DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 62U6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00380

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245574**

2.STATE VENDOR OR MEDICAID NO.
(L2) **151743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **SHOLOM HOME WEST**
(L4) **3620 PHILLIPS PARKWAY SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/15/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **154** (L18)

13.Total Certified Beds **154** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

x B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	154			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, Unit Supervisor 08/27/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/20/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
07/24/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 4, 2021

Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

RE: CCN: 245574
Cycle Start Date: July 15, 2021

Dear Administrator:

On July 15, 2021, a survey was completed at your facility by the Minnesota Department(s) 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 3, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 3, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 3, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 3, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Sholom Home West will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 3, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 15, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/12/21 through 7/15/21, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5574132C/MN73706 H5574136C/MN56466 H5574140C/MN52965 However NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5574131C/MN74370 H5574133C/MN52964 H5574134C/MN60518 H5574135C/MN57417 H5574137C/MN66654 H5574138C/MN58719 H5574139C/MN52275 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/16/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 regulations has been attained.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced	F 583		8/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 2 by: Based on observation, interview and document review, the facility failed to maintain confidentiality of medical information for 1 of 1 (R241) residents observed to have a sign indicating vaccination status on their bedroom door. Findings include: R241's admission Minimum Data Set (MDS) dated 7/14/21, indicated severe cognitive impairment with a diagnosis of heart failure and was receiving end of life care. On 7/12/21, at 5:33 p.m. a sign was observed taped to the outside of 241's room door which informed, "This Resident is on Precautions." "Observation (single use N95 mask, eye protection, gown + gloves). 14 days from move in, ER visit, hospital/TCU stay for UNVACCINATED resident/tenants." When interviewed on 7/13/21 at 8:33 a.m. registered nurse (RN)-A stated the, "Precautions" sign is used for residents who are unvaccinated and under a 14-day observation period. The sign is used to inform staff a resident is not vaccinated. RN-A added no conversation occurred with the resident or the resident's representative regarding having the vaccination status displayed on the door where it can be observed publicly. When interviewed on 7/15/21, at 10:44 a.m. infection preventionist (IP) stated the sign observed on R241's door was not a standard sign and did violate the resident's right to privacy due to the information it contained.	F 583	Residents R241's vaccination status identified on quarantine sign posted on the outside resident's door was immediately removed and replaced with a quarantine sign that did not identify vaccination status. All residents on quarantine at facility had the potential to be affected by the deficient practice. Facility quarantine sign was immediately changed and resident vaccination status was removed from sign. All unvaccinated residents will use updated sign when placed on quarantine. All facility staff were re-educated on resident's rights; not to have vaccination status publicized. Facility staff were educated on the updated sign that only identified resident room precaution status. Facility will conduct five audits per week to ensure compliance for four weeks, five audits per month for three months and the quality assurance committee will review at next meeting for further evaluation. Date of correction: 8/13/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 3 The facility policy titled, "Dignity," created 12/2014 included, "It is the policy of Sholom that residents are cared for in a manner and in an environment that promotes maintenance and/or enhancement of each resident's quality of life. Sholom is committed to an atmosphere that humanizes and individualizes each resident and their experiences."	F 583		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care and podiatry services were provided for 2 of 4 residents (R31 and R41) who were dependent upon staff assistance for activities of daily living (ADLs). Findings include: R31's face sheet printed 7/15/21, indicated R31's diagnosis included lung cancer, bone cancer, type 2 diabetes, and chronic kidney disease stage 3. R31's admission Minimum Data Set (MDS) dated 4/5/21, indicated R31 was cognitively intact and required one-person physical assistance with personal hygiene activities, and one person physical assist for dressing, utilized a wheelchair for mobility, and was on hospice care.	F 677	Residents R31 and R41 have been offered and accepted podiatry service. R31 was seen by podiatry on 8/5 and R41 was seen on 8/3. All residents at facility have the potential to be affected by the deficient practice. All residents will be offered podiatry services upon admission, as needed when a podiatry need is identified and annually during care conferences. An audit of all residents who currently reside at facility was completed. All residents who were not being seen by podiatry were offered podiatry services. A treatment order was initiated for R31 and R41 to have their nails checked weekly. A treatment order was initiated for all residents who reside at facility to have their nails checked weekly. Social Services and nursing staff were	8/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 4 R31's care plan dated 4/20/21, indicated R31 had an alteration in self-care ability related to weakness and deconditioning as evidenced by diagnosis of end stage lung cancer and asthma. The care plan further indicated R31 required assist of 1 with nail care and nail care was to be done weekly with bath and as needed. Diabetic nail care to be done by licensed staff. When observed on 7/12/21, at 1:11 p.m. R31 sat in her recliner chair with her shoes and socks off. R31's great toenail was approximately 1/3 inch overgrown, and the 2nd toe approximately ¼ inch overgrown of the tip of the toes. R31 verified her toenails were overgrown and stated, "it makes me feel angry, it is just stupid." R31 further stated, "We've asked and asked and asked and I have just given up on asking they say I am on the list [podiatrist] and it has been months." When observed on 7/13/21, at 1:42 p.m. R31 sat in her recliner chair with her shoes and socks off. R31's toenails remained uncut. When interviewed on 7/13/21, at 3:23 p.m. licensed practical nurse (LPN)-A verified R31 had "ingrown toenails" on both left and right great toes, and both were, "overgrown." LPN-A described R31's great toenail and second toe nail on the right foot as "thick," and estimated the length of the great toenail to be about 1/4 an inch past the toe and the 2nd toe to be 1/3 of an inch past the toe. LPN-A felt several toes on R31's left foot had been cut and stated, "this left one was already cut so I don't know why it is like this." LPN-A verified the facility had contracted podiatry services. R31 then stated, "I haven't seen anyone since I have been here" but was told she was on the list. LPN-A verified nursing staff	F 677	re-educated on offering podiatry services and weekly nail care. Facility will conduct five audits per week to ensure compliance for four weeks, five audits per month for three months and the quality assurance committee will review at next meeting for further evaluation. Date of correction: 8/5/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 5	F 677		

should be able to cut R31's toenails and stated, "but since she will be seeing a podiatrist, they would just take care of it." LPN-A further verified R31 was diabetic so a licensed staff would have to cut nails and R31 could not do this herself. It was unknown when podiatry services would be provided.

R31's progress note dated 7/14/21, at 12:22 a.m. indicated, "Resident had shower schedule, but she refused after multiple reproaches. Resident let writer did a skin check on her and her skin is intact. however, resident continue to have edema on her lower extremities, and her right big toenails, and second toenails is thick, ingrown, and outgrown. writer trimmed her other toenails except the thick once. writer encourage resident to elevate her legs while sitting in her recliner. Resident said, she wants to see a podiatrist and writer left a VM [voice message] to the NM [nurse manager] about resident's request."

R41's face sheet printed 7/15/21, indicated R41's diagnosis included other drug induced secondary Parkinsonism, chronic pain syndrome, and essential tremor.

R41's admission Minimum Data Set (MDS) dated 4/11/21, indicated R41 had a moderate cognitive impairment, required extensive assistance with personal hygiene activities, and had lower extremity impairment on both sides. R41 utilized a wheelchair for mobility.

R41's vision care area assessment (CAA) dated 4/11/21, indicated R41 had impaired vision including decreased visual acuity and visual field deficit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 6	F 677		

R41's progress note dated 4/7/21, at 3:33 p.m. indicated, "Resident completed the consent for Health Drive, and wishes to be followed by Podiatry and Vision. SW emailed consent to contact at Health Drive."

R41's activity of daily living (ADL) CAA dated 4/22/21, indicated R41 required extensive assistance with grooming.

R41's care plan dated 4/29/21, indicated R41 had an alteration in self-care ability related to Parkinsonism/tremor, anxiety, depression, migraine, personality disorder, and impaired balance and cognition. The care plan further indicated R31 required assist of 1 with nail care and nail care was to be done weekly with bath and as needed. Diabetic nail care to be done by licensed staff.

When interviewed on 7/12/21, at 1:59 p.m. R41 stated her toenails were, "long and they hurt." R41 stated staff examined her feet during showers and "they know about it, but they will not cut them because the nails are too hard, and I have diabetes." R41 stated she was supposed to be on the list for podiatry but had never seen the podiatrist and had been asking for months. R41 stated sometimes her toenails, "hurt" if a shoe or sock were put on, "the wrong way." Both great toenails were approximately 1/3-inch thick and overgrown by about 1/2 inch, curling inward towards the second toe. The toenails on the second toe were overgrown by about 1/3 inch and about ¼ inch thick.

When interviewed on 7/13/21, at 2:02 p.m. R41 stated during morning care, the aid attempted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 7	F 677		

cut her toenails but was unable to do so due to the thickness and stated, "They couldn't cut them and it was hurting me so they stopped."

When observed on 7/14/21, at 9:02 a.m. R41's nails had not been cut. R41 indicated that she asked about podiatry when she first arrived at the facility in April but had not been seen.

When interviewed on 7/15/21, at 12:54 p.m. RN-B assessed R41's toenails as, "thick and overgrown." RN-B stated she was not aware of R41's toenail concerns until last month when R41 missed her first podiatry appointment due to being out of the building at another appointment. RN-B verified R41 was not able to cut her own toenails as, "she is not able to reach them and the thickness." R41 stated she had discomfort when staff applied her socks. RN-B stated R41 was on the podiatry list for August and offered an outside appointment prior to then but R41 declined.

Facility HealthDrive visit report from 3/1/21 through 7/14/21, printed 7/13/21, indicated R41 had her initial podiatry appointment scheduled for 6/4/21, and indicated "unavailable: patient is at an outside Dr. Appt." exam reason "new patient" as of 4/13/21. R31 was not on the podiatry list.

Facility document titled HealthDrive Recall Report specialty: Podiatry printed 7/13/21, indicated upcoming podiatry appointments would be 8/3/21, and 8/5/21. R41 was on the list to be seen. R31 was not on the list to be seen. but

Facility policy titled Nail Care dated 7/17, indicated nail care will be provided weekly on bath days and as needed unless contraindicated, only

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 8 licensed nursing personnel and/or podiatrist may cut/trim diabetic residents' nails.	F 677		
F 812 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 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 and interview, the facility failed to ensure outdated food items were not available for resident consumption. This had the potential to affect 88 of 89 residents who received food from the facility. Findings include: During an observation on 7/12/21, at 12:04 p.m. four Gold's horseradish and beets containers were found in a cooler. The best used by dates of these containers were 9/15/2020.	F 812	Out dated food items identified during survey were immediately removed from cooler and discarded. All at facility had the potential to be affected by the deficient practice. Facility immediately audited all coolers in the kitchen for out dated food items. Facility policy reviewed and remains current. All culinary services staff were re-educated on process for dating and discarding food items.	8/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 9 During an observation on 7/12/21, at 12:20 p.m. three packs of Passover vanilla pudding were found with expiration date 4/2021. Kitchen staff removed the expired pudding and threw it away. During an observation on 7/15/21, at the expired Gold's Horseradish and Beets with expiration date of 9/15/2020 and Kalas herring fillets had not removed from the cooler. Due to the large container of the herring fillets, the expired date was not able to be visualized. When interviewed on 7/12/21, at 12:05 p.m. kitchen manager (KM)-A verified the horseradish and beets were expired. KM-A also stated, "the fish [herring] down there are expired too". KM-A acknowledged staff do not check these items enough and they are used for special occasions. When interviewed on 7/12/21, at 12:21 p.m. Dietary Aide (DA)-A verified the Passover vanilla pudding was expired. When interviewed on 7/15/21, at 11:20 a.m. cook (C)- A stated the expiration dates were checked by the person who stocks. The C-A also stated this person rotated items and made sure everything was dated. When interviewed on 7/15/21, at 12:04 p.m. DA-A stated food was delivered twice a week. Expiration dates were checked and items rotated to the front of the shelf on delivery days. DA-A further stated the Passover food found to be expired was ordered twice a year and was only used during Passover. When interviewed on 7/5/21, at 1:31 p.m. CD	F 812	Facility will conduct five audits per week to ensure compliance for four weeks, five audits per month for three months and the quality assurance committee will review at next meeting for further evaluation. Date of correction: 8/13/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 10 stated the kitchen uses the first in, first out system and there was not a formal bases for checking for expired foods. CD further explained there may be expired food in the coolers and it was the responsibility of everyone who removed food from the cooler to check the dates. CD stated it was her expectation to have food removed when it is outdated and expired foods should not be in coolers for months. A facility policy titled Food Storage dated 2021, indicated all stock must be rotated with each new order received.	F 812		
F 880 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 §483.70(e) and following accepted national standards;	F 880		8/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 §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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to perform hand hygiene after direct contact with residents and high touch environmental surfaces in quarantined residents rooms and subsequently passing meal trays for 3 of 15 residents (R88, R241, and R65) reviewed for dining. Findings include: R88's admission minimum Data Set (MDS) dated 6/28/21, indicated R88's diagnosis included heart failure, and chronic kidney disease, stage 3. R241's MDS dated 3/22/21, indicated R241's diagnosis included coronary artery disease, alcoholic hepatitis without ascites, and cognitive communication deficit. R65's admission MDS dated 6/16/21, indicated R65's diagnosis included lung cancer and other symptoms and signs involving cognitive functions and awareness. When observed on 7/12/21, at 5:48 p.m. nursing assistant (NA)-A delivered a meal tray to R88 and moved a jar of vitamins, a water jug and a Gatorade bottle on bedside table, adjusted the bedside table, removed the plate cover, and exited room. NA-A returned to the dining room and at 5:50 a.m. took another plate from the service line and delivered the meal tray to R241 who was on contact precautions. A PPE (personal protective equipment) cart sat outside	F 880	Please see attached documents for directed plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13	F 880		

the room and contained gowns and gloves. A bottle of surface spray disinfectant and a bottle of hand sanitizer sat on top of the cart. A sign on R241's door included, "This resident is on contact precautions. Observation (single use N95 mask, eye protection, gown + gloves). 14 days from move in, ER visit, hospital/TCU stay for UNVACCINATED residents/tenants. Precautions End: 7-22-21." NA-A did not put on PPE prior to entering R241's room. NA-A moved a white board off the bedside table and placed the meal tray on the recliner chair then, moved remote controls and a water jug from the bedside table and placed the meal tray on the table. NA-A approached and leaned over R41 within one-foot distance and asked if she would like to eat lunch. When 241 could not understand her, NA-A took the white board and white board marker and wrote a message on the white board for R242 which asked if she could get 241 up into the chair. R241 stated she would eat later. At 5:45 p.m. NA-A exited R241's room and returned to the dining room. NA-A took another plate from the dining aid and placed it on top of the meal cart, NA-A reached into the plastic covered meal cart which contained a tray of uncovered cookies, took out a cookie, and placed it on the meal tray. NA-A then went into the refrigerator and took out a carton of milk, placed it on the meal tray, and brought the meal tray to R65. NA-A moved a water jug and remote control on the bedside table, put down the meal tray, and wheeled the bedside table in front of R65. NA-A removed the plate cover, opened the carton of milk, and poured milk into glass for R65, then exited the room. NA-A did not complete hand hygiene throughout this continuous observation.

When interviewed on 7/12/21, at 5:57 p.m. NA-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 verified she had received education on hand hygiene throughout the COVID-19 outbreak. NA-A stated she was not aware she needed to wear PPE into R248's room and stated, "I don't think you need to wear a gown or any other PPE, I don't think so, you just wear your mask, when you finish in room you go wash your hands." NA-A stated she sanitized her hands, "I did spray them in the dining room, didn't you see me?" Facility policy titled Handwashing/Hand Hygiene dated 8/19, directed the use of alcohol based hand rub or soap and water after contact with objects in the immediate vicinity of the residents, before and after entering isolation precaution settings, before and after eating or handling food, before and after assisting a resident with meals. The policy further indicated single-use disposable gloves should be used when in contact with a resident, the equipment, or environment of a resident who is on contact precautions, and hand hygiene was the final step after removing and disposing of PPE. Facility policy titled Employee Sanitary Practices dated 2021, indicated employees will wash hands before handing food, using posted hand-washing procedures.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH** **SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/13/2021. At the time of this survey, Sholom Home West 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/16/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH** **SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. 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. Sholom Home West is a 3-story building with a partial basement that was built in 1989 and determined to be of Type II(222) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 139 beds and had a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH** **SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 census of 90 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 221 SS=F	Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain resident room doors per NFPA 101 (2012 edition), Life Safety Code section 19.3.6.3.5. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/13/2021 between 9:00 AM to 1:00 PM, it was revealed that several of the resident room doors did not close and latch when tested. This deficient condition was verified by the Facility Director at the time of discovery.	K 221	The facility maintenance director and designee completed an audit of all resident sleeping room doors on 7/13/21. All resident sleeping room doors have been tested and repaired if were found to not close or latch as of 08/05/2021. All resident sleeping room doors have demonstrated to fully close and latch. Audits of resident sleeping room doors will be conducted with annual preventative maintenance. Audits will be reported at QA for further evaluation. Date of correction 8/5/21.	8/5/21
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	K 345		8/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH** **SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 3 accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3 and 9.6.1.5, and NFPA 72 (2011 edition), National Fire Alarm and Signaling Code section 14.3.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/13/2021 between 9:00 AM to 1:00 PM, it was revealed that the facility did not complete a semi-annual testing of their fire alarm system. This deficient condition was verified by the Facility Director at the time of discovery.	K 345	The facility maintenance director and/or designee will complete semi-annual testing of the fire alarm system and there was a semi-annual test completed on 06/02/2021. The facility will complete a second semi-annual test of the fire alarm system in November of 2021 and semi-annually moving forward. Audits will be reported at QA for further evaluation. Date of correction 8/5/21.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K 353		8/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH** **SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 4 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, and 9.7.8, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 07/13/2021 between 9:00 AM and 1:00 PM, it was revealed that the facility had (2) sprinkler heads behind the dryers in the laundry room that were showing signs of corrosion. This deficient practice was verified by the Facility Director at the time of discovery.	K 353	The 2 sprinkler heads located behind the dryers in the laundry room that were showing signs of corrosion have since been replaced by Viking Automatic Sprinkler on 07/23/2021. The facility maintenance director and/or designee will complete quarterly maintenance and testing of the automatic sprinkler and standpipe systems in accordance with NFPA 25. The records of system maintenance, inspection, and testing are maintained in a secure location and readily available. Audits will be conducted and reported at QA for further evaluation. Date of correction 8/5/21.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid	K 374		8/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH** **SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 5 bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.6, 19.3.7.8, 19.3.7.9, 8.5.4.1, and 8.2.2.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/13/2021, between 9:00 AM and 1:00 PM, it was revealed that the smoke barrier doors did not close tight when tested at a number of locations throughout the 2nd and 3rd floors. This deficient practice was verified by the Facility Director at the time of discovery.	K 374	All smoke barrier doors on 2nd and 3rd floors have been tested and repaired if were found to not close tightly as of 07/13/2021. As of 08/05/2021 all smoke gaskets have been replaced and all smoke barrier doors close tightly on 2nd and 3rd floors. The facility maintenance director and/or designee will complete routine door audits and preventative maintenance on smoke barrier doors. Audits will be reported to QA for further evaluation. Date of correction 8/5/21.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional	K 914		8/5/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH** **SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 6 testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect electrical receptacles at patient bed locations per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4.1.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/13/2021 between 900 AM to 100 PM, the facility could not provide documentation of testing electrical outlets at patient bed locations. This deficient practice was verified by the Facility Director at the time of discovery.	K 914	The facility maintenance director and designee completed receptacle test on all outlets at patient bed locations on 07/22/2021 and will continue to test receptacles at patient bed locations annually. Records will be maintained of required tests and associated reports or modifications, containing date, room or area tested, and results. Audits will be reported to QA for further evaluation. Date of correction 8/5/21.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		9/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH** **SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 7 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install an essential electrical system per NFPA 99 (2012 edition), Health Care	K 918	On 07/19/2021 the facility had contracted with Ziegler Power Systems and Collins Electrical Construction Co to wire and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH** **SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 8 Facilities Code, section 6.4.1.1.17. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/13/2021, between 9:00 AM and 1:00 PM, the facility did not have an alarm annunciator panel for the generator located at a 24-hour staffed location. This deficient practice was verified by the Facility Director at the time of discovery.	K 918	install an alarm annunciator panel for the generator that is located at a 24-hour staffed location. The facility continues to work towards completion of the installation of the annunciator panel and will demonstrate the working operation of the panel during the re-inspection date. The electrical vendor has indicated the wiring is custom and the order has been placed. The facility maintenance director and/or designee completes essential electric system maintenance and testing. Written records of maintenance and testing are maintained and readily available. A report will be conducted at QA for further evaluation. Date of correction dependent on vendor obtaining necessary supplies for installation. Anticipate within 60 days.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to educate staff on the use and storage of gas equipment per NFPA 99 (2012 edition), Health Care Facilities	K 926	The facility nurse educator in partnership with Northwest Respiratory developed training and competencies for all staff handling and storage of medical gases	9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/13/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH** **SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 926	Continued From page 9 Code, sections 11.5.2.1 through 11.5.2.1.5. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/13/2021, between 9:00 AM and 1:00 PM, it was revealed that the facility had no records on the training of staff on how to use and store medical gas equipment. This deficient condition was verified by the Facility Director at the time of discovery.	K 926	and cylinders. The training included safety guidelines, usage requirements and trained personnel are only allowed to service the equipment. All nursing staff were trained, educated and demonstrated competency. The education will also be incorporated to new hire orientation and annual education moving forward. Competency and education results will be reviewed at QA for further evaluation. Education is scheduled and the anticipated date of correction is 9/10/21.	

Electronically delivered
August 4, 2021

Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: 62U611

Dear Administrator:

The above facility was surveyed on July 12, 2021 through July 15, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/12/21 through 7/15/21, a survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 In addition, complaint investigations were also completed at the time of the licensing survey. The following complaints were found to be SUBSTANTIATED: H5574132C/MN73706 H5574136C/MN56466 H5574140C/MN52965 However NO licensing orders were issued due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5574131C/MN74370 H5574133C/MN52964 H5574134C/MN60518 H5574135C/MN57417 H5574137C/MN66654 H5574138C/MN58719 H5574139C/MN52275 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care and podiatry services were provided for 2 of 4 residents (R31 and R41) who were dependent upon staff assistance for activities of daily living (ADLs). Findings include:	2 920	corrected	8/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 3 R31's face sheet printed 7/15/21, indicated R31's diagnosis included lung cancer, bone cancer, type 2 diabetes, and chronic kidney disease stage 3. R31's admission Minimum Data Set (MDS) dated 4/5/21, indicated R31 was cognitively intact and required one-person physical assistance with personal hygiene activities, and one person physical assist for dressing, utilized a wheelchair for mobility, and was on hospice care. R31's care plan dated 4/20/21, indicated R31 had an alteration in self-care ability related to weakness and deconditioning as evidenced by diagnosis of end stage lung cancer and asthma. The care plan further indicated R31 required assist of 1 with nail care and nail care was to be done weekly with bath and as needed. Diabetic nail care to be done by licensed staff. When observed on 7/12/21, at 1:11 p.m. R31 sat in her recliner chair with her shoes and socks off. R31's great toenail was approximately 1/3 inch overgrown, and the 2nd toe approximately ¼ inch overgrown of the tip of the toes. R31 verified her toenails were overgrown and stated, "it makes me feel angry, it is just stupid." R31 further stated, "We've asked and asked and asked and I have just given up on asking they say I am on the list [podiatrist] and it has been months." When observed on 7/13/21, at 1:42 p.m. R31 sat in her recliner chair with her shoes and socks off. R31's toenails remained uncut. When interviewed on 7/13/21, at 3:23 p.m. licensed practical nurse (LPN)-A verified R31 had "ingrown toenails" on both left and right great	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 4 toes, and both were, "overgrown." LPN-A described R31's great toenail and second toe nail on the right foot as "thick," and estimated the length of the great toenail to be about 1/4 an inch past the toe and the 2nd toe to be 1/3 of an inch past the toe. LPN-A felt several toes on R31's left foot had been cut and stated, "this left one was already cut so I don't know why it is like this." LPN-A verified the facility had contracted podiatry services. R31 then stated, "I haven't seen anyone since I have been here" but was told she was on the list. LPN-A verified nursing staff should be able to cut R31's toenails and stated, "but since she will be seeing a podiatrist, they would just take care of it." LPN-A further verified R31 was diabetic so a licensed staff would have to cut nails and R31 could not do this herself. It was unknown when podiatry services would be provided. R31's progress note dated 7/14/21, at 12:22 a.m. indicated, "Resident had shower schedule, but she refused after multiple reproaches. Resident let writer did a skin check on her and her skin is intact. however, resident continue to have edema on her lower extremities, and her right big toenails, and second toenails is thick, ingrown, and outgrown. writer trimmed her other toenails except the thick once. writer encourage resident to elevate her legs while sitting in her recliner. Resident said, she wants to see a podiatrist and writer left a VM [voice message] to the NM [nurse manager] about resident's request." R41's face sheet printed 7/15/21, indicated R41's diagnosis included other drug induced secondary Parkinsonism, chronic pain syndrome, and essential tremor.	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 5 R41's admission Minimum Data Set (MDS) dated 4/11/21, indicated R41 had a moderate cognitive impairment, required extensive assistance with personal hygiene activities, and had lower extremity impairment on both sides. R41 utilized a wheelchair for mobility. R41's vision care area assessment (CAA) dated 4/11/21, indicated R41 had impaired vision including decreased visual acuity and visual field deficit. R41's progress note dated 4/7/21, at 3:33 p.m. indicated, "Resident completed the consent for Health Drive, and wishes to be followed by Podiatry and Vision. SW emailed consent to contact at Health Drive." R41's activity of daily living (ADL) CAA dated 4/22/21, indicated R41 required extensive assistance with grooming. R41's care plan dated 4/29/21, indicated R41 had an alteration in self-care ability related to Parkinsonism/tremor, anxiety, depression, migraine, personality disorder, and impaired balance and cognition. The care plan further indicated R31 required assist of 1 with nail care and nail care was to be done weekly with bath and as needed. Diabetic nail care to be done by licensed staff. When interviewed on 7/12/21, at 1:59 p.m. R41 stated her toenails were, "long and they hurt." R41 stated staff examined her feet during showers and "they know about it, but they will not cut them because the nails are too hard, and I have diabetes." R41 stated she was supposed to be on the list for podiatry but had never seen the podiatrist and had been asking for months. R41	2 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 6 stated sometimes her toenails, "hurt" if a shoe or sock were put on, "the wrong way." Both great toenails were approximately 1/3-inch thick and overgrown by about 1/2 inch, curling inward towards the second toe. The toenails on the second toe were overgrown by about 1/3 inch and about ¼ inch thick. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their nail care needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure outdated food items were not available for resident consumption. This had the potential to affect 88 of 89 residents who received food from the facility.	21100	corrected	8/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21100	Continued From page 7 Findings include: During an observation on 7/12/21, at 12:04 p.m. four Gold's horseradish and beets containers were found in a cooler. The best used by dates of these containers were 9/15/2020. During an observation on 7/12/21, at 12:20 p.m. three packs of Passover vanilla pudding were found with expiration date 4/2021. Kitchen staff removed the expired pudding and threw it away. During an observation on 7/15/21, at the expired Gold's Horseradish and Beets with expiration date of 9/15/2020 and Kalas herring fillets had not removed from the cooler. Due to the large container of the herring fillets, the expired date was not able to be visualized. When interviewed on 7/12/21, at 12:05 p.m. kitchen manager (KM)-A verified the horseradish and beets were expired. KM-A also stated, "the fish [herring] down there are expired too". KM-A acknowledged staff do not check these items enough and they are used for special occasions. When interviewed on 7/12/21, at 12:21 p.m. Dietary Aide (DA)-A verified the Passover vanilla pudding was expired. When interviewed on 7/15/21, at 11:20 a.m. cook (C)- A stated the expiration dates were checked by the person who stocks. The C-A also stated this person rotated items and made sure everything was dated. When interviewed on 7/15/21, at 12:04 p.m. DA-A stated food was delivered twice a week. Expiration dates were checked and items rotated to the front of the shelf on delivery days. DA-A	21100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21100	Continued From page 8 further stated the Passover food found to be expired was ordered twice a year and was only used during Passover. When interviewed on 7/5/21, at 1:31 p.m. CD stated the kitchen uses the first in, first out system and there was not a formal bases for checking for expired foods. CD further explained there may be expired food in the coolers and it was the responsibility of everyone who removed food from the cooler to check the dates. CD stated it was her expectation to have food removed when it is outdated and expired foods should not be in coolers for months. A facility policy titled Food Storage dated 2021, indicated all stock must be rotated with each new order received. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could review policy's regarding food storage, revise as needed, set up a system to ensure expired food is discarded timely, educate staff and perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and	21375		8/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 9 sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to perform hand hygiene after direct contact with residents and high touch environmental surfaces in quarantined residents rooms and subsequently passing meal trays for 3 of 15 residents (R88, R241, and R65) reviewed for dining. Findings include: R88's admission minimum Data Set (MDS) dated 6/28/21, indicated R88's diagnosis included heart failure, and chronic kidney disease, stage 3. R241's MDS dated 3/22/21, indicated R241's diagnosis included coronary artery disease, alcoholic hepatitis without ascites, and cognitive communication deficit. R65's admission MDS dated 6/16/21, indicated R65's diagnosis included lung cancer and other symptoms and signs involving cognitive functions and awareness. When observed on 7/12/21, at 5:48 p.m. nursing assistant (NA)-A delivered a meal tray to R88 and moved a jar of vitamins, a water jug and a Gatorade bottle on bedside table, adjusted the bedside table, removed the plate cover, and exited room. NA-A returned to the dining room and at 5:50 a.m. took another plate from the service line and delivered the meal tray to R241 who was on contact precautions. A PPE (personal protective equipment) cart sat outside the room and contained gowns and gloves. A	21375	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 10	21375		

bottle of surface spray disinfectant and a bottle of hand sanitizer sat on top of the cart. A sign on R241's door included, "This resident is on contact precautions. Observation (single use N95 mask, eye protection, gown + gloves). 14 days from move in, ER visit, hospital/TCU stay for UNVACCINATED residents/tenants. Precautions End: 7-22-21." NA-A did not put on PPE prior to entering R241's room. NA-A moved a white board off the bedside table and placed the meal tray on the recliner chair then, moved remote controls and a water jug from the bedside table and placed the meal tray on the table. NA-A approached and leaned over R41 within one-foot distance and asked if she would like to eat lunch. When 241 could not understand her, NA-A took the white board and white board marker and wrote a message on the white board for R242 which asked if she could get 241 up into the chair. R241 stated she would eat later. At 5:45 p.m. NA-A exited R241's room and returned to the dining room. NA-A took another plate from the dining aid and placed it on top of the meal cart, NA-A reached into the plastic covered meal cart which contained a tray of uncovered cookies, took out a cookie, and placed it on the meal tray. NA-A then went into the refrigerator and took out a carton of milk, placed it on the meal tray, and brought the meal tray to R65. NA-A moved a water jug and remote control on the bedside table, put down the meal tray, and wheeled the bedside table in front of R65. NA-A removed the plate cover, opened the carton of milk, and poured milk into glass for R65, then exited the room. NA-A did not complete hand hygiene throughout this continuous observation.

When interviewed on 7/12/21, at 5:57 p.m. NA-A verified she had received education on hand hygiene throughout the COVID-19 outbreak.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 11 NA-A stated she was not aware she needed to wear PPE into R248's room and stated, "I don't think you need to wear a gown or any other PPE, I don't think so, you just wear your mask, when you finish in room you go wash your hands." NA-A stated she sanitized her hands, "I did spray them in the dining room, didn't you see me?" Facility policy titled Handwashing/Hand Hygiene dated 8/19, directed the use of alcohol based hand rub or soap and water after contact with objects in the immediate vicinity of the residents, before and after entering isolation precaution settings, before and after eating or handling food, before and after assisting a resident with meals. The policy further indicated single-use disposable gloves should be used when in contact with a resident, the equipment, or environment of a resident who is on contact precautions, and hand hygiene was the final step after removing and disposing of PPE. Facility policy titled Employee Sanitary Practices dated 2021, indicated employees will wash hands before handing food, using posted hand-washing procedures. Suggested Method of Correction: The DON (Director of Nursing) or designee could review/revise facility policies related to hand hygeine, educate staff and perform audits to ensure compliaince. Time Period for Correction: Twenty-one (21) days.	21375		
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights	21860		8/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21860	Continued From page 12 Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain confidentiality of medical information for 1 of 1 (R241) residents observed to have a sign indicating vaccination status on their room's door. Findings include: R241's admission Minimum Data Set (MDS) dated 7/14/21, indicated R241 had severe cognitive impairment. R241's diagnosis included Wernicke's encephalopathy. On 7/12/21 at 5:33 p.m. a sign was observed taped to the outside of 241's room door which informed, "This Resident is on Precautions."	21860	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21860	Continued From page 13 "Observation (single use N95 mask, eye protection, gown + gloves). 14 days from move in, ER visit, hospital/TCU stay for UNVACCINATED resident/tenants." When interviewed on 7/13/21 at 8:33 a.m. registered nurse (RN)-A stated the "Precautions" sign is used for residents who are unvaccinated and under a 14-day observation period. The sign is used to inform staff a resident is not vaccinated. RN-A added no conversation occurred with the resident or the resident's representative regarding having the vaccination status displayed on the door where it can be observed publicly. When interviewed on 7/15/21 at 10:44 a.m. infection preventionist (IP) stated the sign observed on R241's door was not a standard sign and did violate the resident's right to privacy due to the information it contained. The facility policy titled, "Dignity," created 12/2014 included, "It is the policy of Sholom that residents are cared for in a manner and in an environment that promotes maintenance and/or enhancement of each resident's quality of life. Sholom is committed to an atmosphere that humanizes and individualizes each resident and their experiences." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for maintaining confidentiality of records. All staff could be educated as necessary to the importance of complaince with handling and securing medical records. The DON or designee, could perform observational audits to ensure signs containing a resident's protected health	21860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 07/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21860	Continued From page 14 information are not placed in highly visitble locations. The DON or designee could take that information to QAPI to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: (21) days.	21860		