risk for elopement. A PN dated 6/10/20 at lunch time, identified R1 had gone up to R3 and took his drink off of his meal tray. R3 then got upset and told R1, That is mine, get the hell away from here! Staff then came in between the two residents to intervene. R1 started swinging his fists towards R3. Staff was able to separate the two residents and no one was injured. R1 then walked away and started pacing around the unit as R3 continued to eat his lunch. The DON was interviewed on 6/11/20, at 2:57 p.m., regarding the multiple altercations that had occurred between R1, and other residents, as noted above on 5/9/20, 5/22/20, 6/6/20 and 6/10/20. When asked what interventions were put in place to protect R1 and other residents in the unit, the DON said R1 had always been known to wander and it was not a problem before R2 was transferred to the unit from 2 East. The DON explained that R2's cognitive level was above the level of other residents on the unit, R2 was aware of where her room was, and was able to use her bathroom per self, which posed a problem if R1 was laying on her bed. DON said the facility initially put both residents, R1 and R2, on safety checks (30 minutes), after altercations occurred. The DON explained that she had checked with the staff nurses and nurse practitioner (NP) to inquire if R1 had become more aggressive and also stated lab work had been done to see if R1 had an infection. The DON stated with the altercation on 5/9/20, R1 was given a one time dose of [MEDICATION NAME] (antipsychotic, used to treat [MEDICAL CONDITION]) and it was recommended to increase [MEDICATION NAME] (restores the balance of natural substances in the brain), however, after a couple of days R1 went back to baseline. Regarding the altercation that occurred on 5/22/20, DON said the facility started talking about the fact that R1 continued to go into R2's room and so the altercations continued. The interdisciplinary team (IDT) discussed transferring R2 to a different unit, however, the DON acknowledged the move had not taken place and an additional altercation occurred between R1 and R2 on 6/6/20. The altercation on 6/6/20, DON said she was at the facility when the incident took place, and a decision was made to put a wander guard on R2 and move her to another unit. When asked by the surveyor what they did to protect other residents on the unit from R1, she said, We didn't really do anything. She also said the NP recommended increasing R1's dose of [MEDICATION NAME], but the facility did not want to chemically restrain him. (R1) likes to go into (R2's) room, and explained that was why R1 and R2 were constantly having altercations. When surveyor asked why R2, who was not the aggressor, was now being transferred to a different facility, the DON did not respond. Regarding the altercation on 6/10/20, DON said she was not aware of the incident between R1 and R3. The DON reviewed R1's and R3's medical records and verified the nurse had only documented the incident in R1's record. The DON read the progress note and she confirmed it was a resident to resident altercation but again said she was not aware of it and should have been informed. She also said, I think he (R1) needs to go. She said that she had checked with the nurses who reported R1 had not been more aggressive to residents, but to staff. The DON also said the facility is not able to provide one to one supervision to R1 ongoing. The DON said that her expectations were for staff to redirect R1 out of other residents' rooms, I will talk to the administrator to see if someone can watch him until we come up with a better plan. We don't want to snow him, that's not an option. I will talk to the administrator and the NP to see what we can do immediately to protect the other residents. On 6/11/20, at 1:19 p.m. NA-B stated, He (R1) will wander into every room and he keeps coming in and out of rooms all day and you will not find him in just one particular room. We talk to him and he will sometimes listen but at times he is hard to re-direct and we tell the nurse and nurse manager. There was an incident with (R2) and he kept going to her room several times and he would not listen and (R2) was upset. We would redirect him but he doesn't listen and will yell at you and tell

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) you **** you. We are to redirect him when we see him in other resident's rooms. We are supposed to report all allegations of resident to resident to the nurse immediately. He is aggressive both verbally and physically and will hit both staff and residents. NA-B explained that R1 will do this when he is re-directed, and stated, A lot of the residents in the unit have dementia and will not be able to report if he did anything to them because they will forget. It's hard to keep up with him. On 6/11/20, at 1:20 p.m. NA-A said R1 tends to wander and go into other residents' rooms. NA-A was told to sit with R1 in his room until he calms down. NA-A also said he has had to do this several times per shift. On 6/11/20, at 1:23 p.m. social services director designee (SSD)-A said R1 often wanders into other residents rooms. She said redirection works sometimes but he can get volatile. She also said some of the residents don't understand R1's behavior and question why he is in their room. On 6/11/20, at 1:28 p.m. LPN-A stated all allegations of resident to resident altercations were supposed to be reported to the DON or administrator to be investigated. LPN-A also stated R1 required to be constantly re-directed, was combative and staff were supposed to walk away when he was combative and then re-approach. LPN-A further stated staff continued to re-direct him out of other resident rooms, however, he would still find another resident's bed, which was an on-going problem. When asked what else had been tried to keep other residents safe in the unit, as R1 had several altercations with residents on the unit, LPN-A stated re-directing, re-approach and offering him candy or pop. Nothing in particular he is kind of hard depending on his mood. The facility Abuse Prohibition/Vulnerable Adult Plan revised 12/16, indicated the purpose of the policy was to ensure that residents were 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 also directed staff to report any situation that was considered abuse or neglect immediately to the supervisor who would assess the situation to determine if any emergency treatment or action was required. The policy also directed staff immediately upon learning of the incident; staff was to take necessary steps to protect residents from possible subsequent incidents of misconduct while the matter was being investigated. The policy further directed if it was resident to resident abuse, the resident who was the abuser was to be removed to a safe environment to ensure that all other residents remained safe. The immediate jeopardy was removed on 6/12/20, at 9:30 a.m. after it was verified the facility had reviewed and revised R1's care plan to include 1:1 supervision intervention and attempt to send R1 to a geriatric -psych hospital for further evaluation and treatment. The facility reviewed and revised care plans for like residents in the unit and the policy and procedures for abuse prevention, safety, supervision, accidents and resident to resident altercations. The staff education was initiated and remained ongoing regarding proper interventions for safety and supervision of residents after resident to resident altercations. Also the staff were educated on R1's plan of care regarding interventions and supervision. In addition, R1 was transferred out of the facility on 6/12/20, at 10:23 a.m. to the hospital for evaluation due to increased behaviors. The non-compliance remained at the lower scope and severity level of E because the facility failed to put in place interventions to protect all other residents who were vulnerable and with advanced dementia/Alzheimer's, who resided in the AACU wing, from abuse.