



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 7, 2026

Administrator
Sholom Home West
3620 PHILLIPS PARKWAY SOUTH
SAINT LOUIS PARK, MN 55426

RE: CCN: 245574

Cycle Start Date: March 19, 2026

Dear Administrator:

On March 19, 2026, the Minnesota Departments of Health and Public Safety, 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.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245574		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/19/2026	
NAME OF PROVIDER OR SUPPLIER Sholom Home West				STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH , SAINT LOUIS PARK, Minnesota, 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
E0000	Initial Comments On 3/16/26 through 3/19/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			04/24/2026
F0000	INITIAL COMMENTS On 3/16/26 through 3/19/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55748223C (2580797) and H55748224C (1139704) NO deficiencies were cited. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000			
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii)			F0628	R73 was transferred to the hospital. The record has been reviewed and updated to include required transfer documentation.		04/24/2026

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 reverse for further 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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F0628 SS = E	Continued from page 1 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F0628	Continued from page 1 R139 was transferred to the hospital. The record has been reviewed and updated to include required transfer documentation. R141 discharged from the facility to home on 2/8/26. The facility has completed a retrospective review and will ensure required documentation and communication are completed. Moving forward, the facility will ensure residents are protected from inappropriate discharges, have access to advocacy resources, and that the Office of the State Long-Term Care Ombudsman is notified as required. All residents at the facility who are transferred or discharged from the facility are at risk to be affected. All residents' census activity will be audited to ensure the Ombudsman for Long Term Care was notified of resident transfers or discharges. The Facility Transfer/Discharge Policy was reviewed and current. Education will be provided to licensed nursing staff, nurse managers, admissions staff, and charge nurses/building managers on proper transfer and discharge procedures, including updating census status to reflect hospital transfers, ensuring inclusion on required OMB-LTC reporting, and completing all required documentation and resident/family communication. The facility will monitor compliance with transfer and discharge requirements through routine audits, conducted four times per week for four weeks, then four times per month for three months. QA will further review and make recommendations. Date for compliance: April 29th, 2026.	04/24/2026

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F0628 SS = E	Continued from page 2 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and			F0628			04/24/2026

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F0628 SS = E	Continued from page 3 advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and			F0628			04/24/2026

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F0628 SS = E	Continued from page 4 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Ombudsman for Long Term Care (OMB - LTC) was notified of resident transfers or discharges for 3 of 5 residents (R73, R139, R141) reviewed for transfers or discharges from the facility. Findings include: R73's comprehensive Minimum Data Set (MDS), dated 1/28/26, indicated R73 was cognitively intact, and diagnoses included chronic kidney disease, and neuralgia and neuritis (general nerve pain or inflammation). R73's progress note, dated 2/16/26 at 5:43 p.m., indicated R73 was sent to the hospital for blood emesis and loss of consciousness. A subsequent progress note, dated 2/25/26 at 4:05 p.m., indicated			F0628			04/24/2026

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F0628 SS = E	Continued from page 5 R73 was readmitted to the facility on 11/25/26 at 2:00 p.m. The facility's Monthly Notice to OMB-LTC of Emergency Acute Care Transfers and Discharges, dated February 2026, lacked notice of R73's hospital transfer on 2/16/26. R139's comprehensive MDS, dated 2/2/26, indicated R139 had moderate cognitive impairment and diagnoses included congestive heart failure (CHF) and rheumatoid arthritis. R139's progress note, dated 2/9/26 at 12:40 a.m., indicated R139 was sent to the hospital for an acute behavioral status change. A subsequent progress note, dated 2/9/26 at 10:19 a.m., indicated R139 was admitted to the hospital for encephalopathy, and the family did not wish to hold the bed. The facility's Monthly Notice to OMB-LTC of Emergency Acute Care Transfers and Discharges, dated February 2026, lacked notice of R139's hospital transfer on 2/9/26. On 3/19/26 at 2:52 p.m., director of nursing (DON) verified the OBM-LTC was not notified of R73's hospital transfer on 2/16/26, and R139's hospital transfer on 2/9/26. DON stated when a resident was transferred to the hospital, a notification was expected to be sent to the ombudsman. Findings Include - R141's Face Sheet (undated) documented the diagnoses of Sepsis due to methicillin susceptible Staphylococcus aureus (a germ found on people's skin), pneumonia, acute and subacute infective endocarditis (inflammation of the heart's inner lining). R141's Minimum Data Set (MDS), with a registered nurse signing date of 2/07/26, documented R141 was moderately cognitively impaired and require set up to moderate assistance with all activities of daily living. R141's nurse progress notes on 2/08/26, documentation indicated R141 had eloped from the facility being later found wondering at Target. Family			F0628			04/24/2026

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F0628 SS = E	Continued from page 6 arrived and returned R141 to the facility (this was later investigated by the Minnesota Department of Health - Rapid Response Team). Upon returning to the facility, R141's daughter insisted on taking resident home. R141's provider was contacted, and discharge orders were received. During interview on 3/18/26 at 8:36 a.m., the director of nursing (DON) stated she had received a phone call from the facility on 2/8/26, the family was going to take R141 home AMA (against medical advice). Family was upset about the resident's elopement and concerns over staff monitoring resident's whereabouts. DON stated she and the facility staff were trying to prevent a AMA discharge, due to R141 receiving IV antibiotics and level of care. DON stated the daughter informed the facility she was going to take R141 home and place resident on hospice the following morning. R141 was discharge with family on 2/08/26. In a review of the documented listing, provided by the facility by the months submitted to OMB-LTC, the Month of February 2026 lacked R141's name. During interview on 3/19/26 at 2:19 p.m., the DON stated R141's family requested R141's discharge or they would be taking resident AMA (against medical advice). DON stated she involved the primary physician, who at first was against the discharge. However, after family informed facility / primary of the intentions of enrolling R141 into hospice services the following day, the primary physician gave the orders for discharge. DON stated she didn't want the family taking R141 AMA, and due to the emergent situation, wished to make R141 as safe as possible. DON was unable to explain why R141's name was not listed on the February 2026 listing provided to the LTC-OMB. In review of the facility's policy entitled: Transfer and Discharge from the Facility Policy (updated 4/5/25) documented in the procedure section, the following was documented: "9. Fax notice of transfer discharge form to the ombudsman."			F0628			04/24/2026
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements-			F0627	R141 was discharged from the facility on 2/8/26. R141's electronic medical record included a "Discharge Summary," which contained the recapitulation of stay dated 2/8/26, and a "Discharge Plan of Care," which included care instructions and indicated medications were sent home with the resident. These documents were located in the electronic medical record while the		04/24/2026

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F0627 SS = D	Continued from page 7 §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.			F0627	Continued from page 7 survey was being completed. The medical record did not include a signed medication list to confirm medications were received by the resident and/or family at the time of discharge. All residents at the facility who are discharging have the potential to be affected by the deficient practice. The facility will conduct an audit of all discharges for 30 days prior to the date of compliance to ensure there is evidence of a recapitulation of stay, documentation of medications discharged with resident/ family and care instructions sent home with resident/ family at the time of discharge. Facility Transfer and Discharge from the Facility policy was reviewed and current. The facility will educate social services and nurses on the Transfer and Discharge policy. Facility will conduct ongoing audits: three per week for four weeks, then reduce to three per month for three months, and then bring results to QA for further review. Date of Compliance: April 24, 2026		04/24/2026

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F0627 SS = D	Continued from page 8 (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility			F0627			04/24/2026

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F0627 SS = D	Continued from page 9 must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding			F0627			04/24/2026

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F0627 SS = D	Continued from page 10 returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for			F0627			04/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245574		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/19/2026	
NAME OF PROVIDER OR SUPPLIER Sholom Home West				STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH , SAINT LOUIS PARK, Minnesota, 55426			
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F0627 SS = D	Continued from page 11 the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident records upon discharge were complete and accurate for 1 of 1 resident (R141) reviewed for discharge. Findings Include - R141's Face Sheet (undated) documented the diagnoses of sepsis due to methicillin susceptible staphylococcus aureus (a germ found on people's skin), pneumonia, acute and subacute infective endocarditis (inflammation of the heart's inner lining). R141's Minimum Data Set (MDS), with a registered nurse signing date of 2/07/26, documented R141 was moderately cognitively impaired and require set up to moderate assistance with all activities of daily living. R141's nurse progress notes on 2/08/26, indicated R141 had eloped from the facility and was later found wondering at Target. Family arrived and returned R141 to the facility (this was later investigated by the Minnesota Department of Health - Rapid Response Team). Upon returning to the facility, R141's daughter insisted on taking resident home. R141's provider was contacted, and discharge orders were received. R141's electronic medical record, reviewed on 3/18/26, lacked evidence of a recapitulation of stay (a summarization of cares / services performed), documentation of medications sent with and any care instructions which would have been sent home with r141, by the facility on discharge. During interview on 3/18/26 at 8:36 a.m., the director of nursing (DON stated she would look into it, while that information would have been in R141's paper chart. DON stated she had received a phone call from the facility on 2/8/26, family was going to take R141 AMA (against medical advice) being upset about the resident's elopement and concerns over staff monitoring resident's whereabouts. DON stated she and facility staff were trying to prevent a AMA discharge, due to R141 receiving IV antibiotics and level of care. DON stated the daughter informed the facility she was going to take R141 home and place resident on hospice the following morning. DON			F0627			04/24/2026

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F0627 SS = D	Continued from page 12 stated she knew the documents were there. In a follow-up interview on 3/19/26 at 2:35 p.m., DON stated the facility staff were unable to find the requested documents (recapitulation of stay, documentation of medications sent with and any care instructions), after she and the HUC (health unit coordinator) searched R141's paper record and a pile of documents yet to be scanned. DON stated the evening of R141's daughter's request for discharge and family's demand for discharge or would be taking R141 AMA, the facility staff did their best to meet family's demands and contact and process physician's order to meet this request. DON stated she knew the documentation was completed as the requested documents were reviewed with the Rapid Response investigator who investigated R141's elopement days later. DON stated her concern was, during the investigation of the elopement, she may have failed to make copies and the originals may have been given to the Rapid Response investigator. In review of the facility's policy entitled: Transfer and Discharge from the Facility Policy (updated 4/5/25) documented in the procedure section, the following was documented: "1. For resident-initiated discharges, the medical record is expected to contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care. Additionally, the comprehensive care plan will contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident-initiated."			F0627			04/24/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.			F0880	R10 was discharged from the facility on 3/23/26. All residents who reside in the facility with orders for blood glucose monitoring, using a handheld blood glucose monitor are at risk of not having their blood glucose monitor cleaned and disinfected after each use with disinfecting wipes. All residents who use a handheld blood glucose monitor will be audited to ensure their device is cleaned and disinfected. Facility Cleaning of Glucometers policy was reviewed and current. The facility will educate all staff who use blood glucose monitors on the importance of cleaning and disinfecting with disinfecting wipes.		04/24/2026

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F0880 SS = D	Continued from page 13 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			F0880	Continued from page 13 Facility will audit four residents per week who have orders for blood glucose monitoring to ensure the staff clean and disinfect following use per policy, for four weeks, then four times per month for three months. QA will further review and make recommendations. Date for compliance: April 29th, 2026		04/24/2026

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F0880 SS = D	Continued from page 14 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to complete proper disinfection of a blood glucose monitor for 1 of 1 resident (R10) reviewed for glucose monitoring. Findings include: R10's comprehensive Minimum Data Set (MDS), dated 3/4/26, indicated R10 was cognitively intact, and diagnoses included Parkinson's disease, chronic kidney disease and diabetes. R10's Physician Order Report, dated 2/18/26 – 3/18/26, indicated an order for blood glucose monitoring twice a day for diabetes. During observation and interview on 3/18/26 at 8:26 a.m., registered nurse (RN)-C was observed using an Assure Platinum blood glucose monitor (BGM) to check R10's blood glucose level. After RN-C completed the task and returned to the medication cart with the BGM, RN-C donned gloves, pulled a wipe from a blue-topped canister of PDI Sani-Hands Instant Hand Sanitizing Wipes, wiped the entire BGM with the wipe, and stated she would leave it “out to dry”. During interview on 3/18/26 at 8:55 a.m., RN-C stated the facility did not use shared blood glucose monitors and each resident had their own. RN-C stated, “you can use this one” (pointed to the canister of PDI instant hand sanitizing wipes) or “you can use the alcohol wipes to sanitize”. RN-C stated she was trained to sanitize the BGMs after each use. During interview on 3/18/26 at 2:33 p.m., director of nursing (DON) stated staff were expected to clean			F0880			04/24/2026

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F0880 SS = D	Continued from page 15 and disinfect the BGMs after each use with disinfecting wipes, purple, grey, or orange-topped canisters, and hand wipes were “a definite no”. DON stated proper disinfection of blood glucose monitors were important for infection control purposes. The Quality Assurance / Quality Control (QA/QC) Reference Manual for the Assure Platinum Blood Glucose Monitoring (BGM) System, provided by the facility on 3/18/26, indicated cleaning and disinfecting the BGM minimized risk of transmitted blood-borne pathogens, and recommended the use of a commercially available EPA-registered disinfectant detergent or germicide wipe. A list of EPA registered disinfectants included Professional disposables International, Inc (PDI)'s Super Sani-Cloth Germicidal Disposable Wipes. The facility's Cleaning of Glucometers policy, updated 8/29/16, indicated to prevent the transmission of blood-borne pathogens glucometers will be cleaned after every use for shared machines and at least weekly if for individual resident and when visibly soiled, with Sani-Cloth wipes (Purple Cap type) and allowed to dry for 2 minutes. Do not use alcohol wipes.		F0880			04/24/2026	
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to maintain resident equipment cleanliness of intravenous (IV) poles for 1 of 1 resident (R86) reviewed for tube feeding. R86's quarterly Minimum Data Set (MDS) dated 1/23/26, indicated R86 had severe cognitive impairment and was dependent on assistance from staff for activities of daily living (ADLs). R86 diagnoses included dysphagia (difficulty swallowing food or liquids) following stroke, hypertension, gastrostomy tube (tube into stomach for feeding), hemiplegia (paralysis on one side) and hemiparesis (muscle weakness) following stroke, and encephalopathy (group of conditions that cause		F0921	R86's tube feeding pole and the floor under the pole were cleaned. A process was implemented to ensure ongoing daily cleaning of tube feeding poles and the surrounding floor area, as well as cleaning when visibly soiled. All residents at the facility who receive tube feeding have the potential to be affected by the deficient practice. All residents who receive tube feeding will have their tube feeding pole and floor cleaned. Facility Tube Feedings: Gastrostomy policy was reviewed and remains current. Education will be provided to staff on proper infection control practices related to tube feeding equipment and surrounding environment. Tube feeding poles are cleaned daily by nursing staff; surrounding floors are cleaned daily by housekeeping staff and when visibly soiled. Ongoing audits will include observation of tube feeding areas for cleanliness of poles and surrounding floors. The Director of Nursing and Environmental Services Manager or designee are responsible for monitoring compliance. Audits will be completed two times per week for four weeks, then reduced to two times per month for three		04/24/2026	

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F0921 SS = D	Continued from page 16 brain dysfunction). On 3/17/26 at 8:40 a.m., observed IV pole in R86's room with tube feeding pump attached. The pole, pole legs, and floor below were observed to have tan colored, dried substance that dripped down the pole, covered all five legs with several dried spots on the floor. Follow up observations on 3/18/26 at 10:08 a.m.; 3/18/26 at 1:55 p.m.; 3/19/26 at 8:15 a.m. and 3/19/26 at 1:07 p.m., the IV pole, pole legs and floor below continued to have dried tan colored substance. When interviewed on 3/19/26 at 1:28 p.m., registered nurse (RN)-A stated the poles should be cleaned of any formula spills as soon as it was seen as well as when starting or stopping the feeding for infection control reasons. When interviewed on 3/19/26 at 1:51 p.m., nurse manager (NM)-B stated the pumps and poles should be cleaned whenever it is observed to have anything on them. NM-B stated evening shift should clean the pump and pole when they started the tube feeding, day shift should clean the pump and pole off in the morning when the feeding was stopped. NM-B observed the pole and floor, stated should have been taken care of for cleanliness and infection control purposes. Facility policy Tube Feedings: Gastrostomy revised 8/2017, indicated the IV standard and pump was to wiped down daily with a cloth dampened with disinfectant.			F0921	Continued from page 16 months, with results reported to QA for further review. Date of Compliance: April 24, 2026		04/24/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 1, 2026

Administrator
Sholom Home West
3620 PHILLIPS PARKWAY SOUTH
SAINT LOUIS PARK, MN 55426

RE: CCN:245574

Cycle Start Date: March 19, 2026

Dear Administrator:

On March 19, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 June 19, 2026 (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 September 19, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112