STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Lynnhurst LLC	471 Lynnhurst Avenue West Saint Paul, MN 55104

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on interview and document review, the facility failed to revise and update a care plan to ensure it was individualized and comprehensive after a resident was admitted on to a locked behavioral unit for 1 of 1 resident (R1) reviewed for transfer from non-secure to secure unit. Findings include: R1's Minimum Data Set (MDS) dated [DATE], indicated R1 was admitted on [DATE] with diagnoses including non-Alzheimer's dementia, unspecified symptoms and signs with cognitive functions and awareness (an unspecified neurocognitive disorder), hoarding disorder, and other symptoms and sings involving appearance and behavior. R1 was cognitively intact. R1 was ambulatory and required assistance with bathing/showering and toileting hygiene but was otherwise independent with activities of daily living. R1's provider note dated 2/16/24, noted R1 had a history of agitation and behavioral issues and at a previous assisted living facility R1 became combative, police were called and patient was transferred to hospital. R1's care plan included a focus on alteration in mood and behavior dated 2/19/24, and noted alteration in mood and behavior with goals of resident's mood/behavioral state will remain stable and resident will response to interventions by staff to calm and redirect. Interventions dated 2/19/24 included be alert to mood and behavioral changes, monitor and document mood state/behaviors upon occurrence, and medications per doctor's order. Interventions dated 2/28/24 included safety checks as needed, encourage resident to verbalize feelings, praise positive behaviors, monitor and document on mood state, and encourage participation in therapy as this gets resident out of her room and provides socialization. There were no further interventions. R1's Care Conference Form dated 3/4/24, noted Resident is visibly angry and upset. Her guardian/case worker is a trigger for her. Resident also is upset over house being sold as is dictated by her conservatorship. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Target Behavior Form dated 3/20/24, included a review of R1's behavior in the last quarter and noted Resident has been involved in resident-to-resident altercations. Resident has been the victim of the altercations. Resident has been noted by residents and observed by staff antagonizing other residents in the dayroom. Res[ident] at times will accuse staff of using her signature to sell her house or not helping her with finding a more permanent placement. Additionally, res[ident] cannot recall conversations accurately. This presents as her believing staff are working against her resulting in her not communicating her needs. Refusing cares, labs, and vitals at times. Has hx [history] of calling 911 regarding her cares and feelings of safety. Potential causes or identified patterns related to behavior included Subjects like resident's house, placement, and cares trigger resident[']s thinking that staff and others are working against her., When a change in resident[']s daily routine is disrupted or interactions with other residents happen can additionally trigger residents' [sic] thoughts or feelings of safety. Additional comments included requested order for [psychology clinic] consult. The care plan reviewed box was checked and indicated IDT [inter-disciplinary team] reviewed with no changes. R1's provider orders included an order dated 4/2/24 to monitor mood and behaviors and enter a progress note every shift. A progress note dated 4/5/24, indicated R1 was transferred to the hospital for feeling unsafe. The facility's social worker spoke with the resident's guardian and due to R1's behaviors and mental cognition and diagnosis, the guardian and inter-disciplinary team felt R1 was best suited to residing on the facility's locked unit and would return the next day and admit to the locked unit. A progress note dated 4/6/24, indicated R1 returned from the hospital and was admitted to the locked unit. R1's care plan focus on alteration in mood and behavior was revised on 4/8/24, and noted Resident had recent altercation with another resident. Resident has hx [history] of saying she feels unsafe on the floor due to wanting to get out of the facility. Resident was moved from first floor to second floor due to stating she felt unsafe around residents. Interventions were not added or revised. A provider note dated 4/9/24, indicated R1 was increasingly agitated. R1's care plan included a focus dated 4/9/24 indicating a risk/benefit form was in place for non-compliance with cares, treatments, lab draws, vital signs against provider orders, and refusing of meals at times. Interventions dated 4/9/24, included a risk/benefit form was completed and on file, provider was updated, to update responsible party if applicable, and update the form as needed. In an interview on 6/4/24 at 8:55 a.m., trained medication aid (TMA)-A stated R1 used to be downstairs but was moved upstairs after she went to the hospital because she had issues with residents downstairs. TMA-A stated R1 had issues with other residents and had behaviors. TMA-A noted R1 self-isolated, refused meals, refused cares, snapped at staff and wasn't verbally gentle when conversing with staff, was irritated by staff making noises like moving a chair when providing cares to her roommate, and did not use her call light to request assistance from staff when needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/4/24 at 9:11 a.m., the director of nursing (DON) noted R1 resided on the facility's locked unit where residents resided for reasons like being an elopement risk, having mental illnesses, or being unsafe in the community. The DON noted R1 couldn't be with other residents who were more cognitively intact, she needed to be on a behavioral unit because she kept having issues and behaviors and was not safe in the community. The DON stated the hospital and R1's guardian decided she needed to be on the locked unit because of her behaviors. The DON noted R1's behaviors included not telling staff what was going on with her, calling 911, refusing medications, refusing cares, being very verbally aggressive with staff when she is talking, and not getting along with roommates. The DON noted for residents on the locked unit, the facility did behavior care planning with interventions and for R1 this was about managing her behaviors. She stated she would expect the care plan to include interventions like offering choices, involving residents in their cares, re-approaching, re-directing, documenting risks and benefits, and having incentives or rewards if that worked. In an interview on 6/4/24 at 12:18 p.m., R1's guardian stated R1 had a large history of aggressive behaviors towards staff and he believed she had been beginning to target specific residents as well and this was a long-standing pattern of behaviors. The guardian indicated R1 was moved onto the locked unit in April upon return from the hospital because of increased behaviors. In an interview on 6/4/24 at 12:32 p.m., nursing aide (NA)-A stated she had worked at the facility for a long time and knew the residents inside and out. NA-A stated R1 was a very nice person when she wanted to be nice, but when she wasn't she was very very difficult. NA-A noted R1 could be aggressive with staff and would yell at them and was especially difficult regarding food. NA-A noted R1 would throw items like the cover on a plate of food she did not want, unused briefs, or her sheets. In an interview on 6/4/24 at 1:02 p.m., registered nurse (RN)-A stated he worked for a nursing staffing agency and had not worked many days at the facility. He noted he would look at R1's chart to see what behaviors and interventions work for her but wasn't sure off the top of his head what behaviors she had. RN-A stated the only thing he was told about is that sometimes R1 could yell about things or be demanding but he was not sure what interventions worked for her. RN-A stated he would look at R1's care plan to see what interventions work for her and noted sometimes interventions stop working over time and the care plan needs to be updated to be current. RN-A stated it would be helpful for him if the interventions that worked for R1 were in the care plan so, as a travel nurse, he would know because he hadn't known R1 that long. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/4/24 at 1:03 p.m., the DON stated staff did behavior care planning for all residents on the locked unit and they should include the resident's behaviors, their vulnerability, the interventions staff have, and outside services offered like psychology consults. The DON stated that depending on an individual resident's behaviors staff tried to come up with interventions that help. The DON confirmed that R1's behaviors were reviewed in the Target Behaviors Form dated 3/20/24 and were identified as involvement in resident-to-resident altercations, refusing cares and labs and vital signs, calling 911 regarding cares and feelings of safety and identified triggers. The DON stated the specific behaviors and triggers should be on R1's care plan. The DON stated it would be important for staff to know R1's triggers and they were not on her care plan. The DON stated she was aware of R1's aggression with staff and noted R1's behavioral care plan did not include aggression towards staff. The DON stated she did not see rejection of cares on R1's behavioral care plan and interventions would be to re-approach, but she did not see interventions for rejections of care on R1's care plan, she only saw the focus on risk/benefits with the intervention that the risk/benefit form for refusal of cares was completed. The DON noted R1 had been referred to the psychology clinic, but this was not on the care plan. The DON stated R1's care plan was not very comprehensive and specific to her and it can be better. The DON stated she would like to add more to the behavioral care plan and be more specific about R1's behaviors with the inclusion of things like R1 refusing cares, the need to reapproach her three times, her known preferences regarding roommates and environment, and identification of why R1 felt unsafe. Facility policy titled Care Planning dated 1/6/22, included each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs . The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident. The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.