



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 6, 2026

Administrator
SHIRLEY CHAPMAN SHOLOM HOME EAST
740 KAY AVENUE
SAINT PAUL, MN 55102

RE: CCN:245411

Cycle Start Date: July 23, 2026

Dear Administrator:

On July 23, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

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 October 23, 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 January 23, 2027 (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, appearing to read 'M. Poepping', with a stylized, cursive script.

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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245411		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
NAME OF PROVIDER OR SUPPLIER SHIRLEY CHAPMAN SHOLOM HOME EAST				STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE , SAINT PAUL, Minnesota, 55102			
(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			E0000			08/14/2026
F0000	INITIAL COMMENTS A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on (7/20/26-7/23/26) during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements. On 7/20/26-7/23/26, a standard recertification survey (S5411042-0) was conducted at your facility. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. 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			08/14/2026
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals			F0761	R9's insulin pen was discarded, and a new insulin pen was ordered and dated when opened R42's Ativan was discarded and a new bottle of Ativan was ordered and dated when opened R25's Ativan was discarded and a new bottle of Ativan was ordered and dated when opened. All residents at the facility who receive medication from a multi-dose vial, bottle or another container have the potential to be affected by the deficient practice.Facility will conduct whole house audit of all residents who receive medications from a multi-dose vial, bottle or another container and ensure all containers are labeled upon opening. Facility will provide education to all nurses and trained medication aides regarding the importance of dating multi-dose medication vial, bottle or containers when opened.Facility will conduct ongoing audits on residents who receive medications from multi-dose vial, bottle or another		09/09/2026

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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F0761 SS = E	Continued from page 1 in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure multi-dose medications were labeled upon opening and discarded in accordance with professional standards for 1 of 2 medications rooms reviewed and 1 of 5 medication carts reviewed for medication storage. Findings include: R92's entry tracking Minimum Data Set (MDS), indicated R92 admitted for short term rehabilitation on 7/16/26. An observation and interview on 7/20/26 at 5:19 p.m., registered nurse (RN)-E was preparing to administer Lispro insulin to R92. When R92's insulin pen was removed, the open date and initials label was blank. RN-E stated all insulin pens were supposed to be dated with the open date, but on the transitional care unit (TCU) residents were not here for very long so it gets missed sometimes. R42's quarterly MDS dated 7/8/26, indicated R42 had severe cognitive impairment and received hospice services. R25's significant change MDS dated 5/22/26, indicated R25 had severe cognitive impairment and received hospice services. An observation of the third-floor medication room refrigerator on 7/22/26 at 12:51 p.m., contained two open bottles of liquid Ativan for R42 and two open bottles of liquid Ativan for R25. The bottles of Ativan for R42 and R25 had open date and initial labels; however, they were all blank. All bottles of Ativan for R42 and R25 contained medication and were not full. The bottles had a label that started to discard after 60 days. RN-F verified the bottles and the missing			F0761	Continued from page 1 container: four per week for four weeks, then reduce to four per month for three months, and then bring results to QA for further review		09/09/2026

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F0761 SS = E	Continued from page 2 opening dates. RN-F further stated they should be dated when opened and whichever one was older should have been discarded when the newer one opened. RN-F wasn't sure why there were two open bottles and why they were not labeled. An interview on 7/22/26 at 1:01 p.m., licensed practical nurse (LPN)-A had entered the medication room and stated they should be labeled when opened and it was important to know because they are good for only so long. When interviewed on 7/23/26 at 9:21 a.m., RN-B expected insulin pens to be dated when opened. When interviewed on 7/23/26 at 12:09 p.m., the Director of Nursing (DON) stating multiple bottles of opened medications should not be happening. With hospice residents they typically have more than one medication vial in stock, however, staff should be dating them and not opening a new one until needed. A facility policy titled Storage and Expiration Dating of Medications revised 6/30/25, directed staff to follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Furthermore, staff should record the date opened on the primary medication container. If a multidose vial of an injectable medication has been opened, it should be dated and discarded within 28 days unless manufacture guidelines say differently.			F0761			09/09/2026
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from			F0812	Thermometer probe wipes were purchased. Immediate education provided to employees on proper sanitization techniques when obtaining food temperatures. All residents at the facility have the potential to be affected by the deficient practice. The facility will ensure all employees are trained on proper sanitization techniques when obtaining food temperatures. Facility conducted audits of dietary employees obtaining food temperatures to ensure compliance. Facility will conduct ongoing audits: two per week for four weeks, then reduce to two per month for three months, and then bring results to QA for further review.		09/09/2026

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F0812 SS = E	Continued from page 3 consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, document review, the facility failed to ensure a proper sanitization technique was used to obtain food temperatures from ready-to-serve meals from the steam table. This finding had the potential to increase the risk of cross contamination and affect 17 residents who resided on the fourth floor. Findings include: During observation on 7/21/26 at 11:50 a.m., on the fourth floor, dietary aid (DA)-A placed stainless steel trays containing food on the steam table. DA-A washed her hands, put on gloves, got a food thermometer and started to check the food temperatures. DA-A checked the soup temperature first and wiped the thermometer with a napkin, then she checked the steamed vegetables temperature and once again used the same napkin to wipe the thermometer. DA-A stated she always used a napkin to clean the thermometer before she checked the next food item. DA-A stated she was never told to do otherwise. During interview on 7/21/26 at 1:16 p.m., DA-B was cleaning the kitchenette after serving lunch to residents on the second floor. DA-B explained he used a napkin to clean the food thermometer between food items and used a sanitizer solution before he put away the thermometer. During interview on 7/21/26 at 1:57 p.m., culinary services director (CSD) stated she expected the dietary aids will check the food temperature before the food is placed on the steam table. CSD stated the dietary aids needed to check the temperature, write down the temp, wipe off the thermometer with the sanitizing solution, and use a paper towel to dry the thermometer before they checked the next food item. CSD stated they used Ecolab Oasis 146 Multi-Quat Sanitizer diluted following manufacturer's recommendations. CSD stated she had new employees and will need further education.			F0812			09/09/2026

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F0812 SS = E	Continued from page 4 During interview on 7/21/26 at 3:36 p.m., Ecolab district manager (EDM) stated the Ecolab Oasis 146 multi-quat sanitizer was a food surface sanitizer. EDM stated the sanitizer was used to clean tables, and it was also used to wash dishes and silverware. EDM stated if the solution was diluted to sanitize the thermometer it could be safe, but the use of a napkin was concerning because the napkin might be contaminated. During interview on 7/23/26 at 10:52 a.m., director of nursing (DON) stated the expectation was for staff to follow proper sanitization procedures to clean the food thermometers to prevent cross contamination and reduce the risk of foodborne illnesses. Facility's policy titled Food Temperatures: Correct Use of Thermometer dated 10/24/25, indicated all foods were prepared in accordance with the FDA Food code. The policy also indicated the thermometer will be sanitized using a thermometer wipe in between foods of different types to also prevent cross contamination.			F0812			09/09/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure self-administration of medications was assessed and determined to be appropriate for 1 of 1 resident (R9) reviewed for self-administration of medications. Findings include: R9's quarterly Minimum Data Set (MDS) dated 6/01/26, indicated R9 was cognitively intact and required varying levels of assistance with activities of daily living and mobility. Diagnoses included low blood pressure when standing, heart failure, chronic kidney disease, lung disease, and a pacemaker. R9's Self-Administration of Medications (SAM) Assessment dated 3/22/26, indicated R9 responded "No" when asked whether he wanted to self-administer medications or treatments. R9's care plan dated 6/26/26, failed to identify			F0554	R9's eye drops were removed from his room on 7/21/26. R9's self-administration for medication assessment remained current as R9 did not want to self-administer his medications. R9's spouse was immediately educated on the importance of discussing all medical and medication questions with the nurse before bringing medications into the facility. All residents at facility have the potential to be affected by the deficient practice. Facility will conduct an audit of all resident rooms to ensure there are no medications found that did not have self-administration order. Facility will audit all residents who have an order to self-administer medications to ensure their assessment, order, and care plan are completed. Facility will provide education to staff regarding medication storage and self-administration of medication guidelines. Facility will conduct ongoing room audits to check medication storage compliance four times a week one month and then reduce to four per month for three months, and then bring results to QA for further review.		09/09/2026

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F0554 SS = D	Continued from page 5 interventions related to bedside storage or self-administration of eye medications. R9's medical record, reviewed on 07/21/26, lacked evidence of provider orders for Systane Complete or ketotifen fumarate eye drops or authorization for the medications to be kept at the bedside. During observation on 7/20/26 at 4:03 p.m., two bottles of eye drops, Systane Complete and ketotifen fumarate, were observed unsecured on R9's bedside table. The medications lacked pharmacy prescription labels. During interview at that time, R9 stated the eye drops were not facility medications and reported facility staff administered the eye drops at his request. During observation on 7/21/26 at 8:36 a.m., the two eye drop medications remained on R9's bedside table. During interview on 7/21/26 at 8:54 a.m., registered nurse (RN)-C observed the eye drop medications at R9's bedside and verified they lacked pharmacy prescription labels. RN-C stated the medications may have been brought from home, staff administered them at R9's request, and a SAM assessment was required before medications could be kept in a resident's room. RN-C removed the medications and stated she would notify the unit manager. During interview on 7/21/26 at 9:17 a.m., registered nurse (RN)-D stated staff were required to verify the resident's assessment, provider order, medication, and the rights of medication administration before giving medications. During interview on 7/21/26 at approximately 4:00 p.m., the Director of Nursing (DON) stated residents needed to be able to safely self-administer medications, have a completed assessment, and have a provider's order before keeping medications in their room. The DON stated medications kept in resident rooms required a provider's order and a way to identify the medication. The DON expected staff to remove medications not listed on the Medication Administration Record (MAR) and notify the unit manager. Facility's policy titled Self-Administration of Medications dated 11/2018, indicated residents capable of self-administering medications could keep medications at bedside with a physician's order stating the medication "may be kept at bedside for self-administration." The policy required			F0554			09/09/2026

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F0554 SS = D	Continued from page 6 a SAM assessment, identification of bedside medications on the MAR and care plan, and resident education regarding medication use, frequency, storage, and notification of nursing staff when a dose was taken. Nursing staff were required to document self-administration and assess medication effectiveness.			F0554			09/09/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that			F0605	R8's as needed (PRN) Lorazepam order was discontinued on 7/23/26. All residents at the facility with a PRN psychotropic medication have the potential to be affected by the deficient practice. Facility will conduct whole house audit for all residents with PRN psychotropic medication orders to ensure the PRN medication is being used per orders and there is documented supporting rationale for the order in the medical record. Education will be provided to all staff on the requirements for PRN psychotropic medication orders. Facility will conduct ongoing audits: four per week for four weeks, then reduce to four per month for three months, and then bring results to QA for further review		09/09/2026

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F0605 SS = D	Continued from page 7 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific			F0605			09/09/2026

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F0605 SS = D	Continued from page 8 condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure the use of as needed (i.e., PRN) psychotropic medication was limited to 14 days or extended to a certain date with supporting rationale provided by the medical provider for 1 of 5 residents (R8) reviewed for unnecessary medication use. Findings include: R8's comprehensive Minimum Data Set (MDS) dated 7/2/26, indicated R8 had severe cognitive impairment, received hospice services, and had diagnoses of atrial fibrillation, congestive heart failure, renal failure, Alzheimer's disease, depression and psychotic disorder. R8's medical orders dated 7/22/26, included an order for lorazepam (anti-anxiety medication) 0.5 milligrams (mg) orally every 6 hours as needed (PRN) for anxiety, with a discontinuation date of 9/2026. R8's medical administration records (MAR) indicated R8 did not receive any doses of lorazepam between 3/2026 and 7/2026. R8's medical record lacked supporting rationale for the lorazepam order.			F0605			09/09/2026

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F0605 SS = D	Continued from page 9 During interview on 7/23/26 at 10:07 a.m., requested documentation supporting rationale to the corporate director of clinical services (DCS) stated a psychotropic medication ordered PRN, couldn't be ordered for more than 14 days at the time. DCS stated a doctor needed to do a face-to-face visit and provide a rationale for a psychotropic medication ordered PRN for longer than 14 days. During interview on 7/23/26 at 10:19 a.m., director of nursing (DON) the expectation depended on the situation but initially a psychotropic medication to be used PRN couldn't be ordered for longer than 14 days. After the initial 14 days, the use of the medication needed to be reviewed, and the doctor could re-write the order for an additional 14 days or schedule the medication if necessary. DON added an order for a PRN psychotropic medication should be a red flag for the nurses. Nurses should know the CMS regulations. Facility's policy titled Unnecessary Drugs/Psychotropic Medications dated 3/16/25, indicated the resident will be free from chemical restraints and unnecessary medications. The policy also indicated PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.			F0605			09/09/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §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			F0628	R87 was transferred to the hospital. The record has been reviewed and updated to include required transfer documentation. R89 left the facility against medical advice. The record has been reviewed and updated to include required transfer documentation. Facility will ensure all 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.Facility will submit the last 90 days of those who transferred and discharged from the facility to the Office of the State Long- Term Care Ombudsman. All residents at the facility who are transferred or discharged from the facility are at risk of being affected. Education will be provided to all staff to ensure the required OMB-LTC reporting is completed as required.Facility will conduct ongoing audits: four per week for four weeks, then reduce to four per month for three months, and then bring results to QA for further review		09/09/2026

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F0628 SS = D	Continued from page 10 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. (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			F0628			09/09/2026

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F0628 SS = D	Continued from page 11 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 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			F0628			09/09/2026

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F0628 SS = D	Continued from page 12 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 (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:			F0628			09/09/2026

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F0628 SS = D	Continued from page 13 (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 that a discharge notice was sent to the Office of the State Long-Term Care Ombudsman (OOLTC) for 2 of 2 resident (R87, R89) reviewed for discharge. Findings include: R87 R87's admission Minimum Data Set (MDS) dated 4/20/26, indicated R87 was cognitively intact and had diagnoses of hepatic encephalopathy (a brain condition caused by severe liver disease), chronic liver failure, cirrhosis (scarring of the liver), systolic congestive heart failure, and chronic kidney disease. R87's face sheet reviewed on 7/23/26, indicated R87 was admitted to the facility on 4/14/26 and transferred to United Hospital on 4/27/26. R87's progress notes dated 4/27/26, indicated R87 had a change in condition. The nurse notified the provider, who ordered transfer to United Hospital for further evaluation. R87 left the facility with paramedics at 10:50 p.m. A facility document titled Monthly Notice to MN Office of Ombudsman for Long-Term Care of Emergency Acute Care Transfers and Discharges dated 5/1/26, failed to include R87's 4/27/26 facility-initiated hospital transfer. During interview on 7/23/26 at approximately 11:00 a.m., the Corporate Director of Clinical Services (DCS) confirmed R87 was transferred from the facility to the hospital on 4/27/26. DCS confirmed the transfer was not listed on the facility's April			F0628			09/09/2026

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F0628 SS = D	Continued from page 14 Ombudsman notification log and should have been included. R89 R89's admission Minimum Data Set (MDS) dated 4/28/26, indicated R89 had intact cognition with no hallucinations, delusions, or behaviors. R89's Census information dated 4/28/26, indicated that R89 was admitted to the facility on 4/28/26 and discharged on 4/29/26. R89's progress note dated 4/29/26 at 1:54 p.m., stated that R89 left the facility against medical advice (AMA) around 10:30 a.m. In an email correspondence dated 7/17/26 at 12:33 p.m., the OOLTC stated that no transfer and discharge notices from the facility have been received for approximately two years. The OOLTC identified that the last transfer and discharge notice received from the facility was from May 2024. The facility's Monthly Notice to Minnesota OOLTC of Emergency Acute Care Transfers and Discharges dated 5/1/26, indicated that the ombudsman had been notified of 18 resident hospital transfers during the month of April. The document did not include any record of ombudsman notification of discharges including that of R89. Record of ombudsman notification of R89's discharge was requested and not received. During an interview on 7/22/26 at 1:44 p.m., when notified that record of ombudsman notification of R89's discharge was not found in the Monthly Notice to MN OOLTC of Emergency Acute Care Transfers and Discharges, the Director of Clinical Services (DCS) stated that ombudsman notification of AMA discharges may be kept in a different file and she would provide this if able. The DCS stated that the ombudsman should be notified by the Social Services Director (SSD) of all unplanned discharges, including residents who discharge AMA. The SSD was on vacation during survey and unavailable for interview. During an interview on 7/23/26 at 9:38 a.m., the administrator stated that after reviewing their records, she did not have evidence of ombudsman notification for R89's discharge from the facility. A facility policy titled Transfer and Discharge from the Facility updated 4/5/25, indicated the facility			F0628			09/09/2026

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F0628 SS = D	Continued from page 15 should forward a copy of all discharge notices to the OOLTC and required state agencies.			F0628			09/09/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure provider orders were followed to put on leg wraps for 1 of 1 resident (R6) reviewed for edema. In addition, the facility failed to ensure effective collaboration between the facility and the hospice agency for 1 of 1 resident (R8) reviewed who received hospice services. Findings include: R6 R6's quarterly Minimum Data Set (MDS) dated 7/8/26, indicated R6 had intact cognition, had no behaviors and did not reject cares. MDS indicated R6 needed moderate assistance with dressing, putting her shoes on, and showers. R6's Profile form dated 7/23/26, identified diagnoses of essential hypertension, non-rheumatic aortic stenosis, diabetes type II, prosthetic heart valve replacement, morbid obesity, and metabolic encephalopathy. R6's medical orders form dated 7/23/26 included an order to apply leg wraps to bilateral lower extremities; on in the morning and off at night. This order was dated 11/10/25. R6's July treatment medication record (TAR) included the order for leg wraps.			F0684	R6 has orders for bilateral ace wraps to be applied daily in the morning and removed every bedtime. Reeducation was provided immediately to the licensed nursing staff on the importance of applying ace wraps per order and if they are unable to execute on the orders the nurse will notify the nurse manager or supervisor. R8's hospice certification and care plan from hospice was added to R8's medical record. Hospice implemented a binder for R8 for hospice staff to document their visits to allow all facility staff access to hospice communication. All staff will be trained on reviewing the binder to ensure all staff are aware who is on hospice and to improve overall collaboration. All residents at the facility with ace wrap orders and all residents on hospice have the potential to be affected by the deficient practice. Facility will conduct a whole house audit to ensure all residents with ace wrap orders have them applied per orders. Facility will conduct a whole house audit of residents on hospice to ensure the hospice certification, care plan and visit notes are available to the facility staff. Education will be provided to all licensed nursing staff on the importance of following provider orders for ace wraps. Education will be provided to all staff regarding the coordination and collaboration of hospice care. Facility policy regarding Skin Integrity Management was reviewed and updated for edema management. Facility will conduct ongoing audits for ace wrap application: two per week for four weeks, then reduce to four per month for three months, and then bring results to QA for further review. Facility will conduct ongoing audits for hospice service two per week for four weeks, then reduce to four per month for three months, and then bring results to QA for further review.		09/09/2026

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F0684 SS = D	Continued from page 16 During observation and interview on 7/20/26 at 3:25 p.m., R6 was in her room, sitting in her wheelchair. R6 was not wearing the leg wraps, she said she needed help to put them on. R6 said sometimes the staff got busy and didn't wrap her legs. During observation and interview on 7/21/26 at 9:11 a.m., R6 was in her room putting on makeup. R6's leg wraps were on top of her bedside table. R6 stated the staff will help her later to wrap her legs. During interview on 7/21/26 at 10:30 a.m., registered nurse (RN)-G stated he was running behind but would try to wrap R6 legs as soon as possible. During observation on 7/22/26 at 9:05 a.m., R6 was in the dining room and did not have leg wraps on. During observation and interview on 7/22/26 at 12:26 p.m., nurse manager (RN)-H stated the nurses needed to apply leg wraps to resident's legs early in the morning. RN-H stated. If for some reason the nurse on duty got behind with their morning medication pass or other duties, they could let her know as she was willing to support the nurses. RN-H stated the facility needed to follow the doctor's orders and update them as necessary. RN-H verified R6 legs were not wrap, she said she would do it. During interview on 7/23/26 at 10:45 a.m., director of nursing (DON) stated the leg wraps and compression stockings should be applied first thing in the morning. DON stated if the wraps or compression stockings were not applied, the resident's edema could worsen, cause fluid overload, worsened cardiac related symptoms, and possibly have a negative effect on residents' wellbeing. A policy regarding edema and following doctor's orders was requested but none was received. R8 R8's comprehensive Minimum Data Set (MDS) dated			F0684			09/09/2026

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F0684 SS = D	Continued from page 17 7/2/26, indicated R8 had severe cognitive impairment, had no behaviors, did not refuse cares, and needed maximal assistance with toileting hygiene and lower extremity dressing. MDS also indicated R8 needed moderate assistance with upper body dressing and was dependent to put on and take off footwear. MDS indicated diagnoses of stroke, a-fib, congestive heart failure, hypertension, Alzheimer’s disease, and received hospice services. R8’s orders report dated 7/23/26, indicated orders for hospice evaluation and treatment, this order was dated 1/16/26. R8’s progress notes between 7/1/26 and 7/21/26 included only one hospice nurse progress note dated 7/16/26. During observation and interview on 7/20/26 at 4:49 p.m., R8 was visiting with one of her daughters. R8 was confused, was able to answer yes/no questions, but after answering the second question she said she didn’t want to share any information. R8 appeared to be physically comfortable. Per daughter, R8’s didn’t trust new people. During interview on 7/21/26 at 9:20 a.m., R8 was in her room, sitting on her wheelchair folding and putting clothes away in her closet. A hospice massage therapist arrived and stayed with the resident for about one hour. During interview on 7/21/26 at 9:28 a.m., RN-G stated he believed the hospice staff visited R8 on Tuesdays. RN-G said the hospice nurses usually talked to him after they visited R8. RN-G stated he knew R8 had a hospice nursing assistant, a nurse, social worker, spiritual worker, massage therapist, and volunteers, but he didn’t know when they were scheduled to visit R8. RN-G stated he believed the schedule was on the hospice binder, or in the electronic medical record (EMR). RN-G was unable to find the hospice binder, and the hospice schedule was not on her EMR. During interview on 7/21/26 at 9:32 a.m., RN-H stated R8’s hospice information was in front of the resident’s hard chart.			F0684			09/09/2026

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NAME OF PROVIDER OR SUPPLIER SHIRLEY CHAPMAN SHOLOM HOME EAST				STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE , SAINT PAUL, Minnesota, 55102			
(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
F0684 SS = D	Continued from page 18 During document review on 8/21/26 at 9:35 a.m., R8’s hard chart had the following hospice documents: a form that identified the medications covered by hospice, a form with the hospice contact information, and a schedule. However, there was not a care plan and/or the current hospice certification. The July hospice schedule indicated the following visits: Spiritual care: 7/14 and 7/28 Skilled nursing: 7/8, 7/15, 7/22 Massage therapy: 7/8, 7/15, 7/22 Volunteer: 7/1, 7/8, 7/15, 7/22 HHA (home health aide): 7/2, 7/9, 7/16, 7/23 Social worker: 7/17 During interview on 4/21/26 at 9:50 a.m., RN-H verified R8’s hard chart didn’t include a hospice care plan and/or the hospice certification. RN-H also verified there was only one hospice progress note for the month of July. RN-H stated the hospice manager brought both the care plan and the current certification and she would put it on R8’s hard chart. During interview on 7/21/26 at 12:16 p.m., nursing assistant (NA)-C stated she was not sure what hospice did for R8. NA-C stated she had seen volunteers. NA-C stated she had never seen or talked to the hospice nurse or seen the hospice NA. NA-C was not aware if hospice had a schedule and didn’t know when they were coming. NA-C added “The nurse and the nurse manager should know. I am sure they know.” During interview on 7/22/26 at 12:52 p.m., RN-H stated she expected the nurses knew when hospice visited R8. RN-C said she expected the nursing staff to communicate with hospice members before and after their visits and call them to report any changes in condition and to re-order medications. During interview on 7/22/26 at 12:59 p.m., hospice program manager (HPM) stated the hospice program had their own electronic medical record. HPM stated the hospice nurse needed to copy and paste her progress note into R8’s EMR after each visit. HPM			F0684			09/09/2026

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F0684 SS = D	Continued from page 19 stated the rest of the team needed to document their visits on the hospice communication book kept in R8’s room. HPM verified there was not a hospice certification or care plan until yesterday. HPM stated she was working with management about implementing hospice binders which will be more accessible to the facility’s nursing staff. HPM stated the hospice and facility’s social workers and nurse managers met on a weekly basis to review changes of condition, but the facility’s floor staff was not necessarily aware what hospice did for the hospice patients. During interview on 7/23/26 at 10:31 a.m., director of nursing (DON) stated the facility staff should know what services were provided by hospice. DON stated sometimes the facility’s NAs needed to know the services provided by the hospice NA were additional services. DON stated hospice needed to provide a schedule and the resident's hospice care plan to coordinate our resident's cares and to provide continuity of care, we integrate our care plan with hospice. DON stated we will need to do an in-service to educate the staff about where to look for information. DON stated he expected hospice to add their progress notes to the resident’s EMR. Facility's policy titled Hospice Care for Nursing Facility Residents- Coordination of services dated 5/23/16, indicated the hospice program ensures that mechanisms are in place to provide for the coordination of all hospice services provided to patients residing in facilities.			F0684			09/09/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall interventions			F0689	R90 was discharged home from the facility on 7/30/26. All residents at the facility who are at risk for falls have the potential to be affected by the deficient practice. Facility will conduct audits to ensure fall interventions are being implemented. Education will be provided to all staff on the importance of following adhering to fall interventions as outlined in the resident care plan. Therapy staff to work with the nurse manager regarding any deviation to the fall care plan while working with therapy staff. Facility will conduct ongoing audits: four per week for four weeks, then reduce to four per month for three months, and then bring results to QA for further review		09/09/2026

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F0689 SS = D	Continued from page 20 were implemented for 1 of 3 residents (R90) who were at risk of falls. Findings include: R90's face sheet printed 7/22/26, indicated R90 was recently admitted and had diagnoses of stroke with aphagia (trouble finding words to speak), dementia with mood disturbance, and a history of falling. R90's Comprehensive Nursing Assessment dated 7/16/26, indicated R90 had short and long-term memory problems, had severely impaired cognitive skills for daily decision making, and had a history of falling prior to admission. R90's care plan revised 7/20/26, indicated: -R90 had a self-care deficit with mobility and required assist of 1 staff with a gait belt and four wheeled walker for transfers and mobility. - R90 was at risk for falls related to dementia and wandering. Interventions included keeping bed at transferring height, call light in reach and to ensure R90 wore appropriate footwear. R90's medical record lacked indication R90 did not like or refused grip socks. An observation on 7/20/26 at 11:06 a.m., R90 was sitting on the bed in his room. R90 was barefoot with shoes on the floor near the bed. R90 got up and started walking towards the door. R90 was barefoot and was not using his walker. R90 made it outside into the hallway a few steps and stood there for a short time. Unidentified nursing assistant (NA) rushed from the other side and escorted R90 back to his room. An observation on 7/21/26 at 9:08 a.m., R90 was sleeping in bed. R90 had a transfer belt around him and was wearing socks without grips. An observation on 7/21/26 at 10:07 a.m., R90's family member (FM)-A was with him in the hallway. Unknown physical therapy staff and FM-A were walking with R90 in the hallway. R90 was wearing plain socks without grips and no shoes. An observation on 7/21/26 at 11:52 a.m., R90 was lying in bed sleeping. R90 was wearing plain socks without grips. An interview on 7/20/26 at 3:17 p.m., FM-B stated R90 had recently been admitted to the facility and			F0689			09/09/2026

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F0689 SS = D	Continued from page 21 was so confused. R90 had fallen once, and family was trying to be here as much as possible for support. An interview on 7/21/26 at 3:04 p.m., nursing assistant (NA)-B stated R90 was a fall risk and had had a fall since admission. NA-B stated staff frequently check on R90, ensure call light is in reach, and keep the door open. R90's family recently hired a patient care assistant (PCA) to sit with him. NA-B stated appropriate footwear included grippy socks on when in bed and shoes or grippy socks on when walking. NA-B verified R90 was not wearing grippy socks and stated he should be and went to obtain grip socks from the nurse. An interview on 7/21/26 at 3:26 p.m., licensed practical nurse (LPN)-B stated R90 was a fall risk and most of the time had family or PCA in with him. LPN-B verified one intervention for R90 was to have appropriate footwear on and R90 should have grip socks in place. LPN-B was not aware of any refusals of grip socks. An interview on 7/23/26 at 9:21 p.m., RN-B stated after a resident falls, the interdisciplinary team (IDT) meets to review the fall and collaborate on interventions. RN-B identified appropriate footwear to be griped socks when in bed and grip socks or shoes in place when up walking. RN-B expected staff to be following the care planned interventions for falls and stated grip socks should have been in place for R90. An interview on 7/23/26 at 12:09 p.m., the Director of Nursing (DON) expected fall interventions to be in place and stated R90 should have had the grip socks in place. DON further stated this was important to help prevent falls. A facility policy titled Fall Prevention and Management revised 6/21/21, directed staff to implement interventions according to resident specific risk factors and care plans would indicate the resident specific interventions to prevent falls.			F0689			09/09/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or			F0690	R90's provider order received on 7/27/26 to remove foley to initiate voiding trial. R90 failed the voiding trail and the foley was re-inserted on 7/28/26. R90 was seen at Urology on 7/29/26, new DX of BPH foley to remain intact secondary to failed voiding trial with urinary retention. R90 was discharged home from the facility on 7/30/26. All residents with a foley catheter have the potential to be affected by the deficient practice. Facility will conduct whole house audit of all residents with a foley to ensure		09/09/2026

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F0690 SS = D	Continued from page 22 becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure documentation of clinical indications for the continued use of a foley catheter was in place and failed to ensure interventions were in place to prevent urinary tract infections for 1 of 1 residents (R90) reviewed with a catheter. Findings include: R90's face sheet printed 7/22/26, indicated R90 was recently admitted and had diagnoses of stroke with aphagia (trouble finding words to speak), dementia with mood disturbance, urine retention and had a urinary device. R90's Comprehensive Nursing Assessment dated 7/16/26, indicated R90 had short and long-term memory problems, had severely impaired cognitive skills for daily decision making, and was admitted with a foley catheter.			F0690	Continued from page 22 they have appropriate clinical indication/ diagnosis. Facility will audit all residents with a catheter to ensure the catheter bag is below the bladder without any loops or kinks. Education will be provided on the importance of obtaining clinical indication/ justification for all foley catheters as well as ensuring the catheter bad is always before the bladder without loops or kinks. The Urinary Catheter Care Policy was reviewed and updated.Facility will conduct ongoing audits: four per week for four weeks, then reduce to four per month for three months, and then bring results to QA for further review		09/09/2026

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F0690 SS = D	Continued from page 23 R90’s hospital discharge summary dated 7/16/26, indicated R90 had hematuria (blood in the urine) with urinary retention and required a urology consultation. A foley catheter was placed with a plan to discharge with the catheter and have a trial of void in clinic in 2 weeks as well as a trial of void at the skilled nursing facility “next Monday” (7/20/26). R90’s hospital discharge orders dated 7/16/26, indicated R90 required catheter removal on 7/20/26 with a monitor of post void residual at least twice daily for 24 hours or facility protocol. R90’s provider orders dated 7/16/26, indicated the following: -remove foley and perform a trial void on 7/20/26. -R90’s catheter required gravity drainage and instructed staff to not loop or kink the tubing so urine can drain, and to keep the drainage bag below the waist. R90’s care plan date 7/16/26, indicated R90 had a foley catheter related to neurogenic bladder and was at risk for urinary tract infection (UTI). Interventions included to change foley when needed, keep tubing/bag below the bladder, and ensure tubing was free of kinks. R90’s nursing progress note dated 7/20/26 at 9:56 a.m., indicated provider was notified via portal and requested foley removal to be delayed due to resident impulsiveness and self-transferring. R90’s nursing progress note dated 7/20/26 at 4:06 p.m., indicated nurse practitioner (NP)-A provided orders to delay trial void until 7/27/26. R90’s provider note dated 7/20/26, indicated R90 will need trial void and to continue with foley cares. R90’s provider note lacked clinical indication of why catheter removal was delayed. R90’s medical record lacked indication R90’s family had been involved in decision to delay discontinuation of foley, wanting to keep catheter in place or were educated on risks or benefits. An observation on 7/20/26 at 11:06 a.m., R90 was lying in bed sleeping. There was not a catheter bag hanging from his bed or below his waist to facilitate drainage. An observation on 7/21/26 at 9:08 a.m., R90 was sleeping in bed. R90’s catheter tubing was looped			F0690			09/09/2026

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F0690 SS = D	Continued from page 24 and had urine in the tubing. R90’s catheter bag was not hanging to gravity and was not below his waist to facilitate drainage. An observation on 7/21/26 at 11:52 a.m., R90 was lying in bed sleeping. R90’s catheter bag was attached to his leg. The tubing was looped twice and had urine sitting in the tubing. R90’s catheter bag was not hanging below his waist to facilitate drainage. An interview on 7/20/26 at 3:17 p.m., FM-B stated R90 had recently been admitted to the facility and was so confused. R90 was admitted with a catheter. FM-B further stated the catheter was supposed to come out today and was not sure why it was still in. An interview on 7/21/26 at 3:04 p.m., nursing assistant (NA)-B wasn’t sure why R90 had a catheter in place. NA-B stated catheter bags should be hanging below the waist and to gravity, so they drain properly. NA-B verified R90’s catheter was not hanging below waist and the catheter tubing had loops with urine sitting in the tube. NA-B stated normally catheters were hung from the bed and the tubing should not have loops or kinks however, R90 would play or pull on the tubing, and they wanted to keep it out of sight. An interview on 7/21/26 at 3:26 p.m., registered nurse (RN)-A stated R90 was admitted with the catheter for urine retention. RN-A stated R90’s catheter should be below the waist or to gravity and verified R90’s orders. RN-A wasn’t sure of why the trial void and catheter discontinuation was delayed and would need to speak to the nurse manager. An interview on 7/21/26 at 3:21 p.m., RN-B stated R90 had an incident where R90 had been fidgiting with the catheter that caused some bleeding and required the catheter to be replaced. RN-B stated NP-A had made the decision to keep it for an additional week. An interview on 7/22/26 at 9:24 a.m., NP-A stated R90 was very mobile and that was not a “good reason” to delay the catheter removal and trial void. However, trying to prevent falls having the catheter may reduce some impulsiveness with getting out of bed to void. NP-A was aware of the incident that required a catheter change for R90 and stated there were no further complications. NP-A stated she instructed nursing R90’s trial void had to happen sooner than next week if he was discharging from the facility.			F0690			09/09/2026

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F0690 SS = D	Continued from page 25 A follow up interview on 7/23/26 at 9:21 a.m., RN-B expected staff to ensure interventions were put in place for catheters were implemented, including catheter bags that were hung below the waist to facility gravity drainage. RN-B further stated family of R90 had also requested the catheter to stay in longer, however verified there was no documentation of this or education of risks and benefits of keeping the catheter in. An interview on 7/23/26 at 12:09 p.m., the Director of Nursing (DON) expected staff to ensure interventions were in place to prevent UTI when residents have a catheter. Family requesting to keep the foley in isn't the best reason, however if family wanted to keep the catheter in place, education of risks and benefits should be documented and in place. A facility policy titled Urinary Catheter Care no date, directed staff to check frequently to ensure the catheter tubing is free of kinks and ensure the drainage bag is always positioned lower than the bladder to prevent urine in the tubing/bag to flow back into the bladder. The policy did not address clinical indications or justification needed for catheter use.			F0690			
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. 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;			F0880	R11 had all appropriate signage and PPE available outside of their room. Staff involved were educated immediately on the importance of following the enhanced barrier precautions (EBP). All residents at the facility who are on EBP have the potential to be affected by the deficient practice. Education will be provided to all staff regarding the importance of following the EBP signage and donning all required PPE. Facility will conduct ongoing audits: four per week for four weeks, then reduce to four per month for three months, and then bring results to QA for further review		09/09/2026

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F0880 SS = D	Continued from page 26 §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. §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:			F0880			09/09/2026

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F0880 SS = D	Continued from page 27 Based on observation, interview, and document review, the facility failed to ensure staff followed proper infection prevention and control practices by using the required personal protective equipment (PPE) during Enhanced Barrier Precautions (EBP) for 1 of 1 resident (R11) reviewed for infection control. Findings include: R11's comprehensive Minimum Data Set (MDS) assessment dated 7/17/26, indicated R11 had severe cognitive impairment and was dependent on staff for total body care, bed mobility, and transfers. Diagnoses included chronic heart failure, chronic kidney disease, and nontraumatic intracranial hemorrhage (brain bleed). R11's care plan dated 7/21/26, indicated EBP had been initiated on 6/17/26, due to a pressure wound on the right heel. The care plan instructed staff to wear a gown and gloves during high-contact resident care activities, including dressing, providing hygiene care, and changing briefs. During observation on 7/21/26 at 8:45 a.m., nursing assistant (NA)-A provided personal care to R11 without wearing the required gown. NA-A wore a mask and gloves but failed to don the required gown while providing high-contact care. NA-A repositioned R11 from side to side, performed perineal care, changed the brief and clothing, and completed additional personal care without the required PPE. During an interview on 7/21/26 at 9:23 a.m., NA-A stated she believed R11 was not on EBP, although she knew R11 had an open sore on the heel. NA-A stated resident-specific care information was obtained from the care plan and care sheets. NA-A stated there was no sign on the resident's door, so she believed EBP was not required while providing close-contact care. NA-A further stated there would normally be an EBP sign posted on the door and a PPE supply bin located outside the room. After reviewing the information posted above the foam sanitizer dispenser, NA-A acknowledged there was a sign indicating R11 was on EBP and that a gown and gloves should have been worn while providing personal care, including perineal care, changing the brief, changing clothing, and completing hygiene care. During an interview on 7/22/26 at 8:53 a.m., licensed practical nurse (LPN)-A stated it was important for staff to follow each resident's care plan to provide care within the resident's individualized needs and to reduce the risk of			F0880			09/09/2026

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NAME OF PROVIDER OR SUPPLIER SHIRLEY CHAPMAN SHOLOM HOME EAST				STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE , SAINT PAUL, Minnesota, 55102			
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F0880 SS = D	Continued from page 28 infections and injuries. LPN-A stated the expectation was that staff would universally and consistently don and doff all required PPE for residents on EBP, as ordered, to protect residents and reduce the risk of infection transmission. During an interview on 7/23/26 at 9:37 a.m., the Director of Nursing (DON) stated the expectation was for staff to universally and consistently don and doff PPE in accordance with EBP requirements. The DON stated following EBP was important to protect residents, staff, and the community by reducing potential portals of entry for infection and decreasing the risk of transmission. The DON further stated it was important for staff to follow each resident's care plan. The facility policy titled Isolation – Categories of Transmission-Based Precautions updated 5/29/26, directed staff to implement EBP as an infection prevention and control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) within the facility. The policy indicated EBP required the use of a gown and gloves during high-contact resident care activities. High-contact care activities included dressing, bathing, providing hygiene care, transferring residents, changing linens, changing briefs, and providing device care.			F0880			09/09/2026
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years,			F0577	Survey and plan of correction results for preceding three years are now accessible to residents, family, visitors and staff. All residents, family, visitors and staff at the facility have the potential to be affected by the deficient practice. Education will be provided to all staff regarding the importance of ensuring survey and plan of correction results are accessible for the preceding three years. A policy has been established for posting survey results. Facility will conduct ongoing audits: weekly for four weeks, then reduce to one per month for three months, and then bring results to QA for further review.		09/09/2026

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F0577 SS = C	Continued from page 29 and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of correction (POC) for the most recent survey of the facility was readily accessible and that the POC for the three preceding years was available upon request. This had the potential to affect all 82 residents residing in the facility as well as family, visitors, and staff. During observation and record review on 7/22/26 at 8:10 a.m., a review of the survey results binder located near the elevators on the first floor of the facility was completed. Although the binder included the survey results from the past three years, the 2024 and 2025 survey results did not include the facility's plan of correction (POC) or indicate that these could be requested from facility staff. During an interview on 7/22/26 at 2:44 p.m., the administrator stated that she was responsible for maintaining the survey results binder. She stated that the POC for the previous three years should be included with the survey results. The administrator confirmed she had reviewed the binder and stated that the POCs for all surveys occurring from 2024 to current were missing from the binder. A request was made for the facility policy regarding the posting of survey results, but this was not provided.			F0577			09/09/2026

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K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on July 22, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Shirley Chapman Sholom Home East, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			08/14/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245411		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SHIRLEY CH... B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026	
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K0000 Bldg. 02	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: SHIRLEY CHAPMAN SHOLOM HOME EAST is a 4-story building with a full basement. The building was constructed in 2008 and was determined to be of Type II (222) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors, resident sleeping rooms and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 118 beds and had a census of 81 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			08/14/2026
K0324 SS = F Bldg. 02	Cooking Facilities CFR(s): NFPA 101			K0324	On 7/22/2026 facility Director of Engineering adjusted the filters to seal the gaps in the kitchen hood filtration system. All kitchen hoods in the facility were reviewed to ensure compliance. Facility		09/09/2026

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K0324 SS = F Bldg. 02	Continued from page 2 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect the cooking ventilation system in accordance with the NFPA 96, 6.2.3.3, 2011 Edition. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 7/22/2026, between 11:35 AM, observations and staff interview revealed that the kitchen hood filters were not properly sealed leaving a 1" gap between the filters. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324	Continued from page 2 will begin routine audits to ensure the kitchen hood filtration system is sealed properly to meet regulations. Maintenance department will complete audits weekly for 4 weeks, then reduce audits to once monthly for two months. Upon completion of audits, results will be shared with safety committee and QA committee for review and recommendations. All relevant staff will be educated on proper hood placement along with protocol to notify maintenance if filter is not properly sealed.		09/09/2026
K0918 SS = F Bldg. 02	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying			K0918	Director of Engineering commissioned Kodiak Power to sample and test the diesel fuel. On 7/23/26 Kodiak Power completed the testing with no findings. Kodiak Power will add fuel testing to facilities annual inspection going forward. The Director of Engineering will audit annual inspection forms to ensure compliance. On 8/5/2026 facility Director of Engineering purchased a battery		09/09/2026

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K0918 SS = F Bldg. 02	Continued from page 3 service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110 (2010 edition) section 8.3.7.1 and 8.3.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 7/22/2026, at 10:20 AM, it was revealed by a review of available documentation, the facility was not testing the batteries for the Emergency Generators for specific gravity or conductance and had not completed the annual fuel testing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0918	Continued from page 3 conductance tester. Battery testing was completed and has been added to monthly generator load tests and maintenance engineers were educated on the required testing. Results will be printed and attached to the monthly report. The facility director will audit vendor annual inspection reports to ensure compliance.		09/09/2026

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K0921 SS = F Bldg. 02	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to complete a Patient Care Electrical Equipment inventory and inspection in accordance with the NFPA 99, 10.3.5 and 10.3.6, 2012 Edition. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 7/22/2026, at 10:45 AM, it was revealed by a review of available documentation, the facility had not completed an inventory of the Patient Care electrical Equipment that is present in the resident rooms and had not tested that equipment. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0921	On 7/22/2026 facility purchased an electrical equipment testing device, asset inventory labels and created forms to collect the data required to meet regulations. 8/1/2026 The Facility Director of Engineering along with qualified maintenance personnel will develop inventory list of all PCREE pieces of equipment and document results of PCREE testing for each device. The maintenance team will complete annual testing of PCREE devices in resident rooms going forward. The Director of Engineering or designee will audit two resident rooms per week for four weeks, then reduce to random audits to ensure compliance. Results will be presented to the Safety Committee and QA for review and further recommendations.		09/09/2026

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K0923 SS = B Bldg. 02	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to construct a storage space that is of non-combustible materials in accordance with NFPA 99, 11.3.1, 2012 Edition. This deficient finding could have a moderate impact on the residents within the facility.			K0923	On 7/22/2026 the facility Director of Nursing sorted the empty and full oxygen tanks to the Full and Empty side of the Oxygen room as instructed by the wall signage. The facility will provide education for staff regarding proper oxygen storage. Facility will conduct audits of Oxygen rooms to ensure Oxygen is being stored in accordance with NFPA 99. Facility will complete three audits per weekly for four weeks then reduce to monthly for three months. The results of these audits will be presented to the Safety Committee and QA for further review and recommendations.		09/09/2026

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K0923 SS = B Bldg. 02	Continued from page 6 Findings Include: On 07/22/2026, at 10:55 AM, observations and staff interview revealed that in Room C314, there were oxygen tanks that were full and empty being stored together and not properly separated. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0923			09/09/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 16, 2026

Administrator
SHIRLEY CHAPMAN SHOLOM HOME EAST
740 KAY AVENUE
SAINT PAUL, MN 55102

RE: CCN: 245411
Cycle Start Date: September 11, 2026

Dear Administrator:

On September 11, 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.

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized flourish at the end.

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