*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
May 29, 2024

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

RE: CCN: 245148
Cycle Start Date: April 25, 2024

Dear Administrator:

On May 29, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered

May 29, 2024

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

Re: Reinspection Results
Event ID: 7Z9612

Dear Administrator:

On May 29, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 25, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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May 6, 2024

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

RE: CCN: 245148
Cycle Start Date: April 25, 2024

Dear Administrator:

On April 25, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Nathan Schreier, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 25, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 25, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered
May 6, 2024

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: 7Z9611

Dear Administrator:

The above facility was surveyed on April 23, 2024 through April 25, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nathan Schreier, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245148 | A. BUILDING ______ B. WING ______ | C 04/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ESTATES AT ST LOUIS PARK LLC | 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>On 4/24/24 - 4/25/24, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed:<br>H51483319C MN96843<br>H51483360C MN97130<br>with deficiencies cited at F677 and a related deficiency at F558.<br><br>The following complaints were reviewed with no deficiencies cited:<br><br>H51483361C MN97814<br>H51483473C MN97081<br>H51483362C MN98446<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences<br>CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive | F 558 | | 5/28/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/10/2024

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 558 | Continued From page 1<br>services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure a resident call light was within reach for 1 of 3 residents (R3) and failed to ensure call light cords were adequately cleaned for 2 of 3 residents (R1, R3) reviewed for call lights.<br><br>Findings include:<br><br>R3's annual Minimum Data Set (MDS) dated 1/26/24, indicated they were cognitively intact, dependent on staff for toileting, transfer, and personal hygiene, required maximal assistance with bed mobility., and used a power wheelchair. R5 was super morbidly obese and had visual impairment.<br><br>R3's care plan dated 3/29/24, indicated R5 was at risk for falls and directed staff to keep the call light within reach.<br><br>During observation and interview on 4/24/24 at 11:27 a.m., R3 was seated in their wheelchair next to the left side of the bed toward the back of the room. R3's call light cord was draped around the lower right corner of the mattress, then down toward the floor at the end of the bed with the button tucked into the top drawer of the nightstand. The last five inches of the cord were smeared with a crusty brownish substance along two sides, and there was a ring of brown crusted matter around the entirety of the red button. R3 | F 558 | R3 call light was placed within reach and was cleaned immediately. R1 call light was replaced immediately.<br><br>The housekeeping director and team came in early on 4/25/24 and audited and cleaned all call lights and cords. Housekeeping has a routine operating procedure that identifies cleaning call lights and cords as part of their cleaning schedule.<br><br>All residents will be reviewed to ensure call light is within reach.<br><br>All staff will be educated on leaving call lights within reach of residents along with who is responsible for making sure all call light cords are cleaned. Housekeeping staff will be educated on their organizations procedure and all steps when cleaning, specifically noting cleaning call light cords.<br><br>Audits will be completed of call light placement at 5 audits per week per unit. Audits of call light cleanliness will be conducted at 5 rooms per week per unit. The frequency of this will continue weekly x4 weeks and then results will be shared with the facility QAPI committee for input on the need to increase, decrease, or | |

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| F 558 | Continued From page 2 stated they had difficulty with their vision and saw mostly shadows, and staff "very seldom" put the call light in reach once they got out of bed. R3 attempted to move their wheelchair to reach the call light but was unable. R3 stated nobody ever cleaned the call light cord and they did not like that it was dirty.<br><br>R1's quarterly MDS dated 2/7/24, indicated they were cognitively intact, dependent on staff for toileting and transfers, and had diagnoses of super morbid obesity, heart failure, kidney failure, diabetes, and PTSD.<br><br>R1's fall risk care plan intervention dated 4/9/21, included keep call light within reach. The care plan indicated R1 had a self-care deficit related to morbid obesity, diabetes, and a leg amputation and instructed staff to encourage them to use the call light and wait for assistance for help.<br><br>During observation and interview on 4/25/24 at 10:32 a.m., R1 was lying in their bed on their left side. R1 indicated they were about to turn their call light on, grabbed the cord, and pushed the button. Approximately five feet of the cord was soiled and covered with brown crusted smears and spots as it wrapped around the bed rail and down toward the floor. R1 stated they got "used to the dirt", but it bothered them, and they wished it was clean.<br><br>During interview on 4/24/24 at 11:48 a.m., registered nurse (RN)-C stated staff ensured residents had call lights within reach prior to leaving a resident, and checked on them periodically in case the light cord were to fall on the floor. They stated housekeeping cleaned the cords when they cleaned the room, but | F 558 | discontinue the audits. Any discrepancies will be addressed immediately. Director of Nursing/Nurse Manager and/or Designee will be responsible for monitoring. | |

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|---|---|---|---|---|
| F 558 | Continued From page 3 | F 558 | | |

sometimes nursing staff wiped them off if they had time.

During interview on 4/24/24 at 11:52 a.m., housekeeper (HSK)-A stated housekeeping did not wipe down call light cords and nursing cleaned them when needed.

During interview on 4/24/24 at 11:54 a.m., RN-A stated staff ensured residents had call lights within reach before leaving their room in case they needed anything, and thought housekeeping cleaned them when they cleaned the room. They stated since staff gave them to the residents, staff would notice if they were soiled and were expected to clean them. RN-A entered R3's room and confirmed R3 was unable to reach their call light cord. Upon review of the cord, RN-A verified it was soiled, obtained a sanitary wipe, and cleaned off the brown matter before leaving it with R3.

During interview on 4/24/24 at 1:04 p.m., director of housekeeping stated housekeeping staff cleaned the cords, but if they became soiled during the evenings or night, nursing staff cleaned them. They stated they needed to be cleaned for infection control purposes as they may have blood or feces on them, and to maintain resident dignity.

During interview on 4/25/24 at 2:25 p.m., director of nursing (DON) stated staff were expected to assure that all residents had their call light within reach to reduce risk of falling or other injuries. In addition, housekeeping and the nursing staff were expected to clean the call light button and cord as a dirty call light cord and button could place a resident at risk for infection.

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| F 558 | Continued From page 4<br><br>The Call Light Policy dated 5/16/23. indicated call cords, buttons, or other communication devices must be placed where they are within reach of each resident.<br><br>In an email dated 4/25/24 at 3:29 p.m., administrator indicated the facility did not have a policy pertaining to cleaning of call light cords. | F 558 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide toileting and repositing assistance for a 1 of 1 residents (R3) dependent on staff and failed to follow a resident's preference for getting out of bed due to a lack of Hoyer (a full body mechanical lift used to lift and transfer residents) and sling availability for 2 of 2 resident (R3, R1) reviewed for activities of daily living for dependent residents. This had the potential to affect 15 bariatric residents in the facility who required a Hoyer lift for transfers.<br><br>Findings include:<br><br>R3<br><br>R3's annual Minimum Data Set (MDS), dated 3/14/24, indicated R3 was cognitively intact, and was dependent on staff for turning, positioning and toileting. Diagnoses included morbid obesity, | F 677 | R3 and R1 care plans were updated to accommodate preferences. Care guides were updated for R3 and R1 to reflect preferences of getting up. Staff on units work with both residents were educated on their preferences.<br><br>All bariatric residents were interviewed related to their preferences on getting up and going to bed. All bariatric resident care plans and NAR guides were updated per preferences.<br><br>Education will be completed with nursing staff to ensure resident preferences are followed for ADL and individual person centered care.<br><br>Audits will be completed weekly x4 weeks to ensure all bariatric residents have an | 5/28/24 |

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| F 677 | Continued From page 5<br>chronic pain, chronic kidney disease, irritable bowel syndrome with diarrhea, urinary incontinence, history of urinary tract infection, gout, and peripheral vascular disease.<br><br>R3's Care Area Assessment (CAA) dated, 4/25/24, triggered for self-care assistance and mobility indicated R3 was dependent on, staff for toileting, always incontinent of bowel and bladder, and required maximal assistance from staff to roll left and right, sit, and lie in bed.<br><br>R3's care plan dated 2/7/21, indicated R3 preferred to use an incontinence brief for toileting, was unable to stand, unable to pivot, did not like to use a bedpan, and required assist of two staff with toileting & peri-care every 2-3 hours PRN (as needed). Additionally, R3 required assist of two staff with bed mobility and transfers using a Hoyer lift with a large bariatric sling (a sling capable of supporting heavier residents).<br><br>R3's weight summary dated 4/22/24, indicated R2 weighed 437.5 pounds.<br><br>R'3 provider order dated 10/10/23, instructed staff to turn and reposition by propping pillows on the side to relieve pressure and rotate the pillow with each turn every shift.<br><br>During interview on 4/24/24 at 11:27 a.m., R3 was seated in their wheelchair in their room. Several clean absorbent pads were arranged on top of the sheet on the bed. R3 stated they were only allowed to get up out of bed once per day, and if staff put them back into bed to be changed, they left them there for the rest of the day. R3 stated they were up at 7:45 a.m. that morning and had not yet had their incontinence brief changed, but it | F 677 | adequate number of slings to meet their care needs. The frequency of this will continue weekly x4 weeks and then resulted will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue audits. Any discrepancies will be addressed immediately. Director of Nursing/Nurse Manager and/or Designee will be responsible for oversight and monitoring. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 677 | Continued From page 6 | F 677 | | |

was soiled and needed to be addressed. R3 stated they went to the hospital because they had sores that got infected, and they needed to keep their peri-area dry to prevent them from coming back.

During observation and interview on 4/24/24 at 1:54 p.m., R3 stated their brief had still not been changed. The pads on the bed were arranged as before.

During observation on 4/25/24 at 8:15 a.m., R3 was lying in their bed with the head of bed elevated to approximately 35 degrees. A full body mechanical lift was situated against the wall in another hallway on the unit. At 8:51 a.m., R3's call light was on. A nurse responded and indicated staff were waiting for a sling so they could get R3 up. R3 was still in bed at 9:39 a.m.

During observation and interview on 4/25/24 at 10:05 a.m., R3 was in their bed in the same position and stated, "they claim they don't have a sling to get me up", and indicated their incontinence brief was last changed at 7:30 a.m. The mechanical lift was still in the hallway.

During observation on 4/25/24 at 10:17 a.m., director of housekeeping was walking through the hallway and questioned another staff person, "There are no slings on the floor?" They then stated there were no slings in the laundry room.

During interview on 4/25/24 at 10:30 a.m., R3 stated he was waiting on laundry for his sling to get out of bed. He stated his back hurt, and that the mattress did not have enough air in it to support him.

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| THE ESTATES AT ST LOUIS PARK LLC | 3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426 |

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During observation on 4/25/24 at 10:58 a.m., registered nurse (RN)-A informed R3 the sling was being dried in the laundry facility. R3 remained in the same position.

During observation on 4/25/24 at 11:17 a.m., RN-A informed R3 the Hoyer sling was still in the drier at the laundry and still had 8 minutes to dry. R3 remained in bed in the same position.

During observation on 4/25/24 at 12:06 p.m., R3 was out of bed and in his wheelchair.

During interview on 4/25/24 at 12:15 p.m., certified nursing assistant (CNA)-A stated she felt there were enough slings in the facility, but they could use more Hoyer lifts to assist residence for transfers. They stated most of the residents could get out of bed based on their preferences. If a resident was at risk for pressure ulcers, she would check the skin for redness every 2 hours and reposition the resident. For residents who required to be checked and changed or needing repositioning, she referred to the resident care sheet/ care plan. CNA-A confirmed the care sheet for R3 indicated they were on a 2-hour toileting program and a 2-3 hour turn and reposition schedule.

During interview on 4/25/24 at 12:22 p.m., (CNA)-C stated there were not enough slings or Hoyer lifts in the facility and residents had to wait sometimes to get out of bed and staff could not always get them up based on their preferences. She states that if a resident is on a check and change or repositioning schedule, it could be found on the resident care sheet on the unit. Additionally, CNA-C stated CNAs documented all cares performed on a resident in the electronic

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medical record system. She reviewed R3's activity of daily living (ADLs) performed for 4/25/24, and confirmed the check and change and repositioning task had not been documented or completed. She stated if a resident was left unchanged or was unable to reposition per the orders, they were at risk for developing a pressure ulcer and possible bladder infections.

During interview on 4/25/24 at 12:36 p.m., RN-A stated they facility had one functional Hoyer lift on the floor, but they needed more slings and more the help to assist residents with transfers. She stated the facility had a lot of bariatric residents and they were supposed to have their own individual slings, but each time a bariatric resident went to the hospital via ambulance they used the sling to transfer the resident from bed to the ambulance gurney. They were unable to remove them from under the residents prior to transfer to the hospital and the facility did not receive them back wheic led to the shortage. They had ordered a few more but they were costly. They indicated one resident got upset about having to stay in bed over a weekend, but the facility did not have the resources to get them out of bed and staff did not want to use the wrong sling for safety reasons. RN-A indicated R3 should be up for meals, required staff assistance with his check and change schedule, was on a 2-3-hour toileting program, and was at moderate risk for pressure ulcers. She stated that R3 was unable to get up from 8am - 12pm today because R3's sling was in the laundry and confirmed that he should be up every day.

R1

R1's quarterly MDS dated 2/7/24, indicated they

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were cognitively intact, dependent on staff for transfers and toileting, at risk for pressure ulcers, and had diagnoses of super morbid obesity, heart failure, kidney failure, diabetes, left below the knee amputation, and PTSD (post-traumatic stress disorder).

R1's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 7/31/23, indicated R1 had a self-care deficit and needed assistance with activities of daily living (ADLs), and was at risk for further decline in ADLs, unmet hygienic needs, increased risk for skin breakdown, potential for falls, and potential for moods/behaviors.

R1's care plan dated 12/20/23, indicated R1 required assist of two staff with mechanical lift transfer, and instructed staff get R1 up in the morning between 9:00 and 10:00 a.m., and transfer to bed between 7:30-8:00 p.m. On 4/23/24, the care plan directed staff get R1 up between 11:00- 11:30 a.m. and to use a light blue Hoyer (mechanical full body lift) sling size large - 1000 pounds for all transfers, revised 12/1/22.

R1's Weight Summary dated 4/25/24, indicated they were 365.0 pounds.

During observation on 4/25/24 at 8:20 a.m., R1 was lying awake in their bed on their left side with the television on.

During observation and interview on 4/25/24 at 10:32 a.m., R1 was lying in their bed and stated they had not had their incontinence brief changed since the previous night. They stated they wanted to get up at 9:00 a.m., but staff told them they could not do it until 11:00 or 11:30 a.m. "because

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they have other patients to deal with", and the previous day they could not get up until 12:00 p.m. They stated they could tell when they needed to have a bowel movement and could use a bed pain but normally went in their "pants" because of the wait time for staff. R1 did not want to sit in their wet and soiled brief. They stated they used to have a pressure ulcer, but it healed.

During observation and interview on 4/25/24 at 12:05 p.m., R1 was up in their wheelchair in the dining room. R1 stated they just got up.

During interview on 4/25/24 at 12:14 p.m., nursing assistant (NA)-D stated they got R1 out of bed around 12:00 p.m. They indicated there were limited lift slings and staff often had to look for slings in the laundry, and sometimes the facility did not have any so the resident needed to stay in bed all day. NA-D stated R1 was very upset because they could not get out of bed one weekend recently since there was no appropriate sling available for them.

During interview on 4/25/24 at 12:27 p.m., licensed practical nurse (LPN)-A stated they had two lifts on the unit, but one was "sluggish" and they couldn't always find a sling to use with the other one. They stated the slings were kept under residents in their wheelchairs and often became soiled with urine or stool, and there was no backstock. Dirty slings were sent to the laundry, and once cleaned they could take up to two days to dry. They indicated the facility was planning to order more the previous month, but they were not sure if they arrived. LPN-A stated R1 had to stay in bed for a couple of days because they couldn't find a sling to use to get them up. There were a few slings in the laundry, but they did not fit the

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| F 677 | Continued From page 11<br>mechanical lift so they could not be used.<br><br>During interview on 4/25/24 at 2:25 p.m., the director of nursing (DON) stated two Hoyer lifts was enough for all the resident on the unit. She expected all staff to communicate with each other on resident preferences for being up and out of bed/ transferred to assure all resident needs were met. She also stated she felt there were enough slings in the facility but stated there were issues with bariatric residents going to the hospital with the slings and the hospital never returning the slings. Staff were expected to get residents up and transferred per their preferences and provider orders. If a resident was not able to get out of bed or needed to be transferred because of a Hoyer availability, staff were expected to utilize other interventions to assist with resident ADLs. She stated if staff were unable to assist a resident with positioning or toileting because a Hoyer was unavailable, the resident ran the risk of developing a pressure ulcer, UTI, or other infections.<br><br>During interview on 4/25/24 at 2:40 p.m., administrator stated the facility had a shortage of slings recently, but they ordered replacements for the missing bariatric slings through the lift vendor and took about a week to a arrive. They were unsure if other sister facilities used this type of lift and sling.<br><br>During interview on 4/25/24 at 2:45 p.m., administrator in training stated they placed an order for slings on 3/15/24, and the vendor sent two shipments based upon what they had available, however they were not sure what day they were delivered. | F 677 | | |

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| F 677 | Continued From page 12 The activities of daily living policy, dated 3/31/23 identified it is the facility's responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs. | F 677 | | |

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| 2 000 | Initial Comments | 2 000 | | |

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 4/24/24 - 4/25/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and

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identify the date when they will be completed.

The following complaints were reviewed:
H51483361C MN97814
H51483473C MN97081
H51483362C MN98446
H51483319C MN96843
H51483360C MN97130
with licensing orders issued at 0920 and 1810.

Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to

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| 2 000 | Continued From page 2<br>the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |
| 2 920 | MN Rule 4658.0525 Subp. 6 B Rehab - ADLs<br><br>Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:<br>B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide toileting and repositing assistance for a 1 of 1 residents (R3) dependent on staff and failed to follow a resident's preference for getting out of bed due to a lack of Hoyer (a full body mechanical lift used to lift and transfer residents) and sling availability for 2 of 2 resident (R3, R1) reviewed for activities of daily living for dependent residents. This had the potential to affect 15 bariatric residents in the facility who required a Hoyer lift for transfers.<br><br>Findings include:<br><br>R3 | 2 920 | Corrected. | 5/28/24 |

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R3's annual Minimum Data Set (MDS), dated 3/14/24, indicated R3 was cognitively intact, and was dependent on staff for turning, positioning and toileting. Diagnoses included morbid obesity, chronic pain, chronic kidney disease, irritable bowel syndrome with diarrhea, urinary incontinence, history of urinary tract infection, gout, and peripheral vascular disease.

R3's Care Area Assessment (CAA) dated, 4/25/24, triggered for self-care assistance and mobility indicated R3 was dependent on, staff for toileting, always incontinent of bowel and bladder, and required maximal assistance from staff to roll left and right, sit, and lie in bed.

R3's care plan dated 2/7/21, indicated R3 preferred to use an incontinence brief for toileting, was unable to stand, unable to pivot, did not like to use a bedpan, and required assist of two staff with toileting & peri-care every 2-3 hours PRN (as needed). Additionally, R3 required assist of two staff with bed mobility and transfers using a Hoyer lift with a large bariatric sling (a sling capable of supporting heavier residents).

R3's weight summary dated 4/22/24, indicated R2 weighed 437.5 pounds.

R'3 provider order dated 10/10/23, instructed staff to turn and reposition by propping pillows on the side to relieve pressure and rotate the pillow with each turn every shift.

During interview on 4/24/24 at 11:27 a.m., R3 was seated in their wheelchair in their room. Several clean absorbent pads were arranged on top of the sheet on the bed. R3 stated they were only allowed to get up out of bed once per day, and if

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| 2 920 | Continued From page 4 | 2 920 | | |

staff put them back into bed to be changed, they left them there for the rest of the day. R3 stated they were up at 7:45 a.m. that morning and had not yet had their incontinence brief changed, but it was soiled and needed to be addressed. R3 stated they went to the hospital because they had sores that got infected, and they needed to keep their peri-area dry to prevent them from coming back.

During observation and interview on 4/24/24 at 1:54 p.m., R3 stated their brief had still not been changed. The pads on the bed were arranged as before.

During observation on 4/25/24 at 8:15 a.m., R3 was lying in their bed with the head of bed elevated to approximately 35 degrees. A full body mechanical lift was situated against the wall in another hallway on the unit. At 8:51 a.m., R3's call light was on. A nurse responded and indicated staff were waiting for a sling so they could get R3 up. R3 was still in bed at 9:39 a.m.

During observation and interview on 4/25/24 at 10:05 a.m., R3 was in their bed in the same position and stated, "they claim they don't have a sling to get me up", and indicated their incontinence brief was last changed at 7:30 a.m. The mechanical lift was still in the hallway.

During observation on 4/25/24 at 10:17 a.m., director of housekeeping was walking through the hallway and questioned another staff person, "There are no slings on the floor?" They then stated there were no slings in the laundry room.

During interview on 4/25/24 at 10:30 a.m., R3 stated he was waiting on laundry for his sling to get out of bed. He stated his back hurt, and that

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| 2 920 | Continued From page 5 | 2 920 | | |

the mattress did not have enough air in it to support him.

During observation on 4/25/24 at 10:58 a.m., registered nurse (RN)-A informed R3 the sling was being dried in the laundry facility. R3 remained in the same position.

During observation on 4/25/24 at 11:17 a.m., RN-A informed R3 the Hoyer sling was still in the drier at the laundry and still had 8 minutes to dry. R3 remained in bed in the same position.

During observation on 4/25/24 at 12:06 p.m., R3 was out of bed and in his wheelchair.

During interview on 4/25/24 at 12:15 p.m., certified nursing assistant (CNA)-A stated she felt there were enough slings in the facility, but they could use more Hoyer lifts to assist residence for transfers. They stated most of the residents could get out of bed based on their preferences. If a resident was at risk for pressure ulcers, she would check the skin for redness every 2 hours and reposition the resident. For residents who required to be checked and changed or needing repositioning, she referred to the resident care sheet/ care plan. CNA-A confirmed the care sheet for R3 indicated they were on a 2-hour toileting program and a 2-3 hour turn and reposition schedule.

During interview on 4/25/24 at 12:22 p.m., (CNA)-C stated there were not enough slings or Hoyer lifts in the facility and residents had to wait sometimes to get out of bed and staff could not always get them up based on their preferences. She states that if a resident is on a check and change or repositioning schedule, it could be found on the resident care sheet on the unit.

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| **THE ESTATES AT ST LOUIS PARK LLC** | **3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426** |

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Additionally, CNA-C stated CNAs documented all cares performed on a resident in the electronic medical record system. She reviewed R3's activity of daily living (ADLs) performed for 4/25/24, and confirmed the check and change and repositioning task had not been documented or completed. She stated if a resident was left unchanged or was unable to reposition per the orders, they were at risk for developing a pressure ulcer and possible bladder infections.

During interview on 4/25/24 at 12:36 p.m., RN-A stated they facility had one functional Hoyer lift on the floor, but they needed more slings and more the help to assist residents with transfers. She stated the facility had a lot of bariatric residents and they were supposed to have their own individual slings, but each time a bariatric resident went to the hospital via ambulance they used the sling to transfer the resident from bed to the ambulance gurney. They were unable to remove them from under the residents prior to transfer to the hospital and the facility did not receive them back wheic led to the shortage. They had ordered a few more but they were costly. They indicated one resident got upset about having to stay in bed over a weekend, but the facility did not have the resources to get them out of bed and staff did not want to use the wrong sling for safety reasons. RN-A indicated R3 should be up for meals, required staff assistance with his check and change schedule, was on a 2-3-hour toileting program, and was at moderate risk for pressure ulcers. She stated that R3 was unable to get up from 8am - 12pm today because R3's sling was in the laundry and confirmed that he should be up every day.

R1

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| 2 920 | Continued From page 7<br>R1's quarterly MDS dated 2/7/24, indicated they were cognitively intact, dependent on staff for transfers and toileting, at risk for pressure ulcers, and had diagnoses of super morbid obesity, heart failure, kidney failure, diabetes, left below the knee amputation, and PTSD (post-traumatic stress disorder).<br><br>R1's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 7/31/23, indicated R1 had a self-care deficit and needed assistance with activities of daily living (ADLs), and was at risk for further decline in ADLs, unmet hygienic needs, increased risk for skin breakdown, potential for falls, and potential for moods/behaviors.<br><br>R1's care plan dated 12/20/23, indicated R1 required assist of two staff with mechanical lift transfer, and instructed staff get R1 up in the morning between 9:00 and 10:00 a.m., and transfer to bed between 7:30-8:00 p.m. On 4/23/24, the care plan directed staff get R1 up between 11:00- 11:30 a.m. and to use a light blue Hoyer (mechanical full body lift) sling size large - 1000 pounds for all transfers, revised 12/1/22.<br><br>R1's Weight Summary dated 4/25/24, indicated they were 365.0 pounds.<br><br>During observation on 4/25/24 at 8:20 a.m., R1 was lying awake in their bed on their left side with the television on.<br><br>During observation and interview on 4/25/24 at 10:32 a.m., R1 was lying in their bed and stated they had not had their incontinence brief changed since the previous night. They stated they wanted to get up at 9:00 a.m., but staff told them they could not do it until 11:00 or 11:30 a.m. "because | 2 920 | | |

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they have other patients to deal with", and the previous day they could not get up until 12:00 p.m. They stated they could tell when they needed to have a bowel movement and could use a bed pain but normally went in their "pants" because of the wait time for staff. R1 did not want to sit in their wet and soiled brief. They stated they used to have a pressure ulcer, but it healed.

During observation and interview on 4/25/24 at 12:05 p.m., R1 was up in their wheelchair in the dining room. R1 stated they just got up.

During interview on 4/25/24 at 12:14 p.m., nursing assistant (NA)-D stated they got R1 out of bed around 12:00 p.m. They indicated there were limited lift slings and staff often had to look for slings in the laundry, and sometimes the facility did not have any so the resident needed to stay in bed all day. NA-D stated R1 was very upset because they could not get out of bed one weekend recently since there was no appropriate sling available for them.

During interview on 4/25/24 at 12:27 p.m., licensed practical nurse (LPN)-A stated they had two lifts on the unit, but one was "sluggish" and they couldn't always find a sling to use with the other one. They stated the slings were kept under residents in their wheelchairs and often became soiled with urine or stool, and there was no backstock. Dirty slings were sent to the laundry, and once cleaned they could take up to two days to dry. They indicated the facility was planning to order more the previous month, but they were not sure if they arrived. LPN-A stated R1 had to stay in bed for a couple of days because they couldn't find a sling to use to get them up. There were a few slings in the laundry, but they did not fit the mechanical lift so they could not be used.

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| 2 920 | Continued From page 9 | 2 920 | | |

During interview on 4/25/24 at 2:25 p.m., the director of nursing (DON) stated two Hoyer lifts was enough for all the resident on the unit. She expected all staff to communicate with each other on resident preferences for being up and out of bed/ transferred to assure all resident needs were met. She also stated she felt there were enough slings in the facility but stated there were issues with bariatric residents going to the hospital with the slings and the hospital never returning the slings. Staff were expected to get residents up and transferred per their preferences and provider orders. If a resident was not able to get out of bed or needed to be transferred because of a Hoyer availability, staff were expected to utilize other interventions to assist with resident ADLs. She stated if staff were unable to assist a resident with positioning or toileting because a Hoyer was unavailable, the resident ran the risk of developing a pressure ulcer, UTI, or other infections.

During interview on 4/25/24 at 2:40 p.m., administrator stated the facility had a shortage of slings recently, but they ordered replacements for the missing bariatric slings through the lift vendor and took about a week to a arrive. They were unsure if other sister facilities used this type of lift and sling.

During interview on 4/25/24 at 2:45 p.m., administrator in training stated they placed an order for slings on 3/15/24, and the vendor sent two shipments based upon what they had available, however they were not sure what day they were delivered.

The activities of daily living policy, dated 3/31/23 identified it is the facility's responsibility to create

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| 2 920 | Continued From page 10<br>and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident's preferences, choices, values and beliefs.<br><br>SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure the facility maintains an adequate supply of transfer sling to ensure patient care needs are met and educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 2 920 | | |
| 21810 | MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.<br><br>This MN Requirement is not met as evidenced | 21810 | | 5/28/24 |

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| 21810 | Continued From page 11<br>by:<br>Based on observation, interview, and document review, the facility failed to ensure a resident call light was within reach for 1 of 3 residents (R3) and failed to ensure call light cords were adequately cleaned for 2 of 3 residents (R1, R3) reviewed for call lights.<br><br>Findings include:<br><br>R3's annual Minimum Data Set (MDS) dated 1/26/24, indicated they were cognitively intact, dependent on staff for toileting, transfer, and personal hygiene, required maximal assistance with bed mobility., and used a power wheelchair. R5 was super morbidly obese and had visual impairment.<br><br>R3's care plan dated 3/29/24, indicated R5 was at risk for falls and directed staff to keep the call light within reach.<br><br>During observation and interview on 4/24/24 at 11:27 a.m., R3 was seated in their wheelchair next to the left side of the bed toward the back of the room. R3's call light cord was draped around the lower right corner of the mattress, then down toward the floor at the end of the bed with the button tucked into the top drawer of the nightstand. The last five inches of the cord were smeared with a crusty brownish substance along two sides, and there was a ring of brown crusted matter around the entirety of the red button. R3 stated they had difficulty with their vision and saw mostly shadows, and staff "very seldom" put the call light in reach once they got out of bed. R3 attempted to move their wheelchair to reach the call light but was unable. R3 stated nobody ever cleaned the call light cord and they did not like that it was dirty. | 21810 | Corrected. | |

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R1's quarterly MDS dated 2/7/24, indicated they were cognitively intact, dependent on staff for toileting and transfers, and had diagnoses of super morbid obesity, heart failure, kidney failure, diabetes, and PTSD.

R1's fall risk care plan intervention dated 4/9/21, included keep call light within reach. The care plan indicated R1 had a self-care deficit related to morbid obesity, diabetes, and a leg amputation and instructed staff to encourage them to use the call light and wait for assistance for help.

During observation and interview on 4/25/24 at 10:32 a.m., R1 was lying in their bed on their left side. R1 indicated they were about to turn their call light on, grabbed the cord, and pushed the button. Approximately five feet of the cord was soiled and covered with brown crusted smears and spots as it wrapped around the bed rail and down toward the floor. R1 stated they got "used to the dirt", but it bothered them, and they wished it was clean.

During interview on 4/24/24 at 11:48 a.m., registered nurse (RN)-C stated staff ensured residents had call lights within reach prior to leaving a resident, and checked on them periodically in case the light cord were to fall on the floor. They stated housekeeping cleaned the cords when they cleaned the room, but sometimes nursing staff wiped them off if they had time.

During interview on 4/24/24 at 11:52 a.m., housekeeper (HSK)-A stated housekeeping did not wipe down call light cords and nursing cleaned them when needed.

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During interview on 4/24/24 at 11:54 a.m., RN-A stated staff ensured residents had call lights within reach before leaving their room in case they needed anything, and thought housekeeping cleaned them when they cleaned the room. They stated since staff gave them to the residents, staff would notice if they were soiled and were expected to clean them. RN-A entered R3's room and confirmed R3 was unable to reach their call light cord. Upon review of the cord, RN-A verified it was soiled, obtained a sanitary wipe, and cleaned off the brown matter before leaving it with R3.

During interview on 4/24/24 at 1:04 p.m., director of housekeeping stated housekeeping staff cleaned the cords, but if they became soiled during the evenings or night, nursing staff cleaned them. They stated they needed to be cleaned for infection control purposes as they may have blood or feces on them, and to maintain resident dignity.

During interview on 4/25/24 at 2:25 p.m., director of nursing (DON) stated staff were expected to assure that all residents had their call light within reach to reduce risk of falling or other injuries. In addition, housekeeping and the nursing staff were expected to clean the call light button and cord as a dirty call light cord and button could place a resident at risk for infection.

The Call Light Policy dated 5/16/23. indicated call cords, buttons, or other communication devices must be placed where they are within reach of each resident.

In an email dated 4/25/24 at 3:29 p.m., administrator indicated the facility did not have a policy pertaining to cleaning of call light cords.

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| 21810 | Continued From page 14<br><br>SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights clean and within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21810 | | |