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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LUFU
Facility ID: 00380

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

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

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

4. TYPE OF ACTION: 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 **10/14/2014** (L34)

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**

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **179** (L18)

13.Total Certified Beds **179** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____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: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	179			
(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):
Mandatory DPNA, effective 11/07/2014, is discontinued effective 10/14/2014.

17. SURVEYOR SIGNATURE Date :
Momodou Fatty, HFE NE II 10/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/16/2014 (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 **07/24/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/18/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5574

October 17, 2014

Ms. Kim Pederson, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, Minnesota 55426

Dear Ms. Pederson:

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 13, 2014 the above facility is certified for:

179 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 179 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,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

October 16, 2014

Ms. Kim Pederson, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, Minnesota 55426

RE: Project Number S5574023

Dear Ms. Pederson:

On October 7, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 7, 2014. (42 CFR 488.417 (b))

Also, we notified you in our letter of October 7, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 7, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on August 7, 2014, and lack of verification of substantial compliance with the Life Safety Code (LSC) and health deficiencies at the time of our October 3, 2014 notice. The most serious LSC and health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 14, 2014, the Minnesota Department of Health completed a second Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 13, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 7, 2014, as of October 13, 2014.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of October 7, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 7, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 7, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 7, 2014, is to be rescinded.

In our letter of October 7, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 7, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 13, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

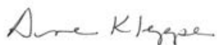
Correction of the Life Safety Code deficiencies cited at the time of the August 7, 2014 standard survey, has been verified.; enclosed please find the CMS-2567B from the October 3, 2014 visit.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this second visit.

Feel free to contact me if you have questions.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

Enclosure

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

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245574	A. Building B. Wing	10/14/2014

Name of Facility	Street Address, City, State, Zip Code
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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 **F0371** Reg. # **483.35(i)** LSC	**10/13/2014**	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	10/16/2014	32984	10/14/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/7/2014

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

AH Form Approved
10/16/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00380	A. Building B. Wing	10/14/2014

Name of Facility	Street Address, City, State, Zip Code
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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 21134 Reg. # MN RULE 4658.0670 Supb LSC	Correction Completed 10/13/2014	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	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:
	GD/AK	10/16/2014	32984	10/14/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/7/2014

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

Protecting, Maintaining and Improving the Health of Minnesotans

October 16, 2014

Ms. Kim Pederson, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, Minnesota 55426

Re: Enclosed Reinspection Results - Project Number S5574023

Dear Ms. Pederson:

On October 14, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 7, 2014. 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.

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

Enclosures

cc: Original - Facility
Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
245574	SHOLOM HOME WEST

Type of Survey (select all that apply):

D	K				

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

Extent of Survey (Select all that apply):

A					

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

SURVEY TEAM AND WORKLOAD DATA

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

	Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1.	~~Team Leader 31223~~	~~09-17-2014~~	~~09-18-2014~~	~~8.00~~	~~0.00~~	~~16.00~~	~~0.00~~	~~0.00~~	~~0.00~~
2.	Team Leader 2nd PCR 32984	10-14-2014	10-14-2014	2.00	0.00	5.00	0.00	0.00	4.50
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

Total Supervisory Review Hours .... ~~1.25~~ 0.75

Total Clerical/Data Entry Hours.. 3.25

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

FORM HCFA-670 (12-91)

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LUFU
Facility ID: 00380

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245574**
2. STATE VENDOR OR MEDICAID NO. (L2) **151743100**

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

4. TYPE OF ACTION: 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 **09/18/2014** (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 **179** (L18)
13.Total Certified Beds **179** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	179			
(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):
Mandatory DPNA is effective 11/07/2014.

17. SURVEYOR SIGNATURE — Kathy Sass, HPR Dietary Specialist — Date: 10/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Anne Kleppe, Enforcement Specialist — Date: 10/03/2014 (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 **07/24/1991** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)
27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

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

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)
30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE **09/18/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4806

October 7, 2014

Ms Kim Pederson, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, Minnesota 55426

RE: Project Number S5574023

Dear Ms. Pederson:

On August 21, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 7, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 18, 2014, the Minnesota Department of Health and on October 3, 2014, the Minnesota Department of Public Safety completed revisits to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2014.

On October 3, 2014, we notified you that based on our revisit, we have determined that your facility has not achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on August 7, 2014. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 7, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 7, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 7, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Sholom Home West is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 7, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the September 18, 2014 was mailed to you October 3, 2014.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 7, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4790

October 3, 2014

Ms. Kim Pederson, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, Minnesota 55426

RE: Project Number S5574023

Dear Ms. Pederson:

On August 21, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 7, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 18, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on August 7, 2014. The deficiency not corrected is as follows:

- **F0371 -- S/S: F -- 483.35(i) -- Food Procure, Store/prepare/serve - Sanitary**

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective October 8, 2014. (42 CFR 488.422)

Correction of the Life Safety Code deficiencies cited at the time of the August 7, 2014 standard survey, has not yet been verified.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 November 7, 2014 (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 February 7, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

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

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245574	A. Building B. Wing	9/18/2014

Name of Facility	Street Address, City, State, Zip Code
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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 **F0159** Reg. # **483.10(c)(2)-(5)** LSC	**09/16/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	**09/16/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**09/16/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**09/16/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	10/03/2014	31223	09/18/2014
CMS RO				

Followup to Survey Completed on: 8/7/2014

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00380	A. Building B. Wing	9/18/2014

Name of Facility	Street Address, City, State, Zip Code
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 21426 Reg. # MN St. Statute 144A.04 Su LSC	09/18/2014	ID Prefix 21610 Reg. # MN Rule 4658.1340 Subp. LSC	09/18/2014	ID Prefix 21630 Reg. # MN Rule 4658.1350 Subp. LSC	09/18/2014
ID Prefix 21665 Reg. # MN Rule 4658.1400 LSC	09/18/2014	ID Prefix 21695 Reg. # MN Rule 4658.1415 Subp. LSC	09/18/2014	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	10/03/2014	31223	09/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/7/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245574	A. Building B. Wing 01 - MAIN BUILDING 01	10/3/2014

Name of Facility	Street Address, City, State, Zip Code
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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
ID Prefix Reg. # NFPA 101 LSC K0018	09/30/2014
ID Prefix Reg. # NFPA 101 LSC K0052	08/08/2014
ID Prefix Reg. # NFPA 101 LSC K0066	09/30/2014
ID Prefix Reg. # NFPA 101 LSC K0144	08/21/2014

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	10/03/2014	28120	10/03/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/7/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING ______ B. WING ______	R 09/18/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A post certification revisit was conducted by the Minnesota Department of Health on September 17 through September 18, 2014. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable 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 371} SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation and maintenance procedures that minimized the potential spread of foodborne illness, having the potential to affect 170 of 171 residents who were served food from the 3S, 3N, 2S and 2N kitchenettes.	{F 371} accepted 10-13-14 [signature]	- fans cleaned - policy/procedure on cleaning & maintenance w/cleaning schedule - all kitchenette refrigerators inspected - policy/procedure updated - staff educated	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 10/13/14

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING ______ B. WING ______	R 09/18/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 371}	Continued From page 1 Findings include: During the foodservice tour on 9/17/14, at 1:15 p.m. the following sanitation problems were observed and confirmed by nutrition services manager (NSM): 1) Three south kitchenette grill below the freezer unit had buildup of food splatter and dust. The NSM stated "Yes it needs to be cleaned." 2) Three north kitchenette grill below the freezer unit had buildup of food splatter and dust. 3) Two south kitchenette grill below the freezer unit had buildup of food splatter and dust. 4) Two north kitchenette grill below the freezer unit had buildup of food splatter and dust. During an interview on 9/17/14, at 1:15 p.m. the NSM verified all the grills below the freezer units in the kitchenettes needed to be cleaned, but that maintenance was responsible for cleaning the outside of the grills. During tour and interview on 9/17/14, at 1:17 p.m. the maintenance worker (MW) verified the grills were "dirty" and needed to be cleaned in all the kitchenette units. MW stated that to his knowledge maintenance is responsible to clean the coils and underneath the freezer, but was not aware it was a maintenance duty to wipe them down every day. During an interview on 9/17/14, at 1:20 p.m. dietary aide - B (DA-B) stated that wiping down the grills is not usually their duty.	{F 371}	F000 This plan and response to these survey findings is written solely to maintain certification in Medicare and Medicaid Assistance programs. These written responses do not constitute an admission of non-compliance with any requirement nor an agreement with any findings. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. F371 F: FOOD PROCURE STORE/PREPARE/SERVE – SANITARY It is the policy of the Sholom Community Alliance to store, prepare, distribute and serve food under sanitary conditions. To ensure continued compliance the following has occurred: Following discovery of the deficient practice and notification of the deficiency by the surveyors, the refrigerators to all unit kitchenettes, to include the grill below it, were thoroughly cleaned.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING ______ B. WING ______	R 09/18/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 371}	Continued From page 2 During tour and interview on 9/17/14, at 1:55 p.m. the food service director (FSD) stated work orders go through facilities management and if work needs to be done, a work order was put in. FSD stated she conducted an audit on 9/11/14 and noted there was a need for cleaning in the kitchenettes and did put in a service request for thorough cleaning of each kitchenette. During tour and interview on 9/17/14, at 2:15 p.m. the interim director of physical plant (IDPP) and administrator (A) verified the grill on the two north unit was dirty and dusty with buildup of food debris and needed to be cleaned. A stated housekeeping was responsible to clean the grills and was aware all four kitchenette grills needed cleaning. During interview on 9/17/14, at 3:07 p.m. the A stated she misspoke, "It's dietary's responsibility to clean the outside of the refrigerator, freezer and the grill below it and they will change the nutrition policy to include cleaning/wiping down the grill/grate." During interview on 9/18/14, at 10:06 a.m. the FSD stated the NSM educated all dietary staff on all policies which included the nutrition refrigerators. That started on 8/4/14, the day the issues were first identified. Audits were completed, that is why a deep cleaning request was put in. FSD verified the dietary staff is responsible for wiping down the exteriors of refrigerators, including the grills below the freezer unit. Review of the Sholom Community Alliance Food Safety and Sanitation policy with revision date 8/2014, indicated nutrition refrigerators in each	{F 371}	The policy and procedure on cleaning and maintenance of equipment along with a cleaning schedule were reviewed and amended to delineate cleaning procedures to nutrition service staff. The procedure now highlights the need to pay special attention to the handle as well as the lower vent grate/grill under the freezer and the cleaning will take place twice daily. As noted in the summary of deficiencies, all dietary staff were educated on the updated policy and procedure and kitchenette refrigerator cleaning schedule. Audits to ensure that equipment is clean and maintained will occur weekly for one month and then quarterly thereafter. Audits will be reviewed at QA meetings for direction or change and determination of whether continuation of audits is necessary based on compliance noted. The Nutrition Service Manager and/or designee are responsible for maintaining compliance with this requirement. Completion date for the plan is October 13th 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING ______ B. WING ______	R 09/18/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 371}	Continued From page 3 dinette will be cleaned and defrosted as scheduled and to "wipe the exterior; pay special attention to the handle."	{F 371}		

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on ___________________

October 3, 2014

Ms. Kim Pederson, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, Minnesota 55426

Re: Project Number S5574023

Dear Ms. Pederson:

On September 18, 2014, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 7, 2014 with orders received by you on August 25, 2014.

State licensing orders issued pursuant to the last survey completed on August 7, 2014 and found corrected at the time of this September 18, 2014 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on August 7, 2014, found not corrected at the time of this September 18, 2014 revisit and subject to penalty assessment are as follows:

- **21134 -- MN RULE 4658.0670 Supb. 2. -- Dishwashing; Sanitation, Storage -- $300.00**

The details of the violations noted at the time of this revisit completed on September 18, 2014 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $300.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

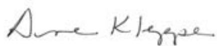
The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Gloria Derfus, Metro Team C Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LUFU
Facility ID: 00380

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/07/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **179** (L18)

13. Total Certified Beds **179** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	179			
(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 :
Sandra Nelson, HFE NE II 09/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 09/18/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4615

August 21, 2014

Ms. Kim Pederson, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, Minnesota 55426

RE: Project Number S5574023

Dear Ms. Pederson:

On August 7, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the 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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - 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;**

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

Informal Dispute Resolution - 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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 September 16, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 16, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 November 7, 2014 (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 February 7, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

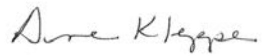
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Received 9-4-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING ______ B. WING ______	08/07/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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 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	F000 This plan and response to these survey findings is written solely to maintain certification in Medicare and Medicaid Assistance programs. These written responses do not constitute an admission of non-compliance with any requirement nor an agreement with any findings. We wish to preserve our right to dispute these findings in there entirety at any time and in any legal action.	
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal	F 159	F 159 E: FACILITY MANAGEMENT OF PERSONAL FUNDS It is the policy as Sholom Home West that residents have a right to access personal funds when they need it. Sholom Home strives to uphold resident rights by ensuring protection of residents, management of residents personal funds while ensuring access to personal funds when the resident needs it, which includes weekend and holidays. Based on this deficient practice, a policy and procedure that allows residents to access funds during the weekend and holidays was devised.	

Receipt [illegible] 9-4-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9-3-14

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING ______ B. WING ______	08/07/2014

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

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F 159	Continued From page 1 funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents with personal trust fund accounts had access to their money after business hours and on weekends. This had the potential to affect 133 (including R142) of 160 residents who had personal funds accounts with the facility. Findings include: R142 stated on 8/5/14, at 3:00 p.m. "absolutely not" when asked if he could get his money when he needed it, including on the weekends. The resident's quarterly Minimum Data Set dated 5/15/14, indicated he was cognitively intact.	F 159	Resident #142 was informed of the new procedure and is in agreement with the plan. He knows personal funds will be available to him when he needs access. All residents and their families have been notified of the changes that allow them to access personal funding during the weekend and holidays. All staff educated on the policy and procedure that upholds resident's rights by ensuring that resident's personal funds are accessible during the weekends. Staff will direct the resident appropriately to obtain their personal funds upon inquiry.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING ______ B. WING ______	08/07/2014

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F 159	Continued From page 2 During an interview on 8/7/14, at 1:40 p.m. an accounting technician (AT) explained that residents had access to their funds Monday through Friday during the hours of 8:00 a.m. to 4:00 p.m. and they closed for lunch from 11:30 a.m. to 12:30 p.m. Additionally, there was no access to personal funds on Saturday because it was the Sabbath and never on Sunday. The AT stated it had not always been that way, as "There used to be a pouch at the front desk, but money was coming up short over and over, so they stopped that." AT verified there was no written policy on residents' access to their personal trust funds accounts.	F 159	Random resident interviews to ensure ease/comfort in obtaining personal funds during the weekends to occur weekly for one month and then quarterly thereafter. Audits will be reviewed at QA meetings for direction or change if necessary and determine if continuation is necessary based on compliance noted. The DON, AR billing manager and/or designee is responsible for maintaining compliance with this requirement. Completion date for the plan is September 16th, 2014.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure housekeeping and maintenance services necessary to maintain an odor free and sanitary environment were provide for 3 of 5 residents (R178, R170, R141) reviewed for environmental concerns. Findings include: R178's bathroom was observed during room observations on 8/5/14, at 3:34 p.m. A strong	F 253	F 253 D: HOUSEKEEPING SERVICES AND MAINATENANCE SEVICES It is the policy of Sholom Home west that housekeeping and maintenance services are provided to maintain a sanitary, orderly and comfortable interior. To assure continued compliance the following plan has been devised and implemented. The policy on daily resident room and bathroom cleaning has been reviewed and remains accurate.	

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

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F 253	Continued From page 3 urine odor was detected in the resident's bathroom. The following day at 11:32 a.m. as well as on 8/7/14, at 8:00 a.m. the malodorous smell remained in the resident's bathroom. R178's quarterly Minimum Data Set (MDS) dated 7/1/14, indicated R178 required extensive physical assistance of one to two staff for all activities of daily living (ADL's) which included toileting and personal hygiene and had a Brief Interview of Mental Status (BIMS) score of three indicating severe cognitive impairment. R170 and R141's bathroom was not free of malodorous smells during the initial tour of the facility on 8/4/14, at 11:47 a.m. R170's quarterly MDS dated 7/15/14, indicated the resident required extensive assistance physical assist of one with toileting and personal hygiene and cognitive skills for daily decision making were severely impaired. R141's quarterly MDS dated 7/8/14, indicated the resident required total physical dependence of two with toileting and extensive physical assist of one staff with personal hygiene. In addition, from the hallway outside R29, R170, and R211's rooms a very strong malodorous smell was also noted. On 8/5/14, at 9:25 a.m. and consecutive days of the survey 8/6/14, at 3:00 p.m. and 8/7/14, at 8:45 a.m. the malodorous smell remained in the hallway. A tour of the facility was conducted on 8/7/14, at 1:45 a.m. through 2:30 p.m. with the administrator, maintenance engineering supervisor (MES), and environmental housekeeping lead. The environmental tour, housekeeping lead verified the offensive odor in R178's room, and stated it was from urine. She	F 253	During the week of August 11th, all housekeepers and janitors were re-educated on the policy for cleaning resident's rooms to include scrubbing bathroom floors and carpets to eliminate malodorous smells. Furthermore, education regarding work order completion for rooms identified to be unsatisfactorily cleansed, due to structure/age of structure needed to occur immediately so the structure could be replaced by maintenance. All resident rooms were inspected following survey and those identified as needing deep cleaning and re-caulking were attended to. Sample residents with affected rooms during survey namely: R 178, R170, and R141 had their bathrooms deep cleaned and re-caulked immediately upon discovery. Furthermore, the carpets were stripped and discarded of and new vinyl flooring is in place. Flooring will cleaned per daily room and bathroom cleaning policy and procedure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 253	Continued From page 4 further stated, "The bathroom needs deep cleaning" and to also be "scrubbed and re-caulked." The administrator verified an odor could be detected coming from R170's and R141's room. The administrator, MES and environmental housekeeping lead all verified the cause of the odors was "urine." The MES explained that carpeting had been removed from R170's room and replaced with hardwood. The MES determined the source of the odor was not from R29's and R211's rooms, but instead was from R170 and R141's shared room. After verifying the smell the administrator stated "It's an easy fix" and directed MES to put a work order for the room. On 8/7/14, at approximately 4:15 p.m. the MES provided a work order dated 7/16/14, for carpet washing for R170 and R141's room. On the bottom of the work order it was dated 7/17/14, and read, "done." Regarding the facility's system for ensuring the work was completed, the MES explained that the staff who put the work order was supposed to report back to the department if the carpet washing had not been completed thoroughly, or if there were any concerns. The Rest Room Floors policy and procedure dated 1/06, directed, "The Rest Rooms at Sholom West will be kept in a clean, sanitary and safe condition."	F 253	Random audits to occur to ensure that rooms and rest rooms are cleaned per policy and work orders are made in a timely manner for rooms/equipment that needs to be fixed. Audits will be completed by Maintenance Engineering Supervisor (MES) and/or designee weekly for one month and then quarterly thereafter. Audits will then be reviewed at QA meetings for direction or change if necessary and determine if continuation of audits is necessary based on compliance noted. The Maintenance Engineering Supervisor (MES) and Environmental Housekeeping Lead and or/designee are responsible for maintaining compliance with this requirement. Completion date for the plan is September 16th 2014.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	F 323 D: FREE OF ACCIDENT HARZARDS/SUPERVISION/ DEVICES It is the policy at Sholom Home West to provide an environment that is free from hazards to prevent avoidable accidents by identifying hazards and risks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bed grab bars were safely secured to the bed frame to minimize the risk of injury for 1 of 3 residents (R251) reviewed for accidents. Findings include: R251's bed grab bars were observed on 8/4/14, at 4:56 p.m. during room observations. Both of the bars were loose and could be moved approximately one to three inches back and forth. R251's diagnoses on the Resident Admission Record dated 10/30/13, included shoulder pain, malaise and fatigue, and debility. R251's Nursing Care Area Assessment (CAA) dated 6/13/14, identified R251 was at risk for falls and required extensive physical assistance from staff for transfers and bed mobility. R251's fall care plan dated 6/20/14, identified R251 was at risk for falls, had a history of falls and had an unsteady gait. The care plan noted the resident required the assistance of one staff with mobility for safety, and the goal was, "Will remain safe and free of injury." A Fall -Safety Risk Assessment dated 6/4/14, indicated R251 had a history falls and utilized grab bars and a toilet safety frame as physical devices. The assessment lacked evidence when and if the grab bars had been checked for safety.	F 323	Based on this deficient practice, the safety risk evaluation policy and procedure which includes the safety risk assessment was evaluated and amended to include an environmental visual assessment for physical devises. All physical devices will be checked during assessment for proper functioning and dated. Assessment addresses the need to complete a work order if the equipment is faulty. Furthermore, all staff in the facility educated on the need to report safety hazards such as faulty equipment as soon as noted through a work order. An inventory of all physical equipment done and work orders for faulty equipment noted through audit completed. R251s grab bars were fixed immediately as stated in the summary statement of deficiencies and all grab bars/physical equipment will be audited randomly on a weekly basis for one month and then quarterly thereafter. Daily visuals will take place by all staff and staff will request repair through work orders as soon as any faulty equipment is noted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING ______ B. WING ______	08/07/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 The grab bars remained loose when observed again on 8/7/14, at approximately 2:10 p.m. at the time of the environmental tour with the administrator and maintenance engineering supervisor (MES). The resident was lying in bed at the time of the tour. Both bed grab bars were checked and again could be moved approximately one to three inches back and forth. The MES verified the bars were both loose and stated, "I can see that [the grab bars were loose]." MES stated he expected the nursing staff who assisted R251 to report the loose grab bars immediately to the maintenance staff. MES reported he would fix the bars immediately, as soon as R251 was out of bed. On 8/7/14, at 2:43 a.m. a registered nurse (RN)-A stated her expectation was for the staff responsible for assisting R251 with cares and transfers to report loose grab bars to the unit secretary or the charge nurse so a work order could be submitted.	F 323	The DON, MES and/or designee will ensure and maintain compliance with this requirement. Completion date for the plan is September 16th 2014.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	F371 F: FOOD PROCURE STORE/PREPARE/SERVE – SANITARY It is the policy of the Sholom Community Alliance to store, prepare, distribute and serve food under sanitary conditions. To ensure continued compliance the following has been implemented.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING ____ B. WING ____	08/07/2014

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F 371	Continued From page 7 Based on observation, interview and document review, the facility failed to follow equipment sanitation and maintenance procedures that minimized the potential spread of foodborne illness, having the potential to affect 158 of 160 residents who were served food from the kitchen and/or kitchenettes. Findings include: During the kitchen tour on 8/4/14, at 11:45 a.m. the following sanitation problems were observed and confirmed by the food service director (FSD) and nutrition services manager (NSM): 1) One large approximately three feet in diameter fan had a heavy buildup of dust with paper particles hanging down from the grill of the fan. The fan was located directly outside the clean dish area, and at the time of the kitchen tour was blowing on four trays of clean dishes drying on a wire rack. 2) Three south kitchenette freezer was observed to have a heavy ice buildup on the inside of the door approximately eight inches wide by 13 inches long. There was heavy frost buildup at the top of the freezer and under the freezer fan positioned at the top of the unit. Frost and ice was observed to have dripped onto four ounce frozen individual ice cream cups. The NSM disposed of four ice cream cups covered with heavy frost and ice buildup and stated the dietary aide should have reported any issues with the freezer to the manager and she would have submitted a maintenance repair request. The NSM stated she was unaware of any maintenance requests related to the issue. The FSD stated she had looked at the freezer last week and there was no	F 371	All fans in the kitchen were located and cleaned immediately upon discovery. A policy and procedure on cleaning and maintenance of equipment along with a cleaning schedule have been devised. All kitchenette refrigerators were inspected for ice buildup, cleanliness and proper function. Maintenance needs were addressed as needed by completion of work order request. The policy and procedure for nutrition service refrigerators was reviewed and amended. The new policy addresses the following: cleaning of refrigerators, defrosting refrigerators, temperature recording of refrigerators and maintenance needs for the refrigerators. Maintenance of equipment following request will take place and thereafter an audit will be completed by Nutrition Service Manager and/or designee to ensure successful repair/replacement/functioning of the equipment.	

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F 371	Continued From page 8 buildup of frost and ice. The FSD verified it should have been reported. During kitchen tour on 8/6/14, at 11:34 a.m. the following sanitation problems were observed and confirmed by nutrition services manager (NSM): 1) Three South kitchenette freezer again had frost buildup on the upper seal of the freezer unit which was falling down onto four ounce frozen individual ice cream cups. There was ice buildup on the bottom of the unit and an approximate three inch icicle on the inside of the door. The NSM stated she had called maintenance on Monday and they said they fixed it. "I will call them again." There were a total of 29 individual ice cream cups in the unit. The NSM disposed of seven individual ice cream cups covered with ice and frost. The freezer also contained an undated 3/4 empty one gallon vanilla ice cream container. A Styrofoam eight ounce cup containing a frozen orange substance in a plastic bag was unlabeled and undated. The NSM stated "I think it is orange pop. It shouldn't be in here if its not marked." The outsides of the refrigerator and freezer doors were unclean containing food splatter and heavy dust buildup on the grill below the freezer. The NSM explained that the dietary aides were responsible for cleaning and wiping down the doors. "I am not sure who should clean the bottom, but yes, I agree it needs to be wiped down more." 2) The two south kitchenette refrigerator and freezer had food splatter on the outside of both units. There was a buildup of food particles in the crevice of the door handle. The grill below the freezer unit had food splatter and dust buildup. The NSM verified it needed to be cleaned.	F 371	All staff has been educated on the policy and procedure and cleaning schedule and random audits to ensure that equipment is clean and maintained to occur weekly then quarterly thereafter. Audits will be reviewed at QA meetings for direction or change if necessary and determine if continuation of audits is necessary based on compliance noted. Completion date for the plan is September 16th, 2014.	

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F 371	Continued From page 9 3) The three north kitchenette refrigerator and freezer also had food splatter on the outside of both units and food particle buildup in the crevice of the door handle. During an interview on 8/7/14, at 12:30 p.m. the NSM stated the facility did not have a policy for reporting maintenance issues, instead, dietary staff told her and she put in a maintenance repair request. During an interview on 8/7/14, at 2:09 p.m. the maintenance engineering supervisor (MES) stated he had received no work order for the three south kitchenette freezer and was unaware of any issue prior to 8/4/14. The MES stated that although he had replaced the gasket, he needed to obtain another one that fit better. Review of Sholom Community Alliance Refrigerators policy with revision date of 8/14, indicated nutrition refrigerators on each station "will be cleaned and defrosted as scheduled," staff were to notify the direct supervisor if any repair was needed, and staff were directed to "wipe the exterior, pay special attention the handle." Review of an undated Weekly Deep Cleaning Schedule indicated the kitchenettes in the dining rooms were to be cleaned every other Monday.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431	F431 E: DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS It is the policy at Sholom Home West to reconcile removal and dispose of fentanyl patches and other narcotics according to State and Federal requirements.	

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F 431	Continued From page 10 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Fentanyl patches were destroyed in a manner that minimized the risk of potential diversion for 1 of 1 resident (R125) who was prescribed the narcotic medication. In addition, the facility failed to ensure	F 431	It is also the policy at Sholom Home West to ensure that drugs and biologicals used in the facility are labelled in accordance with current accepted professional principles and include the appropriate accessory and cautionary inspections and the expiration date when applicable. It is also the policy at Sholom Home West to provide separately locked, permanently affixed compartments for storage of controlled drugs listed in schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity is stored is minimal and a missing dose can easily be detected. All the policy and procedures regarding disposition for narcotics, labelling of drugs, narcotics have been reviewed and remain accurate. Immediately upon error discovery RN-C and all other licensed staff were educated on the proper procedure for Fentanyl disposition in accordance with Facility, State and Federal requirements to avoid diversion.	

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F 431	Continued From page 11 1 of 4 medication refrigerators (2 south) was maintained at temperatures that ensured efficacy of refrigerated medications for 1 of 1 resident (R501) whose medication was stored in the refrigerator, as well as having the potential to affect 32 of 32 residents residing on the unit who may have received the refrigerated medication. Findings include: During the medication administration observation on 8/7/14, at 7:30 a.m. a registered nurse (RN)-C reported he destroyed used Fentanyl patches by placing them in a "biohazard container of some sort." RN-C was then observed as he removed a Fentanyl patch from R125's back and placed it inside a disposable glove. At 7:59 a.m. RN-C then placed the used Fentanyl patch into a large red barrel (red being the designation for biohazard material) in the soiled utility room that was accessible by simply lifting the lid. RN-C was not heard reporting the disposal of the medication to another staff person. When interviewed on 8/7/14, at 4:10 p.m. the consultant pharmacist (CP) stated it would "not be" appropriate to dispose of a Fentanyl patch into a container that was "easily accessible," and a hazardous waste barrel in a soiled utility room would be unacceptable. The director of nursing (DON) was present during the interview and agreed with the statements by the CP. The facility's Disposition of Fentanyl Patches Policy dated 1/13, directed, "When the Fentanyl patch is removed, the licensed nurse must log in the removed patch by placing it on the 'Disposition and Collection of Fentanyl Patches' form. The assigned nurse will notify the building	F 431	Weekly audits will occur for one monthly on all residents' with patch orders to ensure adherence to the policy and procedure that upholds the State and Federal laws. Thereafter the audits will continue quarterly. Audits will be reviewed for direction or change if necessary and determine if continuation is necessary based on compliance. Following the surveyors last measurement of 52 degrees Fahrenheit at 12.02pm, the thermometer at 2 south was replaced and half hour later the temperature was taken. A normal reading of 42 degrees Fahrenheit was recorded and shown to surveyor. A refrigerator log was implemented right away and it has been in place since then with appropriate temperature measurements. All other unis as mentioned in the summary of deficiencies have the logs in place.	

PRINTED: 08/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 12 supervisor, Nurse Manager or director of nursing to obtain the resident's disposition record. The disposition and collection of Fentanyl patch, with remainder of medication attached form, will be double locked in supervisor's office for final disposition." The temperature of the medication refrigerator on the 2 south unit measured 48 degrees Fahrenheit (F) when observed on 8/6/14, at 11:30 a.m. The refrigerator contained two bags of the antibiotic Vancomycin 250 milligrams (mg)/5 milliliters (ml) labeled with R501's name, as well as two boxes of a house supply of Dulcolax suppositories (for constipation). R501's physician orders were then verified with a licensed practical nurse (LPN)-A as Vancomycin 250 mg/5 ml give 5 ml by mouth four times daily for two weeks, from 8/2/14 to 8/16/14. The medication refrigerator temperature and its contents were then verified with a registered nurse (RN)-D. RN-D could not locate evidence staff had measured and recorded temperatures of the refrigerator. At 12:02 p.m. the temperature of the medication refrigerator measured 52 degrees F when re-checked with RN-D. LPN-D then verified temperatures had not been recorded on any of the Medication Administration Records (MARs) on the 2 south unit, and suggested checking with the night nurses. At 12:30 p.m. LPN-D reported a temperature log could not be found "anywhere" and none of the night nurses had returned the staffs' calls. At 2:30 p.m. LPN-D stated that since she had been unable to locate evidence the temperatures had been measured, she had imitated a temperature log.	F 431	All staff were re-educated on the policy and procedure and daily audits of the refrigerator logs will occur to ensure proper storage of medications in the refrigerators and its cleanliness. Any faulty refrigerators/thermometers will be replaced as soon as noted and the temps will be kept at 36-46 degrees Fahrenheit as the policy indicates. Audits will be reviewed at the QA meetings for direction or change if necessary and determine if continuation of audits is necessary based on compliance. The DON and/or designee is responsible for maintaining compliance with this requirement. Completion date for the plan is September 16th 2014.	

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F 431	Continued From page 13 On 8/7/14, at 10:41 a.m. the facility's consultant pharmacist (CP) was interviewed. The CP explained that medication refrigerators should have been maintained between 36 and 46 degrees F to ensure the maintenance of the stability of the medications being stored. The facility's policy for Medication Storage in the Facility dated 10/22/13, directed staff to ensure "medications required to be refrigerated are kept at temperatures ranging from 36-46 degrees Fahrenheit."	F 431		

Minnesota Department of Health

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	00380	A. BUILDING: ______ B. WING ______	08/07/2014

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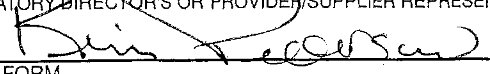
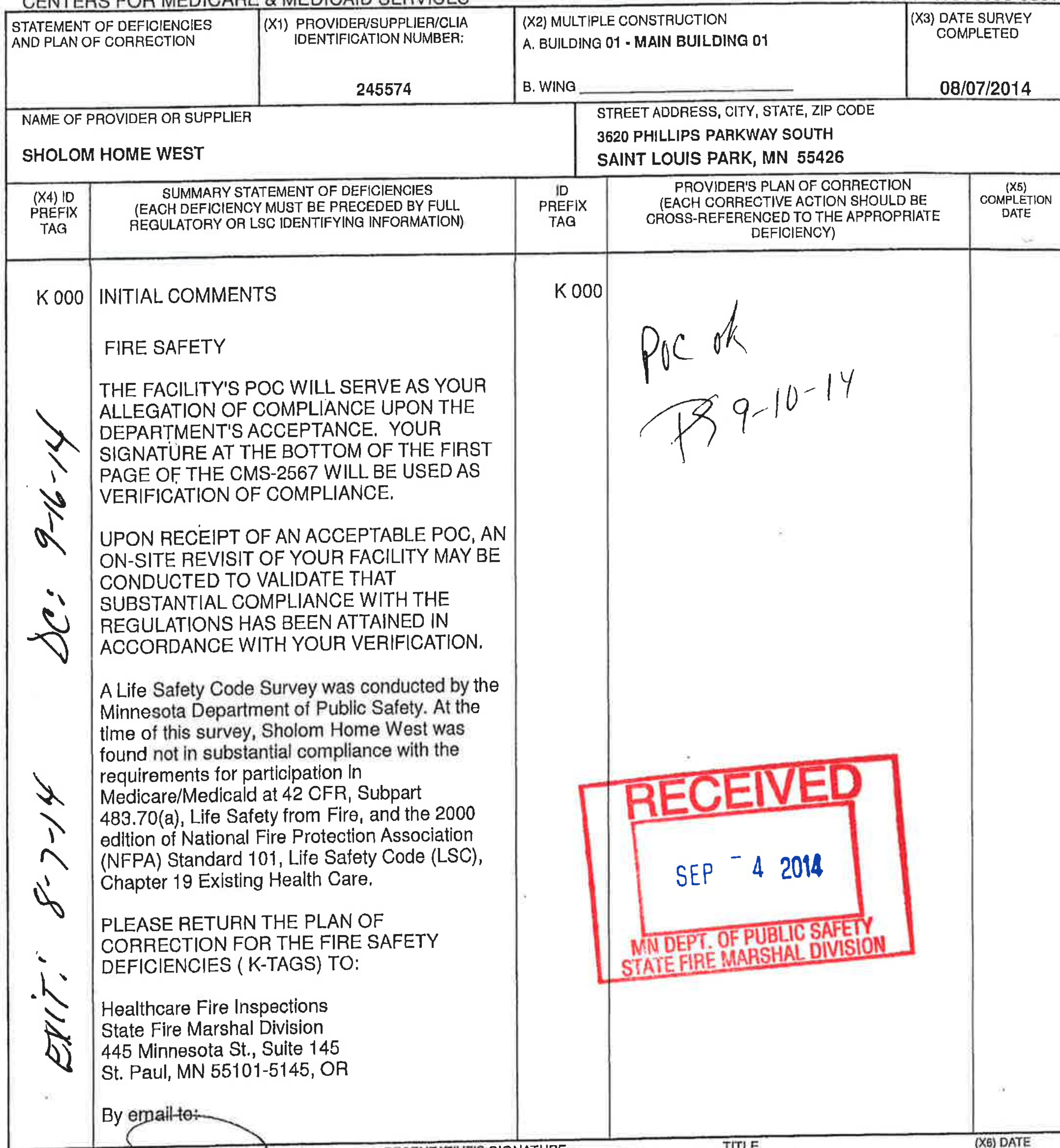
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for 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 8/4/14 through 8/7/14, surveyors of this Department's staff, visited the above provider and the following correction orders are 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, Division of Compliance Monitoring, Licensing and	2 000	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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE



Administrator — 9-3-14

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



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	245574	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/07/2014

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K 000	INITIAL COMMENTS	K 000	POC ok B 9-10-14	

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 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE 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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Sholom Home West was found not 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 19 Existing 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 St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:

Exit: 8-7-14 Dc: 9-16-14

RECEIVED
SEP - 4 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-3-14

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.

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

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SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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K 000	Continued From page 1 Marian.Whitney@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. This 3-story building was determined to be of Type II(222) construction. It has a partial basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 179 beds and had a census of 165 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping	K 018	K 018 F: NFPA LIFE SAFETY CODE STANDARD All electrical closet doors have been assessed. 27 pairs of auto flush bolts need to be replaced and a plan is in place to do so with the completion date of September 30th 2014.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	08/07/2014

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

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K 018	Continued From page 2 the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the residents. Findings include: During facility tour between 9:30 AM and 11:30 AM on 08/07/2014, observation revealed that the electrical closets and linen rooms that open to the corridor have double doors with manual flush bolts on the inactive leafs. These deficient practices were verified by the administrator the time of the inspection.	K 018		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable	K 052	K 052 E: NFPA 101 LIFE SAFETY CODE STANDARDS All smoke detector locations have been checked. There are all now 36" or more from diffusers in day rooms. This was completed on 8/8/14.	

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K 052	Continued From page 3 requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient practice could affect some residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 08/07/2014, observation revealed that the smoke detectors in the remodeled dayrooms are within 36" of the HVAC diffusers. This deficienct practice was verified by the administrator at the time of the inspection.	K 052		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not	K 066	K 066 D: NFPA 101 LIFE SAFETY CODE STANDARDS The trash container was removed from the Physical Therapy entrance door. Cigarette butt containers have been added to the end of the sidewalk nearest the parking lot. All staff were notified of this on 8/13/14. Additional "No Smoking" signage has been ordered and will be in place by 9/30/14.	

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K 066	Continued From page 4 responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to properly enforce the facility smoking policy. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 08/07/2014, observation revealed that there are cigarette butts in the combustible trash can and on the ground near the physical therapy entrance. This deficient practice was verified by the administrator at the time of the inspection.	K 066	The Sholom Home West policy and approved smoking locations is reviewed with all employees and re-iterated during general orientation for new hires and annual anniversary training. Completion date: September 16th 2014.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	N 144 F: NFPA 101 LIFE SAFETY CODE STANDARDS Allied Generator was here on 8/21/14 to review and assess. They advise that there is no need for a 5-minute warm up of the generator prior to monthly load testing. The generator has a block heater and can handle the full load transfer without warm up. An annual load bank test has been scheduled for this generator. ~~Date of completion estimated as September 30th 2014.~~	

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K 144	Continued From page 5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility's emergency generators do not comply with NFPA 99 Health Care Facilities (1999 edition) nor NFPA 110 Standard for Standby Power Systems (1998 edition). This deficient practice could affect all patients. Findings include: On facility tour between 9:30 AM and 11:30 AM on 08/07/2014, record review revealed that the diesel generator is running below its 30% nameplate rating. The monthly genset run is not allowing for the diesel engine to reach stack temperature prior to the 30-minute load test. This deficient practice was verified by the administrator at the time of the inspection.	K 144		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4615

August 21, 2014

Ms. Kim Pederson, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5574023

Dear Ms. Pederson:

The above facility was surveyed on August 4, 2014 through August 7, 2014 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosures

cc: Original - Facility
Licensing and Certification File