



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 28, 2025

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

RE: CCN: 245574
Cycle Start Date: December 5, 2024

Dear Administrator:

On December 18, 2024, we informed you that we may impose enforcement remedies.

On January 8, 2025, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 5, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 5, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 5, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 5, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Sholom Home West will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 5, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 5, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate

formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

Sholom Home West

January 28, 2025

Page 5

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

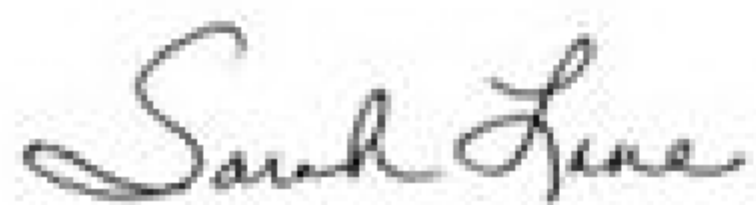
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



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January 28, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: NJXC11

Dear Administrator:

The above facility was surveyed on January 6, 2025 through January 8, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

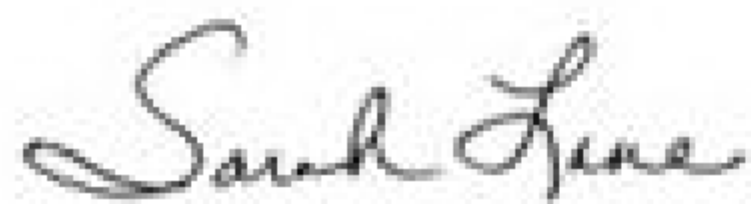
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 02/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245574	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/08/2025
NAME OF PROVIDER OR SUPPLIER SHOLOM HOME WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments On 1/6/25, to 1/8/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 1/6/25 to 1/8/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55743861C (MN109332) H55743862C (MN109171) H55743863C (MN106167) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2025

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

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F 000	Continued From page 1			F 000			
F 585	Grievances			F 585			2/18/25
SS=E	CFR(s): 483.10(j)(1)-(4)						
	§483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance						

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F 585	Continued From page 2 can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions			F 585			

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F 585	Continued From page 3 regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure grievance forms and procedures were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 4 of 4 residents (R26, R35, R102 and R104) reviewed for grievances. Findings include: On 1/7/25 at 1:37 p.m., a resident council meeting was held with four residents which included R26 R26, R35, R102 and R104. During the resident council meeting, all four residents indicated they were not aware how to file a grievance form. R35 stated she thought there was a form at the front door that could be filled out and turned into a nurse. R35 further stated she did not think the form could be filled out without the help of a nurse.			F 585	Education was completed with resident council, R26, R35, R102 and R104 were present. This education included how to report a grievance/concern, grievance process, that grievances can be submitted anonymously if desired and customary follow up steps after a concern is submitted. Facility revised format of the paper concern form to emphasize that contact information is optional and not required. Blank concern forms and secured drop boxes will be placed on each unit to support anonymous submission of concern forms. Facility will post updated procedure on all units to ensure residents are aware of the location of the posted grievance procedure and drop boxes. Education on the new process will occur		

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F 585	Continued From page 4 During an observation on 1/7/25 at 4:36 p.m., the 340 wing had a slot for grievance forms but no forms were present. During an observation/Interview on 1/7/25 at 4:43 p.m., registered nurse (RN)-F stated grievance forms are not kept on the 340 wing. RN-F further stated the forms were down stairs and residents could ask for them if they wanted to fill them out. During an interview on 1/8/25 at 8:29 a.m., guest services (GS) stated residents could grab a grievance form (concern form) from the box on the first floor by the guest services desk or they could ask a nurse to grab one for them. GS further stated when the form was filled out the resident could give the grievance form to a nurse to give to social services. GS revealed forms have always been given to her to give to social services. GS states puts them in the social services directors mail box. During an interview on 1/8/25 at 11:45 a.m., social services director (SSD) indicated grievance forms are put into her mailbox or handed to her directly after they are filled out. SSD further indicated a resident would need to hand the paper copy of the grievance form to someone as there was no box or any other additional place the form could be placed anonymously. SSD stated nurses could also take the form and fill it out online on the facilities intranet. SSD further stated online forms were not accessible to residents and/or family representatives. During an interview on 1/8/25 at 12:35 p.m., administrator indicated residents would give the paper grievance form to a nursing staff or social	F 585	at resident council as well as via a written communication that will be distributed to all residents. Facility will audit to ensure forms and drop boxes are stocked four times each week for four weeks, then four times per month for three months. Will review results with QA cmte for recommendations.		

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F 585	Continued From page 5 worker. Administrator further indicated a form could be left in the dining room or on the nurses station but there were no boxes for the grievance forms to be submitted anonymously. Review of facility form titled Concern Form, dated 6/22, states when complete, please return this form to Guest Services for Director of Social Services. The facility Grievance policy updated 4/17, lacked documentation grievances could be filed anonymously.	F 585			
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 644			2/18/25
			R95 had a PASARR level 2 screening		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245574	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/08/2025
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F 644	Continued From page 6 facility failed to complete a level II preadmission screening and resident review (PASARR) for 1 of 2 residents (R95) reviewed with a new mental illness diagnosis. Findings include: R95's facesheet printed on 1/8/25, indicated R95's original admission date was 12/16/22, and diagnoses at the time of admission included malnutrition, failure to thrive, anxiety, and repeated falls. Further review of the diagnosis listed on face sheet, indicated R95 was diagnosed with delusional disorders, major depressive disorder, and borderline personality disorder on 7/16/24. R95's significant change Minimum Data Set (MDS) assessment dated 10/24/24, indicated R95 had moderately impaired cognition, felt depressed half or more of the days and felt bad about himself nearly every day. R95's current physician orders printed 1/8/25, included risperidone 0.5mg tablet at bedtime for delusional disorders and citalopram 20mg tablet daily for psychosis. Record review of R95's PASARR screen completed on 8/31/23, indicated negative level 1 screening, level 2 screening not needed at time. Record review indicated R95 had new mental health diagnoses on 7/16/24 with no PASARR screen completed with the new diagnoses. During interview on 1/8/25 at 12:45 p.m., social services (SS)-C stated R95 did not have a PASARR completed at the time of new mental	F 644	completed on 1/21/2025. The screening directed R95 to receive medications and mental health services with ACP for anxiety disorder, borderline personality disorder and dementia. R95's admission was approved for severe illness. An Obra 2 was completed for R95 with no new interventions recommended. Care plan reviewed. All residents in the facility who have a mental illness diagnosis are at risk. The facility completed an audit for all residents with a mental illness diagnosis to ensure a PASARR level 2 screening was completed. Any missing resident reviews were requested on 2/7/25 Facility PASARR Screening Policy was reviewed and remains current. Facility educated all staff on the requirements of PASARR level 2 screening. Facility will audit four residents per week who admit with mental illness diagnosis, return from the hospital following a change in their mental health status or remain in the facility with a change in their mental health status, for four weeks, then four times per months for three months. QA will further review and make recommendations.		

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F 644	Continued From page 7 health diagnoses and was not sure who was supposed to complete that, but it should have been done. During interview on 1/8/25 at 12:49 p.m., administrator stated there was a gap in the system for having new PASARR screenings completed and the admissions team took care of making sure residents had a preadmission screening at the time of admission, but a process was lacking for ensuring a new one was completed with a new mental health diagnosis. The facility PASRR Screening policy dated 5/23/18, directed Sholom will comply with DHS regulations regarding screening and necessary updates for persons with developmental or intellectual disorders and those with mental illness. The policy further stated reasons people who have not previously been identified as needing Level II Resident Review includes the addition of or significant increase in antipsychotic or psychotropic medications.	F 644			
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657			2/18/25

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

PRINTED: 02/10/2025
FORM APPROVED
OMB NO. 0938-0391

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F 657	Continued From page 8 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to hold care conference meetings with the resident and/or their representative to allow the resident and/or representative the opportunity to review and participate in the revision of the care plan for 5 of 5 residents (R14, R105, R6, R74,R97) reviewed for care planning. Findings include: R14's facesheet printed on 1/8/25, included diagnoses of Alzheimer's disease, dementia, depression, chronic kidney disease, diabetes, and congestive heart failure (heart doesn't pump as it should). R14's annual Minimum Data Set (MDS) assessment dated 9/26/24, indicated R14 was cognitively intact, had clear speech, could understand and be understood. R14 was independent with activities of daily living (ADL) and with ambulation.	F 657	R14 had a care conference on 1/17/25 with the resident and care team present. R105 had a care conference on 1/29/25 with the resident and resident representative present. R6 had a care conference on 1/9/25 with the resident and resident representative present. R74 had a care conference on 1/16/25 with the resident and resident representative present. R97 had a care conference on 1/16/25 with the resident and translator via phone. All residents who reside in the facility are at risk for an overdue care conference. The facility will complete an audit for all residents and schedule overdue care conferences to ensure all residents have had a documented care conference. Facility Care Planning policy was reviewed and updated. The facility will		

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

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F 657	Continued From page 9 R14's care plan dated 4/14/23, indicated R14's wishes would be respected, and her wishes would be reviewed at quarterly care conferences. Care plan dated 8/2/24, indicated R14's code status would be reviewed with each care conference. During an interview on 1/7/25 at 2:53 p.m., licensed practical nurse (LPN)-B who was also a nurse manager, stated R14's pain was discussed at her care conference today, as was the condition of her room (cluttered). Upon review of care conference notes in the electronic medical record (EMR), R14's last documented care conference was on 7/25/23 - 18 months prior. During an interview on 1/7/25 at 4:10 p.m., social services (SS)-A looked at R14's care conference notes in the EMR and verified that prior to today's care conference (which had not been documented yet), R14's last care conference had been on 7/25/23. SS-A could not explain why this was, as she had only been employed in her role since August 2024. SS-A was aware prior to her, there had been social workers working in a temporary capacity. During an interview on 1/8/25 at 9:48 a.m., the director of nursing (DON) stated she expected care conferences to be conducted every 90 days (or quarterly). The DON reviewed R14's care conference documentation in the EMR and verified the last documented care conference for R14 was on 7/25/23. The DON was not aware until yesterday (1/7/25), when nurse managers brought it to her attention, that care conferences had not been conducted timely. The DON stated social workers were responsible for scheduling,	F 657	educate all staff on the timing requirements for care conferences and who should be invited/ in attendance. Facility will also educate on how to document a late entry in the resident medical record when documenting data that occurred on a prior date. Facility will audit four residents per week to ensure a care conference is offered every 90 days or as needed to both the resident and/or representative, for four weeks, then four times per month for three months. QA will further review and make recommendations.		

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

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OMB NO. 0938-0391

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F 657	Continued From page 10 facilitating and documenting resident care conferences. R105's facesheet printed on 1/8/25, included hemiplegia (weakness or paralysis on one side of the body) following cerebral infarction (stroke), depression and anxiety. R105's quarterly MDS assessment dated 11/21/24, indicated R105 was cognitively intact, had clear speech, could understand and be understood. R105 needed assistance with ADL's including walking. R105's care plan dated 1/10/24, indicated R105's wishes would be respected, and his wishes reviewed at quarterly care conferences. Care plan dated 6/25/24, indicated R105's code status would be reviewed with each care conference. During an interview on 1/6/25 at 6:46 p.m., R105 mentioned discussing provider visits at a care conference, but could not recall the approximate date. Review of care conference notes in the EMR indicated R105's last care conference had been documented on 5/28/24 - eight months prior. During an interview on 1/7/25 at 4:08 p.m., SS-A stated she just documented R105's care conference note from 9/19/24, today. SS-A said she had been confused about where the care conference note should be documented. During an interview on 1/8/25 at 9:46 a.m., the DON was informed of R105's last two care conference dates - 5/28/24, and 9/19/24, with the notes for 9/19/24, having been documented today. The DON reviewed R105's care	F 657			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 657	Continued From page 11 conference notes in the EMR and verified the dates as reported. The DON that late entries for documentation should be identified as such. (The 9/19/24, care conference note documented on 1/8/25, did not indicate it was a late entry). The DON stated she expected care conferences to be conducted according to regulation. The DON stated she would discuss with SS-A and report back. During an interview on 1/8/25 at 12:56 p.m., the DON stated she spoke to SS-A and no rationale had been determined as to why care conferences for R14 and R105 had not been conducted. R6's quarterly MDS assessment dated 12/19/24, indicated R6 had moderately impaired cognition, behavior not directed towards others, required substantial assistance with eating, and substantial assistance with personal hygiene, utilized a wheelchair, diagnoses included renal (kidney) failure, arthritis, and malnutrition. R6's care plan edited 1/2/25, indicated nutrition concern related to inadequate oral intake related to decreased appetite as evidenced by non-significant weight loss, history of behaviors including yelling out rather than using call light, and frequent requests for therapy services. During interview on 1/6/25 at 12:34 p.m., R6 stated she had not had a recent care conference to make her needs known and could not recall when her last care conference was held. Record review of facility electronic health record (EHR) indicated R6 had a quarterly care conference on 3/8/24 and did not have another care conference until 10/9/24.	F 657			

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

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F 657	Continued From page 12 During interview on 1/8/25 at 12:24 p.m., social services (SS)-C stated she missed R6's care conference around 5/24 or 6/24, and further stated it must have been a busy month. SS-C stated she should have had a care conference for R6 every 90 days. R74's quarterly MDS assessment dated 11/4/24, indicated R74 had severe cognitive impairment, required substantial/maximal assistance with activities of daily living (ADL's) and utilized a wheelchair, diagnoses included heart failure, diabetes, depression, and end stage kidney disease. R74's electronic medical record (EMR) indicated the most current care conference was documented on 8/9/24. On 1/6/25 at 7:12 p.m., family member (FM)-A stated R74 had only one care conference she had been aware of, and stated she called social services (SS)-A about four or five times for the last two weeks and left voicemail's asking for a care conference and had not received a phone call back. On 1/7/25 at 9:23 a.m., SS-A stated it was her role to schedule resident care conferences, and care conferences were expected at admission, quarterly and if a resident had a change in condition. SS-A stated she would reach out to the resident's family (representative) via phone call and email with a date and time for the care conference and ensure staff and family were aware. SS-A stated R74's last care conference was 8/9/24, and she placed a phone call to R74's daughter on 11/19/24 to offer a care conference and had not received a call back. SS-A confirmed	F 657			

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

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F 657	Continued From page 13 R74 did not have a care conference quarterly as expected. On 1/7/25 at 10:03 a.m., licensed practical nurse (LPN)-B, known as the nurse manager for second floor north, confirmed R74 had not had a care conference since the documented care conference on 8/9/24. RN-A further stated regular care conferences were important to keep families up to date on how the resident was doing. R97's quarterly MDS assessment dated 12/3/24, indicated R74 was admitted on 1/3/22, preferred language was Spanish and needed/wanted an interpreter to communicate with a doctor or health care staff, moderate cognitive impairment, required partial/moderate assistance with toileting hygiene, upper body dressing, personal hygiene, and utilized a wheelchair, diagnoses included dementia, anxiety, and depression. On 1/6/25 at 4:32 p.m., during a interview using a Spanish interpreter (via telephone) R74 stated he does not have care conferences at the facility. On 1/6/25 at 9:35 a.m., SS-A stated she met with R74 frequently and used an interpreter phone and stated she had informal care conferences with R74 and stated she had not had a formal care conference with R74. SS-A stated R74's last documented care conference was 6/8/24 and stated R74 was expected to have had a care conference after that. SS-A stated residents were expected to have care conferences every 90 days and with significant changes. On 1/7/25 at 2:48 p.m., SS-B, known as the director of social services, stated residents were expected care conferences every 90 days, with a	F 657			

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

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F 657	Continued From page 14 significant change in condition, and if requested. SS-B stated residents and families were expected to be invited to the care conferences. SS-B stated she was not aware R74 and R97's care conferences had not been completed every 90 days and expected the care conferences completed and documented in the EMR. On 1/7/25 at 3:28 p.m., the administrator confirmed via email R74 did not have formally documented care conference notes On 1/7/25 at 3:53 p.m., the DON stated the social services arranged care conferences and residents were expected to have a care conference every 90 days and stated she was not aware care conferences were not completed for R74 and R97 every 90 days. Facility policy on Care Conferences was requested and not received.	F 657			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 679	Therapeutic recreation (TR) met with R97		2/18/25

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F 679	Continued From page 15 review, the facility failed to ensure a resident's preferred activities for individual entertainment were offered for 1 of 1 resident (R97) reviewed for activities. Findings include: R97's quarterly Minimum Data Set (MDS) assessment dated 12/3/24, indicated R74 was admitted on 1/3/22, preferred language was Spanish and needed/wanted an interpreter to communicate with a doctor or health care staff, moderate cognitive impairment, required partial/moderate assistance with toileting hygiene, upper body dressing, personal hygiene, and utilized a wheelchair, diagnoses included dementia, anxiety, and depression and no rejection of care. R97's annual MDS assessment dated 9/3/24, indicated it was "somewhat important" to participate in favorite activities, listen to music, and to go outside and get fresh air when the weather is good. R97's progress note dated 9/16/23 at 1:05 p.m., therapeutic recreation (TR)-A indicated R97 often fatigued/sleeping, pleasant and sometimes interested in snack being distributed, but prefers to stay close to his room/bed, isn't interested in group programming. R97's care plan dated 12/5/24, indicated R97 was able to self-ambulate, enjoys walking, visits from friends, going outside when weather is nice, weakness: confusion, language barrier (Spanish speaking), will invite or ask Spanish speaking TR (therapeutic recreation) to invite to programs of interest, will respect right to refuse programming,			F 679	and completed a preferred activity assessment on 2/6/25. R97 was issued Spanish reading materials per preference and has the opportunity to watch TV in Spanish in his room. Care plan was reviewed and updated for staff to provide R97 with personal invites to structured groups of interests, Daily Chronicles in Spanish, Spanish Activity Calendar and offer weekly opportunities to watch Spanish Speaking Catholic Mass. Invite/ encourage R97 to participate concerts and to sit in the courtyard when weather is nice. Staff to invite R97 to programs of interests; using communications card and/or language line for clear communications Actively seeking Spanish Speaking 1-1 visitor and religious life to offer communion. R97 activities will be tracked in the activity log and will include activities participated in and refused. All residents who reside in the facility are at risk of not attending their preferred activities. The facility will complete an audit for all residents to ensure all residents have been comprehensively assessed, the care plan updated, and attendance/ refusal tracking is complete per each resident's preference. Facility Life Enrichment policy was reviewed and remains current. The facility will educate all staff on the importance of		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 679	Continued From page 16 The record lacked documentation of activities R97 was offered, participated or refused. On 1/6/25 at 4:32 p.m., during an interview with R97 and the assistance of the Language line, R97 stated he spoke Spanish, and did not understand English. R97 was lying in bed with the television on in Spanish. R97 stated he did not understand the staff who did not speak Spanish. R97 stated he felt like a "bird in a cage" and stated the facility did not provide him activities, and just sits in his room all day and watched TV. R97 stated he wished there were activities to do and people to talk with. R97 stated he doesn't get to do activities often, because he speaks Spanish. On 1/7/25 at 10:00 a.m., licensed practical nurse (LPN)-C stated R97s spoke and understood only Spanish. LPN-C stated R97 did not attend activities. On 1/7/25 at 10:20 a.m., LPN-B stated TR staff were expected to offer and invite R97 to activities and was unaware if R97 attended activities. LPN-B stated the facility did not offer activities in Spanish and confirmed R97 spoke and understood only Spanish. On 1/7/25 at 11:11 a.m., TR-B known as the director of TR, stated an activity interest and preference was expected for all residents and confirmed prior to today (1/7/25), an individualized preference for activities was not completed for R97. TR-B confirmed there was not documentation R97 had refused or was offered activities. TR-B stated residents were assessed for their activity preferences quarterly, annually,	F 679	ensuring all residents attend their preferred activities and document attendance/ refusals. Facility will audit four residents per week to ensure they were offered to attend their preferred activity, and the outcome of attendance is documented in the activity log, for four weeks, then four times per months for three months. QA will further review and make recommendations.		

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

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F 679	Continued From page 17 and with significant changes. TR-B stated expectation of therapeutic recreation staff to communicate with R97 using the interpreter phone and offer R97 activities based off preferences. On 1/7/25 at 11:25 a.m., R97 was in bed sleeping. On 1/7/25 at 2:06 p.m., R97 was self propelling in wheelchair in the hallway and had a ice cream cup in his hand. On 1/7/25 at 11:35 a.m., TR-A and TR-C, stated the facility had planned activities for all residents. TR-C confirmed R97 was not asked daily to attend activities, and was not sure when the last time R97 was asked to attend an activity. TR-A and TR-C confirmed the facility did not have any activities offered in Spanish and stated a reason R97 may not attend activities could be because of the language barrier. TR-C confirmed activities were expected documented in the EMR and stated R97 had no activities documented or refused. TR-A and TR-C were not able to identify how R97's preferences were assessed for one-to-one visits given that she was known to not attend group activities or how individualized activities were being offered. On 1/7/25 at 2:42 p.m., social services (SS)-B, known as the director of social services, stated TR staff were expected to invite R97 to activities daily and would expect the facility to implement activities and programs specific to each resident and have Spanish speaking activities individualized for R97. On 1/7/25 at 3:53 p.m., the director of nursing	F 679			

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

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F 679	Continued From page 18 (DON) stated TR staff were expected to offer activities to all residents daily and documenting refusals in the EMR. On 1/8/25 at 8:12 a.m., the administrator indicated she was unable to find documentation about R97's activities beyond the information on the MDS. The facility Life Enrichment Activities policy dated 10/18/22, indicated: Life Enrichment systems and programs are designed to serve the total person and incorporate ALL disciplines. Resident engagement is grounded in honoring the person and their individual purpose through all the wellness dimensions: spiritual, social, physical, intellectual, environmental, emotional and vocational. Meaningful activities are designed to promote life-skills, quality of life and to encourage involvement. Residents participate in self-care, structured recreational programming, and leisure activities. A member of the Recreation team completes a Resident Assessment by interviewing the resident, family or significant other regarding the residents leisure activities , cultural needs, values and choices. The assessor will seek to understand the residents past roles in order to incorporate them into the present daily life. Provide a variety of engaging resident programs designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community Incorporate resident preferences into the calendar Identify based on assessment barriers or	F 679			

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

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F 679	Continued From page 19 preferences related to group size variety based on resident needs provide resource for independent resident interests and hobbies incorporate referrals to the Interdisciplinary team (spiritual care, fitness, culinary, volunteers) Assist as assessed with development of calendar participation(daily, weekly and/or monthly) Identify individual program needs: rooms/set up/supplies/dietary & volunteer requests Encouraging resident participation Personal invites as appropriate	F 679			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning for 1 of 1 resident (R58) who was dependent upon staff for repositioning and high risk for pressure ulcers. Findings include:	F 686	R58 had a comprehensive skin risk assessment completed, care plan and nursing assistant group sheet were updated to include turning and repositioning every 2-3 hours as determined from assessment. Both the care plan and the nursing assistant group sheet for R58 now match and direct staff		2/18/25

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

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F 686	Continued From page 20 R58's facesheet received 1/8/25, included diagnoses of dementia, aphasia (the ability to use or comprehend language is lost or impaired), diabetes mellitus, history of falling and chronic kidney disease. R58's significant change Minimum Data Set (MDS) assessment dated 11/29/24, indicated R58 had severely impaired cognition, and no behaviors. Activities of daily living (ADL's) included R58 uses a wheelchair and is dependent on staff for transfers, bed mobility and locomotion. R58 is able to feed self after setup. R58 has a an unhealed pressure injury that is unstageable with slough and or eschar (dead tissue that impedes healing of wounds) present. R58's Care Area Assessment indicated R58 has an unstageable pressure ulcer on right heel which is covered by slough. R58 has been identified as being at risk for pressure ulcers related to impaired mobility and bowel incontinence. R58 requires assistance with all ADL's. Skin is monitored with daily cares and weekly shower. Wound is improving. R58 has a pressure relieving cushion in his wheelchair and pressure relieving mattress on his bed. R58's Braden Scale for Predicting Pressure Sore Risk dated 10/30/24, had a score of 16 indicating R58 is at risk for skin breakdown. R58's care plan dated 1/6/25, indicated R58 was identified at risk for skin breakdown related to history of right hip and arm fracture, incontinence, and immobility. On 10/2/24, pressure area noted to right heel from hospital stay. Interventions included wound team to assess, apply house lotion as needed to dry skin areas, conduct a skin			F 686	to turn and reposition every 2-3 hours. All residents who reside in the facility who are dependent on staff for repositioning and high risk for pressure ulcers are at risk. The facility will complete an audit for all residents to ensure all residents have appropriate turning and repositioning programs that are reflected and matches both in the care plan and nursing assistant group sheet Facility Skin Integrity Management policy was reviewed and current. The facility will educate all staff on the importance of turning and repositioning per the residents' care plan. The facility will also be educated that the care plan and nursing assistant group sheet must match, in the event the care plan and nursing assistant group sheet do not match the nurse must be notified immediately. Facility will audit four residents per week to ensure they are being turned and repositioned per the care plan as well as auditing to ensure the care plan and nursing assistant group sheets match, for four weeks, then four times per month for three months. QA will further review and make recommendations.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	Continued From page 21 observation daily by nursing assistants (NA) and weekly by a nurse. Incontinence care every 2-3 hours and as needed. Pressure reducing mattress on bed, cushion in wheelchair, and staff assist of 2 to off load resident every 2 hours. R58 was identified as having an alternation in mobility related to history of right hip and arm fracture and the need for assistance with transfer and locomotion by wheelchair daily. R58 at risk for falls, and impaired skin integrity. Interventions included turn and reposition in bed every 2 hours and as needed with total assist of 2 staff. On observation 1/6/25 at 7:05 p.m., R58 was seated in his Broda chair (positioning wheelchair) in his room watching television. R58 had vascular boots on both lower legs and a cushion in his Broda chair. No air mattress was present on his bed. R58 only laughed when asked how he was doing. No verbal response was received other than that. On observation 1/7/25 at 2:22 p.m., R58 was sitting in his Broda chair in his room watching television. Vascular boots present on both lower legs and chair cushion present. On observation 1/7/25 at 4:15 p.m., R58 continued sitting in his Broda chair in his room watching television. Continuous observation was started at 1/8/25 at 7:11 a.m.: 7:11 a.m. - R58 was dressed for the day had on his vascular boots, was sitting in his Broda chair in room which was slanted back at 10 degrees and was watching television. 7:30 a.m. - registered nurse (RN)-E, and registered nurse (RN)-D completed wound care	F 686			

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

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F 686	Continued From page 22 on R58's heel. Wound is open to air with vascular boots on. Measurements were completed 3.5 x 2.5 cm's with edges lifting and no drainage or redness present. Eschar present. Lotion was applied to both lower legs and feet and heels and vascular boots reapplied. There was no position changes completed on R58. 7:46 a.m. - Wound care completed as above and staff left the room. 7:56 a.m. - R58 remains seated in his Broda chair and no staff entered room. 8:13 a.m. - R58 remains seated in his Broda chair and no staff entered the room. 8:30 a.m. - RN-C entered room and administered insulin, and oral medications. No position changes completed. 8:41 a.m. - NA-B entered room and transported R58 to dining room for breakfast. Did not reposition R58. 8:53 a.m. - R58 remains in dining room waiting for his breakfast. 8:57 a.m. - R58 was served breakfast and fed himself after staff set up his meal. 9:07 a.m. - R58 remains in dining room eating. 9:28 a.m. - NA-B brought R58 back to his room in his Broda chair. Chair remains tipped back at 10 degrees. No position changes or incontinence pad check completed. 9:46 a.m. - No change in position. No staff in room. 9:56 a.m. - No change in position. No staff in room. 10:15 a.m., No change in position. No staff in room. On interview 1/8/25 at 10:23 a.m., NA-B stated R58 should be repositioned every 2-3 hours and he is due at 10:00 a.m. to be repositioned. NA-B	F 686			

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

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F 686	Continued From page 23 confirmed there has been no position changes since putting R58 in his chair around 7:00 a.m. this morning. NA-B indicated she would get assistance to reposition him. On interview and observation 1/8/25 at 10:28 a.m., NA-B and NA-C entered R58's room and using a mechanical lift to transfer R58 to his bed. R58 was rolled side to side and incontinence pad was removed with scant amount of stool present. NA-B and NA-C indicated there is some redness present around rectal area extending outwards, but that is R58's normal. NA-B indicated the purple area on right buttock was a previous pressure ulcer that has healed. Requested NA-B push on skin and blanchable areas were present on left buttock, with no blanching noted on right buttock. Red area extended up and down 2 inches from the rectal area and outwards approximately 3-4 inches each direction. R58 was positioned with head of bed at 30 degrees and pillow under lower legs. On interview 1/8/25 at 10:57 a.m., RN-D reviewed R58's NA care sheet and stated R58 should be repositioning every 2-3 hours and as needed. RN-D then reviewed R58's plan of care and stated the care plan directs repositioning every 2 hours so they are not matching. RN-D confirmed the care plan is what should be followed and R58 should be repositioned every 2 hours. On interview 1/8/25 at 12:56 p.m., the director of nursing (DON) stated she would expect the NA's to follow the care plan and reposition R58 every 2 hours. The facility Skin Integrity Management policy last updated 4/2/21, included:	F 686			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	Continued From page 24 Identification of Risk: The first step in prevention of pressure ulcer/ injuries is the identification of the resident at risk for developing pressure ulcer/ injuries (any skin impairment caused by pressure i.e. friction, shearing, direct pressure, etc.). This is followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of interventions. Comprehensive Skin Risk Observation: Risk factors and potential cause(s) will be reviewed, addressed in the analysis and interventions implemented. Examples of risk factors include but are not limited to: Impaired/decreased mobility and decreased functional ability. Based upon the findings of the Comprehensive Skin Risk Observation which includes the Braden Assessment, the consideration of current interventions and resident preferences; a comprehensive analysis will be completed to guide the care plan process. Changes and implementation of interventions will be documented in the care plan.	F 686			
F 803 SS=E	Establish an individualized turning and repositioning schedule if the resident is immobile. Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;	F 803			2/18/25

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F 803	Continued From page 25 §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to provide a process by which residents could make their own food selections for meals for 6 of 6 residents (R241, R73, R6, R23, R104, R35) reviewed for food. Findings include: R241's facesheet printed on 1/8/25, included diagnoses of chronic kidney disease and congestive heart failure (heart doesn't pump as it should). R241's admission Minimum Data Set (MDS) assessment dated 12/23/24, indicated R241 was cognitively intact, had clear speech, could understand and be understood. R241 required supervision for most activities of daily living (ADL)	F 803	Facility staff followed up with R73, R6, R23, R104, R35 to discuss meal preferences and plan to transition to select style menu effective 2/12/25. Residents were satisfied with the proposed changes. R241 discharged from the facility on 1/7/25. Using a select (versus preference based approach) approach to the menu will allow the residents to choose between several options at each meal. Additionally, there will be an alternative menu of always available foods in the kitchenettes on each unit. Facility will provide information to all residents regarding the change in meal		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 803	Continued From page 26 and could eat independently after set-up help. R241's orders dated 12/17/24, indicated a heart healthy diet. R241's care plan dated 12/20/24, indicated R241's preferences would be honored during her stay. Staff responsible for this included nursing and nutritional services. During an interview on 1/6/25 at 3:49 p.m., R241 stated she had been at the facility since 12/17/24, and had not been given a choice of what to eat, adding, if you get started on something, like oatmeal, you get it every day. R241 presented several diet slips and stated, this is what you get -- no options. No weekly menu or alternative menu was visible in R241's room nor was she aware of them. During an interview on 1/7/25 at 9:39 a.m., in the dining room, nursing assistant (NA)-D stated when a resident was admitted, a dietician met with him/her to find out likes/dislikes, and each resident had a diet ordered by a doctor. NA-D presented an electronically generated diet slip with a resident's name, diet order and a list of food items for that meal. NA-D stated if a resident didn't like what they were given, they could tell staff at the time of meal service and request something else. NA-D stated residents did not get a menu ahead of time to make their own food selections. From a window ledge (window looking out into the nurse's station) in the dining room, NA-D obtained a paper "week-at-a-glance" menu for the current week. Listed for each meal, three times a day, was a main entree and below that another meal option. NA-D also presented a paper "Bistro Menu" indicating alterative food			F 803	service, locations of menus and alternatives. Facility will provide education to all staff where to find the menu and the change in the meal service process. Facility will audit meal service and menu placement on each unit four times per week, for four weeks, then four times per months for three months. QA will further review and make recommendations		

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F 803	Continued From page 27 items for lunch and dinner. NA-D stated she did not know if residents received a copy of either menu. Neither was posted or visible in the dining room for residents. During an interview on 1/7/25 at 10:46 a.m., in the dining room, dietary aide, (DA)-A stated after a meal tray was placed in front of a resident in the dining room, he/she could tell a NA if he/she did not like or want that meal. DA-A stated then the NA would bring the tray back to her, she would discard the food, and obtain what the resident wanted. When asked about an alternative menu, DA-A went to binders on the steam table to look for one and did not find one. DA-A acknowledged there was not a weekly menu or an alternate menu posted in the dining room for residents to see. DA-A stated residents were supposed to have menus in their room and thought her manager took them around to resident rooms. During an interview on 1/7/25 at 1:51 p.m., at the resident council meeting, R104 stated whatever was on their diet slip was what they received at meal time; they did not get an opportunity to select something different ahead of time. R104 stated often, residents didn't even know what the meal was as they did not receive a menu prior to meal services. R104 stated the foods we like and dislike were noted on their diet slips, but that was the extent of their food choices. R104 was not aware of an alternative menu. R35 stated she had heard of an alternate menu but didn't know where to find it. Further, R35 stated it was like scratching off a lottery ticket when staff lifted the cover off their plate of food in the dining room --- meaning the meal was a surprise to them. -- R104: quarterly MDS dated 11/1/24, indicated intact cognition, clear speech, could understand			F 803			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 803	Continued From page 28 and be understood, and eat independently after set up help. -- R35: quarterly MDS dated 10/31/24, indicated intact cognition, clear speech, could understand and be understood, and eat independently after set up help. R73's significant change MDS assessment dated 10/17/24, indicated R73 had moderately impaired cognition, no behaviors, required setup or clean-up assistance with eating, and substantial assistance with personal hygiene, utilized a wheelchair, diagnoses included non-Alzheimer's dementia, depression, R73's care plan edited 1/8/24, indicated potential for change in nutrition status related to the need for a therapeutic diet and a BMI (body mass index) that classifies as obese likes egg salad/tuna salad, please offer alternatives at meals if I dislike the daily menu offerings, likes egg salad, tuna salad, PBJ sandwiches on wheat, like to receive less fish at lunch, no rice, no soups with rice/pasta, no orange juice, no bread/rolls with lunch and dinner, provided small portion of starch at lunch and dinner meals would like a salad at lunch and dinner, to receive Mrs Dash and pepper packets with meal, dislike broccoli. On 1/7/25 at 9:08 a.m., R73 stated he did not get a choice of meals and stated he never knew what he was going to eat. R73 stated the facility brings him his meal to his room and it was "always a surprise" and was not given options and was not aware of menu. On 1/7/25 at 9:46 a.m., NA-E stated residents were not given a choice of food choices, the residents were served food from a generated meal ticked. NA-E stated if the resident did not	F 803			

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

PRINTED: 02/10/2025
FORM APPROVED
OMB NO. 0938-0391

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F 803	Continued From page 29 like what was served the staff would have to call the main kitchen and request another option. NA-E stated there were snacks on the floor however there were not main food options. NA-E stated the menu was expected posted outside the dining room, NA-E was observed outside the second floor north dining room and confirmed a menu was not posted. NA-E stated the residents had lots of complaints regarding food and not liking what was served to them. On 1/7/25 at 10:13 a.m., licensed practical nurse (LPN)-A, stated upon admission the dietician assessed residents for preferences, and stated the preferences are entered into the computer and the resident was served food based off those preferences. LPN-A stated there residents were not offered daily choices. R6's quarterly MDS assessment dated 12/19/24, indicated R6 had moderately impaired cognition, behavior not directed towards others, required substantial assistance with eating, and substantial assistance with personal hygiene, utilized a wheelchair, diagnoses included renal (kidney) failure, arthritis, and malnutrition. R6's care plan edited 1/2/25, indicated nutrition concern related to inadequate oral intake related to decreased appetite as evidenced by non-significant weight loss. During interview on 1/7/25 at 9:15 a.m., R6 stated staff always brought her tray and dropped it off, she didn't get a choice and would have liked to have some choices. She further stated nobody came to ask what she wanted for meals and she didn't know where she would get a menu. R23's annual MDS assessment date 12/26/24,	F 803			

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

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F 803	Continued From page 30 indicated R23 had intact cognition, no behaviors, required setup assistance for eating, substantial assistance for personal hygiene, utilized a wheelchair, diagnoses included seizure disorder and depression. R23's care plan printed 1/8/25, indicated R23 would maintain her current weight, consume 50% of meals, and will remain able to make needs known through next review date. During interview on 1/8/25 at 10:04 a.m., R23 stated she did not get to choose her meals and would have liked to have had choices. R23 further stated she used to be able to make choices by selecting on a piece of paper but had not done that for over a year. R23 stated she would have liked to choose her meal ahead of time. On 1/8/25 at 10:37 a.m., an interview was conducted with three members of the survey team, the administrator, director of nursing (DON), registered dietician (RD-E), dining services director (DSD)-C, and chef (C)-D regarding food service concerns. C-D was asked to describe the process by which residents made food selections for each meal. C-D stated on admission, the dietician met with residents to determine preferences, likes and dislikes. RD-E stated this information was then entered into meal-tracker software. The administrator stated it weeded out a resident's dislikes and automatically made food substitutions. In addition, RD-E stated residents were asked upon admission if they wanted a weekly menu and bistro menu (alternate menu). During this interview, the group did not describe a process which allowed residents to have a choice in what	F 803			

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

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F 803	Continued From page 31 foods they were served at meals. DSD-C stated menus should be posted in each dining area. The group was informed menus had not been visible in dining rooms or resident rooms, that residents were not aware of an alternate menu, and felt they had no choice in what foods were served to them. Based on interviews from residents and staff, the group was informed of the meal process described to the survey team: a resident at the table in the dining room would receive a plate of food. That would be the first time residents became aware of what their meal would be. At that point, if a resident didn't like that meal, or didn't feel up to eating that meal, he/she would inform staff in the dining room who would remove the plate of food, discard it and either get something else from the steam table or the kitchen. The group was asked if that was accurate, and C-D stated it was. DSD-C stated residents did not select food prior to meal service but were instead given what was electronically printed on their diet slip based upon the menu for that meal, their likes and dislikes. If they wanted something else, dietary staff could make something different for them at that point. DSD-C stated they could not make different meals for that many residents -- they would be short order cooks, and there wasn't time for that - so it worked better to give residents what was on the menu first, then if a resident didn't want that, something else would be made for him/her. A policy on food preferences, how residents select their food/meals, alternate menu was requested. Facility Dining and Food Preferences policy with revised date 10/2022, was received. The policy indicated individual dining, food and beverage preferences were identified for all residents. Dining services director, or designee	F 803			

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

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FORM APPROVED
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F 803	Continued From page 32 would interview the resident or resident representative to complete a food preference interview within 72 hours of admission. The purpose would be to identify preferences for dining location, meal times, food and beverage preferences. An individual tray assembly ticket would identify all food items appropriate for the resident based on diet order, allergies, intolerances, and preferences. Upon meal services, any resident with expressed or observed refusal of food would be offered an alternate selection of comparable nutrition value.	F 803			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880			2/18/25

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

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F 880	Continued From page 33 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.			F 880			

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F 880	Continued From page 34 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Disease Control (CDC) guidelines by appropriately implementing measures to prevent the spread of infection when the facility failed to ensure personal protective equipment (PPE) was discarded prior to leaving resident rooms (R19 and R1), and failed to follow enhanced barrier precautions (EBP) for 1 of 1 resident (R58) who had an indwelling device present. Findings include: R41's facesheet received 1/7/25, included diagnoses including chronic kidney disease, diabetes mellitus, and dementia. A Event Report for R41 for infection control included a start date of 1/3/25 at 9:09 a.m., indicating on 1/2/25 at 10:09 p.m., R41 had 3 loose stools, poor appetite and was placed on isolation with testing completed for RSV (respiratory syncytial virus) and influenza. R41 was negative for Covid-19. A note dated 1/4/25 at 10:36 p.m., indicated R41 remained in isolation and R41 tested positive for Influenza type A. R1's Resident Face sheet received 1/7/25, included diagnoses of dementia, type 2 diabetes mellitus, and paranoid schizophrenia. R1's progress note dated 1/6/25, included R1 had an emesis and was placed in transmission based precautions (TBP) with Covid-19 test negative and RSV and Influenza tests completed and			F 880	R19's garbage can for discarded personal protective equipment (PPE) was moved inside of the resident's room R1's garbage can for discarded PPE was moved inside of the resident's room. R58 nursing staff were immediately educated to wear PPE per the signs on R58's door to include a gown and gloves. All residents who reside in the facility who are on transmission-based precautions (TBP) are at risk of staff not wearing PPE per the CDC recommendations. All residents on TBP were audited to ensure the garbage can for discarded PPE was inside of the resident's room. All residents who were on enhanced barrier precautions were audited to ensure the door sign outlined the appropriate PPE to wear. Facility Isolation-Categories of Transmission-Based Precautions policy was reviewed and current. The facility will educate all staff on the importance of discarding PPE while inside the residents' room. The facility will also educate all staff on the required PPE to be worn for residents who have enhanced barrier precautions. Facility will audit four residents per week who are on TBP to ensure the garbage can is inside of the resident's room and		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 35 awaiting results. During observation and interview on 1/6/25 at 12:45 p.m., R19's door was closed with a sign that indicated enhanced respiratory precautions. A stop sign was present that directed "please see nurse before you enter the room". PPE cart was present outside the door and a garbage can that had discarded gowns, gloves and masks was outside of the room. R1, 2 doors away from R41's room also had a closed door with a stop sign directing "Stop, please remain in your room" and an enhanced respiratory precautions sign on the door. PPE was present and a trash bin outside of the room with discarded gowns, gloves and masks. Licensed practice nurse (LPN)-A indicated R19 was diagnosed with Influenza A a few days ago and R1 had an emesis this morning and has been tested for Influenza A, Covid-19 and RSV so both are on isolation currently. On observation 1/7/25 at 9:23 a.m., nursing assistant (NA)-A donned gown, gloves, N95 mask and face shield (PPE) and entered R41's room. Upon exit of the room NA-A was wearing the same PPE she entered room in and doffed her PPE and discarded into wastebasket in hallway next to R41's room. NA-A then donned PPE and entered R1's room and upon exit continued to wear PPE donned prior to entering the room. NA-A doffed her gown, gloves, face mask and face shield after exiting the room and disposed of in garbage can outside of R1's room. On observation 1/8/25 at 7:05 a.m., R1 and R41's garbage cans were no longer outside of their rooms. PPE remained present outside the rooms.	F 880	will audit four staff per week to ensure proper PPE is worn for residents who have enhanced barrier precautions, for four weeks, then four times per month for three months. QA will further review and make recommendations.		

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F 880	Continued From page 36 On interview 1/8/25 at 10:17 a.m., NA-A indicated she doffs wherever the garbage cans are located. NA-A stated yesterday morning they were outside of the rooms but have since been moved to inside the rooms. On interview 1/7/25 at 3:36 p.m., registered nurse (RN)-B, also identified as infection preventionist and the director of nursing stated garbage cans were expected to be inside the room for EBP and isolation rooms and staff are expected to remove PPE prior to exiting the room. R58's Resident Face Sheet, received on 1/8/25, included diagnoses of dementia, paranoid schizophrenia, type 2 diabetes mellitus, and benign prostatic hyperplasia (non cancerous enlarged prostate) with lower urinary tract symptoms. R58's plan of care last edited 12/13/24, included resident requires enhanced barrier due to indwelling medical device; urinary catheter. Interventions included a sign on residents door to alert staff and visitors regarding EBP and follow CDC recommendations wearing PPE with high-contact resident care activities with gloves and gown to be worn prior to the high contact care activity. On observation and interview 1/8/25 at 8:30 a.m., R58 had an EBP sign outside of his room, along with a cart with PPE present. Registered nurse (RN)-C entered R58's room wearing gloves but did not wear a gown. RN-C checked R58's blood sugar and administered insulin in R58's abdomen, discarded her gloves and performed hand hygiene. R58 then gave oral medications mixed in pudding via a spoon to R58 without			F 880			

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F 880	Continued From page 37 gloves on. RN-C then exited the room and performed hand hygiene. RN-C indicated they gown if giving personal cares like bathing, toileting, but did not think it was required to gown for medication administration that was completed. On observation and interview 1/8/25 at 10:45 a.m., NA-B and NA-C entered R58's room with a lift after completing hand hygiene and donning gloves only. The lift harness was placed behind and under R58's legs and R58 was placed in his bed. R58 was rolled side to side with pad changed with scant amount of old stool present. Wipes were used to clean R58's rectal area and new pad was placed. R58 was positioned in his bed with pillow under his lower legs and head of bed elevated at 30 degrees. NA-B and NA-C removed gloves and completed hand hygiene upon exit. NA-B stated they only wear gowns when doing catheter or wound care. NA-B stated gowns are not required for type of care provided and NA-C agreed. On interview 1/8/25 at 10:57 a.m., RN-D, also identified as interim care manager, stated she would expect staff to gown and glove with any direct patient care if the resident is on EBP. On interview 1/8/25 at 1:45 p.m., the DON stated staff are expected to gown and glove for EBP patients when providing high contact direct patient care. The facility Isolation - Categories of Transmission-Based Precautions policy last updated 7/12/22, included: - Enhanced barrier precautions are an infection control intervention designed to reduce transmission of multidrug- resistant organisms			F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 880	Continued From page 38 (MDROs) in the facility. Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for resident known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (i.e. residents with wounds or indwelling medical devices - Enhanced barrier precautions will be used for residents with indwelling medical devices or wounds who do not otherwise meet the criteria for contact precautions, even if they have no history of MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. - High-contact resident care activities include: · Dressing · Bathing/ showering · Transferring · Providing hygiene: i.e. brushing teeth, combing hair, and shaving · Changing linens · Changing briefs or assisting with toileting · Device care or use: any device fully embedded in the body without components that communicate with the outside i.e. central line, urinary catheter, nephrostomy tubes, feeding tube, tracheostomy/ ventilator. Pacemakers would not be considered an indication for enhanced barrier precautions · Wound care: any skin opening requiring a dressing - Contact Precautions: Contact Precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident 's environment. Staff and visitors will wear gloves when entering the room. Gloves will			F 880			

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

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F 880	Continued From page 39	F 880			
F 883 SS=D	be removed and hand hygiene performed before leaving the room. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure	F 883		2/18/25	

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F 883	Continued From page 40 that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R24, R25, and R124) received pneumococcal vaccinations based on shared clinical decision-making in accordance with the Center for Disease Control (CDC) recommendations reviewed for immunizations. Findings include: Review of the current CDC recommendations 4/2024, revealed The CDC identified Adults 65 years of age or older received the (PPSV23) or (PCV13) at any age and who have not received	F 883	R24 was offered the PCV20 on 1/7/25 and refused. R25 was offered the PCV20 on 1/7/25 and it was administered on 1/7/25. R124 was offered the PCV20 on 1/7/25 declined and then accepted on 1/17/25. All residents who reside in the facility who are eligible for the pneumococcal vaccine are at risk. The facility conducted an audit of current residents and offered the pneumococcal vaccine to those who were eligible. The		

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

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F 883	Continued From page 41 the Pneumo 20-valent conjugate Vaccine (PCV20) should receive a dose of the PCV20 at least one year after the most recent PPSV23 or PCV13 vaccine. In addition, the CDC identified adults 65 and older who had previously received both PCV13 and PPSV23 at age 65 and older, based on shared clinical decision-making with the patient and the provider one dose of PCV20 at least five years after the last pneumococcal vaccine dose. Review of R24's facesheet identified R24, age 83 was admitted to the facility on 9/30/24. Review of R24's Minnesota Immunization Information Connection (MIIC) record undated, identified R24 received the PPSV23 on 12/17/2004 and 11/18/2019, and received the PCV13 on 12/15/2014. R24's medical record lacked documentation R24 had been offered or received the PCV20 based on shared clinical decision-making. Review of R25's facesheet identified R25, age 84 was admitted to the facility on 10/29/24. Review of R25's MIIC record undated, identified R25 received the PCV13 on 4/11/15. R25's medical record lacked documentation R25 had been offered or received the PCV20 based on shared clinical decision-making. Review of R124's facesheet identified R124, age 83 was admitted to the facility on 9/27/24. Review of R124's MIIC record undated, identified R124 received the PCV13 on 11/24/15. R124's medical record lacked documentation R124 had been offered or received the PCV20 based on shared clinical decision-making. During an interview on 1/7/25 at 4:14 p.m.,	F 883	facility will offer the pneumococcal vaccine to newly admitted residents unless contraindicated. Facility Pneumococcal Immunizations policy was reviewed and current. The facility will educate all staff on the importance of offering and administering pneumococcal vaccines to eligible residents. Facility will audit four current residents and two newly admitted residents per week to determine if the resident is eligible for the pneumococcal vaccine and that timely administration occurred, for four weeks, then four times per month for three months. QA will further review and make recommendations.		

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F 883	Continued From page 42 infection preventionist (IP) confirmed the above findings and indicated the facility follows the CDC guidelines for pneumococcal immunizations. Director of nursing (DON) stated her expectations were that residents receive immunizations following the CDC guidelines. The facility Pneumococcal Immunizations, Adult policy dated 5/16/24, the facility will reduce the incident of pneumococcal disease by offering and providing pneumococcal vaccinations to residents. Residents will be offered the pneumococcal vaccinations and administered, according to the MDH and CDC recommended interval for the vaccines, unless contraindicated, already immunized, or the resident and/or responsible party declines the vaccine.	F 883			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/09/2025. At the time of this survey, Sholom Home West was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/07/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Sholom Home West is a 3-story building with a partial basement that was built in 1989 and determined to be of Type II(222) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification.	K 000			

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K 000	Continued From page 2 The facility has a capacity of 139 beds and had a census of 127 at the time of the survey.	K 000			
K 291 SS=D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 01/09/2025 between 09:15 AM and 01:45 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the emergency light located in the electrical room with the generator transfer switch had been tested monthly for 30 seconds. 2. On 01/09/2025 between 09:15 AM and 01:45 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the emergency light located in the electrical room with the generator transfer switch had been	K 291	Replaced batteries and verified emergency light to be in working order. Created recurring work order to schedule monthly testing of the light for 30 seconds once a month and 90 minutes once a year.	2/14/25	

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K 291	Continued From page 3 tested for 90 minutes within the last year.	K 291			
K 293 SS=E	An interview with the Administrator, Assistant Administrator, and Maintenance Engineer verified these deficient findings at the time of discovery. Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain exit signs per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.10.1, 7.10.5.1, and 7.10.5.2.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 01/09/2025 at 12:29 PM, it was revealed by observation that the exit sign above the door to stairwell 2 in the basement was not illuminated. 2. On 01/09/2025 at 12:47 PM, it was revealed by observation that the exit sign above the smoke barrier doors near resident room N362 was not illuminated. An interview with the Administrator, Assistant	K 293	Facility completed whole house audit of exit signage and repaired/replaced anything deficient. Education will be provided to facility staff to submit a work order if an exit light is dim or not lit. Maintenance team will complete random audits of exit signage.	2/14/25	

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K 293	Continued From page 4	K 293			
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per	K 321			2/14/25
			Maintenance repaired the latch on both laundry room doors and verified that they		

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K 321	Continued From page 5 NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, and 8.3.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/09/2025 at 12:24 PM, it was revealed by observation that both doors to the laundry room in the basement would not positively latch. An interview with the Administrator, Assistant Administrator, and Maintenance Engineer verified this deficient finding at the time of discovery.	K 321	positively latch. Education will be provided to all staff to submit a work order if a door does not latch, so maintenance can do the repair timely.	2/14/25	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code section 19.7.1.6. These deficient findings could have a widespread impact on the residents within the facility.	K 712	Education was provided to maintenance team to review fire drill requirements. Facility revised the fire drill schedule form to more clearly identify what shift each drill should occur on. Administration to audit monthly drills for compliance with schedule.		

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K 712	Continued From page 6 Findings include: 1. On 01/09/2025 between 09:15 AM and 01:45 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill had been conducted during the first shift during the second quarter of 2024. 2. On 01/09/2025 between 09:15 AM and 01:45 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill had been conducted during the third shift during the fourth quarter of 2024. An interview with the Administrator and Assistant Administrator verified these deficient findings at the time of discovery.	K 712			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 26, 2025

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

RE: CCN: 245574
Cycle Start Date: December 5, 2024

Dear Administrator:

On January 28, 2025, we notified you a remedy was imposed. On February 21, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 18, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 5, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 28, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 5, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 18, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 26, 2025

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

Re: Reinspection Results
Event ID: NJXC12

Dear Administrator:

On February 21, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 5, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us