

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER The Estates at St Louis Park LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the comprehensive care plan indicated the presence of a ventriculoperitoneal (VP) shunt and include signs and symptoms of VP shunt malfunction for 1 of 3 residents (R1) reviewed for comprehensive care plans.</p> <p>Findings include:</p> <p>A VP shunt is defined as a plastic tube that drains extra fluid from the brain into the stomach. A VP shunt may become blocked and can cause excess fluid in the brain which is a neurosurgical emergency.</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R1 was cognitively impaired and was mostly independent with activities of daily living.</p> <p>R1's face sheet dated 4/17/25, included diagnoses of dementia, psychotic disturbance, nontraumatic intracranial hemorrhage, restlessness and agitation and, mechanical complication of ventricular intracranial shunt.</p> <p>R1's care plan printed 4/17/25, indicated R1 had a traumatic brain injury and was at risk for alteration in skin integrity related to wandering into other resident's rooms and bumping into doorways. The care plan lacked indication that R1 had a VP shunt, or interventions related to shunt malfunction.</p> <p>R1's physician order dated 1/20/25, indicated to monitor drainage from area on the right back of the scalp. Document any signs or symptoms of infection and notify the doctor. The order did not clarify the open area on the scalp was where the VP shunt was placed.</p> <p>R1's physician order dated 3/6/25, indicated to cleanse the area on the right temple with wound cleanser and pat dry. Apply calcium alginate with silver to wound bed and cover with foam dressing, daily and as needed. The order did not clarify the open area on the scalp was where the VP shunt was placed.</p> <p>On 4/17/25 at 12:19 p.m., licensed practical nurse (LPN)-A was interviewed and stated when R1 arrived, he had a small open area. R1 would constantly pick at it and remove the bandage so the area opened more and began to show signs of infection. There were no interventions in his care plan related to his VP shunt.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/17/25 at 1:11 p.m., LPN-B who was R1's care coordinator was interviewed and stated she was not sure if the care plan mentioned the VP shunt or not. LPN-B stated when R1 was transferred to the facility, staff were not initially aware he had a VP shunt.</p> <p>On 4/17/25 at 1:45 p.m., the director of nursing (DON) was interviewed. DON stated there should have been a care plan for the VP shunt, there was an existing process for adding VP shunt management to the care plan in the facility's care planning process.</p> <p>On 4/17/25 at 2:39 p.m., the administrator was interviewed and stated she would expect a resident to have a section in their care plan about shunts if they have a shunt. The administrator stated there were wound care orders for the shunt but did not clarify the wound was related to the shunt. Administrator verified that it would be difficult for a nurse to respond appropriately to a shunt malfunction without a care plan for malfunction signs, symptoms and interventions.</p> <p>Facility Care Planning policy last revised 11/2024, directed the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.</p>		