Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 28, 2023

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

Re: Reinspection Results
Event ID: S8WJ12

Dear Administrator:

On May 4, 2023 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 March 30, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
April 19, 2023

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

RE: CCN: 245411
Cycle Start Date: March 30, 2023

Dear Administrator:

On March 30, 2023, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 29, 2023, the situation of immediate jeopardy to potential health and safety cited at F 578 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 4, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 4, 2023, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 4, 2023, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; 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 May 4, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Shirley Chapman Sholom Home East will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 4, 2023. 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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 "E" tag), i.e., the plan of correction should be directed to:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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, Licensing and Certification Program 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 September 30, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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 DENIAL OF PAYMENT

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) 565-9462

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245411	A. BUILDING _____ B. WING _____	C 03/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/27/23-3/30/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/27/23 through 3/30/23, 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 survey resulted in an Immediate Jeopardy (IJ) at F578 when R25's providers order for life sustaining treatment (POLST) signed by provider indicated do not resusitate (DNR) with selective treatment, physician orders dated 10/25/22, indicated full code. The IJ began on 10/27/22 and the immediacy was removed on 3/29/23. In addition to the recertification survey, the following complaints were reviewed during the survey: H54119700C (MN00091531) H54119699C (MN00091426) H54119717C (MN00090429) H54119718C (MN00084243) H54119719C (MN00083752)	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2023

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 H5411126C (MN00082381) H5411127C (MN00080260) H5411128C (MN00080171) 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 that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure self-administration of medication (SAM) was appropriate for 1 of 1 resident (R41) who was observed with medications at the bedside. Findings include: R41's significant change minimum data set (MDS) dated 3/15/23, indicated R41 was cognitively intact and required minimal assistance for most activities of daily living (ADLs). R41's diagnoses included anxiety, depression,	F 554	• At the time of incident, R41 had medications at bedside, which lacked a self- administration, storage of medication and physician order indicating he could keep at bedside. R41 had medications removed 3/29, and was given house lotion for his itchy legs. • All residents at facility have the potential to be affected by the deficient practice. • Facility conducted audit of all rooms to ensure there no medications out that did not have SAMS order.	5/3/23

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F 554	Continued From page 2 psychotic disorder, amnesia, and diabetes. R41's care plan dated 3/22/23, indicated R41 had an alteration in self-care ability as evidenced by occasional assist with ADLs. The care plan further indicated, R41 was at risk for skin breakdown related to the use of steroid cream. R41's care plan lacked evidence for SAM. R41's physician orders start date 11/18/22, and discontinued 3/20/23, indicated triamcinolone acetonide (a steroid used to treat skin conditions) lotion; 0.1%. Apply to both LEs (lower extremities) twice a day for pruritis (itchy skin). R41's orders lacked an order for SAM or medications to be kept at the bedside. R41's admission SAM assessment dated 11/13/22, indicated R41 did not want to self-administer medications and therefore an assessment was not completed. R41's electronic health record (EHR) lacked evidence of any additional SAM assessments. R41's March 2023, treatment administration record (TAR) indicated, "PRN [as needed] - Self Administration of medication Observation V3 - complete only if patient is self admin ...once ...3/12/23-3/12/23." R41's TAR indicated on 3/12/23, staff initials in parentheses. TAR legend identified, "Initial parenthesized = Not Administered or Not Charted, see Reasons/Comments." The reasons/comments section was blank. During observation and interview on 3/27/23, at 6:11 p.m. R41's bedside table contained three medications and a fourth medication on the nightstand. The medications included one bottle	F 554	• Facility will provide education to staff regarding medication storage. Facility will audit all residents who have SAMS order. All residents will have observations, orders, and medication storage and care plan completed. • Facility will conduct ongoing room audits to check on medication 5 times a week for four weeks, and then reduce to five per month for three months, and then bring results to QA for further review.	

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F 554	Continued From page 3 and one tube of triamcinolone and two bottles of nystatin. The bottle of triamcinolone had a pharmacy label with R41's name. One of the bottles of nystatin had a pharmacy label with R41's roommates name (R25). The other bottle of nystatin had the pharmacy label torn off and the tube of triamcinolone was unlabeled. All containers appeared to have been used. R41 stated they (staff) gave him those medications to put on himself. R41 further stated he had itchy legs occasionally and the medications helped. R41 could not identify the medications. During observation on 3/28/23, at 10:16 a.m. all four medications were still at R41's bedside. During interview on 3/28/23, at 10:32 a.m. registered nurse (RN)-A stated no residents on fourth floor could self-administer medications and there should not be any medications stored in any resident rooms. RN-A further stated for a resident to have medications in their room they would need an order for SAM and an assessment completed indicating they were safe for SAM. During interview on 3/28/23, at 10:34 a.m. licensed practical nurse (LPN)-B stated no one on fourth floor was able to self-administer medications. LPN-B stated for a resident to SAM they would have to have an order from the provider and an observation (SAM) assessment completed. Self-administration would also be care planned and a change in status would trigger a new assessment. During observation and interview on 3/28/23, at 10:47 a.m. LPN-B confirmed the four medications were in R41's room and one of them was prescribed to R25. LPN-B stated none of the	F 554		

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F 554	Continued From page 4 medications should be there and removed them from the room. During interview on 3/29/23, at 2:43 p.m. director of nursing (DON) stated residents were assessed for SAM upon admission per interview and observation. The assessment was used to determine if the resident could safely self-administer medications. DON further stated a resident also needed a provider order for SAM. DON stated R41 was not assessed for SAM and expectation was for medications not to be in R41's room. Facility policy Self-Administration of Medications dated 11/2018, indicated, "If a resident wishes to self-administer medications or store mediations at bedside, the unit nurse will complete the Self Administration of Medication observation in the EMR [electronic medical record]." The policy further indicated residents assessed as able to safely self-administer may keep medications at the bedside with a physician order indicating, "May be kept at bed side."	F 554		
F 578 SS=K	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		5/3/23

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F 578	Continued From page 5 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents wishes regarding code status were accurately reflected throughout medical records for 4 of 94 residents (R25, R41, R86, R349). The facility staff also lacked a consistent process on where to find the code status. This failure resulted in an immediate jeopardy (IJ) for R25, R41, R86, R349, when their medical records failed to identify the residents'	F 578	• R41, R25, R86, and R349 medical records were audited; assessments for determination of wishes were completed for R41, R25, R86 and R349 via interview with facility social workers, orders were updated as below. An audit to ensure alignment of code status, POLST and Advance Directive was completed on 3/28/23, for the other 89 residents who	

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F 578	Continued From page 6 wishes accurately. The IJ began on 10/27/22, when R25's providers order for life sustaining treatment (POLST) signed by provider indicated do not resuscitate (DNR) with selective treatment. However, the physician orders dated 10/25/22, indicated full code. The code status was not reflected consistently in R25, R86, R41, and R349's medical record. The IJ was identified on 3/28/23. The corporate director of clinical services and the director of nursing (DON) were notified of the IJ on 3/28/23, at 10:58 a.m. The IJ was removed on 3/29/23, but noncompliance remained at the lower scope and severity level of E-patterned scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R25's quarterly MDS dated 2/23/23, indicated R25 had mild cognitive impairment and required limited assistance for most ADLs. R25's care plan dated 3/1/23, R25's care plan lacked reference to advanced directives or code status. R25's physician order dated 10/25/22, indicated full code. R25's POLST signed by provider on 10/27/22, indicated DNR with selective treatment. R25's POLST indicated documentation of discussion with "Other Surrogate" and was signed by R25's spouse (R41). During interview on 3/27/23, at 6:43 p.m. R41	F 578	reside at the facility. There were no concerns identified with the 89 residents, orders, POLST and Advance Directive were consistent and honored the residents wishes. • On 3/28/23, facility social worker and nurse manager verified R41 expressed a desire to be a full code. A new POLST was initiated to reflect CPR was completed with provider signature on 3/28/23, provider order obtained for full code; order in electronic medical record was updated to reflect full code. • On 3/28/23, facility social worker and nurse manager verified with R25's decision maker that R25 was to remain DNR selective treatment. A new POLST was initiated to reflect DNR selective treatment with provider signature on 3/28/23, provider order obtained for DNR selective treatment; order in electronic medical record was updated to reflect DNR. • On 3/28/23, facility social worker and nurse practitioner discussed with R86 two dtr's the desired code status and they expressed desire for R86 to receive CPR. Provider met with R86 and determined R86 remains his own decision maker. An Interpreter met with resident and facility social worker on 3/28/23, R86 expressed desire to receive CPR with selective treatment, new POLST completed on 3/28/23 provider updated and aware, order in electronic medical record was updated to reflect CPR with selective treatment. • On 3/28/23, facility social worker verified R349 expressed a desire to be	

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F 578	Continued From page 7 stated R25 would not want CPR initiated if found unresponsive. R86's admission Minimum Data Set (MDS), dated 1/9/23, indicated R86 has severe cognitive impairment. R86's care plan dated 1/3/23, lacked reference to advanced directives or code status. R86's hospital discharge summary dated 1/3/23, indicated Treatment Options as DNR. R86's physician orders dated 1/3/23, indicated code status DNR. R86's POLST was not dated and was left blank with no choice of full code or DNR and no resident or physician signature. The facility's 24-hour Nurse Report Sheet (not dated) indicated R86 code status was DNR/do not intubate (DNI). During interview on 3/27/23, at 6:03 p.m. licensed practical nurse (LPN)-D stated he verified code status for residents by looking at the POLST in the resident's paper chart, the code status would also be found on the resident's face sheet in the electronic health record (EHR). LPN-D stated he would automatically go to the paper chart for the POLST and provide treatment according to what was indicated on the POLST because in an emergency scrolling through the EHR would take too long. LPN-D indicated a blank POLST means the residents code status is automatically considered a Full Code/ cardiopulmonary resuscitation (CPR). LPN-D confirmed R86 had a blank POLST in his paper chart and stated he	F 578	DNR. A new POLST was completed on 3/28/23, to reflect R349 wishes to be DNR with provider signature. Provider order was obtained; order in electronic medical record was updated to reflect DNR. • Upon audits of new process, there shows a pattern of continued gaps identified despite further education, as follows: o Staff not completing all sections of resident wishes form. o Staff not progress noting complete conversation with resident or representative o Not getting provider order for change o Any discrepancies were corrected immediately to ensure compliance with policy. Education has been provided for each occurrence, and the IDT/QA discussed new process to be put into place. • Facility had QA meeting on 4/24/23 to discuss discrepancies and proposal to adopt a new process for facility staff to follow. This includes: o Review of policy and updated the following: ¿ Removal of determination of wishes form ¿ Nurse will review the code status with the resident or designee and compare to physician order in matrix. Nurse will update physician if new order is needed and document conversation in resident record. ¿ Following admission, facility staff will review the POLST with resident or designee and will obtain signature from provider, and will place in medical record.	

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F 578	Continued From page 8 would initiate CPR if R86 was found unresponsive. During interview on 3/27/23, at 6:08 p.m. registered nurse (RN)-D stated the code status for residents was verified by looking at the 24-hour nurse report form they carry with them which lists each resident's code status. RN-D verified on the 24-hour nurse report sheet R86's code status was DNR/DNI, and she would not initiate CPR if R86 was found unresponsive. During interview on 3/27/23, at 6:19 p.m. family member (FM)-B stated she has been the main interpreter for R86 and did not recall any discussion regarding R86's code status with the facility. FM-B stated she believed R86 would want CPR, but not be hooked up to machines. During interview on 3/27/23, 7:00 p.m. LPN-E indicated on admission the code status is determined by what is listed on the resident's hospital discharge summary and having the resident and/or responsible party verify code status by completing the POLST. Once code status has been determined it would be entered in EHR under orders, and the POLST is placed in medical record. LPN-E confirmed that R86's hospital discharge summary and orders in EHR indicated his code status was DNR. She confirmed that R86 had a blank POLST and stated that a blank POLST does not mean the resident is an automatic full code/CPR. LPN-E also confirmed R86's code status was listed as a DNR/DNI on the nurse 24-hour report form and indicated that code statuses were not to be listed on the 24-hour nurse report form as it is not consistently updated and may not be accurate. LPN-E stated she would not initiate CPR if R86	F 578	¿ Education provided to staff will include: • Nursing staff understand upon admission they must initiate conversation with resident and/or designee regarding wishes around CPR or DNR and ensure it matches the physician order, and Health care directive (if present) and how to document this conversation. If resident is not English speaking, staff should utilize the interpreter line for further assistance. • What steps to take if/when the Resident CPR or DNR , orders and/or Health care directive do not match • Archive any outdated Resident Wishes/Code Status forms and/or Health Care Directive in Matrix • Be able to clearly identify the one and only place to confirm the residents code status is through looking up the current order in Matrix • POLST will be completed after admission BUT THIS IS NOT where staff go to confirm resident code status o Additional house audit was completed on 4/24/23 to ensure that resident determination of wishes form or POLST was present in chart, and orders in matrix are matched. • Facility will continue to audit each new admission and re-admission to facility to ensure compliance with policy for one quarter. The data will be brought to QA for further review and recommendation.	

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F 578	Continued From page 9 was found unresponsive due to the EHR had the code status as DNR. R41's significant change MDS dated 3/15/23, indicated R41 was cognitively intact and required minimal assistance for most ADLs. R41's care plan dated 3/22/23, R41's care plan lacked reference to advanced directives or code status. R41's physician order dated 11/11/22, indicated full code. R41's POLST signed by provider and R41 on 11/14/22, indicated DNR with selective treatment. R41's Associated Clinic of Psychology (ACP) note dated 11/16/22, indicated, "[R41] said he is glad to be alive...not ready to die." R41's nurse practitioner (NP) note dated 12/6/22, indicated, "Advanced Directives: Full Code." During interview on 3/27/23, at 6:43 p.m. R41 stated he would want CPR initiated if found unresponsive. During interview on 3/27/23, at 6:46 p.m. licensed practical nurse (LPN)-A stated a resident's code status could be found in the hard chart on the paper POLST or on the resident's face sheet in the EHR (electronic health record). LPN-A stated scrolling through the face sheet could take too long, therefore would go straight to the resident's hard chart for the POLST and provide treatment according to what was indicated on the POLST. LPN-A confirmed R41's POLST indicated DNR and stated she would not initiate CPR if R41 was	F 578		

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F 578	Continued From page 10 found unresponsive. During interview on 3/27/23, at 6:59 p.m. LPN-B stated code status could be found on the resident's face sheet and the orders in the EHR and on the POLST in the hard chart. LPN-B stated staff should reference the most convenient location to determine code status when a resident was found unresponsive. LPN-B stated if discrepancies noted, staff should go by the most current date between the face sheet, orders in the EHR, and POLST. LPN-B confirmed R41's order in the EHR indicated R41 was a full code as of 11/11/22, and the POLST indicated DNR and dated 11/14/22 and therefore, R41 should be considered DNR, and CPR would not be initiated. R349's admission Minimum Data Set (MDS), dated 3/28/23, indicated R349 was cognitively intact. R349's provider order, dated 3/22/23, indicated a full code (to provide cardiopulmonary resuscitation) status. R349's care plan, dated 3/22/23, lacked direction for code status. An undated facility worksheet, entitled 24-hour Nurse Report Sheet, indicated R349 was a full code status. R349's Physician Order for Life-Sustaining Treatment (POLST) form indicated a Do Not Resuscitate (DNR) status. During an interview on 3/27/23, at 7:13 p.m. R349 stated he completed a POLST on 3/22/23 to declare his DNR status.	F 578		

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F 578	Continued From page 11 During an interview on 3/27/23, at 7:26 p.m. RN-D verified R349's POLST form, signed by R349, indicated a DNR status while the provider orders indicated a full code status. In an emergency, RN-D stated she would look at the 24-hour Nurse Report Sheet for code status. During an interview on 3/28/23, at 8:55 a.m. the director of nursing (DON) stated a resident's admission orders indicated resident's code status. The admitting nurse would verify the code status with resident and/or responsible party by filling out a POLST form and entering the orders into Matrix (electronic health record). In an emergency, the DON stated her expectation was the code status indicated on the POLST and in the electronic health record (EHR) would match so it wouldn't matter where staff looked. DON also stated a resident's code status should never be listed on the 24-hour Nurse Report Sheet and wasn't aware that some were currently listed there. In the case of a blank POLST, the DON stated she didn't know what the policy was regarding whether CPR would be performed by default and would need to review facility policy. In the case of a discrepancy between the POLST and Matrix, the DON stated she would expect staff to follow policies and procedures to get clarification. Further, the DON stated code status was reviewed with resident care conferences and a clear code status was important to ensure the resident's wishes were upheld. The facility's policy Health Care Directives, POLST updated on 6/28/17, indicated facility will respect and follow the advanced directive of the resident, with standard medical practices. Policy lacked evidence of where the staff should find the residents code status.	F 578		

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F 578	Continued From page 12 The IJ was removed on 3/29/23, at 11:30 a.m. when the facility developed and implemented a systemic removal plan which was verified by interview and document review, which included an audit of all resident's code status to ensure residents have matching code status order, POLST and Advanced Directive. The facility also reviewed and updated their Health Care Directive Policy and Procedure, which outlined the implementation of code status and where the staff would locate the code status. All licensed nurses, social services and therapy staff were trained immediately or prior to their next scheduled shift regarding the updated Health Care Directive Policy and how to answer questions or concerns regarding resident code status. All new admissions and readmissions to the facility will have the order, POLST, or Resident Determination of Medical Wishes and Advance Directive match to align with the residents wishes.	F 578		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 604		5/3/23

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F 604	Continued From page 13 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 2 of 2 residents (R68,R86). Findings include: R68's significant change Minimum Data Set (MDS) dated 3/2/23, indicated severe cognitive impairment and diagnoses of unspecified dementia, history of falling, and required extensive assist for most activities of daily living (ADLs). The MDS further identified physical restraints were not used. R68's active physician orders in the electronic medical record (EMR) were reviewed and lacked orders for any restraints. R68's care plan dated 3/8/23, indicated R68	F 604	• Upon further investigation, resident had been noted to be restless during the evening, and had not been sleeping due to noise of roommate. R68 was moved to a private room on 3/31, and facility rented a specialty high low/bed with fall mats for each side of the bed. Staff were educated not to use pillows under residents sheets. • R86: resident's bed had been pushed up against the wall. Facility assessed toileting, implemented a revised toileting care plan, implemented two fall mats beside bed, and moved bed from the wall. Staff were immediately educated to not use pillows in bed sheets. • All residents have the potential to be affected by this practice. All residents bed placement will be audited. Facility will also audit pillow placement while in bed. • All staff will be educated on restraint	

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F 604	Continued From page 14 required assist of one to two staff to assist with bed mobility. R68's care plan dated 3/16/23, indicated risk for falling due to a history of falls, impaired mobility, and poor safety awareness with an intervention, "Bedroom furniture rearranged, bed moved against the wall, opposite side the resident prefers to exit/enter bed." R68's Event Report dated 2/9/23, in the EMR indicated an unwitnessed fall. R68 was in bed prior to the fall and was found on the floor mat. Contributing factors included impaired mental status, and a history of falls, change in vital signs, and was bare foot. Adaptive equipment used at the time of the fall included a floor mat and a low bed. The report indicated the cause of the fall was due to unsteady gait/balance/endurance and mental status change and follow up interventions included low bed when in bed, safety checks, and a perimeter mattress was provided to assist R68 with defining the edges of the bed/mattress. R68's Event Report dated 2/10/23, in the EMR indicated an unwitnessed fall on 2/10/23 and was found by the nurse. According to the report, R68 was located between the bed and the wall and following the fall, bed room furniture was rearranged, and the bed was moved against the wall, opposite side of the resident preferred to exit/enter bed. R68's Event Report dated 3/5/23, in the EMR indicated R68 had an unwitnessed fall and was found on the mat by the bedside. The report indicated R68 rolled out of bed and a note added in the Event Report dated 3/7/23, indicated R68 self transferred and ambulated in the hallway.	F 604	policy and procedure, and appropriate fall interventions. • Facility will audit five residents per week for four weeks, who are deemed high fall risk, and will audit fall interventions, bed and pillow placement. We will then move to five per month for three months and then bring results to QA for further review.	

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F 604	Continued From page 15 R68's Event Report dated 3/15/23, in the EMR indicated R68 had an unwitnessed fall in room and was located on the floor with the wheelchair located against the side of his body. During observation on 3/28/23, at 2:50 p.m. R68 was in bed with the bed in a low position and a mat on the floor. The bed was pushed up against the wall towards R68's right side and his head faced the window. R68 had a perimeter mattress. During interview 3/28/23, at 3:40 p.m. family member (FM)-A stated R68 has had several falls and still thinks he can walk and tries to get up. During observation on 3/29/23, at 7:26 a.m. R68 was in bed and a pillow was located under the fitted sheet on R68's left side towards the outside of the bed positioned next to his hips and thighs. Nursing assistant (NA)-A removed the pillow and placed it in R68's wheelchair. R68 had a perimeter mattress with a raised edge approximately four inches located lengthwise on the upper and lower third of the mattress. During observation 3/29/23, at 7:32 a.m. nursing assistant (NA)-A turned R68 towards the outside of the bed. R68 did not assist. During observation and interview 3/29/23, at 7:46 a.m. NA-A stated they apply the pillow under the bed sheet and turn R68 towards the wall to prevent him from getting up. NA-A stated R68 rolls out of bed if the bed is not pushed against the wall, and added since the bed is against the wall, R68 tries to sit up on the other side of the bed.	F 604		

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F 604	Continued From page 16 During interview on 3/29/23, at 8:01 a.m. licensed practical nurse (LPN)-C stated they used pillows on the side of the bed to prevent residents from falling off and stated she has seen R68 swing his legs on the edge of the bed and yell and added staff may have applied the pillow under the bed sheet to prevent R68 from rolling. R86's MDS, dated 1/9/23, indicated R86 had severe cognitive impairment and was diagnosed with Alzheimer's disease, dysphagia (difficulty swallowing), intracranial injury (brain injury), right sided weakness in upper and lower extremity, and required extensive assist for most activities of daily living (ADLs). The MDS further identified physical restraints were not used. R86's physician orders in the EMR were reviewed and lacked orders for any restraints. R86's care plan updated on 2/23/23, indicated R86 is at risk for falls and has the following interventions in place: hourly rounding on night shift, specialty hi-low bed with fall mat, assist with bathroom needs after meals and as needed, keep up after meals until needing to lay down to assist in preventing falls from bed, random/frequent safety checks as able, tilt-n-space wheelchair, provide orientation to use of the call light, and ensure call light is within reach.	F 604		

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F 604	Continued From page 17 R86's admission observation for adaptive equipment/physical device/restraint dated 1/4/23, indicated no restraints in use. R86's quarterly observation for restraint dated on 3/19/23, indicated no restraints in use. R86's quarterly observation for adaptive equipment/physical device/restraint dated 3/23/23, indicated no restraints in use. During observation on 3/27/23, at 2:09 p.m. R86 was in bed. Bed was pushed up against the wall, two pillows tucked under fitted sheet on the right side of his body, and floor mat next to bed. During interview on 3/27/23, at 2:16 p.m. FM-B confirmed that staff tuck pillows underneath R86's fitted sheets to prevent him from getting up on his own. FM- B stated the resident was unable to remove pillows himself as they are tucked in on his right side which was his weak side. During observation and interview on 3/27/23, at 6:55 p.m. nursing assistant (NA)-C assisted R86 with positioning in bed. NA-C placed a pillow under R86's right arm and another pillow under his legs. NA-C put bed in lowest position and placed floor mat next to bed. NA-C stated he placed pillows to assist with offloading and resident comfort. NA-C stated R86 has the floor mat in place because he gets out of bed on his own. NA-C stated he would not place pillows under fitted sheets which would be considered a restraint. During observation on 3/28/23, at 10:08 a.m. R86 observed in bed with pillows tucked under fitted	F 604		

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F 604	Continued From page 18 sheet, on the right side of his body. During observation and interview on 3/28/23, at 10:10 a.m. NA-B stated R86 required his bed to be in the lowest position and floor mat in place as fall interventions. NA-B stated the pillows are tucked under the sheet for comfort and then stated, "I bet you think they are a restraint" and removed the pillows from under the fitted sheet and placed them under the right side of his body over the sheet. NA-B asked R86 if he wanted the pillows where she placed them. R86 did not respond. NA-B left pillows in place. NA-B stated she was unsure if R86 would be able to remove pillows under the fitted sheet due to his right sided weakness. During interview on 3/28/23, at 11:26 a.m. LPN-D stated R86 lacks safety concept due to his dementia which is why pillows are tucked under his fitted sheet as a fall intervention, the pillows keep him in bed and promote safety by having them in place. LPN-D stated R86 would need assistance with removing the pillows as he has right sided weakness. LPN-D stated physician orders and/or an assessment are not needed to place pillows under fitted sheet as it is a nurse judgement call on adding fall interventions. During observation on 3/29/23, at 7:03 a.m. R86 observed sleeping in bed, bed against wall, floor mat in place, two pillows tucked under fitted sheet on right side of body. During interview and observation on 3/29/23, at 7:25 a.m. LPN-E stated the facility does not use restraints, if they did, an assessment and physician orders would be required prior to implementing the restraint. LPN-E stated pillows	F 604		

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F 604	Continued From page 19 are used for repositioning but would be placed on top of the sheet, never tucked under the fitted sheet which could prevent a resident from repositioning themselves and freely move their body. LPN-E verified two pillows were tucked under R86's fitted sheet and stated they shouldn't be there because he cannot remove them himself due to right sided weakness. LPN-E removed pillows from under fitted sheet. During interview on 3/29/23, at 2:50 p.m. director of nursing (DON) stated she would not expect staff to place a pillow under the fitted sheet to keep a resident from getting up and added they do not want to prohibit movement. Facility policy Physical Restraint dated 11/2022, indicated restraints of any type will not be used as punishment/discipline or as a substitute for more effective medical and nursing care or for the convenience of the facility staff. A physical restrain is defined as any manual method, physical or mechanical device, equipment or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to their body.	F 604		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning	F 660		5/3/23

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F 660	Continued From page 20 process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who	F 660		

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F 660	Continued From page 21 made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement an effective discharge planning process which included resident and/or responsible party for 1 of 1 (R86) reviewed for discharge planning process. Findings Include: R86's Admission Record identified admission on 1/3/23. R86's Minimum Data Set (MDS), dated 1/9/23,	F 660	• R86 and family are working with social services on discharge planning and Social Services has offered alternative placement and is assisting family as needed. • All residents in facility will have the potential to be affected. All residents will be audited to ensure discharge planning assistance has been offered and documented if appropriate. • Discharge planning will begin upon admission to the facility.	

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F 660	Continued From page 22 indicated R86 has severe cognitive impairment and was diagnosed with Alzheimer's disease, dysphagia (difficulty swallowing), intracranial injury (brain injury), right sided weakness in upper and lower extremity, and required extensive assist for most activities of daily living (ADLs). Social services progress note on 2/21/23, recorded as late entry on 2/23/23, at 12:40 p.m. stated writer met with resident's daughter regarding his need for long term care (LTC) following therapy. We discussed that our LTC can't accommodate him due to the level of care he needs. Family understands and would like him to continue receiving part-B therapy as long as possible as he is making some gains. Writer will assist them with placement when therapy ends. Social services progress note on 3/10/23, stated writer and physical therapy (PT) called R86's daughter and let her know about last covered day (LCD) in therapy of 3/15/23, and other placement will need to be found as facility isn't able to meet resident's needs in LTC. We discussed that writer could help family locate a more appropriate facility or give resources for home care beyond Medicare services. Daughter stated she will talk it over and let writer know how they'd like to proceed. She asked how long he could remain on the unit, writer said there is no specific time limit, but other placement does need to be located. Facility Assessment Tool dated July 2022, indicated they are licensed to provide care for 74 residents in LTC and cannot accommodate tracheostomy (surgical airway) care, ventilator or respirator (devices that help with breathing), BIPAP/CPAP (devices that help with breathing). Facility assessment tool does not indicate they	F 660	• Facility has reviewed and updated the discharge policy to reflect guidance on alternate placement for resident. The facility will complete education with the social service team on discharge planning policy and procedure. Facility will audit three new admissions or readmissions/ per week for four weeks, to ensure the discharge planning process has been initiated upon admission and the res/res representative is involved in the discharge planning process. Facility will then audit three new admissions or readmissions a month for three months, and then bring to QA for further review.	

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F 660	Continued From page 23 are not able to accommodate needs requiring an assist of two with activities of daily living (ADL's) or assistance from staff while in the bathroom. During interview on 03/27/23, at 2:16 p.m. family member (FM)-B stated attended a care conference about a month ago when Medicare coverage was ending for R86. FM-B stated was told R86 cannot stay here because he needs an assist of two for transfers. FM-B stated feels they are saying he can't stay because they think he's a difficult resident and because he is on Medicaid. FM-B stated the only assistance she has received with finding alternative placement was a list of facilities she was told to call to see if they can accept R86. FM-B stated she called the facilities on the list she was given but once they talk to facility staff they tell her they cannot accept R86. FM-B stated R86 was not present during conversation regarding him needing alternative placement. FM-B stated she would like resident to remain at the facility. During interview on 3/29/23, at 10:37 a.m. nursing assistant (NA)-B stated she was unaware of any discharge plan for R86. NA-B stated he should move to one of the LTC floors if he can't go home. NA-B stated she is not aware of R86 having any behaviors and he is pleasant and redirectable. During interview on 3/29/23, at 10:50 a.m. social services (SS)-A stated discharge planning starts on day one of a residents stay in rehab, she meets with resident and/or responsible party to discuss goals and outcomes for discharge. SS-A stated they have a care conference (CC) by day twenty-one and quarterly thereafter. SS-A stated they have two floors for LTC residents. If a	F 660		

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F 660	Continued From page 24 resident wants to stay or transfer to LTC after rehab she would notify the nurses on the LTC floor and have them assess the resident to see if the residents' needs can be met. SS-A stated we wouldn't have taken the resident in the first place if we can't meet their needs, but the nurse still needs to do an assessment. SS-A stated if the nurse determines the residents' needs cannot be met in LTC the resident and/or responsible party is notified with the specific reason to why they aren't able to accommodate the resident. SS-A stated R86 was assessed for placement in LTC but was told they were not able to accommodate R86's needs because he was a "heavy assist of two". SS-A also stated R86 required someone to stay with him at all times while he was in the bathroom due to his fall risk and was also something LTC was not able to accommodate. SS-A stated she gave a list of facilities to R86's family to check out and if they liked them she would send referral information to the facility of their liking. SS-A stated no referrals have been sent at this time. SS-A stated she believes R86 was aware his family was looking for alternative placement, but her conversations have been with R86's family due to him not speaking English. SS-A also stated she was unsure if R86 would understand discharge planning due to his diagnosis of dementia. SS-A confirmed R86 is his own decision maker at this time and family do not have Power of Attorney (POA). SS-A stated LTC does currently have residents who require an assist of two with activities of daily living (ADLs) and residents who require assistance while using the bathroom. SS-A states she was unsure of why they can accept those residents in LTC and not R86 but was up to the nurses to determine. SS-A stated payor source was not taken into consideration for placement in LTC. If a resident	F 660		

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F 660	Continued From page 25 doesn't have the private pay funds, she would assist them with applying for Medicaid, which she has completed with R86's family. During interview on 3/29/23, at 12:38 p.m. registered nurse (RN)-B stated social services notifies the LTC nurses when a resident in rehab may need LTC placement. RN-B stated one of the LTC nurses would complete a chart review on the rehab resident to determine if the resident's needs could be met. The nurse would then notify social services of their decision and they would notify family. RN-B stated they are able to accommodate residents who require an assist of two with ADLs and can assist residents who need assistance while in the bathroom. RN-B stated the interdisciplinary team (IDT) reviewed R86 for placement in LTC but they did not have a bed available for him. RN-B stated they have four upcoming new admissions to one of the LTC floors. During interview on 03/29/23, at 12:48 p.m. LPN-B stated rehab referrals to LTC are discussed at the daily IDT meeting and one of the nurse managers would complete a chart audit to determine if they can meet the resident's needs in LTC. Social services notifys the resident and/or responsible party of their decision and reason for not accepting the resident. LPN- B stated some reasons for not accepting residents are history of behaviors which are not redirectable, acuity is too high, frequent falls, language barriers, bariatric needs, resident condition unstable. LPN-B confirmed they currently have residents living on the LTC units which require an assist of two and residents who require assistance while in the bathroom. LPN-B stated R86 was assessed for placement in LTC but believes they didn't have a	F 660		

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F 660	Continued From page 26 bed available for him. LPN-B stated they have LTC availability at this time. LPN-B did not think payor source was considered when determining placement in the LTC units. During interview on 3/30/23, at 9:06 a.m. director of nursing (DON) stated when a rehab resident requires LTC placement they would discuss the resident at IDT and one of the LTC nurses would complete an assessment. Social services would communicate and document in electronic health record (EHR) the specific reason that was given to the resident and/or responsible party if they could not accommodate the resident in LTC. DON stated payor source was not taken into consideration when determining placement in LTC. DON stated they can assist residents who require an assist of two with ADLs and residents who require assistance while using the bathroom. DON stated most residents need assistance while in the bathroom because they are at risk for falls. DON then gave an example of if they were to accept a resident who required an assist of three with ADL's in rehab, then they wouldn't say we can't provide that same level of assistance in LTC because we already accepted and provide that level of assistance. DON stated R86 was previously reviewed for LTC placement but they did not have a bed available at that time. DON stated she was not aware that R86's family was told the facility can't accommodate his needs because he required an assist of two with ADLs and needs assistance while in the bathroom. DON stated that information would be inaccurate as they can accommodate those specific needs in LTC. DON stated as of 3/24/23, the facility started the process of reassessing R86 for LTC. DON did not know why the resident and family was not made aware of the reassessment or why	F 660		

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F 660	Continued From page 27 social services was still under the impression the facility could not meet R86's current needs. Facility's policy Discharge Plan of Care and Summary does not define the process of finding alternative placement for a resident they are not able to accommodate needs for. Additonal policies for discharge planning not received.	F 660		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or	F 732		5/3/23

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F 732	Continued From page 28 written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the required nurse staff information was posted daily. This had the potential to affect all of the 94 residents residing in the facility and/or their visitors who may wish to view this information. Findings include: On 3/27/23, at 11:59 a.m. the facility's posted nursing hours for 3/23/23, were observed on a wall located on the main floor by the water fountain. On 3/28/23, at 9:00 a.m. the facility's posted nursing hours for 3/28/23, were observed on a wall located on the main floor by the water fountain. On 3/29/23, at 12:29 p.m. the facility's posted nursing hours for 3/28/23, were observed on a wall located on the main floor by the water fountain. On 3/30/23, at 9:00 a.m. the facility's posted nursing hours for 3/28/23, were observed on a wall located on the main floor by the water fountain.	F 732	• This deficiency has the potential affect all residents. The facility immediately provided education to the staffing coordinator and the charge of building on requirements posting staffing hours. • Facility reviewed policy, and it remains current. Facility put folder in COB book with instructions and has updated process to ensure data will be posted on a daily basis at the beginning of each shift. • Facility will audit three times per week on varying shifts for four weeks, then move to three per month for three months, and then bring to QA for further review.	

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F 732	Continued From page 29 On 3/30/23, at 9:20 a.m. the director of nursing (DON) was interviewed and stated the daily postings are posted on a wall located on the main floor by the water fountain. DON stated it is her expectation the staffing coordinator (SC) post the daily posting and is checked, updated and posted every morning, it is also checked and updated every shift as needed. On 3/20/23, at 11:10 a.m. the SC was interviewed, and confirmed she creates the daily postings and post them Monday through Friday. She creates and leaves the daily posting for the overnight nurse to post for Saturday and Sunday. She confirmed that the daily posting dated 3/23/23, was still posted when she arrived to work on Monday, 3/27/23. She also confirmed on 3/29/23, the daily posting was dated 3/28/23. She stated she believes she did update the posting on 3/29/23, and must have forgotten to update the date on the posting. SC stated the purpose of the daily postings is so others know what the current resident census is, how many staff are in the building, and it would be used to track the amount of people in the building during an emergency. The facility's policy Posting of Staffing Hours updated in October 2022, indicated nursing staff data would be posted in a designated public area by the staffing personnel. The data would be posted on a daily basis at the beginning of each shift.	F 732		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices	F 810		5/3/23

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F 810	Continued From page 30 The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adaptive equipment to promote independence with eating and drinking for 1 of 1 resident (R86) who was reviewed for nutrition and observed having difficulty eating and drinking. Findings Include: R86's Minimum Data Set (MDS) dated 1/9/23, indicated R86 has severe cognitive impairment and was diagnosed with Alzheimer's disease, dysphagia (difficulty swallowing), intracranial injury (brain injury), right sided weakness in upper and lower extremity, and required extensive assist for most activities of daily living (ADLs) including feeding assistance. R86's care plan updated on 1/18/23, indicated per occupational therapy (OT) plate guard, hard plastic cup, built up utensils, and dycem (non-slip material) under plate for all meals to increase independence with self-feeding and required feeding assistance at meals. R86's OT Evaluation and Plan of Treatment dated, 1/4/23, indicated patient will safely perform self-feeding tasks with set-up assistance with use of scoop dish with plate guard, built-up utensils, and sippy cup for use in order to increase independence in self-feeding.	F 810	• R86 did not have recommended adaptive equipment during meal time. Staff did not offer to assist. Upon notification, staff got the resident the appropriate equipment and did assist resident with intake. • Facility conducted a house audit for residents who have therapy recommendations to use adaptive equipment during meal time. Facility will observe residents during meal time. Those who need adaptive equipment and assistance will be assessed to ensure their needs are met. Facility has also updated the meal tickets to reflect adaptive equipment needed. Group sheets and care plans were reviewed to ensure adaptive equipment needs were up to date. • Facility will provide education to TR, therapy, social service, dieticians, culinary, and nursing staff to ensure understanding. • Facility will audit that adaptive equipment and assistance is accurate during meal times five times a week, varying shifts for four weeks, then five times a month for three months, and then bring to the QA team for further review.	

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F 810	Continued From page 31 R86's OT Discharge Summary dated, 3/13/2023, indicated patients treatment had not changed since evaluation on 1/4/23. During observation and interview on 3/27/23, at 12:43 p.m. R86 was sitting at the dining room table attempting to feed himself with a plastic spoon and stated he needed help to eat. No staff in dining room to assist him. His meal was in a styrofoam container, plastic utensils and styrofoam cups. No dycem noted. During observation on 3/28/23, at 9:56 a.m. R86 was sitting at the dining room table with thickened fluids given to him in a styrofoam cup. During observation on 3/29/23, at 8:58 a.m. R86 was served thickened water and juice in plastic cups, oatmeal in a bowl and given a plastic spoon. No dycem noted. During interview on 3/29/23, at 9:03 a.m. nursing assistant (NA)-B stated if a resident needed adaptive equipment during meals, it would be listed on the care sheet assignments they carry with them. She didn't think R86 used any adaptive equipment. NA-B verified on the NA care sheet assignment listed under special needs stated R86 was a feeding assist, and listed under snack/meal he used a plate guard, hard plastic cup, and dycem under the plate for all meals. NA-B confirmed R86 should be provided with adaptive equipment at all meals. NA-B stated that maybe R86 wasn't getting the adaptive equipment because it was Passover. During observation and interview on 3/29/23, 9:05 a.m. dietary aide (DA)-A R86's meal ticket did not indicate he required adaptive equipment with	F 810		

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F 810	Continued From page 32 meals. DA-A stated they don't know if a resident requires adaptive equipment unless nursing tells them however, she did recall R86 used to use a different spoon with a black handle but she was told it was too heavy for him and was told not to give it to him. DA-A stated that it was possible that R86 wasn't getting the adaptive equipment because it was Passover. During interview on 3/29/23, at 9:15 a.m. licensed practical nurse (LPN)-D stated residents are assessed upon admission to see if they will need any assistance with feeding. LPN-D stated OT will evaluate, treat and make recommendations to nursing. If R86 required adaptive equipment it would be listed in his care plan. LPN-D confirmed residents care plan stated R86 should have a plate guard, hard plastic cup, built up utensils and dycem under his plate for all meals. LPN-D stated nursing can make the decision to stop using adaptive equipment after observing the resident's abilities and see improvements. LPN-D believed R86 had made enough improvements to no longer require them. During interview on 3/29/23, at 9:25 a.m. director of rehab (DOR) stated therapy makes the recommendations for adaptive equipment for residents. Recommendations are shared with nursing and dietary so staff can be educated on devices and recommendations are placed in residents care plan. DOR stated it would be difficult for a resident to eat without the recommended adaptive equipment as it is put in place to make it easier for the resident to participate and promotes resident independence. During interview on 3/30/23, at 8:56 a.m. director of nursing (DON) stated resident's need for	F 810		

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F 810	Continued From page 33 adaptive equipment is addressed upon admission, quarterly observations, and with change in condition. Nursing is notified by therapy of their recommendation. The nurse manager enters recommendations into the resident's care plan, onto the NA care sheet assignments and informs the dietary department. She stated adaptive equipment should also be listed on the resident's meal ticket. DON's expectation was R86 be provided his adaptive equipment for all meals and stated a nurse could not make the decision to stop using adaptive equipment, only OT could make those changes. During interview on 3/30/23, at 10:22 a.m. corporate nurse consultant (CNC) stated the facility always makes an exception for adaptive equipment use during Passover so it would not be a reason R86 hasn't been provided his equipment. The facility's policy Physical Restraints Physical Device/Adaptive Equipment revised 7/16, indicated the facility would assure that maximum autonomy, quality of life and comfort would be provided to our residents by making every effort to support resident self-determination, individualization and care and freedom of movement.	F 810		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and	F 867		5/3/23

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F 867	Continued From page 34 procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success,	F 867		

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F 867	Continued From page 35 and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope	F 867		

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F 867	Continued From page 36 and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assessment and Assurance (QAA)/Quality Assurance Process improvement (QAPI) committee was effective in implementing appropriate action plans to correct a quality deficiency identified during a previous survey related to advanced directives which resulted in a deficiency identified during this survey. This deficient practice had the potential to affect all 95 residents currently residing in the facility.	F 867	• R41, R25, R86, and R349 medical records were audited; assessments for determination of wishes were completed for R41, R25, R86 and R349 via interview with facility social workers, orders were updated as below. An audit to ensure alignment of code status, POLST and Advance Directive was completed on 3/28/23, for the other 89 residents who reside at the facility. There were no concerns identified with the 89 residents, orders, POLST and Advance Directive	

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F 867	Continued From page 37 Findings include: A facility quality assurance (QA) task force was developed to review the deficient practices as well as areas of concern that were identified during the survey process. Weekly meetings were scheduled to identify and review the identified areas of focus. These meetings were dated 4/4/22-5/11/22 and the meeting notes revealed on 3/19/22, an immediate jeopardy (IJ) was issued at F678 when the facility failed to provide cardiopulmonary respiration (CPR) to a resident who was found unresponsive (without pulse or respirations). Upon investigation, the facility staff implemented the following corrective action to prevent reoccurrence -an audit of all resident's charts who had passed away was completed to ensure the staff had followed the residents wishes -staff were educated on Sholom CPR policy to include what staff were to do when they found a resident unresponsive: check physician's order for life sustaining treatment (POLST), initiate CPR immediately if directed by POLST, call 911 and follow the CPR policy and procedure. Please see F578: Based on interview and document review, the facility failed to ensure residents wishes regarding code status were accurately reflected throughout their chart for 4 of 94 (R41, R25, R86, R349). The facility staff also lacked a consistent process on where to find the code status. This failure resulted in an immediate jeopardy (IJ) for R41, R25, R86, R349, when their medical records failed to identify the residents wishes accurately.	F 867	were consistent and honored the residents wishes. • This deficient practice has the ability to affect all residents who reside at facility. • The facility has created an action plan for this plan of correction that will be used for quality assurance meetings. The action plan identifies the issue, root cause, corrective measures to be put into place, and status updates and recommendations that includes an audit process. Our audits will be reviewed at each QA meeting, and will be monitored by Sholom Quality Care Committee. The facility will also educate facility staff regarding the QA process and plan. • A quality care committee member will review facility audits weekly and bring data and summarization to the QCC committee for recommendations and review. Upon determination of compliance with QA regulatory requirements, the QCC will determine what audits and practices will be put into place, discontinued or need to continue.	

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F 867	Continued From page 38 The QAPI agenda for first quarter (Q1) dated 4/26/22, indicated the facility would perform ongoing audits to maintain compliance with end of life wishes. The team will conduct audits of all residents who pass away from April - June (2022) to ensure end of life wishes were followed. Following that timeframe, the facility will reduce audits to monthly and then randomly select residents who pass away to ensure end of life wishes were being followed. The QAPI agenda for second quarter (Q2) dated 7/21/22, indicated the facility would conduct audits of all residents who passed away and to ensure end of life wishes were followed. No issues were noted. The team will continue auditing three random resident's randomly over next quarter. Action Plan completed: documentation. Audits were performed on residents who had passed away 4/2/22-9/24/22 to see if their wishes had been followed, however 5 of those resident's audits revealed their newest POLST hadn't been uploaded in the electronic medical record (EMR) which was where the staff looked to determine a resident's code status. There was no evidence this issue had been addressed. During an interview on 03/30/23, at 12:07 p.m. the corporate nurse consultant (CNC) stated the facility completes audits for each deficiency they receive and then they discuss the results of the audits at QA to determine how long they should continue them (if at all) or if they need to change the frequency. The CNC further stated she knows the facility completed a "whole house" audit when they first received the IJ on 3/19/22 but couldn't remember if they conducted on going audits.	F 867		

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F 867	Continued From page 39 During a follow up interview on 3/30/23, at 2:10 p.m. the director of nursing (DON) and CNC stated they were unable to locate the folders which included the original education and on-going audits for code status. The facility's QAPI policy dated 1/1/20, indicated the committee must develop and implement corrective action when a quality issue is identified, and monitor to ensure performance goals or targets are achieved, and revise corrective action when necessary.	F 867		
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 §483.70(e) and following accepted national standards;	F 880		5/3/23

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F 880	Continued From page 40 §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.	F 880		

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F 880	Continued From page 41 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure current standards of practice for catheter care was followed for 1 of 1 resident (R68). R68's significant change Minimum Data Set (MDS) dated 3/2/23, indicated severe cognitive impairment and diagnoses of unspecified dementia, urinary tract infection, had an indwelling urinary catheter, and required extensive assist for most activities of daily living (ADLs). R68's care plan dated 2/7/23, indicated R68 had a suprapubic catheter due to urinary retention and was at risk of urinary tract infections. The care plan lacked interventions to keep the catheter off of the floor. R68's care plan dated 3/3/23, indicated R68 had a history of urinary tract infections. R68's urology progress note dated 2/15/23, indicated a urine culture was positive for klebsiella oxytoca (a bacteria that can cause different types of healthcare associated infections), and providencia rettgeri (a bacteria that can cause catheter associated urinary tract infections) and with the placement of a suprapubic catheter (a tube used to drain urine that is inserted in the bladder through an incision in the abdomen), was provided Zosyn (an antibiotic).	F 880	• R68 had care plan reviewed and updated to ensure interventions were in plan to keep catheter off the floor, which included a catheter storage bag to be used, that is hung on the bedside. At the time incident, facility staff were provided education regarding the use of alcohol wipes after draining urine to prevent infection, proper hand hygiene. • All residents who have catheter could be affected by deficient practice. • Facility will conduct a whole house audit on residents who have catheters to ensure proper care plan, interventions are in place per facility policy to keep catheter off of the floor. Education will also be provided to clinical staff regarding cleaning of catheter tubing after emptying drainage bag, and hand hygiene. Facility reviewed policy and it remains current. • Facility will audit three residents each week for four weeks, three residents per month for resident who have catheter, to ensure care is being provided properly, per facility policy and infection control guidelines for three months, and then bring to QA for further direction and review.	

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	245411	A. BUILDING _____ B. WING _____	C 03/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42 During observation on 3/29/23, at 7:26 a.m. R68 was in bed and his catheter bag was located on the floor without a barrier between the floor and the catheter bag. At 7:36 a.m. nursing assistant (NA)-A picked up the catheter off the floor, did not clean the end of the catheter tube, and drained the urine in a graduate canister, shook the bottom of the catheter tube to remove drops of urine, locked the tubing and clipped the end piece of the catheter tubing back onto the bag. The end of the catheter was not cleaned prior to putting the end piece on the catheter bag. NA-A changed gloves, but did not clean hands and proceeded to don R68's shirt. During interview on 3/29/23, at 7:53 a.m. NA-A stated you are supposed to wipe the end of the catheter with alcohol after draining the urine to prevent infection, but had not seen alcohol wipes in two months. During interview on 3/29/23, at 8:01 a.m. licensed practical nurse (LPN)-C stated she expected the NA's to wipe the catheter end with an alcohol wipe after draining urine from the bag. During interview on 3/29/23, at 2:50 p.m. the director of nursing stated the catheter bag should be hanging off the bed or in a storage bag and the end of the catheter tubing should be wiped before closing after draining urine. A policy Urinary Catheter Care-Closed System dated 5/7/18, indicated the procedure was to prevent catheter associated urinary tract infections. Use standard precautions when handling or manipulating the drainage system. Be sure the catheter tubing and drainage bag are kept off the floor.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245411	A. BUILDING _____ B. WING _____	C 03/30/2023

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245411	A. BUILDING **02 - SHIRLEY CHAPMEN SHOLOM HOME EAST** B. WING _____	**03/29/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 03/29/2023. At the time of this survey, Shirley Chapman Sholom Home East 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		04/25/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245411	A. BUILDING **02 - SHIRLEY CHAPMEN SHOLOM HOME EAST** B. WING _____	**03/29/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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. SHIRLEY CHAPMAN SHOLOM HOME EAST is a 4-story building with a full basement. The building was constructed in 2008, and was determined to be of Type II (222) construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and all resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 118 beds and had a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245411	A. BUILDING **02 - SHIRLEY CHAPMEN SHOLOM HOME EAST** B. WING _____	**03/29/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 census of 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to inspect the Fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/29/2023, at 09:30 AM, it was revealed by observation the facility did not conduct its semi-annual fire alarm system inspection. An interview with the Campus Director of Engineering verified this deficient finding at the time of discovery.	K 345	1. At the time of the survey, the fire alarm testing had been performed on January 4th 2023 however prior testing could not be confirmed. An additional semi-annual test is schedule to be performed on May 9th 2023. 2. To prevent this deficiency from reoccurring, this will be scheduled in advance with monitoring company, and also added to Administrators outlook calendar. Facility will conduct audit at quarterly QA meeting to ensure compliance with schedule. 3. Administrator or designee.	5/3/23

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 19, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: S8WJ11

Dear Administrator:

The above facility was surveyed on March 27, 2023 through March 30, 2023 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:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00496	A. BUILDING: _____ B. WING _____	C 03/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/27/23-3/30/23, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. The following licensing orders were issued: 0505, 0945, 1565, 1840 . Please indicate in your	2 000		

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2 000	Continued From page 1 electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed during the survey. H54119700C (MN00091531) H54119699C (MN00091426) H54119717C (MN00090429) H54119718C (MN00084243) H54119719C (MN00083752) H5411126C (MN00082381) H5411127C (MN00080260) H5411128C (MN00080171) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction	2 000		

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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they	2 505		5/3/23

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2 505	Continued From page 3 restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 2 of 2 residents (R68,R86). Findings include: R68's significant change Minimum Data Set (MDS) dated 3/2/23, indicated severe cognitive impairment and diagnoses of unspecified dementia, history of falling, and required extensive assist for most activities of daily living	2 505	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 505	Continued From page 4 (ADLs). The MDS further identified physical restraints were not used. R68's active physician orders in the electronic medical record (EMR) were reviewed and lacked orders for any restraints. R68's care plan dated 3/8/23, indicated R68 required assist of one to two staff to assist with bed mobility. R68's care plan dated 3/16/23, indicated risk for falling due to a history of falls, impaired mobility, and poor safety awareness with an intervention, "Bedroom furniture rearranged, bed moved against the wall, opposite side the resident prefers to exit/enter bed." R68's Event Report dated 2/9/23, in the EMR indicated an unwitnessed fall. R68 was in bed prior to the fall and was found on the floor mat. Contributing factors included impaired mental status, and a history of falls, change in vital signs, and was bare foot. Adaptive equipment used at the time of the fall included a floor mat and a low bed. The report indicated the cause of the fall was due to unsteady gait/balance/endurance and mental status change and follow up interventions included low bed when in bed, safety checks, and a perimeter mattress was provided to assist R68 with defining the edges of the bed/mattress. R68's Event Report dated 2/10/23, in the EMR indicated an unwitnessed fall on 2/10/23 and was found by the nurse. According to the report, R68 was located between the bed and the wall and following the fall, bed room furniture was rearranged, and the bed was moved against the wall, opposite side of the resident preferred to exit/enter bed.	2 505		

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2 505	Continued From page 5 R68's Event Report dated 3/5/23, in the EMR indicated R68 had an unwitnessed fall and was found on the mat by the bedside. The report indicated R68 rolled out of bed and a note added in the Event Report dated 3/7/23, indicated R68 self transferred and ambulated in the hallway. R68's Event Report dated 3/15/23, in the EMR indicated R68 had an unwitnessed fall in room and was located on the floor with the wheelchair located against the side of his body. During observation on 3/28/23, at 2:50 p.m. R68 was in bed with the bed in a low position and a mat on the floor. The bed was pushed up against the wall towards R68's right side and his head faced the window. R68 had a perimeter mattress. During interview 3/28/23, at 3:40 p.m. family member (FM)-A stated R68 has had several falls and still thinks he can walk and tries to get up. During observation on 3/29/23, at 7:26 a.m. R68 was in bed and a pillow was located under the fitted sheet on R68's left side towards the outside of the bed positioned next to his hips and thighs. Nursing assistant (NA)-A removed the pillow and placed it in R68's wheelchair. R68 had a perimeter mattress with a raised edge approximately four inches located lengthwise on the upper and lower third of the mattress. During observation 3/29/23, at 7:32 a.m. nursing assistant (NA)-A turned R68 towards the outside of the bed. R68 did not assist. During observation and interview 3/29/23, at 7:46 a.m. NA-A stated they apply the pillow under the	2 505		

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	00496	A. BUILDING: _____ B. WING _____	C 03/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 505	Continued From page 6 bed sheet and turn R68 towards the wall to prevent him from getting up. NA-A stated R68 rolls out of bed if the bed is not pushed against the wall, and added since the bed is against the wall, R68 tries to sit up on the other side of the bed. During interview on 3/29/23, at 8:01 a.m. licensed practical nurse (LPN)-C stated they used pillows on the side of the bed to prevent residents from falling off and stated she has seen R68 swing his legs on the edge of the bed and yell and added staff may have applied the pillow under the bed sheet to prevent R68 from rolling. R86's MDS, dated 1/9/23, indicated R86 had severe cognitive impairment and was diagnosed with Alzheimer's disease, dysphagia (difficulty swallowing), intracranial injury (brain injury), right sided weakness in upper and lower extremity, and required extensive assist for most activities of daily living (ADLs). The MDS further identified physical restraints were not used. R86's physician orders in the EMR were reviewed and lacked orders for any restraints. R86's care plan updated on 2/23/23, indicated R86 is at risk for falls and has the following interventions in place: hourly rounding on night shift, specialty hi-low bed with fall mat, assist with bathroom needs after meals and as needed, keep up after meals until needing to lay down to assist in preventing falls from bed,	2 505		

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2 505	Continued From page 7 random/frequent safety checks as able, tilt-n-space wheelchair, provide orientation to use of the call light, and ensure call light is within reach. R86's admission observation for adaptive equipment/physical device/restraint dated 1/4/23, indicated no restraints in use. R86's quarterly observation for restraint dated on 3/19/23, indicated no restraints in use. R86's quarterly observation for adaptive equipment/physical device/restraint dated 3/23/23, indicated no restraints in use. During observation on 3/27/23, at 2:09 p.m. R86 was in bed. Bed was pushed up against the wall, two pillows tucked under fitted sheet on the right side of his body, and floor mat next to bed. During interview on 3/27/23, at 2:16 p.m. FM-B confirmed that staff tuck pillows underneath R86's fitted sheets to prevent him from getting up on his own. FM- B stated the resident was unable to remove pillows himself as they are tucked in on his right side which was his weak side. During observation and interview on 3/27/23, at 6:55 p.m. nursing assistant (NA)-C assisted R86 with positioning in bed. NA-C placed a pillow under R86's right arm and another pillow under his legs. NA-C put bed in lowest position and placed floor mat next to bed. NA-C stated he placed pillows to assist with offloading and resident comfort. NA-C stated R86 has the floor mat in place because he gets out of bed on his own. NA-C stated he would not place pillows under fitted sheets which would be considered a restraint.	2 505		

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2 505	Continued From page 8 During observation on 3/28/23, at 10:08 a.m. R86 observed in bed with pillows tucked under fitted sheet, on the right side of his body. During observation and interview on 3/28/23, at 10:10 a.m. NA-B stated R86 required his bed to be in the lowest position and floor mat in place as fall interventions. NA-B stated the pillows are tucked under the sheet for comfort and then stated, "I bet you think they are a restraint" and removed the pillows from under the fitted sheet and placed them under the right side of his body over the sheet. NA-B asked R86 if he wanted the pillows where she placed them. R86 did not respond. NA-B left pillows in place. NA-B stated she was unsure if R86 would be able to remove pillows under the fitted sheet due to his right sided weakness. During interview on 3/28/23, at 11:26 a.m. LPN-D stated R86 lacks safety concept due to his dementia which is why pillows are tucked under his fitted sheet as a fall intervention, the pillows keep him in bed and promote safety by having them in place. LPN-D stated R86 would need assistance with removing the pillows as he has right sided weakness. LPN-D stated physician orders and/or an assessment are not needed to place pillows under fitted sheet as it is a nurse judgement call on adding fall interventions. During observation on 3/29/23, at 7:03 a.m. R86 observed sleeping in bed, bed against wall, floor mat in place, two pillows tucked under fitted sheet on right side of body. During interview and observation on 3/29/23, at 7:25 a.m. LPN-E stated the facility does not use restraints, if they did, an assessment and	2 505		

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2 505	Continued From page 9 physician orders would be required prior to implementing the restraint. LPN-E stated pillows are used for repositioning but would be placed on top of the sheet, never tucked under the fitted sheet which could prevent a resident from repositioning themselves and freely move their body. LPN-E verified two pillows were tucked under R86's fitted sheet and stated they shouldn't be there because he cannot remove them himself due to right sided weakness. LPN-E removed pillows from under fitted sheet. During interview on 3/29/23, at 2:50 p.m. director of nursing (DON) stated she would not expect staff to place a pillow under the fitted sheet to keep a resident from getting up and added they do not want to prohibit movement. Facility policy Physical Restraint dated 11/2022, indicated restraints of any type will not be used as punishment/discipline or as a substitute for more effective medical and nursing care or for the convenience of the facility staff. A physical restrain is defined as any manual method, physical or mechanical device, equipment or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to their body. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for restraint use. The DON could provide training to all staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one	2 505		

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2 505	Continued From page 10 (21) days	2 505		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adaptive equipment to promote independence with eating and drinking for 1 of 1 resident (R86) who was reviewed for nutrition and observed having difficulty eating and drinking. Findings Include: R86's Minimum Data Set (MDS) dated 1/9/23, indicated R86 has severe cognitive impairment	2 945	corrected	5/3/23

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2 945	Continued From page 11 and was diagnosed with Alzheimer's disease, dysphagia (difficulty swallowing), intracranial injury (brain injury), right sided weakness in upper and lower extremity, and required extensive assist for most activities of daily living (ADLs) including feeding assistance. R86's care plan updated on 1/18/23, indicated per occupational therapy (OT) plate guard, hard plastic cup, built up utensils, and dycem (non-slip material) under plate for all meals to increase independence with self-feeding and required feeding assistance at meals. R86's OT Evaluation and Plan of Treatment dated, 1/4/23, indicated patient will safely perform self-feeding tasks with set-up assistance with use of scoop dish with plate guard, built-up utensils, and sippy cup for use in order to increase independence in self-feeding. R86's OT Discharge Summary dated, 3/13/2023, indicated patients treatment had not changed since evaluation on 1/4/23. During observation and interview on 3/27/23, at 12:43 p.m. R86 was sitting at the dining room table attempting to feed himself with a plastic spoon and stated he needed help to eat. No staff in dining room to assist him. His meal was in a styrofoam container, plastic utensils and styrofoam cups. No dycem noted. During observation on 3/28/23, at 9:56 a.m. R86 was sitting at the dining room table with thickened fluids given to him in a styrofoam cup. During observation on 3/29/23, at 8:58 a.m. R86 was served thickened water and juice in plastic cups, oatmeal in a bowl and given a plastic	2 945		

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2 945	Continued From page 12 spoon. No dycem noted. During interview on 3/29/23, at 9:03 a.m. nursing assistant (NA)-B stated if a resident needed adaptive equipment during meals, it would be listed on the care sheet assignments they carry with them. She didn't think R86 used any adaptive equipment. NA-B verified on the NA care sheet assignment listed under special needs stated R86 was a feeding assist, and listed under snack/meal he used a plate guard, hard plastic cup, and dycem under the plate for all meals. NA-B confirmed R86 should be provided with adaptive equipment at all meals. NA-B stated that maybe R86 wasn't getting the adaptive equipment because it was Passover. During observation and interview on 3/29/23, 9:05 a.m. dietary aide (DA)-A R86's meal ticket did not indicate he required adaptive equipment with meals. DA-A stated they don't know if a resident requires adaptive equipment unless nursing tells them however, she did recall R86 used to use a different spoon with a black handle but she was told it was too heavy for him and was told not to give it to him. DA-A stated that it was possible that R86 wasn't getting the adaptive equipment because it was Passover. During interview on 3/29/23, at 9:15 a.m. licensed practical nurse (LPN)-D stated residents are assessed upon admission to see if they will need any assistance with feeding. LPN-D stated OT will evaluate, treat and make recommendations to nursing. If R86 required adaptive equipment it would be listed in his care plan. LPN-D confirmed residents care plan stated R86 should have a plate guard, hard plastic cup, built up utensils and dycem under his plate for all meals. LPN-D stated nursing can make the decision to stop using	2 945		

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2 945	Continued From page 13 adaptive equipment after observing the resident's abilities and see improvements. LPN-D believed R86 had made enough improvements to no longer require them. During interview on 3/29/23, at 9:25 a.m. director of rehab (DOR) stated therapy makes the recommendations for adaptive equipment for residents. Recommendations are shared with nursing and dietary so staff can be educated on devices and recommendations are placed in residents care plan. DOR stated it would be difficult for a resident to eat without the recommended adaptive equipment as it is put in place to make it easier for the resident to participate and promotes resident independence. During interview on 3/30/23, at 8:56 a.m. director of nursing (DON) stated resident's need for adaptive equipment is addressed upon admission, quarterly observations, and with change in condition. Nursing is notified by therapy of their recommendation. The nurse manager enters recommendations into the resident's care plan, onto the NA care sheet assignments and informs the dietary department. She stated adaptive equipment should also be listed on the resident's meal ticket. DON's expectation was R86 be provided his adaptive equipment for all meals and stated a nurse could not make the decision to stop using adaptive equipment, only OT could make those changes. During interview on 3/30/23, at 10:22 a.m. corporate nurse consultant (CNC) stated the facility always makes an exception for adaptive equipment use during Passover so it would not be a reason R86 hasn't been provided his equipment.	2 945		

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2 945	Continued From page 14 The facility's policy Physical Restraints Physical Device/Adaptive Equipment revised 7/16, indicated the facility would assure that maximum autonomy, quality of life and comfort would be provided to our residents by making every effort to support resident self-determination, individualization and care and freedom of movement. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to ensuring residents have adaptive equipment with meals and following the care plan. The DON or designee could provide training for all nursing staff related to residents who need adaptive equipment with meals and following the care plan based on the assessment. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 945		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure	21565	corrected	5/3/23

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21565	Continued From page 15 self-administration of medication (SAM) was appropriate for 1 of 1 resident (R41) who was observed with medications at the bedside. Findings include: R41's significant change minimum data set (MDS) dated 3/15/23, indicated R41 was cognitively intact and required minimal assistance for most activities of daily living (ADLs). R41's diagnoses included anxiety, depression, psychotic disorder, amnesia, and diabetes. R41's care plan dated 3/22/23, indicated R41 had an alteration in self-care ability as evidenced by occasional assist with ADLs. The care plan further indicated, R41 was at risk for skin breakdown related to the use of steroid cream. R41's care plan lacked evidence for SAM. R41's physician orders start date 11/18/22, and discontinued 3/20/23, indicated triamcinolone acetonide (a steroid used to treat skin conditions) lotion; 0.1%. Apply to both LEs (lower extremities) twice a day for pruritis (itchy skin). R41's orders lacked an order for SAM or medications to be kept at the bedside. R41's admission SAM assessment dated 11/13/22, indicated R41 did not want to self-administer medications and therefore an assessment was not completed. R41's electronic health record (EHR) lacked evidence of any additional SAM assessments. R41's March 2023, treatment administration record (TAR) indicated, "PRN [as needed] - Self Administration of medication Observation V3 - complete only if patient is self admin ...once ...3/12/23-3/12/23." R41's TAR indicated on	21565		

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21565	Continued From page 16 3/12/23, staff initials in parentheses. TAR legend identified, "Initial parenthesized = Not Administered or Not Charted, see Reasons/Comments." The reasons/comments section was blank. During observation and interview on 3/27/23, at 6:11 p.m. R41's bedside table contained three medications and a fourth medication on the nightstand. The medications included one bottle and one tube of triamcinolone and two bottles of nystatin. The bottle of triamcinolone had a pharmacy label with R41's name. One of the bottles of nystatin had a pharmacy label with R41's roommates name (R25). The other bottle of nystatin had the pharmacy label torn off and the tube of triamcinolone was unlabeled. All containers appeared to have been used. R41 stated they (staff) gave him those medications to put on himself. R41 further stated he had itchy legs occasionally and the medications helped. R41 could not identify the medications. During observation on 3/28/23, at 10:16 a.m. all four medications were still at R41's bedside. During interview on 3/28/23, at 10:32 a.m. registered nurse (RN)-A stated no residents on fourth floor could self-administer medications and there should not be any medications stored in any resident rooms. RN-A further stated for a resident to have medications in their room they would need an order for SAM and an assessment completed indicating they were safe for SAM. During interview on 3/28/23, at 10:34 a.m. licensed practical nurse (LPN)-B stated no one on fourth floor was able to self-administer medications. LPN-B stated for a resident to SAM they would have to have an order from the	21565		

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21565	Continued From page 17 provider and an observation (SAM) assessment completed. Self-administration would also be care planned and a change in status would trigger a new assessment. During observation and interview on 3/28/23, at 10:47 a.m. LPN-B confirmed the four medications were in R41's room and one of them was prescribed to R25. LPN-B stated none of the medications should be there and removed them from the room. During interview on 3/29/23, at 2:43 p.m. director of nursing (DON) stated residents were assessed for SAM upon admission per interview and observation. The assessment was used to determine if the resident could safely self-administer medications. DON further stated a resident also needed a provider order for SAM. DON stated R41 was not assessed for SAM and expectation was for medications not to be in R41's room. Facility policy Self-Administration of Medications dated 11/2018, indicated, "If a resident wishes to self-administer medications or store mediations at bedside, the unit nurse will complete the Self Administration of Medication observation in the EMR [electronic medical record]." The policy further indicated residents assessed as able to safely self-administer may keep medications at the bedside with a physician order indicating, "May be kept at bed side." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the	21565		

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21565	Continued From page 18 importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 28, 2023

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

RE: CCN: 245411
Cycle Start Date: March 30, 2023

Dear Administrator:

On April 19, 2023, we notified you a remedy was imposed. On May 4, 2023 the Minnesota Departments of Health and Public Safety 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 May 3, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 4, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 19, 2023, 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 May 4, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on May 3, 2023, 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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us