

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Sholom Home West		STREET ADDRESS, CITY, STATE, ZIP CODE 3620 Phillips Parkway South Saint Louis Park, MN 55426	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47264</p> <p>Based on observation, interview, and document review, the facility failed to provide a call light to one of three residents (R2) reviewed for access to call lights when R2 did not have a functioning call light for an unknown number of weeks.</p> <p>Findings Include:</p> <p>R2's Minimum Data Set (MDS) admission assessment dated [DATE], indicated R2 was admitted to the facility on [DATE]. The MDS indicated R2 was continent of bowel and bladder, and independent with toileting. R2's brief interview for mental status (BIMS) was 15 indicating intact cognition.</p> <p>The census report, undated, indicated R2 moved to room [ROOM NUMBER] on 3/7/24.</p> <p>R2's Quarterly Review MDS dated [DATE], indicated R2 was frequently incontinent of bowel and bladder.</p> <p>R2's Significant Change in Status MDS dated [DATE], indicated R2 required moderate assistance with toileting.</p> <p>R2's care plan indicated the call light was to be accessible and within reach whenever the resident was in his room.</p> <p>The facility was unable to provide call light log for R2's room for the last two weeks.</p> <p>The facility was unable to provide maintenance records for R2's call lights for the two weeks leading up to 3/12/25.</p> <p>During an observation on 3/12/25 at 9:30 a.m., R2 did not have a call light within reach. The head of the bed was flush to the wall containing the call light box. The call light box had space for two extension cords on the left and right side of the box. The outlet on the left side of the box had a corded call light inserted appropriately, and the call light was wrapped around his roommate's bed rail. The outlet on the right side of the box did not have a corded call light extending from it.</p> <p>During an observation on 3/12/25 at 2:00 p.m., the interim nurse manager was unable to locate R2's call light.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/12/24 at 9:30 a.m., R2 stated he had not had a call light for several months. R2 stated he had spoken to maintenance about this issue at an unknown time and was told they would have to cut an extra hole in the wall in order to give him a call light. R2 stated the unnamed maintenance employee told him they would not do this and did not offer him a new call light. R2 stated he has been using his roommate's call light since he was told this. R2 stated when he has an incontinent episode at night, he wakes his roommate up and has her press the call light in order to get help from nursing staff.</p> <p>During an interview on 3/12/25 at 12:55 p.m., registered nurse (RN)-A stated if there was an issue with a resident's call light, she would contact their maintenance team to have it fixed immediately.</p> <p>During an interview on 3/12/25 at 1:13 p.m., RN-B stated call lights need to be functioning and within reach of a resident in their room. RN-B stated if a call light is malfunctioning, she can submit a work order or call their maintenance staff. RN-B stated if maintenance is not able to immediately fix the issue, they provide the resident with a bell to contact nursing staff.</p> <p>During an interview on 3/12/25 at 1:41 p.m., RN-C stated if a resident's call light is broken staff should contact maintenance staff. RN-C stated a functioning call light should always be within reach.</p> <p>During an interview on 3/12/25 at 1:46 p.m., nursing assistant (NA)-A stated if a resident's call light is not working he would tell the nurse immediately to have it serviced. NA-A stated if a resident call light is missing, he would report it to maintenance. NA-A stated a call light should be within reach of a resident.</p> <p>During an interview on 3/12/25 at 1:50 p.m., the interim nurse manager stated every resident gets a call light. The interim nurse manager stated if a call light is not working, they will call maintenance and get it serviced. The interim nurse manager stated they can either temporarily move the resident to a different room with a functioning call light, or give the resident a bell and implement regular rounding until the issue is resolved. The interim nurse manager stated R2 had not informed them there was an issue with his call light. The interim nurse manager stated she would submit a work order immediately.</p> <p>During an interview on 3/12/25 at 2:29 p.m., the interim nurse manager stated R2 has been supplied with a bell, and maintenance was in his room servicing the call light.</p> <p>On 3/12/25 at 3:38 p.m., the director of nursing (DON) stated when she entered R2's room, she only saw one cord coming from the call light box. The DON stated it is her expectation every resident has a functioning call light.</p> <p>During the exit conference on 3/12/25 at 4:10 p.m., the administrator stated R2's call light had been repaired.</p> <p>A facility policy titled Call light dated 5/2017, indicated every resident of the facility must be provided with a functioning accessible call light. The policy stated call lights are always left within reach of the resident. The policy stated call light issues must be reported to maintenance immediately.</p>		