### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: KVMG

### ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

	PAR	Γ I - TO BE COM	PLETED BY	THE STAT	E SURVEY AGENCY	Fac	cility ID: 00496
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245411	).	3. NAME AND AD (L3) SHIRLEY C			E EAST	4. TYPE OF ACTION:	7 (L8)
2.STATE VENDOR OR MEDICAID NO.		(L4) 740 KAY AV	ENUE			1. Initial 3. Termination	2. Recertification 4. CHOW
(L2) <b>529242500</b>		(L5) SAINT PAUI	L, MN		(L6) <b>55102</b>	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR	RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Com	
6. DATE OF SURVEY 11/04/2	2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		FISCAL YEAR ENDING D	DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	S:			
From (a):		X A. In Compliar	nce With		And/Or Approved Waivers Of Th	ne Following Requirements:	
To (b):		Program Re	equirements		2. Technical Personnel	6. Scope of Service	s Limit
		Compliance			3. 24 Hour RN	7. Medical Director	t.
12.Total Facility Beds	<b>108</b> (L18)	1. A	Acceptable POC		4. 7-Day RN (Rural SNF		ie
		D. Natin Cam	-1:id- D		5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	<b>108</b> (L17)		pliance with Progra ents and/or Applied		* Code: <b>A*</b>	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
108							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARKS	G (IF APPLICABLE	SHOW LTC CANCELL	LATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AI	PPROVAL	Date:
Jonathan Hill, I	HFE NE II		11/04/2015	(L19)	Kate JohnsTon, Pr	rogram Specialist	11/13/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	` ′	OFFICE OR SINGLE STAT	ΓE AGENCY	(L20)
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH	CIVIL	21. 1. Statement of Finance		
_X 1. Facility is Eligible to Parti	cipate	RIGI	HTS ACT:		Ownership/Control    Both of the Above :	Interest Disclosure Stmt (HCFA-	1513)
2. Facility is not Eligible	(L21)						
	(L21)				I		
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L3	30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	ГЕ	<u>VOLUNTARY</u> 0	<u>INVOLUNTA</u>	RY
02/01/1987					01-Merger, Closure	05-Fail to Mee	t Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	ent 06-Fail to Mee	t Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of Involuntary Termination	<u>OTHER</u>	
	A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider St	atus Change
			(L44)			00-Active	
(L27)	B. Rescind Su	spension Date:					
			(L45)				
28. TERMINATION DATE:	29	9. INTERMEDIARY/C	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION (	OF APPROVAL DA	ATE	Posted 11/16/2015 Co.		
	or ac:	10/12/2015		or a			
	(L32)			(L33)	DETERMINATION APPRO	OVAL	



### Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245411 November 13, 2015

Ms.. Ann Thole, Administrator Shirley Chapman Sholom Home East 740 Kay Avenue Saint Paul, Minnesota 55102

Dear Ms.. Thole:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 18, 2015 the above facility is certified for or recommended for:

108 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 108 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered November 13, 2015

Ms. Ann Thole, Administrator Shirley Chapman Sholom Home East 740 Kay Avenue Saint Paul, Minnesota 55102

RE: Project Number S5411025

Dear Ms. Thole:

On September 17, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 3, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 4, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 19, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 3, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 18, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 3, 2015, effective October 18, 2015 and therefore remedies outlined in our letter to you dated September 17, 2015, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245411	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/4/2015
Name	of Facility		Street Address, City, State, Zip Code	
SH	IIRLEY CHAPMAN SHOLOM HOME EAS	Т	740 KAY AVENUE SAINT PAUL, MN 55102	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y	5) Date	(Y4) Item	(Y	(5) Date	(Y4)	Item	(Y5)	) D:	ate
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix	F0282	10/18/2015	ID Prefix	F0312	10/18/2015		ID Prefix	F0314		10/18/2015
-	483.20(k)(3)(ii)	_		483.25(a)(3)				483.25(c)		
LSC		_	LSC		_		LSC			
		Composition			Competion					Compation
		Correction Completed			Correction Completed					Correction Completed
ID Prefix	F0356	10/18/2015	ID Prefix	F0441	10/18/2015		ID Prefix			Completed
Rea.#	483.30(e)		Rea.#	483.65			Reg. #			
LSC		 _	LSC		_		-			
		Correction			Correction					Correction
		Completed			Completed					Correction
ID Prefix			ID Prefix				ID Prefix			Completed
Reg. #			Reg. #				Reg. #			
		— —	_		<u> </u>					
		Correction			Correction					Correction
ID Prefix		Completed	ID Profiv		Completed		ID Profix			Completed
		_								
Reg. #		<u></u>	Reg. #				Reg. #			
		_	LSC			+-				
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix		_		ID Prefix			
Reg. #			Reg. #				Reg. #			
LSC		_	LSC		_		LSC			
Reviewed By	Reviewed	d By	Date:	Signature of Su	rveyor:			Da	ate:	
State Agency	,	SR/KJ	11/13/20	15	25	480			11/0	04/2015
Reviewed By	Reviewed	і Ву	Date:	Signature of Su	rveyor:			Da	ate:	
CMS RO										
Followup to	Survey Completed on:				ny Uncorrected			-		
	9/3/2015			Uncorre	cted Deficiencie	s (CMS	3-2567) Sent	to the Facility?	/ES	NO

Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245411	(Y2) Multiple Constru A. Building B. Wing	ELEY CHAPMEN SHOLOM HOME EAST	(Y3) Date of Revisit 10/21/2015
Name of Facility		Street Address, City, State, Zip Code	
SHIRLEY CHAPMAN SHOLOM HOME EAS	Т	740 KAY AVENUE SAINT PAUL. MN 55102	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4	l) Item	(	(Y5) I	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			10/18/2015		ID Prefix			09/25/2015		ID Prefix			_
Reg. #	NFPA 101				Reg. #	NFPA 101				Reg. #			_
LSC	K0025				LSC	K0050				LSC			_
			Correction					Correction					Correction
ID Drofiv			Completed		ID Drofiv			Completed		ID Drofiv			Completed
ID Prefix					ID Prefix			=					_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			
			0					0					0
			Completed					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg.#			-		Reg. #			_
LSC					LSC								_
				_					+				_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			·		ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			<del>-</del> -
			Correction					Correction					Correction
ID Drofiv			Completed		ID Drofiv			Completed		ID Drofiv			Completed
													_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
Reviewed By	Review	ed B	у	Da	te:	Signature of	f Surve	yor:				Date:	
State Agency	,	GS	S/KJ	11,	/13/201				258	22		10/2	21/2015
Reviewed By	Review	red B	Sy	Da	te:	Signature of	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed on:					Check f	or anv	Uncorrected I	Defi	ciencies. Was	a Summary of	1	
	9/1/2015						-				to the Facility?	YES	NO
				1									



Protecting, Maintaining and Improving the Health of Minnesotans

November 13, 2015

Ms. Ann Thole, Shirley Chapman Sholom Home East 740 Kay Avenue Saint Paul, Minnesota 55102

Re: Enclosed Re-inspection Results - Project Number S5411025

Dear Ms. Thole:

On November 4, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a re-inspection of your facility, to determine correction of orders found on the survey completed on September 3, 2015. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kate JohnsTon, Program Specialist

Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

#### 

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
			_		Correction Completed 10/18/2015			20920 MN Rule 4658.0525 Subj	_
ID Prefix Reg. #		Correction Completed 10/18/2015	ID Prefix Reg. #		Correction Completed 10/18/2015 od.:		ID Prefix Reg. # LSC		
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		ID Prefix Reg. # LSC		Correction Completed
Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed		Reg. #		Correction Completed
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed		ID Prefix Reg. #		Correction Completed
Reviewed By State Agency Reviewed By		SR/KJ	Date: 11/13/20 Date:	Signature of Survey  15  Signature of Survey		25	480	Date:	04/2015
	Survey Completed on: 9/3/2015	/(00)		Check for any Uncorrected				a Summary of to the Facility? YES	NO

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: KVMG

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		PARI	1 - TO BE COM	PLETED BY I	HE STAT	E SURVEY AGENCY	Faci	lity ID: 00496
MEDICARE/MEDICAID PRO     (L1)			3. NAME AND ADD (L3) SHIRLEY CI (L4) 740 KAY AVI (L5) SAINT PAUI	HAPMAN SHOL ENUE		E EAST (L6) 55102		2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGI	E OF OWNERSHIP		7. PROVIDER/SUF		Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit  8. Full Survey After Compl	9. Other
	09/03/2015  1 TJC 3 Other	(L34) _ (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DA	TE: (L35)
11. LTC PERIOD OF CERTIFICATION (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds	108 108		B. Not in Com	equirements	1	And/Or Approved Waivers Of The  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SNF)  5. Life Safety Code  * Code: A1*	6. Scope of Services 7. Medical Director	
14. LTC CERTIFIED BED BREA 18 SNF 18.	AKDOWN /19 SNF 108	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37)  16. STATE SURVEY AGENCY	(L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGNATURE	NEWI INIO (II 711 I	LICITELL	Date :			18. STATE SURVEY AGENCY AP	PPROVAI	Date:
	ı Fatty, HF	E NE I		09/30/2015	(L19)	Kate JohnsTon, Pr		10/11/2015
	PAR	T II - TO	BE COMPLETE	D BY HCFA RI	. ,	OFFICE OR SINGLE STAT	TE AGENCY	(L20)
19. DETERMINATION OF ELIC  1. Facility is Elig  2. Facility is not	ible to Participate	(L21)		IPLIANCE WITH C	EIVIL	21. 1. Statement of Financ 2. Ownership/Control 3. Both of the Above :	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-15	513)
22. ORIGINAL DATE  OF PARTICIPATION  02/01/1987  (L24)	В	C AGREEM EGINNING  .41)		24. LTC AGREEME ENDING DATE (L25)		26. TERMINATION ACTION:  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimburseme	05-Fail to Meet l	Y Health/Safety
25. LTC EXTENSION DATE:	27. AL A.	TERNATIV Suspension	E SANCTIONS of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Stat 00-Active	tus Change
				(L45)				
28. TERMINATION DATE:		29	0. INTERMEDIARY/C 03001	ARRIER NO.		30. REMARKS		
	(L28	3)	03001		(L31)			
31. RO RECEIPT OF CMS-1539		32	2. DETERMINATION (	OF APPROVAL DA	ГЕ	Posted 10/12/2015 Co	).	
	(L32	)			(L33)	DETERMINATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 17, 2015

Ms. Ann Thole, Administrator Shirley Chapman Sholom Home East 740 Kay Avenue Saint Paul, Minnesota 55102

RE: Project Number S5411025

Dear Ms. Thole:

On September 3, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

### <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

### **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:

Susanne Reuss, Unit Supervisor Minnesota Department of Health Licensing and Certification Program Health Regulation Division P.O. Box 64900 85 East Seventh Place, Suite 220 St. Paul, Minnesota 55164-0900

**Telephone:** (651) 201-3793

Fax: 651-215-9697

### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 18, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

### ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Shirley Chapman Sholom Home East September 17, 2015 Page 4

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.

### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

### FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 3, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 March 3, 2016 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Shirley Chapman Sholom Home East September 17, 2015 Page 5

### INFORMAL DISPUTE RESOLUTION

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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:

Mr. Gary Schroeder, Interim Supervisor Health Care Fire Inspections State Fire Marshal Division Email: gary.schroeder@state.mn.us

**Telephone:** (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 10/12/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	IPLE CONSTRUCTION (	X3) DATE SURVEY COMPLETED
		245411	B. WING _		09/03/2015
	PROVIDER OR SUPPLIER  CHAPMAN SHOLON	I HOME EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE SAINT PAUL, MN 55102	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	as your allegation of Department's accept	of correction (POC) will serve f compliance upon the otance. Because you are	F 00	00	
	at the bottom of the	our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.			
F 282 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	F 28	32	10/18/15
	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of			
	by: Based on observat review, the facility of for incontinence cal	ion, interview and document lid not follow the plan of care re and prevention of pressure ident (R47) observed for and repositioning.		F282 Services provided or arranged by the facility are provided by qualified pers accordance with the resident's writte plan of care.	sons in
	Findings include:  R47's plan of care vin elimination.	was not followed for alteration		Resident #R47 mobility care plan an NAR assignment sheet has been reviewed and is current.	d
	R47's plan of care f	or alteration in elimination, 5, indicated the following		Other residents with a Braden score indicating a high risk for skin breakd will have their care plans and NAR	
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

**Electronically Signed** 

09/25/2015

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.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245411	B. WING _		09/	03/2015
	PROVIDER OR SUPPLIER  CHAPMAN SHOLON	M HOME EAST		STREET ADDRESS, CITY, STATE, ZIP CO 740 KAY AVENUE SAINT PAUL, MN 55102	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312 SS=D	"Resident is inconti Resident is checke [when needed] and needed with total care plan approach resident for incontine after each incontine R47's plan of care skin breakdown d/t bladder incontinent skills. The care plan check for incontine Review of the care AM/PM Group 2 unand reposition ever change.  Continuous observatransferred into a Bremained in the chaintervened at noon, the Broda chair and hours later). R47's and pericare was conted on R47's skir Interview with licens and nursing assistated R47 was to be check repositioned every completed since be 483.25(a)(3) ADL CDEPENDENT RES	nent of bowel and bladder d q [every] 2 hours and PRN cleaned and changed as are of two staff members." The les directed staff to check hence every two hours and as and change with good pericare lence episode.  identified resident as at risk for (due to) daily bowel and les and decreased mobility in approaches directed staff to ince q two hours and PRN.  specialist assignment sheet ledated, directed staff to turn by two hours, and check and attion on 9/3/15, R47 was leroda chair at 9:10 a.m., and lair until the surveyor attion bed at 12:10 p.m. (three incontinent product was wet, ompleted. No redness was in.  sed practical nurse (LPN)-A, ant (NA)-A, at noon, indicated leked and changed and two hours and had not been lefore breakfast.  CARE PROVIDED FOR	F 28	assignment sheets reviewed as needed.  Policy and procedure for folloplan of care has been review current.  Nursing staff will be re-educated following the plan of care by the second state of the second sta	ted on the Oct. 9, 2015.  Idits will be imes a week then weekly or rauditing	10/18/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE S COMPL	
		245411	B. WING		09/03	3/2015
	PROVIDER OR SUPPLIER  CHAPMAN SHOLO	M HOME EAST	7	STREET ADDRESS, CITY, STATE, ZIP CODE 240 KAY AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	maintain good nutr and oral hygiene.	age 2 s the necessary services to ition, grooming, and personal  NT is not met as evidenced	F 312			
	by: Based on observareview, the facility services regarding	tion, interview, and document failed to provide necessary timely incontinence care for 1 observed for incontinence		F312 Residents who are unable to carry of activities of daily living do receive the necessary services to maintain good nutrition, grooming, and personal hy	ne od	
	1/12/15, indicated staff for her activition mobility. A mechan and R47 was incor	ssessment (CAA), dated R47 was totally dependent on es of daily living (ADLs) and ical lift was used to transfer national bladder. vocalize of indicate in any way d.		Resident #47 incontinence care pla NAR assignment sheet has been reviewed and is current.  Other residents who are dependent incontinence care, toileting and are risk for skin breakdown will have the care plans and NAR assignment sh reviewed and updated as needed.	t in at high eir	
	indicated R47 had transfers, and cogridementia and Alzh R47's care plan, edfollowing "Alteratio CONTINENCE: Reand bladderResident hours and PRN [as changed as needed members."	dited on 7/1/15, indicated the		Policy and Procedure for toileting an incontinence care per the plan of cabeen reviewed and is current.  Nursing staff will be re-educated on toileting and incontinence care per plan of care by Oct.9, 2015.  Repositioning and toileting audits we completed on 3 residents, 3 times a on varying shifts for 4 weeks and the weekly x 2 months. Nurse Manager designees are responsible for audit and follow-up.	are has the till be a week tien tris or	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245411	B. WING		09/0	03/2015
	PROVIDER OR SUPPLIER  CHAPMAN SHOLON	I HOME EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314 SS=D	brought back to her surveyor intervence of the Broda chair a incontinent of urine nursing assistant (N Interview with NA-A (LPN)-A at noon on was to be checked and verified R47 ha incontinence since 483.25(c) TREATM PREVENT/HEAL P Based on the compresident, the facility who enters the facil does not develop prindividual's clinical of	fed breakfast, and then room. At 12:10 p.m. the I, and R47 was transferred out and into bed. R47 was pericares were completed by IA)-A.  and licensed practical nurse 9/3/15, they indicated R47 and changed every two hours, d not been checked for before breakfast.  ENT/SVCS TO	F 312	Results of audits will be reports to t committee and action plans develo needed.  Completion date for compliance is 2015	ped as	10/18/15
	pressure sores receservices to promote prevent new sores.  This REQUIREMENT by: Based on observative review, the facility for residents (R47) in the pressure ulcer development of the pressure ulcers.  Findings include:	eives necessary treatment and e healing, prevent infection and		F314 The facility does ensure that each resident who enters the facility with pressure sore does not develop presores unless the individual clinical condition demonstrates that they wunavoidable.  Resident #R47 assessments, repositioning and incontinence care	essure ere	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
		245411	B. WING		09/0	03/2015
NAME OF I	PROVIDER OR SUPPLIEF	l .	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	•	
SHIRI EV	CHAPMAN SHOLO	M HOME FAST		740 KAY AVENUE		
SHINLL	CHAPINIAN SHOLO	WITHOWIE EAST		SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 314	1/12/15, indicated staff for her activiti mobility, and that a transfer her because addition, the CAA of bowel and blade and her immobility increased risk for junless staff reposion R47's Skin Risk As Scale)-a tool used dated 6/23/15, indincluded: cardioval incontinence, and risk assessment in manually, incontine required total assist Braden scale date very limited with reskin was often movery limited in contine was adequate, and a problem. The Braden scale date very limited in contine and turning and research in the assessment	R47 was totally dependent on les of daily living (ADLs) and a mechanical lift was used to see she was chair bound. In indicated R47 was incontinent der, and that because of that in a chair and bed, she was at pressure ulcer development tioned her routinely.  Is sessment with (Braden to predict skin breakdown) icated R47's clinical risk factors scular disease, chronic cognitive impairment. The skin indicated R47 was lifted ent of bowel and bladder, and stance with bed mobility. R47's d6/26/15, indicated R47 was esponding to stimuli, that her ist, the resident was chairfast, trolling body position, nutrition d that friction and shearing was aden score was 12, which put for pressure sore development. Indicated the skin treatments to eving device for chair and bed, positioning program.	F3	and NAR assignment shereviewed and is current.  Other residents with a Braindicating high risk for skir have their care plans and assignment sheets review as needed.  Repositioning and toileting completed on 3 residents, on varying shifts for 4 week x2 months. Nurse Manage are responsible for auditing Policy and Procedure for prisk, toileting and incontine the plan of care has been current.  Nursing staff will be re-edutoileting and incontinence plan of care by Oct.9, 201  Repositioning and toileting completed on 3 residents, weeks on varying shifts fo weekly x 2 months. Nurse designees are responsible and follow-up.	den score n breakdown will NAR ed and updated g audits will be 3 times a week ks then weekly ers or designees g and follow-up. pressure sore ence care per reviewed and is ucated on care per the 5. g audits will be 3 times a r 4 weeks then Managers or	
	SKIN BREAKDOV bladder incontinent stoolsand decreased	nt is identified as at risk for VN d/t [due to] daily bowel and uce with frequent loose ased mobility skills. Skin risk ssue tolerance done quarterly		Results of audits will be re QA committee and action as needed.  Completion date for comp 2015	plans developed	
		ated care specialist assignment of for nursing assistant staff to				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245411	B. WING _		09.	/03/2015	
	PROVIDER OR SUPPLIER  CHAPMAN SHOLON	M HOME EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE SAINT PAUL, MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATI	ULD BE	(X5) COMPLETION DATE	
F 356 SS=C	to turn and reposition of two with the Hoy  During continuous was transferred into taken to breakfast, brought back to he surveyor intervened of the Broda chair a observation, R47 with the perineal area with assistant (NA)-A. Note that the perineal area with a supposed to be reported as a supposed to be repor	A7 required assist of two staff on every two hours, and assist er lift to transfer.  observations on 9/3/15, R47 of the Broda chair at 9:10 a.m., fed breakfast, and then recom. At 12:10 p.m. the d, and R47 was transferred out and into bed. During the ras incontinent of urine, when ras cleansed by nursing to reddened areas were noted onducted with NA-A and thourse (LPN)-A at noon on PN-A verified R47 was repositioned, and checked and hours. They also confirmed repositioned since before  O NURSE STAFFING  ost the following information on and the actual hours worked regories of licensed and staff directly responsible for hift: reses.	F 3:			10/18/15	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245411	B. WING		09/03/2015
	PROVIDER OR SUPPLIER  CHAPMAN SHOLO	M HOME EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE SAINT PAUL, MN 55102	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTIC
F 356	specified above on of each shift. Data o Clear and readal o In a prominent pl residents and visite.  The facility must, u make nurse staffin for review at a cost standard.  The facility must m staffing data for a required by State la This REQUIREME by: Based on observareview, the facility staff posting reflect both licensed and thad the potential to members and all 9 facility.  Findings include:  On 8/31/15, at app staff posting was owheelchair level in elevators near the was dated 8/31/15 information of the chours worked for relicensed practical religions.	ost the nurse staffing data a daily basis at the beginning must be posted as follows: ole format. ace readily accessible to	F 356	F356 The daily nurse staffing posting has revised to include actual shift hours worked for each category of nursing as well as total hours worked each Audits will be conducted weekly for weeks then monthly x 3 months to compliance. Results of audits will b reported to the QA committee and a plans developed as needed. Completion date for compliance is 6 2015	g staff shift. 4 ensure e action

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		245411	B. WING		09/03/2015		
	PROVIDER OR SUPPLIER  CHAPMAN SHOLON	M HOME EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 356	of staff working for Evening and Night actual hours worked. On 9/1/15, 9/2/15, a 10:30 a.m. and 12: postings were obseworked, including the shifts.  During an interview on 9/3/15, at 11:16 confirmed the nurse one always used. Ir staff worked shorte hours worked by nulacking and stated staff.	ours worked and the number the nursing staff on Day, shifts, the form lacked the d by the above categories.  and 9/3/15, at approximately 18 p.m. the nurse staff erved to have no actual hours ne start and end times of  with the staffing coordinator a.m. the staffing coordinator e staff posting format was the n addition, she stated some r shifts. She verified the actual ursing staff at the facility was she would inform the director or that could be corrected	F 3	356			
F 441 SS=D	dated 9/3/15, include 6:30 to 2:30 p.m. for and NAs) and regulday shift. It also incepool employees as staff, 2:30 p.m. for NA a staff. It did not addreategory.  483.65 INFECTION SPREAD, LINENS  The facility must estinfection Control Presafe, sanitary and of the state of the st	department staffing guidelines ded the day shift start time of or internal pool staff (licensed lar staff picking up an extra luded start times for internal 6:30 a.m. for licensed and NA NA, 2:45 p.m. for licensed, and 11:00 p.m. for licensed ess all actual hours worked by I CONTROL, PREVENT	F 4	.41		10/18/15	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		245411	B. WING		09/03/2015
	PROVIDER OR SUPPLIER  CHAPMAN SHOLO	M HOME EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE SAINT PAUL, MN 55102	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIES OF THE APPROPRIES OF T	D BE COMPLÉTION
F 441	Program under wh (1) Investigates, co in the facility; (2) Decides what p should be applied (3) Maintains a recactions related to in (b) Preventing Sprogram (1) When the Infect determines that a prevent the spreadisolate the resident (2) The facility must communicable discrement to contact direct contact will the (3) The facility must hands after each of the hand washing is in professional practic (c) Linens Personnel must hat transport linens so infection.	ection.  of Program stablish an Infection Control ich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and ord of incidents and corrective infections.  ead of Infection tion Control Program resident needs isolation to a for infection, the facility must the stage or infected skin lesions with residents or their food, if the ransmit the disease.  It require staff to wash their irect resident contact for which dicated by accepted	F 44		
	by: Based on observareview, the facility infection control pr	ation interview and document failed to implement proper actices for 1 of 1 resident oserved to have a received an		F441 The facility maintains an infection program designed to provide a sa sanitary and comfortable environn	fe,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245411	B. WING		<del></del>	09/0	03/2015
	PROVIDER OR SUPPLIER  CHAPMAN SHOLON	I HOME EAST		7	TREET ADDRESS, CITY, STATE, ZIP CODE 40 KAY AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	(LPN)-B was obserfor injection. LPN-B correct dose of insuabdomen with an ato dry and then admidid not wear gloves LPN-B washed her administration. Inte she indicated she digiving insulin.  Review of the facilit administration proceute following:  1. Review physicial correct amount of modern administration with administration proceute following:  1. Review physicial correct amount of modern administration with administration proceute following:  1. Review physicial correct amount of modern administration with administration proceute following:  1. Review physicial correct amount of modern administration with administration proceute following:  1. Review physicial correct amount of modern administration proceute following:  1. Review physicial correct amount of modern administration proceute following:  1. Review physicial correct amount of modern administration proceute following:  1. Review physicial correct amount of modern administration proceute following:  1. Review physicial correct amount of modern administration proceute following:  1. Review physicial correct amount of modern administration proceute following:  1. Review physicial correct amount of modern administration proceute following:  1. Review physicial correct amount of modern administration proceute following:  1. Review physicial correct amount of modern administration proceute following:  1. Review physicial correct amount of modern administration proceute following:  2. Wash hands thought administration proceute following:  1. Review physicial proceute following:  2. Wash hands thought administration proceute following:  3. Review physicial proceute following:  4. Review physicial proceute following:  4. Review physicial proceute following:  5. Review physicial proceute following:  6. Review physicial proceute following:  8. Review physicial proceute following:  9. Review physici	p.m. licensed practical nurse ved to prepare R272 insulin entered R272's room with the Ilin. LPN-B cleansed R272's cohol wipe, allowed the area ninistered the insulin. LPN-B to administer the insulin. hands before and after the rview with LPN-B at 5:12 p.m. id not wear gloves when  y's subcutaneous medication edure dated 10/22/13 directed on order and calculate the nedication. Iroughly and put on gloves. The same wash hands.	F 4	41	to help prevent the development ar transmission of disease and infction. The policy and procedure for subcutaneous injections has been reviewed and is current.  Nurses will be re-educated on policing procedure for subcutaneous injections. Oct.9, 2015.  Random audits of insulin injections completed by Nurse Managers or designee weekly x 4 weeks then mix 3 months to ensure compliance. The results will be reviewed by QA command action plans developed as need. Completion date for compliance is Oct.18,2015.	ey and ons by will be conthly Audit mittee	

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - SHIRLEY CHAPMEN SHOLOM HOME **EAST** B. WING 09/01/2015 245411 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 740 KAY AVENUE SHIRLEY CHAPMAN SHOLOM HOME EAST SAINT PAUL, MN 55102 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 K 000 INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety state Fire Marshal Division. At the time of this survey, SHIRLEY CHAPMAN SHOLOM HOME EAST was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

09/25/2015

(X6) DATE

**Electronically Signed** 

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.

Facility ID: 00496

	(I EMENT OF BELLOCETORE (VII) CONTRACTOR (VIII)			PLE CONSTRUCTION G 02 - SHIRLEY CHAPMEN SHOLOM HOME		E SURVEY PLETED	
		245411	B. WING			09/01/2015	
NAME OF PROVIDER OR SUPPLIER SHIRLEY CHAPMAN SHOLOM HOME EAST				74	IREET ADDRESS, CITY, STATE, ZIP CODE 10 KAY AVENUE AINT PAUL, MN 55102		
 (X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	,	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Or by email to: Marian.Whitney@s Angela.Kappenmar THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO  1. A description of v to correct the deficit  2. The actual, or pro-	tate.mn.us and n@state.mn.us  RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:  what has been, or will be, done dency.  oposed, completion date.	K	000			
	prevent a reoccurred SHIRLEY CHAPMA a 4-story building was constructed determined to be of the building is fully. The facility has a fir detection in the cornicors and all restor automatic fire defection.	rection and monitoring to ence of the deficiency.  AN SHOLOM HOME EAST is with a full basement. The ructed in 2008, and was f Type II(222) construction. If the sprinklered throughout. The alarm system with smoke ridors, spaces open to the sident rooms that is monitored epartment notification. The ity of 98 beds and had a					
K 025 SS=D	NOT MET as evide NFPA 101 LIFE SA Smoke barriers are least a one-hour fire accordance with 8.3 terminate at an atrice	42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD constructed to provide at e resistance rating in 3. Smoke barriers may um wall. Windows are ted glazing or by wired glass	K	)25			10/18/15

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SHIRLEY CHAPMEN SHOLOM HOME EAST		(X3) DATE SURVEY COMPLETED	
		245411	B. WING		09/0	01/2015
	PROVIDER OR SUPPLIER Y CHAPMAN SHOLON	I HOME EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 025	panels in approved separate compartn floor. Dampers are penetrations of smo	frames. A minimum of two nents are provided on each not required in duct oke barriers in fully ducted and air conditioning systems.	K 02	5		
	Based on observation maintain the smoke the requirements of Sections 19.3.7, 19. This deficient pract staff and visitors with Findings include:  On facility tour betwo 09/01/2015, it was expected to the section of th	s not met as evidenced by: tion, the facility failed to barrier in accordance with f NFPA 101 - 2000 edition, .3.7.3, 8.3, 8.3.2 and 8.3.6. tice could affect all residents, thin the smoke compartments.  I yeen 9:30 AM and 2:30 PM on observed that the 3rd floor is by Electrical Room C-321 tien tested.		K-025 There is a set of smoke barrier doc located on the 3rd floor by electrica C-321 that did not fully close when The doors will be repaired so as to properly close. The ESD will monitopractices and proper procedures a followed to preserve the integrity of rated partitions. This repair will be completed by October 18, 2015	al room tested. or all re	
K 050 SS=C	of Physical Plant (D NFPA 101 LIFE SA Fire drills are held a varying conditions, The staff is familiar that drills are part o Responsibility for p assigned only to co qualified to exercise	s verified by the facility Director (PB) at the time of discovery. FETY CODE STANDARD at unexpected times under at least quarterly on each shift, with procedures and is aware of established routine. It is an	K 05			9/25/15

Event ID: KVMG21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN EAST	(X3) DATE SURVEY COMPLETED		
		245411	B. WING _		09/01	/2015
	PROVIDER OR SUPPLIER Y CHAPMAN SHOLOI	M HOME EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE C	(X5) COMPLETION DATE
K 050	·	y be used instead of audible	K 05	50		
	Based on review of interview, it was de to conduct fire drills LSC (00) Section 1 could affect how st.  Findings include:  On facility tour betw 09/01/2015, based documentation it w not varied throughouring the last 12 m Of the 4 drills cond 11:00 PM and 11:44.  This deficiency was	ucted all were done between		K-050 Fire drills need to be conducted at times. The schedule for fire drills heen re-developed to ensure that foccur at unexpected times under vocaditions. The fire drill schedule meets the requirements of the life code as the drills have been schedoccur at different times throughout night shift. The ESD or his designed be responsible for ensuring these drills are conducted as scheduled.  The Shaller Campus safety commit periodically review these fire drills compliance. The re-development of fire drill schedule was done on Seg 25, 2015	as ire drills arying sow safety luled to the e will fire  ttee will for of the	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted September 17, 2015

Ms. Ann Thole, Administrator Shirley Chapman Sholom Home East 740 Kay Avenue Saint Paul, Minnesota 55102

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5411025

Dear Ms. Thole:

The above facility was surveyed on August 31, 2015 through September 3, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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

Shirley Chapman Sholom Home East September 17, 2015 Page 2

column also includes the findings that are in violation of the state statute after the statement, "This Rule 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 me.

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,

Kate JohnsTon, Program Specialist

Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 09/17/2015 FORM APPROVED

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:		
		00496	B. WING		09/03/20	15
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLOM HO	ME EAST	AVENUE AUL, MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CO	(X5) MPLETE DATE
2 000	2 000 Initial Comments		2 000			
	****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not corrected not corrected shall be with a schedule of finithe Minnesota Depart.  Determination of whe corrected requires correquirements of the minumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessmither as a survey.	ther a violation has been				
	that may result from rorders provided that a	earing on any assessments non-compliance with these a written request is made to 15 days of receipt of a for non-compliance.				
	surveyors of this Dep above provider and the were issued. When or please sign and date, orders and return the	mber 1, 2, and 3, 2015, artment's staff visited the ne following licensing orders orrections are completed, make a copy of these original to the Minnesota Health Regulation Division,				

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE :	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING:		COMP	ETED
		00496	B. WING		09/	03/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLOM HO	ME EAST	AVENUE			
			AUL, MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 000	Continued From page 1		2 000			
	Licensing and Certific 64900, Saint Paul, Mi	cation Program; PO Box N 55164-0900				
	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 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.					
	FOURTH COLUMN V	OF CORRECTION." THIS AL DEFICIENCIES ONLY.				
		IIREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.				
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565			
		nprehensive plan of care ersonnel involved in the				

Minnesota Department of Health STATE FORM

STATE FORM 6899 KVMG11 If continuation sheet 2 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00496	B. WING		09/03/2015	
	ROVIDER OR SUPPLIER	740 KAY	DDRESS, CITY, STA	TE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLOM HO	ME EAST SAINT PA	UL, MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From page	2	2 565			
	by: Based on observation review, the facility did for incontinence care ulcers for 1 of 1 reside incontinence care, an Findings include:	t is not met as evidenced  n, interview and document not follow the plan of care and prevention of pressure ent (R47) observed for d repositioning.				
	elimination, last editer following "Resident is bladder Resident is and PRN [when need changed as needed with members." The care staff to check residen hours and as needed good pericare after ear Review of R47's plan as at risk for skin breat	with total care of two staff plan approaches directed t for incontinence every two and clean and change with ach incontinence episode.  of care identified resident akdown d/t (due to) daily				
	mobility skills. The ca	continenceand decreased re plan approaches direct ntinence q two hours and				
	AM/PM Group 2 unda	pecialist assignment sheet ated, directed staff to turn two hours, and check and				
		on on 9/3/15, R47 was da chair at 9:10 a m., and				

Minnesota Department of Health

STATE FORM 6899 KVMG11 If continuation sheet 3 of 15

	OF DEFICIENCIES OF CORRECTION		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00496		B. WING		09/03/2015		
	ROVIDER OR SUPPLIER	ME EAST	740 KAY AV	ADDRESS, CITY, STATE, ZIP CODE  Y AVENUE  PAUL, MN 55102				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
2 565	Continued From page remained in the chair intervened at noon. Report the Broda chair and in hours later). R47's indicated on R47's skin.  Interview with license and nursing assistant R47 was to be checked repositioned every two completed since before SUGGESTED METH director of nurses or conserve residents to and toileting was being the care plan. If the permatch the care plan, revised or staff could repositioning and toile specific to meet the nurse of the care the nurse of the nurse	until the surveyor (47 was transferred on to bed at 12:10 p.m. continent product was appleted. No redness of the following transfer (LP (NA)-A, at noon, indeed and changed and to hours and had not the breakfast.  OD OF CORRECTION designee could random provided as descriptories of cares did the care plan could be instructed in properting practices that weeds of the resident.	three swet, was  N)-A, icated been  N: The omly tioning bed in not le er ere	2 565				
2 900	MN Rule 4658.0525 S Ulcers Subp. 3. Pressure so	·	ssure	2 900				
	of nursing services m development of a nur provides that:	ust coordinate the sing care plan which						
	A. a resident who without pressure sore pressure sores unless condition demonstrate	s the individual's clin						

Minnesota Department of Health

STATE FORM 6899 KVMG11 If continuation sheet 4 of 15

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Minnesota Department of Health

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00496	B. WING		09	/03/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE			
SHIRLEY	CHAPMAN SHOLOM HO	ME EAST	AVENUE AUL, MN 55102				
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	(X5) COMPLETE DATE		
2 900	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		2 900		FROFNAIE		
	Scale)-a tool used to dated 6/23/15, indicat included: cardiovascu incontinence, and cog risk assessment indic manually, incontinent required total assistar Braden scale dated 6	predict skin breakdown) ed R47's clinical risk factors lar disease, chronic gnitive impairment. The skin					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00.400		B. WING			2/00/0045	
		00496		B. WING		0	9/03/2015	
NAME OF P	ROVIDER OR SUPPLIER			DRESS, CITY, STA	TE, ZIP CODE			
SHIRLEY	CHAPMAN SHOLOM HO	ME EAST	740 KAY A					
				JL, 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 900	00 Continued From page 5			2 900				
skin was often moist, very limited in controll was adequate, and the a problem. The Brade R47 at a high risk for The assessment indicate a pressure relieving and turning and repose R47's care plan, edite following: "Resident is SKIN BREAKDOWN of bladder incontinence stoolsand decrease assessment and tissuand prn."		the resident was chilling body position, report friction and sheat en score was 12, when the pressure sore devected the skin treating device for chair as sitioning program.  The device for chair as identified as at rist different loose and mobility skills. Skills.	nutrition ring was nich put elopment. nents to nd bed, d the k for wel and					
	Review of the undated care specialist assignment sheet (a worksheet for nursing assistant staff to utilize) indicated R47 required assist of two staff to turn and reposition every two hours, and assist of two with the Hoyer lift to transfer.							
	During continuous ob was transferred into taken to breakfast, fe brought back to her r surveyor intervened, of the Broda chair an observation, R47 was the perineal area was assistant (NA)-A. No on R47's skin.	the Broda chair at 9: ad breakfast, and the oom. At 12:10 p.m. and R47 was transf d into bed. During the is incontinent of uring s cleansed by nursi	10 a.m., en the erred out ne e, when ng					
	An interview was con licensed practical nur 9/3/15. NA-A and LP supposed to be repo- changed every two h R47 had not been re	rse (LPN)-A at noon N-A verified R47 wa sitioned, and checke ours. They also con	on s ed and firmed					

Minnesota Department of Health

STATE FORM 6899 KVMG11 If continuation sheet 6 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUP IDENTIFICATION		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00496		B. WING		09/03	/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SHIRLEY	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 900	Continued From page 6			2 900			
	breakfast.						
	SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance.						
	TIME PERIOD FOR ( (21) days	CORRECTION: TO	wenty one				
2 920	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.			2 920			
	This MN Requirement by: Based on observation review, the facility fails services regarding time of 2 resident (R47) ob- care.	i, interview, and d ed to provide nec nely incontinence	ocument essary care for 1				
	Findings include:						
	R47's Care Area Asset 1/12/15, indicated R4 staff for her activities mobility. A mechanica and R47 was incontin R47 was unable to vo	7 was totally dependent of daily living (AD il lift was used to the ent of bowel and	endent on Ls) and transfer bladder.				

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STATE FORM 6899 KVMG11 If continuation sheet 7 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00496		B. WING		09/	03/2015
	ROVIDER OR SUPPLIER CHAPMAN SHOLOM HO	ME EAST	740 KAY A	PRESS, CITY, STA VENUE JL, MN 55102	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENC Y MUST BE PRECEDED I .SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 920	Continued From page that she had to void.  R47's Bladder Assess indicated R47 had im transfers, and cognitive dementia and Alzheim.  R47's care plan, edite following "Alteration in CONTINENCE: Reside hours and PRN [as not changed as needed with members."  During continuous ob was transferred into the taken to breakfast, feeder brought back to her resurveyor intervened, of the Broda chair and incontinent of urine, purising assistant (NA Interview with NA-A at (LPN)-A at noon on 9 was to be checked arrand verified R47 had incontinence since be suggested by the policies of the policies	sment dated 6/25/1 paired mobility, deprete impairment due ner's disease.  Indoor 7/1/15, indicate a elimination: Ident is incontinent of the ischecked q [every eleded] and cleaned with total care of two eleded and chair at 9 do breakfast, and the form. At 12:10 p.m. and R47 was transic into bed. R47 was transic into bed. R47 was transic electron el	ted the of bowel ery] 2 d and o staff  5, R47 :10 a.m., en the ferred out s pleted by eal nurse ed R47 wo hours, for  ION: The evise as egarding daily rovide policies s) could	2 920			

Minnesota Department of Health

STATE FORM 6899 KVMG11 If continuation sheet 8 of 15

Minnesota Department of Health

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPL	
		00496		B. WING		09/0	03/2015
NAME OF P	ROVIDER OR SUPPLIER	STRE	EET ADDR	ESS, CITY, STA	TE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLOM HO	ME EAST	KAY AVE NT PAUL	ENUE ., MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From page	e 8		2 920			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.						
21375	5 MN Rule 4658.0800 Subp. 1 Infection Control; Program			21375			
	home must establish	control program. A nursing and maintain an infection gned to provide a safe and					
	This MN Requirement is not met as evidenced by: Based on observation interview and document review, the facility failed to implement proper infection control practices for 1 of 1 resident (R272) who was observed to have a received an insulin injection.						
	Findings include:						
	(LPN)-B was observe for injection. LPN-B e correct dose of insulir abdomen with an alco to dry and then admin did not wear gloves to LPN-B washed her ha administration. Intervi	.m. licensed practical nurse d to prepare R272 insulin ntered R272's room with the n. LPN-B cleansed R272's phol wipe, allowed the area nistered the insulin. LPN-B o administer the insulin. ands before and after the ew with LPN-B at 5:12 p.m. not wear gloves when					
	administration proced the following :	s subcutaneous medication ure dated 10/22/13 directed order and calculate the dication.					

Minnesota Department of Health STATE FORM

6899 KVMG11 If continuation sheet 9 of 15

Minnesota Department of Health

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURV	
7.1.10 1 2 11 1		152.4111.107.11.101.11.101.11.11	A. BUILDING: _		00 22.72	
		00496	B. WING		09/03/2	2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLOM HO	ME EAST	Y AVENUE PAUL, MN 55102			
240.15	CHMMADV CT		·	DDOVIDEDIS DI ANI OF CODDECTIO	N.	0.450
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
21375	Continued From page	e 9	21375			
	2. Wash hands thoroughly and put on gloves.  10Remove gloves and wash hands.  Interview on 9/2/15, at 1:15 p.m. the director of nursing indicated staff are supposed to wear gloves when they give insulin.  SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review policy and procedures regarding infection control program. The director of nursing or her designee could educate staff on policy and procedures and develop a monitoring system to ensure compliance with wearing gloves during administration of medications via injection.					
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty one				
21426	MN St. Statute 144A. Prevention And Contr	04 Subd. 3 Tuberculosis rol	21426			
	maintain a comprehe infection control programment tuberculosis in issued by the United Control and Prevention Tuberculosis Eliminat	ram according to the most nfection control guidelines States Centers for Disease				
	This program must in infection control plan unpaid employees, coresidents, and volunted Health shall provide to	clude a tuberculosis that covers all paid and ontractors, students, eers. The Department of				
	(b) Written complian be maintained by the	ce with this subdivision must nursing home.				

Minnesota Department of Health

STATE FORM 6899 KVMG11 If continuation sheet 10 of 15

Minnesot	a Department of Health	<u> </u>				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		00496	B. WING		00/0-	3/2015
		00430			1 03/0	3/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
SHIDI EV	CHAPMAN SHOLOM HO	ME EAST 740 KAY	AVENUE			
SHIKLET	CHAPINAN SHOLOW HO	SAINT PA	AUL, MN 55102			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
				,		
21426	Continued From page	e 10	21426			
	This MN Doguiromon	t is not met as evidenced				
	by:	it is not met as evidenced				
		nd document review, the				
	facility failed to ensure					
	,	ST) was completed within				
	,	sion for 1 of 5 residents				
		illed to ensure to complete				
		ng Tool for Nursing Home				
		ome Residents for 5 of 5				
	_	1, R15, R159, R215). The				
	, ,	e chest x-ray documentation				
	_	or 1 of 5 residents (R191).				
		, ,				
		ocument results of the TST of 5 residents (R15, R159,				
	_	· · · · · · · · · · · · · · · · · · ·				
	Baseline TB Screening	led to ensure to complete				
	` ′	3 of 5 employees (E1, E3,				
	results of the TST tha	acility failed to document				
		reviewed for TB screening.				
	employees (E4, E5) i	eviewed for 1B screening.				
	Findings include:					
	_	72 hours of admission:				
		the facility on 6/27/15, per				
		ng record. The Baseline TB				
		ig record. The baseline 15 irsing Home and Boarding				
	_	s was not completed. The				
		is was not completed. The				
	the first step TST on 8					
	•	illimeter) induration was				
	documented.	minicial) induiation was				
	aocumentea.					
	Screening:					
		the facility on 4/9/15, per				
	i i i i o was aumilleu lu	the facility of 17/3/13, per	1	1		

Minnesota Department of Health

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF		` ′	CONSTRUCTION	(X3) DATE S	
ANDILAN	or dortheorion	IDENTIFICATION	THOMBER.	A. BUILDING: _		O O IVII E	LILD
		00496		B. WING		09/0	03/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLOM HO	ME EAST	740 KAY A\ SAINT PAU	/ENUE L, MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE Y MUST BE PRECEDE .SC IDENTIFYING INFO	NCIES D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From page the Minimum Data Serecord. The Baseline Nursing Home and Boresidents was not co R191 was admitted to the MDS entry tracking Screening Tool for Nur Care Home Residents R15 was admitted to the MDS entry tracking Screening Tool for Nur Care Home Residents R159 was admitted to the MDS entry tracking Screening Tool for Nur Care Home Residents R215 was admitted to the MDS entry tracking Screening Tool for Nur Care Home Residents R215 was admitted to the MDS entry tracking Screening Tool for Nur Care Home Residents E1's start date was 6/ screening Tool for He was not complete. E3's start date was 6/ screening Tool for He was not complete. E5's start date was 8/ screening Tool for He was not dated, was not Lack of chest x-ray do	et (MDS) entry tra TB Screening To- coarding Care Hor- impleted.  The facility on 3/ ag record. The Ba- irsing Home and as was not completed.  The facility on 5/3/ ag record. The Ba- irsing Home and as was not completed.  The facility on 6/3/ ag record. The Ba- irsing Home and as was not completed.  The facility on 7/ ag record. The Ba- irsing Home and as was not completed.  The Baseling Home and Baseling	ol for ne  14/15, per reseline TB Boarding red.  0/15, per reseline TB Boarding red.  27/15, per reseline TB Boarding red.  18/15, per reseline TB Boarding red.  18/15, per reseline TB Boarding red.  18/15, per reseline TB Boarding red.  In the the reseline TB (HCWs)  It in the the reseline TB (HCWs)	21426			
	R191 was admitted to the MDS entry tracking						

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00496	B. WING		09	0/03/2015
	PROVIDER OR SUPPLIER  CHAPMAN SHOLOM HO	OME EAST	ADDRESS, CITY, STATE AY AVENUE PAUL, MN 55102	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21426	Screening Tool for N Care Home Residen Medication Administ March 2015 revealed x-ray dated 3/14/15. 2/28/15, did not inclu Lack of induration do R15 was admitted to the MDS entry tracki Screening Tool for N Care Home Residen MAR for May 2015 r first step TST on 5/3 induration was docur was given on 6/6/15, induration was docur R159 was admitted to the MDS entry tracki Screening Tool for N Care Home Residen MAR for August 201 the first step TST on 8/30/15, no induration R215 was admitted to the MDS entry tracki screening Tool for N Care Home Residen MAR for August 201 the first step TST on 8/30/15, no induration R215 was admitted to the MDS entry tracki screening Tool for N Care Home Residen MAR for July 2015 re first step TST on 7/1 no induration was do TST was given on 7/1 no induration was do Lack of results docur E4's start date was 7/1	ursing Home and Boarding ts was not completed. The ration record (MAR) for d R191 received a chest Chest x-ray results dated ade TB results.  Documentation: In the facility on 5/30/15, per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The evealed R15 was given the 0/15, was read on 6/1/15, nomented. A second step TST, was read on 6/8/15, nomented.  To the facility on 6/27/15, per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The pursing Home and Boarding ts was not completed. The prevaled R159 was given 8/28/15, was read on many was documented.  To the facility on 7/18/15, per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The pursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed. The per ng record. The Baseline TB ursing Home and Boarding ts was not completed.	21426			

Minnesota Department of Health

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Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00496	B. WING		09/03/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 00:00:2010
SHIRLEY	CHAPMAN SHOLOM HO	ME EAST			
		SAINT PA	UL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
21426	Continued From page	e 13	21426		
	screening Tool for He was not dated. The fi 8/10/15, and was not On 9/3/15, at approxi information was requinot provided in resperesidents.  Shaller Campus Police	mately 3:30 p.m. additional ested from DON and was ct to TB screening for cy and Procedure			
	Tuberculosis Control origin 12/00, 4/2011, "prospective skilled n be screened by the A designee prior to adm Pre-Admission TB Scintradermal tuberculir administered to all sk seventy-two (72) hou is written documentat within the last three (3 contraindicated in writwo-step Mantoux prothe initial Mantoux test be administered in ap If more than three (3) between the first and procedure will be reprositive reaction to the of a previous positive x-ray unless there is a chest x-ray within the chest x-ray cannot be	Plan - Residents date of revision date 7/15, directed ursing facility residents will dmission Department or nission by using a greening tool. A standard in skin test (Mantoux) will be illed facility residents within are of admission, unless there ion of a negative Mantoux and months or if ting by a physician. A procedure will be followed. If set is negative, a second will proximately two (2) weeks. Weeks have lapsed second steps, the entire eated. All residents with a me Mantoux test or a history reaction will have a chest documentation of a negative past three (3) months. A e substituted for the Mantoux ening does not serve to			
	Sholom Tuberculosis Volunteers dated 6/23	Screening-Employees &			

Minnesota Department of Health

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Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00496	B. WING		09/03/2015
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZID CODE	03/00/2010
		740 KAY	, ,	TE, ZIF CODE	
SHIRLEY	CHAPMAN SHOLOM HO	ME EAST	AUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
21426	Continued From page	e 14	21426		
	documentation will ind (month, day, year), the induration (if no indurant interpretation (popolicy of this facility the screened for TB upinclude assessing for TB disease, assessing the presence of infect tuberculosis by admirror a single IGRA."  SUGGESTED METHORIZED METHORIZED TO TREVIEW/revise policies Tuberculosis screening ensure the policy was	clude the date of the test e number of millimeters of ation, document "0" mm) sitive or negative). It is the nat all health care workers con hire. This testing will current symptoms of active g TB history and testing for cion with Mycobacterium histering either a 2-step TST  OD OF CORRECTION: The designee, could on resident and employee ng and perform audits to			

Minnesota Department of Health

PRINTED: 10/16/2015 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00496 09/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE SHIRLEY CHAPMAN SHOLOM HOME EAST SAINT PAUL, MN 55102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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.

Minnesota Department of Health

**INITIAL COMMENTS:** 

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

On August 31, September 1, 2, and 3, 2015, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed. please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Health Regulation Division,

**Electronically Signed** 09/25/15

STATE FORM KVMG11 If continuation sheet 1 of 15

TITLE

(X6) DATE

Minnesota Department of Health

_	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00496		B. WING		09/0	03/2015
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
SHIRLE	CHAPMAN SHOLON	M HOME EAST	740 KAY A SAINT PA	AVENUE UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1		2 000			
	Licensing and Certification Program; PO Box 64900, Saint Paul, MN 55164-0900  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 no column entitled "ID statute/rule out of columnary Stateme and replaces the "To correction order. The findings which are in after the statement, evidence by." Followare the Suggested I Time period for Corrections of the statement of the Suggested I Time period for Corrections of the Sugg	Prefix Tag." The state ompliance is listed ent of Deficiencies" of Comply" portion on the state of the surveyors of the surveyor	ate in the column of the udes the ate statute net as findings				
	PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA	N WHICH STATES, IN OF CORRECTIC ERAL DEFICIENCIE	N." THIS S ONLY.				
	THERE IS NO REC PLAN OF CORREC MINNESOTA STAT	CTION FOR VIOLAT	TIONS OF				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Compreh	ensive	2 565			10/18/15
	Subp. 3. Use. A comust be used by all care of the resident	personnel involved					

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.	·		
		00496	B. WING		09/0	3/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHIRLE	CHAPMAN SHOLON	/ HOME FAST	AVENUE AUL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 2	2 565			
	by: Based on observation review, the facility of for incontinence calculcers for 1 of 1 resincontinence care, and the second reviews the second review the second reviews the second review the second reviews the second revi	ent is not met as evidenced ion, interview and document did not follow the plan of care re and prevention of pressure sident (R47) observed for and repositioning.		Corrected Completion date for coi is Oct. 18, 2015	mpliance	
	Findings include:					
	R47's plan of care was not followed for alteration in elimination.					
	Review of R47's plan of care for alteration in elimination, last edited on 7/1/15, indicated the following "Resident is incontinent of bowel and bladder Resident is checked q [every] 2 hours and PRN [when needed] and cleaned and changed as needed with total care of two staff members." The care plan approaches directed staff to check resident for incontinence every two hours and as needed and clean and change with good pericare after each incontinence episode.					
	as at risk for skin be bowel and bladder mobility skills. The	an of care identified resident reakdown d/t (due to) daily incontinenceand decreased care plan approaches direct continence q two hours and				
	AM/PM Group 2 un	specialist assignment sheet adated, directed staff to turn by two hours, and check and				
		ation on 9/3/15, R47 was roda chair at 9:10 a.m., and				

Minnesota Department of Health

STATE FORM 6899 KVMG11 If continuation sheet 3 of 15

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00496		B. WING		09/0	3/2015
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLON	I HOME EAST	740 KAY A SAINT PA	WENUE UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	remained in the chaintervened at noon. the Broda chair and hours later). R47's and pericare was conoted on R47's skir. Interview with licens and nursing assista R47 was to be checrepositioned every completed since be SUGGESTED MET director of nurses of observe residents the care plan. If the match the care plan revised or staff courepositioning and to specific to meet the TIME PERIOD FOR (21) days.	air until the surveyor R47 was transferred into bed at 12:10 incontinent production production at the continent production at the continent production at the continent production at the continent production of cares and provision of cares and the care plan could be instructed in production of the care standard practices the cared of the residual production of the cared of the residual production of the cared of the residual production of the residua	red out of p.m. (three t was wet, ess was e. (LPN)-A, indicated and not been continued escribed in a did not uld be proper lat were dent.	2 565			
2 900	MN Rule 4658.0528 Ulcers  Subp. 3. Pressure comprehensive res of nursing services development of a n	sores. Based on tident assessment, must coordinate the	he the director ne	2 900			10/18/15
	A. a resident wh without pressure sores unle condition demonstr	ess the individual's	elop s clinical				

Minnesota Department of Health

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00496	B. WING		09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLON	M HOME EAST 740 KAY A		00		
(VA) ID	SLIMMADV STA	TEMENT OF DEFICIENCIES	UL, MN 551	PROVIDER'S PLAN OF CORRECTION	- NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 4	2 900			
	authenticates, that	they were unavoidable; and				
	receives necessar	ho has pressure sores y treatment and services to revent infection, and prevent yeloping.				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that 1 of 2 residents (R47) in the sample who were at risk for pressure ulcer development received the necessary care to prevent development of pressure ulcers.			0900 Corrected Completion date for compliance is 2015	Oct.18,	
	Findings include:					
	1/12/15, indicated If staff for her activities mobility, and that a transfer her becaus addition, the CAA ir of bowel and bladd and her immobility	essessment (CAA), dated R47 was totally dependent on es of daily living (ADLs) and mechanical lift was used to se she was chair bound. In adicated R47 was incontinent er, and that because of that in a chair and bed, she was at ressure ulcer development ioned her routinely.				
	Scale)-a tool used dated 6/23/15, indic included: cardiovas incontinence, and crisk assessment incontine manually, incontine required total assis Braden scale dated	sessment with (Braden to predict skin breakdown) cated R47's clinical risk factors cular disease, chronic cognitive impairment. The skin dicated R47 was lifted nt of bowel and bladder, and tance with bed mobility. R47's 16/26/15, indicated R47 was sponding to stimuli, that her				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BOILDING.			
		00496		B. WING		09/0	3/2015
NAME OF PROV	/IDER OR SUPPLIER				STATE, ZIP CODE		
SHIRLEY CH	IAPMAN SHOLON	I HOME EAST	740 KAY A SAINT PA	AVENUE .UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRIEM OF THE APP	ULD BE	(X5) COMPLETE DATE
skii ver waa a p R4 The be and R4 folli SK bla sto assa and Re she utill to t of t Du waa tak bro sur of t obs the assa on An lice 9/3 sup	ry limited in contrus adequate, and problem. The Brain of a high risk for a pressure relieved turning and report. The scare plan, ed lowing: "Resident (IN BREAKDOW) adder incontinence of the sessment and tisk dight of the undark et (a worksheet lize) indicated R4 turn and reposition the work of the Hoyel and the Broda chair a servation, R47 was sistant (NA)-A. No R47's skin.  Interview was constant of the proposed to be reported to the proposed to the	olling body position that friction and shaden score was 12, or pressure sore dedicated the skin treating device for chair ositioning program ited 6/30/15, indicated is identified as at rown downward to the constant of the	a, nutrition earing was which put evelopment. atments to r and bed,  ted the risk for bowel and se Skin risk e quarterly assignment nt staff to f two staff and assist  3/15, R47 9:10 a.m., then n. the ensferred out g the rine, when rsing were noted  and on on was cked and	2 900			

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-	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED
		00496	B. WING		09/03/2015
NAME OF F	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE	
SHIRLEY	CHAPMAN SHOLON	M HOME FAST	AY AVENUE 「PAUL, MN 55 <sup>。</sup>	102	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 900	breakfast.  SUGGESTED MET Director of Nursing policies and proced residents at risk or staff on pressure ul monitoring system to TIME PERIOD FOR (21) days	THOD OF CORRECTION: Tor designee could review lures regarding care for with pressure ulcers, educacers protocols and develop to ensure compliance.  R CORRECTION: Twenty o	ite a ne		10/10/15
2 920	Subp. 6. Activities comprehensive reshome must ensure B. a resident who activities of daily liviservices to maintain and personal and o	is unable to carry out ing receives the necessary a good nutrition, grooming,	g		10/18/15
	review, the facility fa services regarding	on, interview, and documer ailed to provide necessary timely incontinence care for observed for incontinence		2920 Corrected Completion date for compliance is 0 2015	Oct.18,
	1/12/15, indicated F staff for her activitie mobility. A mechani and R47 was incom	ssessment (CAA), dated R47 was totally dependent on the sof daily living (ADLs) and the cal lift was used to transfer tinent of bowel and bladder vocalize of indicate in any v			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | (X4) DATE SURVEY COMPLETED | (X5) DATE SURVEY COMPLETED | (X5) DATE SURVEY COMPLETED | (X6) DATE SURVEY COMPLETE

	00-100				09/03/2013
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
SHIRLEY	CHAPMAN SHOLOM HOME EAST	740 KAY A SAINT PA	AVENUE UL, MN 551	02	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 920	Continued From page 7		2 920		
	that she had to void.				
	R47's Bladder Assessment dated 6/25/1 indicated R47 had impaired mobility, de transfers, and cognitive impairment due dementia and Alzheimer's disease.  R47's care plan, edited on 7/1/15, indicated following "Alteration in elimination: CONTINENCE: Resident is incontinent and bladderResident is checked q [evhours and PRN [as needed] and cleane changed as needed with total care of two members."	pendent to ated the of bowel ery] 2 d and			
	During continuous observations on 9/3/was transferred into the Broda chair at 9 taken to breakfast, fed breakfast, and the brought back to her room. At 12:10 p.m surveyor intervened, and R47 was transfof the Broda chair and into bed. R47 was incontinent of urine, pericares were commursing assistant (NA)-A.	9:10 a.m., nen . the ferred out			
	Interview with NA-A and licensed practic (LPN)-A at noon on 9/3/15, they indicate was to be checked and changed every tand verified R47 had not been checked incontinence since before breakfast.	ed R47 wo hours,			
	SUGGESTED METHOD OF CORRECT DON or designee(s) could review and renecessary the policies and procedures at the need for assistance with activities of living. The DON or designee (s) could p training for all appropriate staff on these and procedures. The DON or designee monitor to assure all residents are received adequate and appropriate care.	evise as regarding daily rovide policies (s) could			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00496	B. WING		09/0	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
SHIRLE	CHAPMAN SHOLON	I HOME FAST	AY AVENUE PAUL, MN 55 <sup>-</sup>	102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 8	2 920			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-or	ne			
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			10/18/15
	home must establis	on control program. A nursing the and maintain an infection signed to provide a safe and nt.				
	by: Based on observati review, the facility fa infection control pra	ent is not met as evidenced on interview and document ailed to implement proper actices for 1 of 1 resident served to have a received a		21375 Corrected Completion date for compliance is 2015	s Oct.18,	
	Findings include:					
	(LPN)-B was obsert for injection. LPN-B correct dose of insuabdomen with an alto dry and then admidid not wear gloves LPN-B washed her administration. Inter	p.m. licensed practical nursived to prepare R272 insulin entered R272's room with talin. LPN-B cleansed R272's loohol wipe, allowed the areaninistered the insulin. LPN-B to administer the insulin. hands before and after the rview with LPN-B at 5:12 p.r id not wear gloves when	he a			
	administration proceed the following:	y's subcutaneous medicatio edure dated 10/22/13 directon order and calculate the nedication.				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00496		B. WING		09/0	3/2015
	PROVIDER OR SUPPLIER	1 HOME EAST	740 KAY		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375 21426	2. Wash hands tho 10Remove glov Interview on 9/2/15 nursing indicated st gloves when they g SUGGESTED MET director of nursing opolicy and procedur program. The director of nursing opolicy and procedur program. The director of monitoring could educate staff develop a monitoring compliance with we administration of monitoring the period of the could be supported by the could b	proughly and put on res and wash hands at 1:15 p.m. the deaff are supposed to restrict the result of	irector of o wear  CTION: The ald review ion control er designee edures and electron.	21375			10/18/15
	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volument Health shall provide regarding implement (b) Written compliate to the maintained by the shall provided the shall pro	nensive tuberculosis ogram according to infection control grad d States Centers for tion (CDC), Division lation, as published ality Weekly Report include a tuberculous in that covers all paracontractors, studer inteers. The Departre et echnical assistan intation of the guidel	the most uidelines r Disease n of in CDC's (MMWR). sis id and lts, ment of ce ines.				

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PRINTED: 10/16/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ B. WING 00496 09/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE SHIRLEY CHAPMAN SHOLOM HOME EAST SAINT PAUL, MN 55102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21426 Continued From page 10 21426 This MN Requirement is not met as evidenced Based on interview and document review, the 21426 facility failed to ensure tuberculosis (TB) Corrected tuberculin skin test (TST) was completed within Completion date for compliance is 72 hours from admission for 1 of 5 residents Oct.18,2015 (R159). The facility failed to ensure to complete Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents for 5 of 5 residents (R113, R191, R15, R159, R215). The facility failed to ensure chest x-ray documentation included TB results for 1 of 5 residents (R191). The facility failed to document results of the TST that was given for 3 of 5 residents (R15, R159, R215). The facility failed to ensure to complete Baseline TB Screening Tool for Healthcare Workers (HCWs) for 3 of 5 employees (E1, E3, E5). In addition, the facility failed to document results of the TST that was given for 2 of 5 employees (E4, E5) reviewed for TB screening. Findings include: TST not given within 72 hours of admission: R159 was admitted to the facility on 6/27/15, per

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documented.

Screening:

the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. The MAR for August 2015 revealed R159 was given the first step TST on 8/28/15, was read on 8/30/15, no 0 mm (millimeter) induration was

R113 was admitted to the facility on 4/9/15, per

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00496	B. WING		09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
SHIRLE	CHAPMAN SHOLON	I HOME EAST 740 KAY A	AVENUE .UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 11	21426			
	record. The Baselir	Set (MDS) entry tracking ne TB Screening Tool for Boarding Care Home completed.				
	the MDS entry track Screening Tool for	to the facility on 3/14/15, per king record. The Baseline TB Nursing Home and Boarding ints was not completed.				
	the MDS entry track Screening Tool for	to the facility on 5/30/15, per king record. The Baseline TB Nursing Home and Boarding ints was not completed.				
	the MDS entry track Screening Tool for	to the facility on 6/27/15, per king record. The Baseline TB Nursing Home and Boarding nts was not completed.				
	the MDS entry track screening Tool for I	to the facility on 7/18/15, per king record. The Baseline TB Nursing Home and Boarding nts was not completed.				
		6/8/15. The Baseline TB Healthcare Workers (HCWs)				
		6/22/15. The Baseline TB Healthcare Workers (HCWs)				
		8/10/15. The Baseline TB Healthcare Workers (HCWs) not complete.				
		documentation: I to the facility on 3/14/15, per king record. The Baseline TB				

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COMPLETED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: \_\_\_\_\_

> B. WING \_\_\_\_ 00496 09/03/2015

		00496				09/03/20	JIO
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS. CITY. S	TATE, ZIP CODE		
			740 KAY		,		
SHIRLEY	CHAPMAN SHOLON	II HOME EAST		UL, MN 5510	n2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFO	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CC	(X5) DMPLETE DATE
21426	Continued From pa	ıge 12		21426			
	Screening Tool for Care Home Reside Medication Adminis March 2015 reveale x-ray dated 3/14/15 2/28/15, did not inc	ents was not comp stration record (MA ed R191 received b. Chest x-ray res	leted. The AR) for a chest				
	Lack of induration of R15 was admitted to the MDS entry track Screening Tool for Care Home Reside MAR for May 2015 first step TST on 5/ induration was door was given on 6/6/18 induration was door	to the facility on 5/king record. The E Nursing Home and ents was not comp revealed R15 was (30/15, was read of umented. A secon 5, was read on 6/8	Baseline TB d Boarding eleted. The s given the on 6/1/15, no ed step TST				
	R159 was admitted the MDS entry track Screening Tool for Care Home Reside MAR for August 20 the first step TST of 8/30/15, no induration	king record. The E Nursing Home and ents was not comp 15 revealed R159 n 8/28/15, was rea	Baseline TB d Boarding leted. The was given ad on				
	R215 was admitted the MDS entry track screening Tool for N Care Home Reside MAR for July 2015 first step TST on 7/ no induration was of TST was given on to no induration was of	king record. The E Nursing Home and ents was not comp revealed R215 wa (19/15, was read of documented. A sec 7/25/15, was read	Baseline TB d Boarding eleted. The as given the on 7/21/15, cond step				
Minnesota D	Lack of results doc E4's start date was was given on 7/8/19 negative reading was epartment of Health	7/27/15. A second 5, was read on 7/1					

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STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00496	B. WING		09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
SHIRLE	CHAPMAN SHOLON	M HOME EAST 740 KAY SAINT PA	AVENUE AUL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From pa	age 13	21426			
	screening Tool for I was not dated. The 8/10/15, and was n On 9/3/15, at approinformation was recont provided in respresidents.	oximately 3:30 p.m. additional quested from DON and was pect to TB screening for				
	Tuberculosis Controrigin 12/00, 4/201 "prospective skilled be screened by the designee prior to an Pre-Admission TB intradermal tuberculadministered to all seventy-two (72) had is written documen within the last three contraindicated in with two-step Mantoux the initial Mantoux be administered in lift more than three between the first an procedure will be repositive reaction to of a previous positix-ray unless there is chest x-ray within the chest x-ray within the chest x-ray cannot test. Chest x-ray screen sholom Tuberculos	olicy and Procedure of Plan - Residents date of 1, revision date 7/15, directed 1 nursing facility residents will a Admission Department or dmission by using a Screening tool. A standard ulin skin test (Mantoux) will be skilled facility residents within ours of admission, unless there tation of a negative Mantoux (a) months or if writing by a physician. A procedure will be followed. If test is negative, a second will approximately two (2) weeks. (3) weeks have lapsed and second steps, the entire epeated. All residents with a the Mantoux test or a history vereaction will have a chest is documentation of a negative the past three (3) months. A be substituted for the Mantoux creening does not serve to the saccondermine the server of the Screening-Employees & //23/14, directed "TST"				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0496

NAME OF PROVIDER OR SURPLIER

STREET ADDRESS CITY STATE ZIP CORE

	AME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  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) COMPLETE DATE				
21426	Continued From page 14  documentation will include the date of the test (month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (positive or negative). It is the policy of this facility that all health care workers be screened for TB upon hire. This testing will include assessing for current symptoms of active TB disease, assessing TB history and testing for the presence of infection with Mycobacterium tuberculosis by administering either a 2-step TS or a single IGRA."  SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	e						

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