| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245148 | A. Building<br>B. Wing | 08/07/2025 |

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| The Estates at St Louis Park LLC | 3201 Virginia Avenue South<br>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 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>(continued on next page) |

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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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a resident's preferred activities for individual entertainment were available for 1 of 1 resident (R3) reviewed for activities. Findings include:R3's annual Minimum Data Set (MDS) dated [DATE], indicated R3 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADLs). Preferences for routine and activities was not assessed. R3's MDS indicated R3 had zero minutes of recreational therapy (to include recreational and music therapy) in the lookback period. R3's diagnoses include hemiplegia (weakness) and hemiparesis (paralysis) following cerebral infarction affecting right dominant side, dementia, contracture of muscle, aphasia (conditioning affecting speech) and depression. R3's care plan (CP) dated 7/8/25, indicated R3 spoke Vietnamese, Cantonese, and some English. In his free time, he enjoys watching TV-especially Chinese dramas, listening to Vietnamese music, and watching movies. The CP further indicated, Resident has a smart TV so he can watch TV and listen to music in his language. This is his favorite thing to do. R3's physician order dated 12/13/24, indicated, Non-pharmacologic interventions offered to relieve pain: 1. Music 2. Redirection 3. Reposition.Document which # intervention was used.In addition, R3's order dated 12/13/24, indicated, Ensure resident is in the dining room for lunch and dinner. R3's Activity/Leisure Time task report dated 7/1/25 through 7/31/25, indicated the following: -TV in room/group-11 times-Looking out the window/music/time spent in room-independent-9 times R3's Activity/Leisure Time task report dated 8/1/25 through 8/5/25, indicated the following:-TV in room/group on 8/2, 8/4, and 8/5. -Looking out the window/music/time spent in room-independent on 8/4. During observation on 8/4/25 at 1:36 p.m., R3 was in room in Broda-type wheelchair in middle of the room facing the wall opposite his TV. The TV had a purple screen indicating, we are having difficulty connecting. R3 was not facing the window. During interview 8/4/25 at 4:24 p.m., family member (FM)-A stated expectation for staff to take R3 out to the common area 2-3 hours each day. FM-A also stated R3 liked to be next to the window so he could look outside and that R3 also enjoyed watching TV or listening to Vietnamese music in his room. During observation on 8/5/25 at 8:29 a.m. , R3 lying in bed awake by window. TV was on a dresser at the foot of the bed. The TV was on with the purple screen still displaying, we are having difficulty connecting on the screen. During observation on 8/5/25 at 1:21 p.m., R3 sitting up in wheelchair in room awake in the middle of the room. The room was quiet and the TV still showing the no connection message. During observation on 8/5/25 at 1:37 p.m., an activity with a movie, music and nail care in the common area on the first floor. R3 was not in attendance. During observation on 8/5/25 at 3:03 p.m., R3 was lying in bed awake. The room was quiet, and the TV still displayed the no connection message. During observation on 8/5/25 at 3:16 p.m., licensed practical nurse (LPN)-B was in R3's room assisting with reposition. Replaced called and left the room. LPN-B did not address the TV or lack of music. During observation on 8/6/25 at 7:23 a.m., R3 was lying in bed awake with the TV on still displaying the no connection message. Nursing Assistant (NA)-C performed cares on R3's roommate and left the room. NA-C did not address the TV or lack of music. During observation on 8/6/25 at 8:38 a.m., LPN-B, NA-B and NA-C in to perform morning cares and get R3 up for a shower. R3's window blinds were closed for privacy during cares. R3 moaned during cares and transfer. During observation on 8/6/25 at 9:14 a.m., R3 was wheeled back to his room after the shower, dressed in a new gown and transferred back to bed by NA-B and NA-C. R3's window blinds were still closed and the TV displaying the same message. During observation on 8/6/25 at 9:36 a.m., LPN-A in R3's room to administer medications via G-tube (gastronomy tube). LPN-A placed medications and other supplies on top of the dresser where the TV sat. R3 moaned several times during medication administration. LPN-A left the room and did not address the no connection message on the TV, lack of music, or the closed blinds. During observation on 8/6/25 at 10:37 a.m., LPN-A in R3's room to apply face lotion, neck brace and palm protector. R3 awake and groaning. LPN-A left the room and did not address the no connection message on the TV, lack of music, or the closed blinds. During observation on 8/7/25 at 8:16 a.m., R3 lying in bed in room awake. R3's blinds were still closed and the TV still displaying the no connection message. During observation and interview on 8/7/25 at 8:21 a.m., NA-A stated R3 should be out of his room for lunch and when in his room he enjoyed looking out the window, watching TV and listening to music in his own language. NA-A into R3's room and confirmed the TV was not tuned to any show or music and the blinds were closed. During interview on 8/7/25 at 8:26 a.m., registered nurse (RN)-A stated R3 should be out of his room in the morning and back to lie down after lunch |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess and monitor a skin condition for 1 of 1 resident (R88) reviewed for red areas on chin. Further, the facility failed to ensure a critical lab was followed up on timely for 1 of 1 resident (R138) reviewed for labs.<br><br>Findings include:<br><br>R88‘s quarterly Minimum Data Set (MDS) dated [DATE], indicated R88 had short- and long-term memory problems and moderately impaired cognitive skills for daily decision making. R88 was independent for most activities of daily living. R88‘s diagnoses included coronary artery disease, heart failure, hypertension, diabetes mellitus, dementia, anxiety, and depression. R88 had no skin condition concerns.<br><br>R88‘s care plan had a focus area for skin initiated 7/23/20 and indicated R88 was at risk for alteration in skin breakdown secondary to diagnosis of diabetes and refusals of cares: showers/baths, etc R88 had history of rash to arms, upper back, and body which healed up and returned after a few days to months. The focus area included an update dated 8/5/25 which indicated R88 had red spots on her face around her mouth. Interventions included to encourage and reapproach if refusing shower, R88 had a pressure reducing mattress to bed, skin assessment to be completed per policy, treatments as ordered as needed, and R88 turned and repositioned independently. An intervention dated 8/6/25, indicated R88 tended to scratch her head and skin and refused nail care and directed staff to keep nails trimmed.<br><br>A provider encounter dated 6/30/25, indicated R88 had a past medical history of seborrheic dermatitis (itchy, scaly skin patches and flakes on oily areas of skin), rash and other nonspecific skin eruption, pruritus (sensation of itching). The encounter indicated R88 had no new rashes, lumps, sores, dryness, pruritic lesions, or skin breakdown.<br><br>Progress notes reviewed did not indicate R88 had red areas on her chin prior to 8/5/25.<br><br>Physician orders did not indicate R88 had red areas on her chin prior to 8/6/25. A physician order dated 8/6/25, directed staff to apply triamcinolone acetonide external cream 0.025% (percent) to R88‘s rash/lesions on face two times a day for two weeks and monitor for worsened skin condition.<br><br>R88‘s skin assessments dated 6/30/25 to 8/4/25, indicated R88 refused skin checks/showers at times, but R88‘s visible skin was intact with no new skin issues.<br><br>During observation and interview on 8/4/25 at 4:03 p.m., R88 had approximately five to six red circular spots on and around her chin. The red areas were not raised. R88 stated she would use lotion if given to her, and red areas on skin had been happening for “forever”.<br><br>During observation and interview on 8/5/25 at 1:54 p.m., R88 was sitting in her room in a chair watching television. The red areas around R88‘s chin appeared unchanged from previous observation. R88 stated the areas were not painful and did not itch. R88 was not sure if the red areas were better or worse than prior. R88 stated she got the red areas from resting her chin on her hands while watching television.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During observation and interview on 8/5/25 at 2:08 p.m., registered nurse (RN)-B stated they were not aware of the red areas on R88‘s face. RN-B stated residents had weekly skin checks on their shower days. RN-B stated staff documented new skin concerns, called the provider, and monitored the area of concern. RN-B looked at R88‘s face and stated the red areas looked like R88 picked her skin. RN-B stated R88 scratched her head and scratching her chin may be new. RN-B stated they encouraged R88 to stop scratching herself and observed for bleeding or redness when they saw R88 scratch her forehead.<br><br>During interview on 8/6/25 at 10:25 a.m., nursing assistant (NA)-D stated R88 required minimal or set-up assistance for cares and worked on the unit frequently. NA-D stated R88 did not scratch her head often, and NA-D distracted her with television and coffee. NA-D stated they saw the red areas on R88‘s chin “some time back”.<br><br>During interview on 8/7/25 at 11:07 a.m., licensed practical nurse (LPN)-C stated staff noted the red areas on R88‘s face two days ago and called the provider. LPN-C stated R88 had a history of rashes on her body and requested the provider look at the red areas around R88’s chin to determine what treatment was needed. LPN-C stated they had never seen R88 scratch her head or skin but added the scratching to the care plan when they were made aware by other staff.<br><br>During interview on 8/7/25 at 1:08 p.m., the director of nursing (DON) expected staff to call a provider for possible treatment and monitor residents with a new skin concern. The DON stated it was important for staff to manage skin concerns.<br><br>The facility’s Skin Assessment and Wound Management policy dated 2/2025, directed staff to notify a nurse when skin changes were identified and implement appropriate preventative skin measures.<br><br>See also F698.<br><br>R138's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, did not have behaviors or reject care, had a wheelchair for mobility, required substantial assistance with dressing, toileting hygiene, and personal hygiene, had anemia (low hemoglobin or HGB), end-stage renal disease (ESRD), a coagulation defect (a bleeding disorder affecting the blood's ability to clot), and thrombocytopenia (a condition of a low platelet count in the blood which can lead to increased bleeding and bruising). Further, R138 was on dialysis.<br><br>R138's Physician's Orders form indicated the following orders:<br><br>7/16/25, dialysis every Monday, Wednesday, and Friday.<br><br>8/5/25, lab CBC (complete blood count which includes a HGB), CMP, Mg, PTH, CRP, INR (a blood test that indicates how well the blood is able to clot), Phosphorus on 8/5/25.<br><br>R138's hospital discharge orders dated 7/27/25, indicated a CBC, INR, and CMP was recommended on 7/30/25.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R138's care plan dated 7/14/25, indicated R138 was at risk for complications related to dialysis and interventions included to call the physician if any changes in the dialysis port line, fistula to left forearm, excess bleeding, notify dialysis of any concerns, send communication folder to dialysis with each run. Additionally, an intervention dated 8/6/25, indicated to monitor the central dialysis port line on the right upper chest for signs of bleeding every shift.<br><br>R138's care plan dated 7/15/25, indicated R138 had a nutritional problem related to ESRD and interventions included obtaining and monitoring lab and diagnostic work as ordered and report the results to the physician and follow up as indicated.<br><br>R138's labs collected on 8/5/25 at 6:05 p.m., with a fax time stamp at the top of the form dated 8/5/25 at 8:53 p.m., indicated the following:<br><br>HGB 6.7 (LL) and the normal reference range was 13.5 to 17.5 g/dl (grams per deciliter).<br><br>Platelets (platelets are essential for blood clotting) 78 (L) and the normal reference range was 150 to 450 x 10(9)L. A legend at the bottom of the lab form indicated an (LL) was a critically low lab value and an (L) value was a low lab value. Further, the lab result form contained an illegible signature.<br><br>R138's labs collected on 8/5/25 at 6:55 p.m., with a fax time stamp at the top of the form dated 8/5/25 at 9:33 p.m., indicated the following:<br><br>INR: 3.2 (H) with a reference range of 0.9 to 1.1. The legend at the bottom of the lab form indicated an (H) was a high level. Further, the lab result form contained an illegible signature.<br><br>R138's nurse practitioner (NP)-E notes dated 8/4/25 at 2:25 p.m., indicated on 7/29/25 R138 had chronic, stable anemia of chronic disease and required multiple transfusions during hospitalization with no signs of bleeding. The note further indicated to check HGB as soon as possible (lab can't come until tomorrow), and discussed low HGB during dialysis can cause aches due to blood pull off and if abdominal pain is severe before work up can be completed by lab, can discuss hospitalization for uncontrolled pain and suspected symptomatic anemia. Additionally, the note indicated R138 received 2 units of packed red blood cells the week of 7/20 and R138's HGB at the time of discharge was 7.8. NP-E indicated R138 was visibly uncomfortable duet o lower abdominal pain and was concerned about symptomatic anemia and R138's code status was a full code and was unclear what R138's baseline HGB was but, the note indicated r138's HGB was stable at 7 to 8 now.<br><br>R138's progress notes dated 7/21/25 at 10:46 p.m., indicated R138 was transferred to the hospital with a HGB of 6.3.<br><br>R138's progress notes dated 7/27/25 at 10:25 p.m., indicated R138 was readmitted from the hospital.<br><br>During interview on 8/4/25 at 1:42 p.m., family member (F)-B stated R138 went to the hospital with a low HGB and the physician put notes in for discharge to check a HGB on 7/30/25, and when asked, the facility did not have the labs set up until Monday so the labs will be drawn on 8/5/25, and added R138 had transfusions every two to three weeks because his HGB dropped.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 8/6/25 at 12:16 p.m., licensed practical nurse (LPN)-E stated R138 had low HGB's and health unit coordinators (HUC's) collect lab results and if a lab was critical, staff received a call from the pathway and then staff were to contact the provider as soon as possible.<br><br>During interview on 8/6/25 at 12:29 p.m., HUC-H stated when lab results came back she prints the lab and verified she received orders for labs from the NP on 7/30/25 but did not see any results. HUC-H added R138 came back on a weekend and they did not work on the weekend so nursing processed the orders. HUC-H stated R138's HGB was 6.7 on 8/5/25 and stated the lab was not critical and if there were critical results, the lab calls to report the results to the nurse. HUC-H further stated the lab reports had a reference range on the report that indicated the HGB should be 13.5 to 17.5 and if it was above or below that range, they called the provider. HUC-H stated they faced the results to NP-E on 8/5/25.<br><br>During interview on 8/6/25 at 12:46 p.m., nursing assistant (NA)-H stated R138's wheelchair came back from dialysis, but he thought R138 went to the hospital because the chair came back but R138 did not.<br><br>During interview on 8/6/25 at 1:58 p.m., registered nurse (RN)-E stated the lab calls to inform of a critical lab and then staff are supposed to call the provider right away. If a lab is not critical staff fax the provider. Further, RN-E stated if they receive a lab it was documented in the electronic medical record (EMR). RN-E viewed R138's labs and verified R138's HGB was low and stated LL meant the HGB was low and added maybe the lab was low from the previous lab. RN-E verified a lab value of LL indicated it was critically low and opened NP-E's note dated 8/4/25 that indicated R138's HGB was 7.8 on 7/26/25, and verified R138's HGB on 8/5/25, was 6.7 and stated she had to check the progress notes. RN-E verified the progress notes lacked evidence the physician was called and stated a HGB of 6.7 was a critical lab and stated the nurse should have called the provider.<br><br>During interview on 8/6/25 at 2:32 p.m., LPN-E stated she had not heard the results of R138's labs and stated staff observe the lab results and call the provider right away when a lab was critical versus faxing and is documented in a progress note and stated the HGB result should have been called to the provider already. LPN-E stated when a lab result is received, the HUC collects them and scans them and puts them in the nursing station and the nurses should have visual checks to send information to the provider. If a lab is normal it will be faxed. LPN-E clarified the lab will be received at the nursing station and whoever sees the fax reads it and stated the physician should have been contacted right away.<br><br>During interview on 8/6/25 at 2:35 p.m., with the director of nursing (DON) and LPN-E, LPN-E verified RN-F signed R138's lab form. The DON stated the NP should have been notified immediately.<br><br>During interview on 8/6/25 at 2:39 p.m., RN-F stated he worked on the evening of 8/5/25, and viewed R138's lab results, however did not call the provider.<br><br>During interview on 8/6/25 at 2:41 p.m., NP-E stated she has not received a call on R138's labs and stated usually critical lab results were called to the provider and had not seen anything from the on call provider either.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 8/7/25 at 10:43 a.m., the DON stated R138's baseline HGB on follow up notes were 7 to 7.2 and further stated RN-F was suspended and added the lab always called when there was a critical lab and RN-F did not receive a call, however expected if a nurse put a signature on a lab, they had to review it and still expected if a nurse placed their name on something they had to look at what the report indicated and further stated they conducted house-wide education and added, the lab didn't do their part, but that didn't excuse the nurse from doing their part.<br><br>A policy on critical lab results was requested on 8/7/25 at 1:30 p.m., however was not provided.<br><br>A PDF form provided on 8/8/25 at 3:02 p.m., indicated education was provided to RN-F the provider of a critical lab must be notified immediately, ensure monitoring is in place for the critical lab, notify the guardian and representative, call the DON, and if hospitalization is recommended, it must happen immediately. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure range of motion (ROM) was completed on 2 of 2 residents (R3, R35) reviewed who had limited range of motion. In addition, the facility failed to ensure the regular use of a palm protector for 1 of 1 residents (R3) reviewed for splint/brace use.<br><br>Findings include:<br><br>R3’s annual Minimum Data Set (MDS) dated [DATE], indicated R3 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADLs). R3’s MDS indicated zero minutes of restorative nursing to include passive and active range of motion (ROM) and splint or brace assistance. R3’s MDS further indicated “Behavior not exhibited” for rejection of care assessment. R3’s diagnoses include hemiplegia (weakness) and hemiparesis (paralysis) following cerebral infarction affecting right dominant side, Parkinson’s, dementia, contracture of muscle, aphasia (conditioning affecting speech) and depression.<br><br>R3’s care plan (CP) dated 7/8/25, indicated R3 had hemiplegia/hemiparesis and Parkinson’s and required “Range of motion (active or passive) with am/pm care daily.” R3’s CP further indicated R3 often refused donning of or often removed splint from right hand. The CP indicated R3 had a history of and was at risk for skin breakdown on right hand due to contracture and instructed staff to keep a [NAME] hand guard on at all times.<br><br>R3's nursing care sheet updated 8/6/35, instructed staff, Perform Passive ROM LE [lower extremity] and upper twice daily. The care sheet indicated, Palmar guard on.<br><br>R3’s Restorative/Functional Maintenance Program dated 6/21/24, indicated, “Right Hand…Palmar hand guard…please keep palmar hand guard on at all times…”<br><br>R3’s physician order dated 12/13/24 indicated, “Perform PROM twice a day every day and evening shift.”<br><br>R3’s physician order dated 7/15/25 indicated, “Protection from skin breakdown: Please keep Palmar Hand Guard on R hand on at all times. Okay to remove to wash or during bathing tasks.”<br><br>R3’s physician order dated 7/23/25 indicated, “PROM [passive range of motion] to Bilat [bilateral] UE’s [upper extremities] once daily – work within pt’s pain tolerance.”<br><br>During observation on 8/4/25 at 1:36 p.m., R3 in room in Broda type chair and has a piece of gauze in right contracted hand. dry lips.<br><br>During interview on 8/4/25 at 4:14 p.m. family member (FM)-A, stated facility was supposed to be getting a brace or splint for R3’s right hand but could not recall ever seeing one. FM-A stated R3’s right arm and hand were severely contracted. FM-A stated R3 should be receiving ROM and that his right palm required protection from skin breakdown.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During observation on 8/5/25 at 1:21 p.m., R3 was awake and up in wheelchair in room. R3 did not have a brace or palmar hand guard on right hand.<br><br>During observation and interview on 8/6/25 at 8:38 a.m., licensed practical nurse (LPN)-B, nursing assistant (NA)-B, and NA-C into R3’s room for morning cares and transfer to shower chair for weekly shower. NA-B and NA-C performed peri care and prepped R3 for a shower. NA-B stated he worked with R3 regularly and had not seen R3’s palmar guard for about two weeks. NA-C stated had last seen a brace or palmar guard on R3 a long time ago. NA-B had to move the foot of R3’s bed in order to access the top drawer of R3’s nightstand. R3’s palmar guard was in the drawer. NA-B stated R3 should have it on at all times when not in shower. R3 was transferred to shower chair via Hoyer lift and then taken to the shower room. No ROM observed.<br><br>During interview on 8/6/25 at 9:12 a.m., LPN-B stated she trimmed R3’s fingernails the previous day and did notice he was not wearing a brace or palmar protector. LPN-B stated she placed a piece of gauze in R3’s hand since she could not find the protector. LPN-B stated R3 should have at least two palmar protectors so he would have one available while they washed the other one, and that one should be on at all times.<br><br>During observation on 8/6/25 at 9:14 a.m., NA-B and NA-C wheeled R3 back to room in shower chair. R3 was transferred back to bed. NA-B and NA-C dried R3, placed a new brief, and donned a new gown. NA-B left the room while NA-C finished performing morning cares on R3. NA-C applied body lotion, but did not perform any ROM. The palm protector that NA-B found earlier remained on top of R3’s nightstand and was not applied. NA-C left the room.<br><br>During observation and interview on 8/6/25 at 10:37 a.m., LPN-A into R3’s room to apply face cream and done a neck brace. LPN-A also placed R3’s palm protector on right hand by prying open each of R3’s fingers and actively wrap R3’s hand around it. LPN-A stated sometimes R3 would not have the palm protector in place because he would sometimes remove the palm protector himself. LPN-A stated the palm protector was to prevent skin breakdown on R3’s palm and to prevent the contracture from getting worse.<br><br>During observation on 8/6/25 at 1:34 p.m., LPN-B and NA-C in R3’s room providing cares. No ROM observed.<br><br>During observation on 8/7/25 at 8:16 a.m., R3 was awake lying in bed in room. R3 had the palm protector on and did show evidence of rejecting the splint or trying to remove it.<br><br>During interview on 8/7/25 at 8:26 a.m., registered nurse (RN)-A stated R3 should receive ROM on arm and hands daily and should have his hand guard on all the time.<br><br>During interview on 8/7/25 at 8:31 a.m., LPN-B stated would expect R3 to receive ROM twice a day as ordered and to have the palmar grip on all the time.<br><br>During interview on 8/7/25 at 8:59 a.m., physical therapist (PT)-A stated would expect restorative nursing orders to be carried our as written. PT-A stated continuous refusal, or noncompliance should be communicated to therapy and a new assessment could be completed to determine if the ROM and/or the protector was still appropriate.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 8/7/25 at 9:08 a.m., occupational therapist (OT)-A would expect [NAME] guard on for skin protection if ordered and would expect ROM to be completed as ordered or recommended. OT-A stated the goal of long term care restorative nursing was to maximize the functioning yet understood that as residents approached end of life, they were allowed to refuse treatment or services.<br><br>During interview on 8/7/25 at 9:48 a.m., director of nursing (DON) stated expectation for ROM to be completed as ordered for R3 and that a palm protector would be on at all times. DON stated if staff were unable to locate the palm protector, she would expect to be notified so a replacement could be ordered. DON further stated if a resident always continuously refused or rejected care, that would be documented and communicated to therapy so they could re-evaluate the need for treatment.<br><br>Facility policy requested but not received. Per email received on 8/7/25 at 10:30 a.m., “Related to ROM/maintenance policy, we also do not have one. Each program is individualized for the resident, and we would follow therapies recommendations related to that resident.”<br><br>R35’s Optional State Assessment (OSA) dated 7/15/25, indicated intact cognition, did not have behaviors, and did not reject cares. Additionally, R35 required extensive assistance with bed mobility, toileting, and was dependent on staff for transfers.<br><br>R35’s quarterly Minimum Data Set (MDS) dated [DATE], indicated an impairment in range of motion to one side on the upper and lower extremities.<br><br>R35’s medical Diagnosis form indicated the following diagnoses: discitis unspecified lumbosacral region (inflammation of discs in the spine), other paralytic syndrome following unspecified cerebrovascular disease bilaterally (both sides), hemiplegia (paralysis on one side of the body), major depressive disorder, and chronic pain syndrome.<br><br>R35’s physician orders saved 8/5/25 at 12:07 p.m., lacked orders resident was on a range of motion program.<br><br>R35’s care sheet dated 8/2025, indicated R35 required assist of 1 with dressing, grooming, oral cares, and bathing. The care sheet lacked information R35 was on any type of range of motion program or that R35 had a contracture.<br><br>R35's care sheet updated on 8/5/25, lacked evidence R35 was on any type of range of motion program or that R35 had a contracture.<br><br>R35’s care plan revised on 8/5/25, indicated R35 had an alteration in mobility related to a history of stroke with paraparesis and pain. Interventions indicated R35 required encouragement to perform bilateral lower extremity and right-hand range of motion to prevent further contracture and assist as needed. Further, interventions indicated to follow handouts in the closet door.<br><br>All physical therapy (PT) and OT evaluations and progress notes were requested on 8/7/25 at 1:30 p.m. The following notes were provided:<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R35’s occupational therapy (OT) evaluation and plan of treatment form dated 4/22/22, indicated R35 had an evaluation only and reached a plateau and utilized a Hoyer lift. R35’s right and left upper extremity range of motion was within functional limits and there were no functional limitations were present due to contractures. The notes lacked information a range of motion program was recommended or initiated, or that R35 refused a ROM program.<br><br>R35’s OT evaluation and plan of treatment form dated 8/26/22, indicated a referral was made due to wheelchair seating and positioning. R35’s assessment indicated right upper extremity range of motion was within normal limits, and the left upper extremity range of motion was impaired. Further, left upper extremity range of motion to the shoulder, wrist, and forearm was impaired OT did not try range of motion to the left upper extremity hand. Further, no functional limitations were present due to contractures. Additionally, R35 could not propel the wheelchair due to a flaccid left upper extremity due to a stroke. The notes lacked information a range of motion program was recommended or initiated, or that R35 refused a ROM program.<br><br>R35’s OT evaluation and plan of treatment form dated 10/9/25 through 11/7/24, indicated nursing reported an ill-fitting wheelchair and was referred for wheelchair positioning. Further, R35’s right and left upper extremity range of motion was within functional limits and did not have functional limitations [NAME] to a contracture. The notes lacked information a range of motion program was recommended or initiated, or that R35 refused a ROM program.<br><br>R35’s OT evaluation and plan of treatment form dated 5/2/25 to 5/31/25, indicated R35’s back rest was uneven due to a broken piston. Further, R35’s right and left upper extremity range of motions was within functional limits and did not have functional limitations due to contractures. Additionally, adjustments to current wheelchair were beyond the scope of OT, but R35 would require additional services to assess and correct positioning after repairs are made. The notes lacked information a ROM program was recommended or initiated, or that R35 refused a ROM program.<br><br>R35’s OT evaluation and plan of treatment forms from 4/22/22, to 5/31/25, lacked information R35 refused treatments.<br><br>An OT evaluation and plan of treatment form dated 8/6/25, and completed by OT-B, indicated R35 was referred to therapy by staff for bilateral hand contractures R35 had previously refused range of motion or splinting to address the issue and would benefit from skilled OT to assess bilateral upper contractures and develop passive range of motion (PROM) to maintain function. Further no contraindications were present. R35’s evaluation indicated R35’s ROM to index finger had a resting contracture, and middle, ring, and little finger was impaired. Further, R35’s left upper extremity ROM indicated the index and ring finger was impaired. Further, functional limitations were not present due to a contracture.<br><br>R35’s PT (physical therapy) evaluation and plan of treatment notes dated 4/22/22, indicated R35 had functional limitation present due to contractures of both ankles and had PRAFO boots and PT was not treating contracture however nursing managed the contracture with the PRAFO boots. The form lacked information regarding R35’s upper extremities.<br><br>R35’s PT evaluation and treatment plan dated 9/13/22 to 10/12/22, indicated nursing managed R35’s contractures with an AFO (foot and ankle brace) for bilateral lower extremities that were worn daily. The form lacked information regarding R35’s upper extremities.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R35’s PT progress report forms dated 9/13/22 to 9/27/22, were reviewed and lacked information PT addressed upper extremity ROM or whether R35 had contractures to upper extremities.<br><br>R35’s PT evaluation and treatment plan form dated 11/15/23, indicated R35 was referred to therapy for strengthening and assessment for an upgrade in transfers. R35 had PRAFO boots for contracture management by nursing staff and the contractures were too advanced that standing and ambulation was not realistic and was at maximum potential. The form lacked information regarding R35’s upper extremities.<br><br>R35’s PT evaluation and treatment plan form dated 10/11/24, indicated R35 was referred for a PT evaluation and treatment and prior functioning indicated R35 required a Hoyer lift for transfers and nursing managed R35’s bilateral ankle contractures with PRAFO boots. The notes lacked information regarding R35’s upper extremities.<br><br>R35’s progress notes were reviewed from 4/21/22, to 8/6/25, and lacked evidence R35 refused a passive range of motion (PROM) program, until 8/6/25 at 12:26 p.m., when a therapy note was entered indicating R35 was assessed for bilateral contractures by OT and acknowledged previous refusals to develop a PROM program but was now willing to participate and design a PROM program and further education to nursing and to aides on administration to promote maximal function.<br><br>R35’s nurse practitioner (NP) notes dated 5/23/24, 5/28/24, 5/29/24, 8/9/24, 9/26/24, 12/2/24, 1/1/25, 1/9/25, 1/16/25, 1/23/25, 3/5/25, 3/19/25, 4/17/25, 6/9/25, 6/25/25, and 8/6/25, indicated R35 had contractures to his left-hand fingers.<br><br>During interview and observation on 8/4/25 at 2:59 p.m., R35 stated sometimes staff did exercises. R35 could not open his left-hand ring finger and 5th digit (pinky). R35 did not have a splint or brace on his left hand.<br><br>During interview on 8/5/25 at 2:54 p.m., R35 stated he could not move his left hand much and wanted help with that. R35 could not bend his left pointer finger and could not straighten his left ring finger and stated he had this prior to coming to the facility.<br><br>During interview on 8/5/25 at 1:08 p.m., nursing assistant (NA)-A stated they used a care plan and followed what was on the Kardex in order to know what cares a resident required and stated if a resident required ROM, it would be on their care plan and if a resident refused, they let the nurse know and refusals were documented in the computer. NA-A stated most of the time, R35 did not refuse cares and stated she did not see R35 had any ROM for his hands and stated ROM was on their care sheet. R35 pulled out a care sheet and stated R35 was not on her group but could ask the nurse.<br><br>During interview on 8/5/25 at 1:14 p.m., NA-F stated they looked at their care plan to know who had ROM and further stated pictures showed what to do up to patient tolerance for ROM. NA-F verified R35 did not have ROM instruction in his room and was not located inside or outside R35’s closet. NA-F stated he just set down his care sheet and did not have the care sheet.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 8/5/25 at 1:27 p.m., OT-B ROM was largely based on diagnosis at evaluation and if a resident had impaired muscle function would require passive or active ROM. (passive ROM is when someone else moves the limb, active ROM is when the patient moves the limb) and further stated residents who had a stroke could have ROM to possibly regain function. OT-B stated both PT and OT completed ROM, but if it was for the upper body, OT completed ROM and PT completed the lower body ROM. OT-B stated last time he saw R35 was in May 2025, for a wheelchair issue and in October to November 2024 saw R35 and stated he was very nice and was not resistant to therapy and was willing to participate and did not recall R35 having any contractures and stated R35 had paralytic syndrome, cerebrovascular disease and discitis and did not see anything about upper body ROM in the notes. OT-B viewed R35’s notes and stated he had not seen a need for ROM for R35’s upper extremities. OT-B further stated instructions for therapy would be posted in a resident’s room.<br><br>During interview on 8/5/25 at 2:31 p.m., physical therapist (PT)-A stated OT handled upper body ROM and sometimes if PT saw a resident, would incorporate upper body in their plans. PT-A stated residents who required ROM included those with a diagnosis of hemiplegia and some residents came in with baseline contractures and would work on preventing the contractures from getting worse. PT-A further stated contractures were painful and viewed therapy notes and verified R35 did not have any PROM but had PRAFO boots and thought R35 had a home exercise program for his legs and verified R35 did not have any documentation for upper body ROM and verified there was no home exercise program for R35’s upper body and did not know if R35 had contractures to his upper body adding their last evaluations didn’t identify upper body contractures.<br><br>During interview on 8/5/25 at 2:58 p.m., NA-E stated he knew what cares a resident required based on the care plan and further stated R35 never refused cares and added if a resident refused, they documented in the chart and the nurses documented refusals. NA-E stated had not seen a hand brace for R35 and stated they used them to make sure a resident’s hand didn’t close.<br><br>During interview on 8/5/25 at 3:09 p.m., licensed practical nurse (LPN)-D stated she knew what cares a resident required by looking at the care plan and refusals were documented in progress notes. LPN-D stated therapy instructs staff how to complete ROM and either the nurses or the aides complete ROM, if the nurse completes ROM, it shows up on the medication administration record (MAR) and treatment administration record (TAR) and further stated there is an order for ROM if nursing completes ROM. LPN-D stated she did not think R35 was on a therapy program. LPN-D viewed R35’s orders and verified there were no orders for a ROM program and further, reviewed R35’s care plan and verified R35’s care plan indicated to follow PT and OT for mobility but lacked any instruction and verified there was no ROM care plan in R35’s chart. LPN-D stated R35 was alert and oriented and stated R35 was so contracted. LPN-D stated all the care plan indicated was to follow instructions and that it was from 2022 and did not know where the instructions were. LPN-D further stated R35 had a contracture on his left hand that was present when LPN-D started working at the facility and added R35 may need something for his hand and had not seen a brace for R35 and added normally they put a brace on to keep the hand from closing.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 8/5/25 at 3:30 p.m., LPN-B stated she supervised the floor and further ROM exercises would be on a care guide and the nurses make sure aides perform the ROM, and the ROM was on a nursing order. LPN-B stated if a resident had a contracture, she expected a resident to have something in place such as home exercises because they want to maintain functioning and if a program was recommended and the resident refused, it was documented in a progress note. LPN-B stated R35 had paralysis on one side and stated R35 had a contracture on the left hand and viewed the care sheet and verified there was no direction for ROM for R35’s extremities on the care sheet. LPN-B viewed R35’s care plan and verified the care plan lacked ROM interventions. LPN-B further stated R35’s risks for contractures included having discitis, paralytic syndrome, hemiplegia and chronic pain and expected R35 have a cushion to prevent his hand from closing. LPN-B viewed nursing assistants Task forms and verified the NA’s did not have ROM on a Task for documenting.<br><br>During interview on 8/7/25 at 10:55 a.m., the director of nursing stated therapy completed screening but was not sure how frequently. Further, the DON stated contractures were documented in the care plan and the physicians should have documentation in their notes as well as treatment orders. If a resident refuses treatment orders, it was documented in a progress note. The DON stated she thought R35 had a home program. The DON further stated they hadn’t had ROM programs at the facility and completed a sweep and provided ROM programs if residents had a contracture to maintain and improve abilities and further stated they put exercises in residents’ rooms in the closets or by the bed if a resident approved. The DON stated she recognized they were working out the kinks.<br><br>R35’s physician’s orders form saved 8/7/25, at 8:03 a.m., was later updated to include the following orders:<br><br>8/6/25, ROM: thumb: 1. Flexion and extension (thumb bending and straightening, 2. Abduction and adduction see detailed instructions in resident closet or restorative binder.<br><br>8/6/25, ROM fingers 1) flexion and extension (finger bending and straightening), 2) abduction and adduction finger spreading, see detailed instructions in resident closet or restorative binder.<br><br>8/6/25, home exercise program daily seated in chair, kick, straighten operated leg and try to hold it for 3 seconds. Repeat 20 times, 1 to 2 times per day.<br><br>8/6/25, home exercise program daily seated in chair 8 leg out to the side, sitting straight, move legs slowly apart, then together again. Do one leg at a time. Repeat 20 times, one to two times a day.<br><br>8/6/25, home exercise program daily seated in the chair pillow squeeze, place one pillow under and one between knees. Squeeze knees together while straightening them by pushing down into the pillow, hold for 5 seconds. Repeat 20 times one to two times a day.<br><br>8/6/25, home exercise program daily, seated in chair, march, bring knee up toward chest, repeat with the other leg to complete the set. Repeat 20 times one to two times a day.<br><br>8/6/25, home exercise program daily supine, slide foot up, bend knee and pull heel toward buttocks. Hold three seconds. Return and repeat with the other knee to complete the set. Repeat 20 times once daily.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 8/6/25, home exercise program daily supine straight leg raise, bend one leg, raise other leg 6 to 8 inches with knee locked. Exhale and tighten thigh muscles while raising the leg. Repeat using the other leg. Repeat 20 times once daily.<br><br>8/6/25, home exercise program daily supine push knee into the bed, slowly tighten muscles on thigh of straight leg while counting out loud to 10. Repeat 20 times once daily.<br><br>8/6/25, home exercise program daily supine butt squeezes squeeze buttocks muscles as tightly as possible while counting out loud to 10. Repeat 20 times once daily.<br><br>8/6/25, home exercise program daily to bilateral lower extremities supine leg out to the side slide one leg out to the side. Keep the kneecap pointing toward the ceiling and gently bring leg back to the pillow and repeat with the other leg to complete the set. Repeat the set 20 times, once daily.<br><br>A PDF document signed by OT-B on 8/7/25, was later provided by the facility on 8/7/25, at 1:19 p.m., that indicated R35 was previously evaluated for wheelchair placement and positioning in the fall of 2022 and the fall of 2025 and had resting contractures at both evaluations, but had no complaints of pain with functional ROM and refused a ROM program or splinting and was not appropriate for splinting as reversal of his contractures was unlikely and would not contribute for increased activity of daily living (ADL) performance. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a scheduled pain medication was available as ordered for 1 of 1 resident (R102) reviewed for pain. Findings include:R102's significant change Minimum Data Set (MDS) dated [DATE], indicated intact cognition, required partial to moderate assistance with toileting hygiene, supervision with upper and lower body dressing and set up assist with personal hygiene. Further, R102's active diagnoses included: amputation, diabetes mellitus, acquired absence of left leg below the knee, and cutaneous abscess of limb. Additionally, R102 had scheduled pain medication, as needed pain medications, did not receive non medication interventions, had occasional pain during the last 5 days, that occasionally affected sleep, interfered with therapy activities, day to day activities and had a numerical rating of a 4 out of 10 on a 0 to 10 pain scale. R102 had a surgical wound and required surgical wound care and took opioid medications.R102's pain care area assessment 7/13/25, indicated pain would be addressed in the care plan to avoid complications and minimize risks. Further, medications and treatments were in accordance with the physician or nurse practitioner (NP) order and the floor nurse was to update the provider on any changes in pain complaints as needed and staff were directed to observe resident for non-verbal signs of pain with examples given of facial grimacing or guarding.R102's care plan dated 11/11/24, indicated R102 had an alteration in comfort due to recent left below the knee amputation (BKA) and interventions indicated completing a pain assessment per protocol, providing non medicinal forms of pain such as positioning, rest, massage, providing pain medication as ordered by the physician, documenting on the effectiveness of the pain medication, encouraging resident to verbalize discomfort, monitor for verbal and nonverbal indicators of discomfort, and further resident would be interviewed to determine acceptable level of pain control and contact the provider when pain level was not acceptable. R102's care plan dated 8/6/25, indicated R102 had an alteration in skin integrity due to left lower extremity BKA and interventions included R102 preferred to do his own dressing on his own pace due to pain, NPWT (negative pressure wound therapy, a treatment that uses controlled suction to promote healing in slow healing or non-healing wounds): Suction -125 on left BKA.R102's Pain Evaluation form dated 7/7/25 at 10:56 a.m., indicated R102 had occasional pain in the last 5 days that occasionally affected sleep, therapy activities, day to day activities and rated his worst pain over the last 5 days as a 4 on a 0-10-point scale. R102 stated pain was mild. Further, R102 was on a Butrans transdermal patch (a long-acting opioid) weekly 10 mcg/hr (micrograms/hour) every Tuesday, along with methocarbamol (a muscle relaxant) 500 milligrams (MG) three times, pregabalin (a medication to treat nerve pain) 100 mg three times a day and a Lidocaine patch 4% (a medication to treat pain) once daily. Additionally, R102 received oxycodone (an opioid) 10 mg every three hours as needed and acetaminophen (Tylenol) 1000 mg every 8 hours as needed. The evaluation indicated R102's pain was controlled with scheduled and PRN (as needed) pain medication and the pain regimen was effective. No other pain evaluation forms were completed after 7/7/25. R102's Physician's Orders form indicated the following orders related to pain:2/12/24, non-pharmacological pain interventions: 0=no intervention, 1=ice, 2=heated blankets, 3=massage, 4=repositioning, 5=music, 6=essential oils, 7=food and drink, 8=relaxation breathing.7/1/25, Lidocaine external patch 4% apply to BKA left lower extremity topically one time a day for pain 12 hours on and 12 hours free and remove per schedule.7/30/25, Acetaminophen (Tylenol) 1000 mg by mouth three times a day for pain.6/30/25, Methocarbamol (a muscle relaxant brand name Robaxin) oral tablet, give 500 mg by mouth three times a day for pain.7/25/25, hold from 7/25/25 to 7/26/25 and discontinue on 8/6/25 at 11:40 a.m., Pregabalin oral capsule 150 mg give 150 mg by mouth three times a day for pain related to complete traumatic amputation of left lower leg.8/6/25, Pregabalin oral capsule 150 mg by mouth three times a day for pain.-Oxycodone (opioid)7/1/25, and discontinued on 7/18/25, oxycodone 10 mg tablet, give 10 mg by mouth every 3 hours as needed for severe pain. 7/18/25, and discontinued on 7/25/25, oxycodone 5 mg tablet, give 10 mg by mouth every 3 hours as needed for pain, do not use 10 mg tablet, give two tablets a maximum of 5 doses per day (50mg/day).7/25/25, and discontinued on 7/30/25, oxycodone 5 mg tablets, give 10 mg by mouth every 3 hours as needed for pain a maximum of 5 doses per day (50 mg/day).7/30/25, and discontinued on 8/6/25 at 11:42 a.m., oxycodone 5 mg tablets, give 15 mg every 4 hours as needed for pain for a maximum of 3 doses per day (45mg/day). 8/6/25, Oxycodone 5 mg tablets, give 15 mg every 4 hours as needed for pain. -Butrans7/1/25, and discontinued on 7/18/25, Butrans transdermal patch weekly 10 mcg/hr apply 1 patch transdermally one time |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245148 | A. Building<br>B. Wing | 08/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Estates at St Louis Park LLC | 3201 Virginia Avenue South<br>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 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and document review, the facility failed to ensure ongoing communication and collaboration with dialysis services for 1 of 1 resident (R138) who had a critically low hemoglobin. Findings include:See also F684: R138's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, did not have behaviors or reject care, had a wheelchair for mobility, required substantial assistance with dressing, toileting hygiene, and personal hygiene, had anemia (low hemoglobin or HGB), end-stage renal disease (ESRD), a coagulation defect (a bleeding disorder affecting the blood's ability to clot), and thrombocytopenia (a condition of a low platelet count in the blood which can lead to increased bleeding and bruising). Further, R138 was on dialysis. R138's Physician's Orders form indicated the following orders:7/16/25, dialysis every Monday, Wednesday, and Friday. 8/5/25, lab CBC (complete blood count which includes an HGB), CMP, Mg, PTH, CRP, INR (a blood test that indicates how well the blood can clot), Phosphorus on 8/5/25. R138's hospital discharge orders dated 7/27/25, indicated a CBC, INR, and CMP was recommended on 7/30/25. R138's care plan dated 7/14/25, indicated R138 was at risk for complications related to dialysis and interventions included to call the physician if any changes in the dialysis port line, fistula to left forearm, excess bleeding, notify dialysis of any concerns, send communication folder to dialysis with each run. R138's labs collected on 8/5/25 at 6:05 p.m., with a fax time stamp at the top of the form dated 8/5/25 at 8:53 p.m., indicated the following:HGB 6.7 (LL) and the normal reference range was 13.5 to 17.5 g/dl (grams per deciliter). Platelets (platelets are essential for blood clotting) 78 (L) and the normal reference range was 150 to 450 x 10(9)L. A legend at the bottom of the lab form indicated an (LL) was a critically low lab value and an (L) value was a low lab value. Further, the lab result form contained an illegible signature.R138's labs collected on 8/5/25 at 6:55 p.m., with a fax time stamp at the top of the form dated 8/5/25 at 9:33 p.m., indicated the following:INR: 3.2 (H) with a reference range of 0.9 to 1.1. The legend at the bottom of the lab form indicated an (H) was a high level. Further, the lab result form contained an illegible signature.R138's nurse practitioner (NP)-E notes dated 8/4/25 at 2:25 p.m., indicated on 7/29/25, R138 had chronic, stable anemia of chronic disease and required multiple transfusions during hospitalization with no signs of bleeding. The note further indicated to check HGB as soon as possible (lab can't come until tomorrow), and discussed low HGB during dialysis can cause aches due to blood pull off and if abdominal pain is severe before work up can be completed by lab, can discuss hospitalization for uncontrolled pain and suspected symptomatic anemia. Additionally, the note indicated R138 received 2 units of packed red blood cells the week of 7/20 and R138's HGB at the time of discharge was 7.8. NP-E indicated R138 was visibly uncomfortable due to lower abdominal pain and was concerned about symptomatic anemia and R138's code status was a full code and was unclear what R138's baseline HGB was but, the note indicated R138's HGB was stable at 7 to 8 now.R138's hospital history and physical note dated 8/6/25, indicated R138 presented with abdominal pain with abdominal wall cellulitis, possible cholecystitis, and chronic normocytic anemia with a HGB of 7.2 and further indicated the HGB was stable from baseline of 7-8 g/dl range. R138's progress notes dated 7/21/25 at 10:46 p.m., indicated R138 was transferred to the hospital with a HGB of 6.3. R138's progress notes were reviewed from 8/5/25, and lacked evidence dialysis staff or the provider were notified of R138's critically low HGB. During interview on 8/6/25 at 12:46 p.m., nursing assistant (NA)-H stated R138's wheelchair came back from dialysis, but he thought R138 went to the hospital because the chair came back but R138 did not. During interview on 8/6/25 at 12:51 p.m., with the dialysis registered nurse (RN)-D stated they sent R138 to the hospital from dialysis due to confusion following dialysis and due to an issue with R138's skin on his abdomen and stated she had not been informed by the facility of any declining health and had not received a report from the facility. RN-D stated per dialysis policy, if a HGB is 7 or below, the patient needs to go to the emergency room for a blood transfusion and further stated she did not receive a report on R138's HGB and stated the facility should have called the provider. During interview on 8/6/25 at 1:58 p.m., RN-E stated the lab calls to inform of a critical lab and then staff are supposed to call the provider right away. If a lab is not critical staff fax the provider. Further, RN-E stated if they receive a lab it was documented in the electronic medical record (EMR). RN-E viewed R138's labs and verified R138's HGB was low and stated LL meant the HGB was low and added maybe the lab was low from the previous lab. RN-E verified a lab value of LL indicated it was critically low and opened NP-E's note dated 8/4/25, that indicated R138's HGB was 7.8 on 7/26/25, and verified R138's HGB on 8/5/25, was 6.7 and stated she had to check the progress notes. RN-E |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure kitchen staff used hair restraints while serving food. This had the potential to affect all the residents who reside on 2 South wing who receive eat meals. Findings include:During observation and interview on 8/7/25 at 8:33 a.m., cook (C)-A served food from a steam table on the 2 South unit. C-A had a full head of hair and facial hair on chin and cheeks approximately 1/4 inch long. C-A did not wear a hair net or beard guard. C-A stated he was supposed to wear a hair net but forgot to don one, but was not familiar with a beard guard. C-A left the unit. During observation on 8/7/25 at 8:43 a.m., C-A came back to unit with hair net on and a beard guard and continued to serve food from the steam table. During interview on 8/7/25 at 8:54 a.m., culinary director (CD) stated expectation for servers to wear hair nets and beard guards when dishing up food from the steam table. During interview on 8/7/25 at 9:48 a.m., director of nursing (DON) stated would expect hair nets on when serving food but was unfamiliar with the regulations regarding beard guards. DON further stated would expect staff to follow the policy. Facility policy on hair restraint was requested but not provided. Email received on 8/7/25 at 10:30 a.m., indicated, We do not have a specific policy related to hairnets. Here is a snippet from our handbook: Hairnets must be worn when walking in or through the kitchen areas. |