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	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

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 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. Findings include: R3's annual Minimum Data Set (MDS) dated [DATE], 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. 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. 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. R1's quarterly MDS dated [DATE], 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. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 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. Findings include: R3 R3's annual Minimum Data Set (MDS), dated [DATE], 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 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE], 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). 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 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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. 47372