STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245411	A. BUILDING _____ B. WING _____	10/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHIRLEY CHAPMAN SHOLOM HOME EAST	740 KAY AVENUE SAINT PAUL, MN 55102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 10/13/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 10/13/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		11/6/20

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

Electronically Signed | 10/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 1	F 880		

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;

§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

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

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F 880	Continued From page 2 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to properly assess residents for signs and symptoms of COVID-19 in accordance with Centers for Disease Control (CDC) infection control guidelines when they failed to check and document resident vital signs and respiratory status daily for 4 of 6 residents (R1, R2, R3, R4) who were randomly reviewed for COVID-19 infection monitoring. Current CDC guidelines, updated 6/25/20, indicate nursing homes are to actively monitor all residents at least daily for fever	F 880	Facility placed COVID monitoring in the EMAR on 10-14-20 for R1-4 to correct deficient practice. This will ensure nursing staff are complying with infection control guidelines. On 10/15/20, a whole house audit was conducted and all residents had order placed in electronic medical record for COVID monitoring. Every resident upon admission will receive this order in their record.	

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F 880	Continued From page 3 (Temperature=100.0 degrees Fahrenheit) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. Review of the facility's vital signs (VS) book included a Resident Monitoring policy and forms with an AM and PM line listing with six columns to be completed. The columns were labeled "Time, Temp, O2, RR (respiratory rate), HR (heart rate), New/Worse Cough, Diarrhea." Two rows were listed for each day. R1's resident monitoring forms in the VS book dated 9/1/20 - 10/12/20, indicated neither VS nor symptom screening were documented on 5 days. Additionally, VS were documented but not symptom screening an additional 9 days. R1's progress notes (PN) and electronic medical record (EMR) VS section lacked documentation of symptom monitoring or VS for these dates. R1's PN showed R1 remained in the building during this time frame. R2's resident monitoring forms dated 9/1/20 - 10/12/20, indicated neither VS nor symptom screening were documented on 4 days. R2's PN and EMR VS section lacked documentation of symptom monitoring or VS for these dates. R2's PN showed R2 remained in the building during this time frame. The PN indicated R2 was moved to the facility's isolation (COVID) unit from 9/27/20 - 10/5/20. R3's resident monitoring forms dated 9/1/20 - 10/12/20, indicated neither VS nor symptom screening were documented on 8 days. R3's PN and EMR VS section lacked documentation of symptom monitoring or VS for these dates. The	F 880	Nurse Managers will run report weekly to ensure compliance for four weeks, monthly for three months and the quality assurance committee will review at next meeting for further evaluation.	

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F 880	Continued From page 4	F 880		

PN indicated R3 was moved to the facility's COVID unit from 9/27/20 - 10/5/20.

R4's resident monitoring forms dated 9/1/20 - 10/12/20, indicated neither VS nor symptom screening were documented on 12 days. Review of R4's VS in the EMR indicated temperature and pulse documented on 1 of the 12 days and pulse and respiratory rate documented on 1 of the 12 days that were missing from the VS book.

During interview 10/13/20, at 9:43 a.m. license practical nurse (LPN)-B stated for COVID-19 monitoring they were checking (VS) twice daily on every resident. Further, if any change in condition like elevated temperature, cough, diarrhea or shortness of breath occurred, they would update the nurse manager and physician and place the resident on precautions. LPN-B stated when COVID-19 monitoring was completed, it was documented in the VS book on the nurse's desk. LPN-B stated the monitoring was not documented daily in the EMR, rather, at the end of the month, the sheets were uploaded into the EMR documents.

During interview 10/13/20, at 10:57 a.m. licensed practical nurse (LPN)-A stated they look for increased temperature, diarrhea and upset stomach on every resident every day. If a resident had a high temperature, they would receive a COVID test. LPN-A further stated there was a VS book (paper log) that was used to document the VS and other COVID symptoms. The VS and assessment should be done on every day, but it was not done consistently, especially on weekends. The nursing assistants typically take the VS and document in the VS book. Then they take the book to the nurse for

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F 880	Continued From page 5	F 880		

review.

During interview 10/13/20, at 11:03 a.m. RN-A stated residents should be assessed for signs and symptoms of COVID-19 twice a day and that it should be documented in the VS book. RN-A further stated it was the nurse's responsibility to check the VS book to ensure completion.

During interview 10/13/20, at 11:50 a.m. licensed practical nurse (LPN)-C stated the expectation is for the COVID-19 screening to be completed twice daily and documented in the VS book for verification and tracking. LPN-C was unable to verify if the monitoring had been completed on the days which showed gaps in documentation.

During interview 10/13/20, at 12:10 p.m. NA-A stated they were supposed to do VS in the morning and in the evening. VS included respiratory rate, pulse, temperature, and oxygen saturation. NA-A further stated whoever took the VS was supposed to enter them into the vitals book and that VS might not get done if they are short staffed that day.

During interviewed 10/13/20, at 12:55 p.m. RN-B stated surveillance for residents included VS and oximetry two times a day. RN-B further stated the nurses also asked every resident generally how they were doing that day. Vitals were documented on a sheet and scanned into the electronic chart monthly. "The expectation is that it is done twice a day, morning and evening. It is probably the manager's job to look and make sure it is done."

During interviewed 10/13/20, at 2:23 p.m. director of nursing (DON) stated the expectation was that

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F 880	Continued From page 6 COVID-19 screening was done two times a day on all residents. DON further stated this screening was documented on paper in the vitals book and it was the nurse's responsibility to look at the documented screening and assess for trends. Review of the facility policy Resident Monitoring dated 4/2/20, indicated all residents would be monitored for changes in temperature, pulse, oxygen saturations (sats), cough, diarrhea and respiratory rates. The policy further indicated staff would obtain resident temperature, O2 sats, respiratory rate, cough, and evidence of diarrhea twice daily for all residents and that these findings would be documented in the EMR	F 880		

Electronically delivered

October 26, 2020

Administrator
Shirley Chapman Sholom Home East
740 Kay Avenue
Saint Paul, MN 55102

RE: CCN: 245411
Cycle Start Date: October 6, 2020

Dear Administrator:

On October 23, 2020, we informed you that we may impose enforcement remedies.

On October 13, 2020, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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:

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 6, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 6, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 6, 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.

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 January 6, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Shirley Chapman Sholom Home East will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 6, 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:

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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 April 6, 2021 (six months after the identification of noncompliance) 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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245411	SHIRLEY CHAPMAN SHOLOM HOME E

Type of Survey (select all that apply):

M					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 42579	10-13-2020	10-13-2020	0.50	0.00	5.50	0.00	0.00	5.00
2. 42584	10-13-2020	10-13-2020	1.00	0.00	6.50	0.00	0.50	2.50
3. 43074	10-13-2020	10-13-2020	0.00	0.00	8.00	0.00	0.00	0.00
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 1.50

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N