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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KVMG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00496

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245411**

2.STATE VENDOR OR MEDICAID NO.
(L2) **529242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **SHIRLEY CHAPMAN SHOLOM HOME EAST**
(L4) **740 KAY AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55102**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/04/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **108** (L18)

13.Total Certified Beds **108** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	108			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jonathan Hill, HFE NE II — 11/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/13/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/16/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/12/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245411	A. Building B. Wing	11/4/2015

Name of Facility	Street Address, City, State, Zip Code
SHIRLEY CHAPMAN SHOLOM HOME EAST	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) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/18/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **10/18/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/18/2015**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **10/18/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/18/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/KJ	11/13/2015	25480	11/04/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/3/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245411	02 - SHIRLEY CHAPMEN SHOLOM HOME EAST	10/21/2015

Name of Facility	Street Address, City, State, Zip Code
SHIRLEY CHAPMAN SHOLOM HOME EAST	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0025	10/18/2015	ID Prefix Reg. # NFPA 101 LSC K0050	09/25/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GS/KJ	Date: 11/13/2015	Signature of Surveyor: 25822	Date: 10/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/1/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00496	A. Building B. Wing	11/4/2015

Name of Facility	Street Address, City, State, Zip Code
SHIRLEY CHAPMAN SHOLOM HOME EAST	740 KAY AVENUE SAINT PAUL, MN 55102

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
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **10/18/2015**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **10/18/2015**	ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp. 6 B** LSC	Correction Completed **10/18/2015**
ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp. 1** LSC	Correction Completed **10/18/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 3** LSC	Correction Completed **10/18/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/KJ	11/13/2015	25480	11/04/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/3/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KVMG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00496

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245411**
2.STATE VENDOR OR MEDICAID NO.
(L2) **529242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **SHIRLEY CHAPMAN SHOLOM HOME EAST**
(L4) **740 KAY AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55102**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/03/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **108** (L18)

13.Total Certified Beds **108** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	108			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Momodou Fatty, HFE NE II 09/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/12/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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.

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245411	A. BUILDING _____ B. WING _____	09/03/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not follow the plan of care for incontinence care and prevention of pressure ulcers for 1 of 1 resident (R47) observed for incontinence care, and repositioning. Findings include: R47's plan of care was not followed for alteration in elimination. R47's plan of care for alteration in elimination, last edited on 7/1/15, indicated the following	F 282	F282 Services provided or arranged by the facility are provided by qualified persons in accordance with the resident's written plan of care. Resident #R47 mobility care plan and NAR assignment sheet has been reviewed and is current. Other residents with a Braden score indicating a high risk for skin breakdown will have their care plans and NAR	10/18/15

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

Electronically Signed | 09/25/2015

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F 282	Continued From page 1 "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. R47's plan of care identified resident as at risk for skin breakdown d/t (due to) daily bowel and bladder incontinence ...and decreased mobility skills. The care plan approaches directed staff to check for incontinence q two hours and PRN. Review of the care specialist assignment sheet AM/PM Group 2 undated, directed staff to turn and reposition every two hours, and check and change. Continuous observation on 9/3/15, R47 was transferred into a Broda chair at 9:10 a.m., and remained in the chair until the surveyor intervened at noon. R47 was transferred out of the Broda chair and into bed at 12:10 p.m. (three hours later). R47's incontinent product was wet, and pericare was completed. No redness was noted on R47's skin. Interview with licensed practical nurse (LPN)-A, and nursing assistant (NA)-A, at noon, indicated R47 was to be checked and changed and repositioned every two hours and had not been completed since before breakfast.	F 282	assignment sheets reviewed and updated as needed. Policy and procedure for following the plan of care has been reviewed and is current. Nursing staff will be re-educated on the following the plan of care by Oct. 9, 2015. Repositioning and toileting audits will be completed on 3 residents, 3 times a week on varying shifts for 4 weeks then weekly x 2 months. Nurse Managers or designees are responsible for auditing and following up. Results of audits will be reported to the QA committee and action plans developed as needed. Completion date for compliance is Oct. 18,2015	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		10/18/15

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F 312	Continued From page 2 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary services regarding timely incontinence care for 1 of 2 resident (R47) observed for incontinence care. Findings include: R47's Care Area Assessment (CAA), dated 1/12/15, indicated R47 was totally dependent on staff for her activities of daily living (ADLs) and mobility. A mechanical lift was used to transfer and R47 was incontinent of bowel and bladder. R47 was unable to vocalize of indicate in any way that she had to void. R47's Bladder Assessment dated 6/25/15, indicated R47 had impaired mobility, dependent transfers, and cognitive impairment due to dementia and Alzheimer's disease. R47's care plan, edited on 7/1/15, indicated the following "Alteration in elimination: CONTINENCE: Resident is incontinent of bowel and bladder...Resident is checked q [every] 2 hours and PRN [as needed] and cleaned and changed as needed with total care of two staff members." During continuous observations on 9/3/15, R47 was transferred into the Broda chair at 9:10 a.m.,	F 312	F312 Residents who are unable to carry out activities of daily living do receive the necessary services to maintain good nutrition, grooming, and personal hygiene. Resident #47 incontinence care plan and NAR assignment sheet has been reviewed and is current. Other residents who are dependent in incontinence care, toileting and are at high risk for skin breakdown will have their care plans and NAR assignment sheets reviewed and updated as needed. Policy and Procedure for toileting and incontinence care per the plan of care has been reviewed and is current. Nursing staff will be re-educated on toileting and incontinence care per the plan of care by Oct.9, 2015. Repositioning and toileting audits will be completed on 3 residents, 3 times a week on varying shifts for 4 weeks and then weekly x 2 months. Nurse Managers or designees are responsible for auditing and follow-up.	

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F 312	Continued From page 3 taken to breakfast, fed breakfast, and then brought back to her room. At 12:10 p.m. the surveyor intervened, and R47 was transferred out of the Broda chair and into bed. R47 was incontinent of urine, pericares were completed by nursing assistant (NA)-A. Interview with NA-A and licensed practical nurse (LPN)-A at noon on 9/3/15, they indicated R47 was to be checked and changed every two hours, and verified R47 had not been checked for incontinence since before breakfast.	F 312	Results of audits will be reports to the QA committee and action plans developed as needed. Completion date for compliance is Oct.18, 2015	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This 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. Findings include: R47's Care Area Assessment (CAA), dated	F 314	F314 The facility does ensure that each resident who enters the facility without a pressure sore does not develop pressure sores unless the individual clinical condition demonstrates that they were unavoidable. Resident #R47 assessments, repositioning and incontinence care plan	10/18/15

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F 314	Continued From page 4 1/12/15, indicated R47 was totally dependent on staff for her activities of daily living (ADLs) and mobility, and that a mechanical lift was used to transfer her because she was chair bound. In addition, the CAA indicated R47 was incontinent of bowel and bladder, and that because of that and her immobility in a chair and bed, she was at increased risk for pressure ulcer development unless staff repositioned her routinely. R47's Skin Risk Assessment with (Braden Scale)-a tool used to predict skin breakdown) dated 6/23/15, indicated R47's clinical risk factors included: cardiovascular disease, chronic incontinence, and cognitive impairment. The skin risk assessment indicated R47 was lifted manually, incontinent of bowel and bladder,and required total assistance with bed mobility. R47's Braden scale dated 6/26/15, indicated R47 was very limited with responding to stimuli, that her skin was often moist, the resident was chairfast, very limited in controlling body position, nutrition was adequate, and that friction and shearing was a problem. The Braden score was 12, which put R47 at a high risk for pressure sore development. The assessment indicated the skin treatments to be a pressure relieving device for chair and bed, and turning and repositioning program. R47's care plan, edited 6/30/15, indicated the following: "Resident is identified as at risk for SKIN BREAKDOWN d/t [due to] daily bowel and bladder incontinence with frequent loose stools...and decreased mobility skills. Skin risk assessment and tissue tolerance done quarterly and prn." Review of the undated care specialist assignment sheet (a worksheet for nursing assistant staff to	F 314	and NAR assignment sheet has been reviewed and is current. Other residents with a Braden score indicating high risk for skin breakdown will have their care plans and NAR assignment sheets reviewed and updated as needed. Repositioning and toileting audits will be completed on 3 residents, 3 times a week on varying shifts for 4 weeks then weekly x2 months. Nurse Managers or designees are responsible for auditing and follow-up. Policy and Procedure for pressure sore risk, toileting and incontinence care per the plan of care has been reviewed and is current. Nursing staff will be re-educated on toileting and incontinence care per the plan of care by Oct.9, 2015. Repositioning and toileting audits will be completed on 3 residents, 3 times a weeks on varying shifts for 4 weeks then weekly x 2 months. Nurse Managers or designees are responsible for auditing and follow-up. Results of audits will be reported to the QA committee and action plans developed as needed. Completion date for compliance is Oct.18, 2015	

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F 314	Continued From page 5 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 observations on 9/3/15, R47 was transferred into the Broda chair at 9:10 a.m., taken to breakfast, fed breakfast, and then brought back to her room. At 12:10 p.m. the surveyor intervened, and R47 was transferred out of the Broda chair and into bed. During the observation, R47 was incontinent of urine, when the perineal area was cleansed by nursing assistant (NA)-A. No reddened areas were noted on R47's skin. An interview was conducted with NA-A and licensed practical nurse (LPN)-A at noon on 9/3/15. NA-A and LPN-A verified R47 was supposed to be repositioned, and checked and changed every two hours. They also confirmed R47 had not been repositioned since before breakfast.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356		10/18/15

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F 356	Continued From page 6 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nursing staff posting reflected the actual hours worked by both licensed and non-licensed nursing staff. This had the potential to affect staff, visitors, family members and all 99 residents residing at the facility. Findings include: On 8/31/15, at approximately 1:15 p.m. the nurse staff posting was observed to be posted at wheelchair level in the hallway to the right of the elevators near the main entrance. The posting was dated 8/31/15, and included the required information of the census and the number of hours worked for registered nurses (RN), licensed practical nurses (LPN) and nursing assistants (NA) staff. Although the posting	F 356	F356 The daily nurse staffing posting has been revised to include actual shift hours worked for each category of nursing staff as well as total hours worked each shift. Audits will be conducted weekly for 4 weeks then monthly x 3 months to ensure compliance. Results of audits will be reported to the QA committee and action plans developed as needed. Completion date for compliance is Oct.18, 2015	

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F 356	Continued From page 7 included the total hours worked and the number of staff working for the nursing staff on Day, Evening and Night shifts, the form lacked the actual hours worked by the above categories. On 9/1/15, 9/2/15, and 9/3/15, at approximately 10:30 a.m. and 12:18 p.m. the nurse staff postings were observed to have no actual hours worked, including the start and end times of shifts. During an interview with the staffing coordinator on 9/3/15, at 11:16 a.m. the staffing coordinator confirmed the nurse staff posting format was the one always used. In addition, she stated some staff worked shorter shifts. She verified the actual hours worked by nursing staff at the facility was lacking and stated she would inform the director of nursing (DON) so that could be corrected moving forward. The facility nursing department staffing guidelines dated 9/3/15, included the day shift start time of 6:30 to 2:30 p.m. for internal pool staff (licensed and NAs) and regular staff picking up an extra day shift. It also included start times for internal pool employees as 6:30 a.m. for licensed and NA staff, 2:30 p.m. for NA, 2:45 p.m. for licensed, 10:30 p.m. for NA and 11:00 p.m. for licensed staff. It did not address all actual hours worked by category.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		10/18/15

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F 441	Continued From page 8 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This 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	F 441	F441 The facility maintains an infection control program designed to provide a safe, sanitary and comfortable environment and	

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F 441	Continued From page 9 insulin injection. Findings include: On 8/31/15, at 5:10 p.m. licensed practical nurse (LPN)-B was observed to prepare R272 insulin for injection. LPN-B entered R272's room with the correct dose of insulin. LPN-B cleansed R272's abdomen with an alcohol wipe, allowed the area to dry and then administered the insulin. LPN-B did not wear gloves to administer the insulin. LPN-B washed her hands before and after the administration. Interview with LPN-B at 5:12 p.m. she indicated she did not wear gloves when giving insulin. Review of the facility's subcutaneous medication administration procedure dated 10/22/13 directed the following : 1. Review physician order and calculate the correct amount of medication. 2. Wash hands thoroughly and put on gloves. 10. ...Remove 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.	F 441	to help prevent the development and transmission of disease and infction. The policy and procedure for subcutaneous injections has been reviewed and is current. Nurses will be re-educated on policy and procedure for subcutaneous injections by Oct.9, 2015. Random audits of insulin injections will be completed by Nurse Managers or designee weekly x 4 weeks then monthly x 3 months to ensure compliance. Audit results will be reviewed by QA committee and action plans developed as needed. Completion date for compliance is Oct.18,2015	

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	245411	A. BUILDING **02 - SHIRLEY CHAPMEN SHOLOM HOME EAST** B. WING _____	**09/01/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	K 000	EPOC	

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

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

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K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. SHIRLEY CHAPMAN SHOLOM HOME EAST is a 4-story building with a full basement. The building was constructed in 2008, and was determined to be of Type II(222) construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and all resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 98 beds and had a census of 82 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass	K 025		10/18/15

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	245411	A. BUILDING **02 - SHIRLEY CHAPMEN SHOLOM HOME EAST** B. WING _____	**09/01/2015**

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

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K 025	Continued From page 2 panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the smoke barrier in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all residents, staff and visitors within the smoke compartments. Findings include: On facility tour between 9:30 AM and 2:30 PM on 09/01/2015, it was observed that the 3rd floor smoke barrier doors by Electrical Room C-321 did not full close when tested. This deficiency was verified by the facility Director of Physical Plant (DB) at the time of discovery.	K 025	K-025 There is a set of smoke barrier doors located on the 3rd floor by electrical room C-321 that did not fully close when tested. The doors will be repaired so as to properly close. The ESD will monitor all practices and proper procedures are followed to preserve the integrity of all fire rated partitions. This repair will be completed by October 18, 2015	
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded	K 050		9/25/15

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K 050	Continued From page 3 announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 9:30 AM and 2:30 PM on 09/01/2015, based on review of available documentation it was reveled that Fire drills were not varied throughout the shift on the Night Shift during the last 12 months. Of the 4 drills conducted all were done between 11:00 PM and 11:40 PM This deficiency was verified by the facility Director of Physical Plant (DB) at the time of discovery.	K 050	K-050 Fire drills need to be conducted at varying times. The schedule for fire drills has been re-developed to ensure that fire drills occur at unexpected times under varying conditions. The fire drill schedule now meets the requirements of the life safety code as the drills have been scheduled to occur at different times throughout the night shift. The ESD or his designee will be responsible for ensuring these fire drills are conducted as scheduled. The Shaller Campus safety committee will periodically review these fire drills for compliance. The re-development of the fire drill schedule was done on September 25, 2015	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00496	A. BUILDING: _____ B. WING _____	09/03/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 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,	2 000		

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2 000	Continued From page 1 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 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		

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2 565	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not follow the plan of care for incontinence care and prevention of pressure ulcers for 1 of 1 resident (R47) observed for incontinence care, and repositioning. 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. Review of R47's plan of care identified resident as at risk for skin breakdown d/t (due to) daily bowel and bladder incontinence ...and decreased mobility skills. The care plan approaches direct staff to check for incontinence q two hours and PRN. Review of the care specialist assignment sheet AM/PM Group 2 undated, directed staff to turn and reposition every two hours, and check and change. Continuous observation on 9/3/15, R47 was transferred into a Broda chair at 9:10 a.m., and	2 565		

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2 565	Continued From page 3 remained in the chair until the surveyor intervened at noon. R47 was transferred out of the Broda chair and into bed at 12:10 p.m. (three hours later). R47's incontinent product was wet, and pericare was completed. No redness was noted on R47's skin. Interview with licensed practical nurse (LPN)-A, and nursing assistant (NA)-A, at noon, indicated R47 was to be checked and changed and repositioned every two hours and had not been completed since before breakfast. SUGGESTED METHOD OF CORRECTION: The director of nurses or designee could randomly observe residents to ensure proper repositioning and toileting was being provided as described in the care plan. If the provision of cares did not match the care plan, the care plan could be revised or staff could be instructed in proper repositioning and toileting practices that were specific to meet the needs of the resident. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician	2 900		

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2 900	Continued From page 4 authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. 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. Findings include: R47's Care Area Assessment (CAA), dated 1/12/15, indicated R47 was totally dependent on staff for her activities of daily living (ADLs) and mobility, and that a mechanical lift was used to transfer her because she was chair bound. In addition, the CAA indicated R47 was incontinent of bowel and bladder, and that because of that and her immobility in a chair and bed, she was at increased risk for pressure ulcer development unless staff repositioned her routinely. R47's Skin Risk Assessment with (Braden Scale)-a tool used to predict skin breakdown) dated 6/23/15, indicated R47's clinical risk factors included: cardiovascular disease, chronic incontinence, and cognitive impairment. The skin risk assessment indicated R47 was lifted manually, incontinent of bowel and bladder,and required total assistance with bed mobility. R47's Braden scale dated 6/26/15, indicated R47 was very limited with responding to stimuli, that her	2 900		

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2 900	Continued From page 5 skin was often moist, the resident was chairfast, very limited in controlling body position, nutrition was adequate, and that friction and shearing was a problem. The Braden score was 12, which put R47 at a high risk for pressure sore development. The assessment indicated the skin treatments to be a pressure relieving device for chair and bed, and turning and repositioning program. R47's care plan, edited 6/30/15, indicated the following: "Resident is identified as at risk for SKIN BREAKDOWN d/t [due to] daily bowel and bladder incontinence with frequent loose stools...and decreased mobility skills. Skin risk assessment and tissue tolerance done quarterly and prn." 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 observations on 9/3/15, R47 was transferred into the Broda chair at 9:10 a.m., taken to breakfast, fed breakfast, and then brought back to her room. At 12:10 p.m. the surveyor intervened, and R47 was transferred out of the Broda chair and into bed. During the observation, R47 was incontinent of urine, when the perineal area was cleansed by nursing assistant (NA)-A. No reddened areas were noted on R47's skin. An interview was conducted with NA-A and licensed practical nurse (LPN)-A at noon on 9/3/15. NA-A and LPN-A verified R47 was supposed to be repositioned, and checked and changed every two hours. They also confirmed R47 had not been repositioned since before	2 900		

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2 900	Continued From page 6 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 CORRECTION: Twenty one (21) days	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary services regarding timely incontinence care for 1 of 2 resident (R47) observed for incontinence care. Findings include: R47's Care Area Assessment (CAA), dated 1/12/15, indicated R47 was totally dependent on staff for her activities of daily living (ADLs) and mobility. A mechanical lift was used to transfer and R47 was incontinent of bowel and bladder. R47 was unable to vocalize of indicate in any way	2 920		

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2 920	Continued From page 7 that she had to void. R47's Bladder Assessment dated 6/25/15, indicated R47 had impaired mobility, dependent transfers, and cognitive impairment due to dementia and Alzheimer's disease. R47's care plan, edited on 7/1/15, indicated the following "Alteration in elimination: CONTINENCE: Resident is incontinent of bowel and bladder...Resident is checked q [every] 2 hours and PRN [as needed] and cleaned and changed as needed with total care of two staff members." During continuous observations on 9/3/15, R47 was transferred into the Broda chair at 9:10 a.m., taken to breakfast, fed breakfast, and then brought back to her room. At 12:10 p.m. the surveyor intervened, and R47 was transferred out of the Broda chair and into bed. R47 was incontinent of urine, pericares were completed by nursing assistant (NA)-A. Interview with NA-A and licensed practical nurse (LPN)-A at noon on 9/3/15, they indicated R47 was to be checked and changed every two hours, and verified R47 had not been checked for incontinence since before breakfast. SUGGESTED METHOD OF CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with activities of daily living. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care.	2 920		

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2 920	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. 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: On 8/31/15, at 5:10 p.m. licensed practical nurse (LPN)-B was observed to prepare R272 insulin for injection. LPN-B entered R272's room with the correct dose of insulin. LPN-B cleansed R272's abdomen with an alcohol wipe, allowed the area to dry and then administered the insulin. LPN-B did not wear gloves to administer the insulin. LPN-B washed her hands before and after the administration. Interview with LPN-B at 5:12 p.m. she indicated she did not wear gloves when giving insulin. Review of the facility's subcutaneous medication administration procedure dated 10/22/13 directed the following : 1. Review physician order and calculate the correct amount of medication.	21375		

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21375	Continued From page 9 2. Wash hands thoroughly and put on gloves. 10. ...Remove 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 CORRECTION: Twenty one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		

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This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure tuberculosis (TB) tuberculin skin test (TST) was completed within 72 hours from admission for 1 of 5 residents (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 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 documented.

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

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the Minimum Data Set (MDS) entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed.

R191 was admitted to the facility on 3/14/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed.

R15 was admitted to the facility on 5/30/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed.

R159 was admitted to the facility on 6/27/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed.

R215 was admitted to the facility on 7/18/15, per the MDS entry tracking record. The Baseline TB screening Tool for Nursing Home and Boarding Care Home Residents was not completed.

E1's start date was 6/8/15. The Baseline TB screening Tool for Healthcare Workers (HCWs) was not complete.

E3's start date was 6/22/15. The Baseline TB screening Tool for Healthcare Workers (HCWs) was not complete.

E5's start date was 8/10/15. The Baseline TB screening Tool for Healthcare Workers (HCWs) was not dated, was not complete.

Lack of chest x-ray documentation:
R191 was admitted to the facility on 3/14/15, per the MDS entry tracking record. The Baseline TB

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21426	Continued From page 12 Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. The Medication Administration record (MAR) for March 2015 revealed R191 received a chest x-ray dated 3/14/15. Chest x-ray results dated 2/28/15, did not include TB results. Lack of induration documentation: R15 was admitted to the facility on 5/30/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. The MAR for May 2015 revealed R15 was given the first step TST on 5/30/15, was read on 6/1/15, no induration was documented. A second step TST was given on 6/6/15, was read on 6/8/15, no induration was documented. R159 was admitted to the facility on 6/27/15, per 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 induration was documented. R215 was admitted to the facility on 7/18/15, per the MDS entry tracking record. The Baseline TB screening Tool for Nursing Home and Boarding Care Home Residents was not completed. The MAR for July 2015 revealed R215 was given the first step TST on 7/19/15, was read on 7/21/15, no induration was documented. A second step TST was given on 7/25/15, was read on 7/27/15, no induration was documented. Lack of results documentation: E4's start date was 7/27/15. A second step TST was given on 7/8/15, was read on 7/10/15, no negative reading was documented.	21426		

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21426	Continued From page 13 E5's start date was 8/10/15. The Baseline TB screening Tool for Healthcare Workers (HCWs) was not dated. The first step TST was given 8/10/15, and was not read. On 9/3/15, at approximately 3:30 p.m. additional information was requested from DON and was not provided in respect to TB screening for residents. Shaller Campus Policy and Procedure Tuberculosis Control Plan - Residents date of origin 12/00, 4/2011, revision date 7/15, directed "prospective skilled nursing facility residents will be screened by the Admission Department or designee prior to admission by using a Pre-Admission TB Screening tool. A standard intradermal tuberculin skin test (Mantoux) will be administered to all skilled facility residents within seventy-two (72) hours of admission, unless there is written documentation of a negative Mantoux within the last three (3) months or if contraindicated in writing by a physician. A two-step Mantoux procedure will be followed. If the initial Mantoux test is negative, a second will be administered in approximately two (2) weeks. If more than three (3) weeks have lapsed between the first and second steps, the entire procedure will be repeated. All residents with a positive reaction to the Mantoux test or a history of a previous positive reaction will have a chest x-ray unless there is documentation of a negative chest x-ray within the past three (3) months. A chest x-ray cannot be substituted for the Mantoux test. Chest x-ray screening does not serve to establish a resident's baseline Mantoux." Sholom Tuberculosis Screening-Employees & Volunteers dated 6/23/14, directed "TST	21426		

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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 TST 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.	21426		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 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,	2 000		

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2 000	Continued From page 1 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 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		10/18/15

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2 565	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not follow the plan of care for incontinence care and prevention of pressure ulcers for 1 of 1 resident (R47) observed for incontinence care, and repositioning. 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. Review of R47's plan of care identified resident as at risk for skin breakdown d/t (due to) daily bowel and bladder incontinence ...and decreased mobility skills. The care plan approaches direct staff to check for incontinence q two hours and PRN. Review of the care specialist assignment sheet AM/PM Group 2 undated, directed staff to turn and reposition every two hours, and check and change. Continuous observation on 9/3/15, R47 was transferred into a Broda chair at 9:10 a.m., and	2 565	Corrected Completion date for compliance is Oct. 18, 2015	

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2 565	Continued From page 3 remained in the chair until the surveyor intervened at noon. R47 was transferred out of the Broda chair and into bed at 12:10 p.m. (three hours later). R47's incontinent product was wet, and pericare was completed. No redness was noted on R47's skin. Interview with licensed practical nurse (LPN)-A, and nursing assistant (NA)-A, at noon, indicated R47 was to be checked and changed and repositioned every two hours and had not been completed since before breakfast. SUGGESTED METHOD OF CORRECTION: The director of nurses or designee could randomly observe residents to ensure proper repositioning and toileting was being provided as described in the care plan. If the provision of cares did not match the care plan, the care plan could be revised or staff could be instructed in proper repositioning and toileting practices that were specific to meet the needs of the resident. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician	2 900		10/18/15

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2 900	Continued From page 4 authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. 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. Findings include: R47's Care Area Assessment (CAA), dated 1/12/15, indicated R47 was totally dependent on staff for her activities of daily living (ADLs) and mobility, and that a mechanical lift was used to transfer her because she was chair bound. In addition, the CAA indicated R47 was incontinent of bowel and bladder, and that because of that and her immobility in a chair and bed, she was at increased risk for pressure ulcer development unless staff repositioned her routinely. R47's Skin Risk Assessment with (Braden Scale)-a tool used to predict skin breakdown) dated 6/23/15, indicated R47's clinical risk factors included: cardiovascular disease, chronic incontinence, and cognitive impairment. The skin risk assessment indicated R47 was lifted manually, incontinent of bowel and bladder,and required total assistance with bed mobility. R47's Braden scale dated 6/26/15, indicated R47 was very limited with responding to stimuli, that her	2 900	0900 Corrected Completion date for compliance is Oct.18, 2015	

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2 900	Continued From page 5 skin was often moist, the resident was chairfast, very limited in controlling body position, nutrition was adequate, and that friction and shearing was a problem. The Braden score was 12, which put R47 at a high risk for pressure sore development. The assessment indicated the skin treatments to be a pressure relieving device for chair and bed, and turning and repositioning program. R47's care plan, edited 6/30/15, indicated the following: "Resident is identified as at risk for SKIN BREAKDOWN d/t [due to] daily bowel and bladder incontinence with frequent loose stools...and decreased mobility skills. Skin risk assessment and tissue tolerance done quarterly and prn." 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 observations on 9/3/15, R47 was transferred into the Broda chair at 9:10 a.m., taken to breakfast, fed breakfast, and then brought back to her room. At 12:10 p.m. the surveyor intervened, and R47 was transferred out of the Broda chair and into bed. During the observation, R47 was incontinent of urine, when the perineal area was cleansed by nursing assistant (NA)-A. No reddened areas were noted on R47's skin. An interview was conducted with NA-A and licensed practical nurse (LPN)-A at noon on 9/3/15. NA-A and LPN-A verified R47 was supposed to be repositioned, and checked and changed every two hours. They also confirmed R47 had not been repositioned since before	2 900		

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2 900	Continued From page 6 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 CORRECTION: Twenty one (21) days	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary services regarding timely incontinence care for 1 of 2 resident (R47) observed for incontinence care. Findings include: R47's Care Area Assessment (CAA), dated 1/12/15, indicated R47 was totally dependent on staff for her activities of daily living (ADLs) and mobility. A mechanical lift was used to transfer and R47 was incontinent of bowel and bladder. R47 was unable to vocalize of indicate in any way	2 920	2920 Corrected Completion date for compliance is Oct.18, 2015	10/18/15

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2 920	Continued From page 7 that she had to void. R47's Bladder Assessment dated 6/25/15, indicated R47 had impaired mobility, dependent transfers, and cognitive impairment due to dementia and Alzheimer's disease. R47's care plan, edited on 7/1/15, indicated the following "Alteration in elimination: CONTINENCE: Resident is incontinent of bowel and bladder...Resident is checked q [every] 2 hours and PRN [as needed] and cleaned and changed as needed with total care of two staff members." During continuous observations on 9/3/15, R47 was transferred into the Broda chair at 9:10 a.m., taken to breakfast, fed breakfast, and then brought back to her room. At 12:10 p.m. the surveyor intervened, and R47 was transferred out of the Broda chair and into bed. R47 was incontinent of urine, pericares were completed by nursing assistant (NA)-A. Interview with NA-A and licensed practical nurse (LPN)-A at noon on 9/3/15, they indicated R47 was to be checked and changed every two hours, and verified R47 had not been checked for incontinence since before breakfast. SUGGESTED METHOD OF CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with activities of daily living. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care.	2 920		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. 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: On 8/31/15, at 5:10 p.m. licensed practical nurse (LPN)-B was observed to prepare R272 insulin for injection. LPN-B entered R272's room with the correct dose of insulin. LPN-B cleansed R272's abdomen with an alcohol wipe, allowed the area to dry and then administered the insulin. LPN-B did not wear gloves to administer the insulin. LPN-B washed her hands before and after the administration. Interview with LPN-B at 5:12 p.m. she indicated she did not wear gloves when giving insulin. Review of the facility's subcutaneous medication administration procedure dated 10/22/13 directed the following : 1. Review physician order and calculate the correct amount of medication.	21375	21375 Corrected Completion date for compliance is Oct.18, 2015	10/18/15

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	00496	A. BUILDING: _____ B. WING _____	09/03/2015

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21375	Continued From page 9 2. Wash hands thoroughly and put on gloves. 10. ...Remove 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 CORRECTION: Twenty one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		10/18/15

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21426	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) tuberculin skin test (TST) was completed within 72 hours from admission for 1 of 5 residents (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 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 documented. Screening: R113 was admitted to the facility on 4/9/15, per	21426	21426 Corrected Completion date for compliance is Oct.18,2015	

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21426	Continued From page 11 the Minimum Data Set (MDS) entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. R191 was admitted to the facility on 3/14/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. R15 was admitted to the facility on 5/30/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. R159 was admitted to the facility on 6/27/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. R215 was admitted to the facility on 7/18/15, per the MDS entry tracking record. The Baseline TB screening Tool for Nursing Home and Boarding Care Home Residents was not completed. E1's start date was 6/8/15. The Baseline TB screening Tool for Healthcare Workers (HCWs) was not complete. E3's start date was 6/22/15. The Baseline TB screening Tool for Healthcare Workers (HCWs) was not complete. E5's start date was 8/10/15. The Baseline TB screening Tool for Healthcare Workers (HCWs) was not dated, was not complete. Lack of chest x-ray documentation: R191 was admitted to the facility on 3/14/15, per the MDS entry tracking record. The Baseline TB	21426		

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21426	Continued From page 12 Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. The Medication Administration record (MAR) for March 2015 revealed R191 received a chest x-ray dated 3/14/15. Chest x-ray results dated 2/28/15, did not include TB results. Lack of induration documentation: R15 was admitted to the facility on 5/30/15, per the MDS entry tracking record. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was not completed. The MAR for May 2015 revealed R15 was given the first step TST on 5/30/15, was read on 6/1/15, no induration was documented. A second step TST was given on 6/6/15, was read on 6/8/15, no induration was documented. R159 was admitted to the facility on 6/27/15, per 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 induration was documented. R215 was admitted to the facility on 7/18/15, per the MDS entry tracking record. The Baseline TB screening Tool for Nursing Home and Boarding Care Home Residents was not completed. The MAR for July 2015 revealed R215 was given the first step TST on 7/19/15, was read on 7/21/15, no induration was documented. A second step TST was given on 7/25/15, was read on 7/27/15, no induration was documented. Lack of results documentation: E4's start date was 7/27/15. A second step TST was given on 7/8/15, was read on 7/10/15, no negative reading was documented.	21426		

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21426	Continued From page 13 E5's start date was 8/10/15. The Baseline TB screening Tool for Healthcare Workers (HCWs) was not dated. The first step TST was given 8/10/15, and was not read. On 9/3/15, at approximately 3:30 p.m. additional information was requested from DON and was not provided in respect to TB screening for residents. Shaller Campus Policy and Procedure Tuberculosis Control Plan - Residents date of origin 12/00, 4/2011, revision date 7/15, directed "prospective skilled nursing facility residents will be screened by the Admission Department or designee prior to admission by using a Pre-Admission TB Screening tool. A standard intradermal tuberculin skin test (Mantoux) will be administered to all skilled facility residents within seventy-two (72) hours of admission, unless there is written documentation of a negative Mantoux within the last three (3) months or if contraindicated in writing by a physician. A two-step Mantoux procedure will be followed. If the initial Mantoux test is negative, a second will be administered in approximately two (2) weeks. If more than three (3) weeks have lapsed between the first and second steps, the entire procedure will be repeated. All residents with a positive reaction to the Mantoux test or a history of a previous positive reaction will have a chest x-ray unless there is documentation of a negative chest x-ray within the past three (3) months. A chest x-ray cannot be substituted for the Mantoux test. Chest x-ray screening does not serve to establish a resident's baseline Mantoux." Sholom Tuberculosis Screening-Employees & Volunteers dated 6/23/14, directed "TST	21426		

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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 TST 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.	21426		