### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: XY1C Facility ID: 00380

<ol> <li>MEDICARE/MEDICAID PROVID</li> </ol>	DER	3. NAME AND AD	DRESS OF FAC	CILITY		4. TYPE OF A	ACTION: <b>7</b> (L8)
NO.(L1) <b>245574</b>		(L3) SHOLOM H	OME WEST			1. Initial	2. Recertification
2. STATE VENDOR OR MEDICAL	O NO.	(L4) <b>3620 PHILL</b>	IPS PARKWA	Y SOUTH		3. Termination	
(L2 ) <b>151743100</b>		(L5) <b>SAINT LOU</b>	IS PARK, MN	1	(L6) <b>55426</b>	5. Validation 7. On-Site Vi	
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Surve	y After Complaint
6. DATE OF SURVEY 9/28	3/ <b>2016</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	EISCAL VEAD	ENDING DATE: (L25)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	•
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	Δς.			
From (a):	11	A T C 1:		715.	And/Or Approved Waivers Of	f The Following Rea	uirements:
To (b):		^	quirements		Technical Personne	- '	e of Services Limit
. ,		Compliance	Based On:		3. 24 Hour RN		cal Director
10.71.17.17.71	.=- (7.10)	1. A	cceptable POC		4. 7-Day RN (Rural S	NF) 8. Patien	nt Room Size
12. Total Facility Beds	179 (L18)	B W. G	r salab		5. Life Safety Code	9. Beds/	Room
13.Total Certified Beds	<b>179</b> (L17)	B. Not in Comp	and/or Applied \		* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN	rioquirements	and of rippined	, arvers.	15. FACILITY MEETS	(2.2)	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	)
179	17 5111	101	IID		1001 (6) (1) 01 1001 (j) (1).		
(L37) (L38)	(L39)	(L42)	(L43)				
(E37) (E30)	(1237)	(2.12)	(E13)				
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION 1	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Magdalene Jares, HF	E NE II	1	0/19/2016				
Magaalerie bares, Fil	LINE		0/19/2010	(L19)	Kamala Fiske-Downing.	Enforcement S	<u>Specialist</u> 10/19/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAL	OFFICE OR SINGLE S	STATE AGENC	CY
19. DETERMINATION OF ELIGIBI	LITY		PLIANCE WITH ITS ACT:	H CIVIL	21. 1. Statement of Fina	ancial Solvency (HCI rol Interest Disclosure	
1. Facility is Eligible to	Participate	KIOI	IISACI.		3. Both of the Abov		, suit (HC1A-1313)
2. Facility is not Eligible							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	L ITC ACREEA				
OF PARTICIPATION			I. LTC AGREEN	MENT	26. TERMINATION ACTION	N:	(L30)
	BEGINNING	G DATE	ENDING DA		26. TERMINATION ACTION VOLUNTARY 0		(L30) OLUNTARY
07/24/1991	BEGINNING	G DATE				<u>0</u> <u>INV</u>	. ,
		G DATE	ENDING DA		VOLUNTARY 0	<u>0</u> <u>INV</u> 05-F	OLUNTARY
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	(L41) 27. ALTERNATI	G DATE  VE SANCTIONS n of Admissions:	ENDING DA		VOLUNTARY 0  01-Merger, Closure  02-Dissatisfaction W/ Reimbur	0 INV 05-F sement 06-F	OLUNTARY Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI	VE SANCTIONS	ENDING DA		VOLUNTARY 0  01-Merger, Closure  02-Dissatisfaction W/ Reimbur.  03-Risk of Involuntary Termination	0 INV 05-1 sement 06-1 ion OTI 1 07-1	COLUNTARY Fail to Meet Health/Safety Fail to Meet Agreement HER
(L24)	(L41)  27. ALTERNATI  A. Suspension	VE SANCTIONS	ENDING DA		VOLUNTARY 0  01-Merger, Closure  02-Dissatisfaction W/ Reimbur.  03-Risk of Involuntary Termination	0 INV 05-1 sement 06-1 ion OTI 1 07-1	COLUNTARY Fail to Meet Health/Safety Fail to Meet Agreement HER Provider Status Change
(L24) 25. LTC EXTENSION DATE:	(L41)  27. ALTERNATI  A. Suspension	VE SANCTIONS n of Admissions:	ENDING DA		VOLUNTARY 0  01-Merger, Closure  02-Dissatisfaction W/ Reimbur.  03-Risk of Involuntary Termination	0 INV 05-1 sement 06-1 ion OTI 1 07-1	COLUNTARY Fail to Meet Health/Safety Fail to Meet Agreement HER Provider Status Change
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(L24) 25. LTC EXTENSION DATE: (L27)	(L41)  27. ALTERNATI  A. Suspension  B. Rescind St	VE SANCTIONS n of Admissions: uspension Date:	(L25) (L44) (L45)		VOLUNTARY 0  01-Merger, Closure  02-Dissatisfaction W/ Reimbur  03-Risk of Involuntary Terminati  04-Other Reason for Withdrawal	0 INV 05-1 sement 06-1 ion OTI 1 07-1	COLUNTARY Fail to Meet Health/Safety Fail to Meet Agreement HER Provider Status Change
(L24) 25. LTC EXTENSION DATE: (L27)	(L41)  27. ALTERNATI  A. Suspension  B. Rescind St	VE SANCTIONS n of Admissions: uspension Date:	(L25) (L44) (L45)		VOLUNTARY 0  01-Merger, Closure  02-Dissatisfaction W/ Reimbur  03-Risk of Involuntary Terminati  04-Other Reason for Withdrawal	0 INV 05-1 sement 06-1 ion OTI 1 07-1	COLUNTARY Fail to Meet Health/Safety Fail to Meet Agreement HER Provider Status Change
(L24) 25. LTC EXTENSION DATE:  (L27) 28. TERMINATION DATE:	(L41)  27. ALTERNATI A. Suspension B. Rescind St	VE SANCTIONS n of Admissions: uspension Date:  D. INTERMEDIARY/ 03001	(L25)  (L44)  (L45)  CARRIER NO.	(L31)	VOLUNTARY 0  01-Merger, Closure  02-Dissatisfaction W/ Reimbur  03-Risk of Involuntary Terminati  04-Other Reason for Withdrawal	0 INV 05-1 sement 06-1 ion OTI 1 07-1	COLUNTARY Fail to Meet Health/Safety Fail to Meet Agreement HER Provider Status Change
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### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245574

October 17, 2016

Mr. Ronald Donacik, Administrator Sholom Home West 3620 Phillips Parkway South Saint Louis Park, MN 55426

Dear Mr. Donacik:

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

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

Effective September 28, 2016 the above facility is certified for:

179 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 179 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

**Health Regulation Division** 

Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

### **Revised Letter**

Electronically delivered October 19, 2016

Mr. Ronald Donacik, Administrator Sholom Home West 3620 Phillips Parkway South Saint Louis Park, MN 55426

RE: Project Number S5574025, and Complaint Numbers H5574083 and H5574085

Dear Mr. Donacik:

Please note that the exit date for this facility has been changed. This letter has been revised to include this change.

On August 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 12, 2016 that included an investigation of complaint number H5574083 and H5574085. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 20, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 12, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 12, 2016, effective September 28, 2016 and therefore remedies outlined in our letter to you dated August 26, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Sholom Home West October 19, 2016 Page 2

Kumalu Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

### POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	/ISIT
	A. Building B. Wing		Y2	9/28/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
SHOLOM HOME WEST		3620 PHILLIPS PARKWAY SOUTH			
		SAINT LOUIS PARK, MN 55426			

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

ITE Y4		<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5	ITEM Y4			DATE Y5
ID Prefix	F0157	Correction	ID Prefix	F0225		Correction	ID Prefix			Correction
Reg. #	483.10(b)(11)	Completed		483.13 - (4)	(c)(1)(ii)-(iii), (c)(2)	Completed	Reg. #	483.13(c)		Completed
LSC		09/28/2016	LSC			09/28/2016	LSC			09/28/2016
ID Prefix	F0241	Correction	ID Prefix	F0280		Correction	ID Prefix	F0282		Correction
Reg. #	483.15(a)	Completed	Reg. #		(d)(3), 483.10(k)	Completed	Reg. #	483.20(k)(3)(ii)		Completed
LSC		09/28/2016	LSC	(2)		09/28/2016	LSC			09/28/2016
ID Prefix	F0309	Correction	ID Prefix	F0312		Correction	ID Prefix	F0314		Correction
Reg. #	483.25	Completed	Reg. #	483.25	(a)(3)	Completed	Reg. #	483.25(c)		Completed
LSC		09/28/2016	LSC			09/28/2016	LSC			09/28/2016
ID Prefix	F0323	Correction	ID Prefix	F0334		Correction	ID Prefix	F0353		Correction
Reg. #	483.25(h)	Completed	Reg. #	483.25	(n)	Completed	Reg. #	483.30(a)		Completed
LSC		09/28/2016	LSC			09/28/2016	LSC			09/28/2016
ID Prefix	F0364	Correction	ID Prefix	F0428		Correction	ID Prefix	F0441		Correction
Reg. #	483.35(d)(1)-(2)	Completed	Reg. #	483.60	(c)	Completed	Reg. #	483.65		Completed
LSC		09/28/2016	LSC			09/28/2016	LSC			09/28/2016
REVIEWI STATE A		REVIEWED BY (INITIALS) GD/kfd	<b>DATE</b> 10/19/2	016	SIGNATURE OF	SURVEYOR	32982		DATE	9/28/2016
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 8/12/2016				R ANY UNCORREC					s 🗆 no	

### POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION  A. Building 01 - MAIN BUILDING 01			DATE OF REV	'ISIT
	B. Wing	Y	2	9/20/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
SHOLOM HOME WEST		3620 PHILLIPS PARKWAY SOUTH			
		SAINT LOUIS PARK, MN 55426			

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

ITE Y4		<b>DATE</b> Y5	ITEM Y4		ATE ITE		<b>DATE</b> Y5
ID Prefix		Correction	ID Prefix		rection ID Pr		Correction
Reg. #	NFPA 101	Completed	Reg. #	101 Cor	npleted Reg.	# NFPA 101	Completed
LSC	K0050	09/08/2016	LSC K0052	09/0	8/2016 LSC	K0054	09/08/2016
ID Prefix		Correction	ID Prefix	Cor	rection ID Pr	efix	Correction
Reg. #	NFPA 101	Completed	Reg. #	101 Cor	npleted Reg.	#	Completed
LSC	K0056	09/08/2016	LSC K0069	09/0	8/2016 LSC		
ID Prefix	_	Correction	ID Prefix	Cor	rection ID Pr	efix	Correction
Reg. #		Completed	Reg. #	Cor	npleted Reg.	#	Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Cor	rection ID Pr	efix	Correction
Reg. #		Completed	Reg. #	Cor	npleted Reg.	#	Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Cor	rection ID Pr	efix	Correction
Reg. #		Completed	Reg. #	Cor	npleted Reg.	#	Completed
LSC			LSC		LSC		
REVIEW STATE A		REVIEWED BY (INITIALS) TL/kfd	<b>DATE</b> 10/14/2016	SIGNATURE OF SURV	/EYOR 370	09	<b>DATE</b> 9/20/2016
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DATE
	FOLLOWUP TO SURVEY COMPLETED ON 8/9/2016			R ANY UNCORRECTED CTED DEFICIENCIES (C			F NO



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

### **Revised Letter**

Electronically delivered

October 19, 2016

Mr. Ronald Donacik, Administrator Sholom Home West 3620 Phillips Parkway South Saint Louis Park, MN 55426

Re: Reinspection Results - Project Number S5574025, and Complaint Numbers H5574083 and H5574085

Dear Mr. Donacik:

Please note that the exit date for this facility has been changed. This letter has been revised to include this change.

On September 28, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 29, 2016, that included an investigation of complaint number H5574083 and H5574085. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program Program Assurance Unit

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

			STAT	E FORM: REV	ISIT REPORT				
_	ER / SUPPLIER / CLIA ICATION NUMBER	MULTIPLE CON A. Building B. Wing	ISTRUCTIO	DN			Y2	DATE OF RE	VISIT
	F FACILITY	11 0			STREET ADDRESS, (	CITY, STATE	·- I		13
SHOLO	M HOME WEST				3620 PHILLIPS PARK	WAY SOUTH	4		
					SAINT LOUIS PARK,	MN 55426			
	,			Survey Report (pre					y
Y4		Y5	Y4		Y5	Y4		DA Y	
ID Prefix	20265	Correction	ID Prefix	20565	Correction	ID Prefix	20570	Corr	rection
Reg. #	MN Rule 4658.0085	Completed	Reg. #	MN Rule 4658.040 Subp. 3	5 Completed	Reg. #	MN Rule 4658.04 Subp. 4	05 Com	npleted
LSC		09/28/2016	LSC		09/28/2016	LSC		09/2	8/2016
ID Prefix	20800	Correction	ID Prefix	20830	Correction	ID Prefix	20850	Corr	rection
Reg. #	MN Rule 4658.0510 Subp. 1	Completed	Reg. #	MN Rule 4658.052 Subp. 1	0 Completed	Reg. #	MN Rule 4658.055 Subp. 2 D	20 Com	npleted

09/28/2016

Correction

Completed

09/28/2016

Correction

Completed

09/28/2016

Correction

LSC

Reg. #

Reg. #

LSC

LSC

ID Prefix 21375

ID Prefix 21530

ID Prefix 22000

MN Rule 4658.0800

MN Rule 4658.1310

Subp. 1

A.B.C

09/28/2016

Correction

Completed

09/28/2016

Correction

Completed

09/28/2016

Correction

09/28/2016

Correction

Completed

09/28/2016

Correction

Completed

09/28/2016

Correction

LSC

Reg. #

Reg. #

LSC

LSC

ID Prefix 20900

ID Prefix 21390

ID Prefix 21665

MN Rule 4658.0525

MN Rule 4658.0800

Subp. 4 A-I

Subp. 3

LSC

Reg. #

Reg. #

LSC

LSC

ID Prefix 20960

ID Prefix 21426

ID Prefix 21805

MN Rule 4658.0600

MN St. Statute 144A.04

Subp. 1

Subd. 3

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: XY1C Facility ID: 00380

	IAKI I-	TO BE COMIT	DETED DI	IIIE SIAI	E SURVET AGENCI		racinty ib. 00380
MEDICARE/MEDICAID PROVID     NO.(L1) 245574	DER	3. NAME AND AL (L3) <b>SHOLOM H</b>		CILITY		4. TYPE OF ACT	ION: <u>2 (</u> L8)  2. Recertification
2. STATE VENDOR OR MEDICAID	NO	(L4) 3620 PHILL	IPS PARKWA	AY SOUTH		3. Termination	4. CHOW
(L2 ) <b>151743100</b>	TNO.	(L5) SAINT LOU	JIS PARK, MI	N	(L6) <b>55426</b>	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey Af	
6. DATE OF SURVEY <b>08/1</b>	2/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		FISCAL YEAR ENI	DING DATE: (L35)
0 Unaccredited 1 TJC	(===)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
2 AOA 3 Other							
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	e ,	ments:
To (b):		_	equirements		2. Technical Personnel	6. Scope of	Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical l	Director
12 T-4-1 Filit- D- d-	150 (110)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Ro	oom Size
12. Total Facility Beds	179 (L18)	Vanavara			5. Life Safety Code	9. Beds/Roo	om
13.Total Certified Beds	<b>179</b> (L17)	X B. Not in Con Requirements	npliance with Pro and/or Applied	-	* Code: <b>R</b> *	(L12)	
14. LTC CERTIFIED BED BREAKDO	)WN	<u> </u>			15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
179	17 5141	ici	Ш		1001 (c) (1) 01 1001 (j) (1).	(===)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
	`			,			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Rebecca Wong, HFE	NE II	0	09/11/2016	(L19)	Kamala Fiske-Downing.	Enforcement Spe	<u>cialist</u> 09/20/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	` ′	OFFICE OR SINGLE S	STATE AGENCY	(220)
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WIT	H CIVIL	21. 1. Statement of Fina		
1. Facility is Eligible to	Participate	KIGI	HTS ACT:		3. Both of the Above	ol Interest Disclosure Str e:	nt (HCFA-1313)
2. Facility is not Eligible	2						
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLU</u>	UNTARY
07/24/1991					01-Merger, Closure	05-Fail t	o Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail t	o Meet Agreement
25. LTC EXTENSION DATE:		VE SANCTIONS	(220)		03-Risk of Involuntary Termination	on OTHER	
23. LIC EXTENSION DATE.		n of Admissions:			04-Other Reason for Withdrawal	·	ider Status Change
	A. Suspensio	ii oi Adillissiolis.	(L44)			00-Activ	_
(L27)	B. Rescind S	uspension Date:	(L++)				
		<b>r</b>	(L45)				
28. TERMINATION DATE:	29	9. INTERMEDIARY/	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAL	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	
-				Į.			



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 26, 2016

Mr. Steve Fritzke, Administrator Sholom Home West 3620 Phillips Parkway South Saint Louis Park, MN 55426

RE: Project Number S5574025 and Complaint Numbers H5574081 and H5574082, H5574083, H5574084 and H5574085

Dear Mr. Fritzke:

On August 12, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, investigation of complaint number H5574083 was completed. The complaint was substantiated and deficiencies were cited at F241, F312, F314, F353. An investigation of complaint number H5574085 was completed. The complaint was substantiated and deficiencies were cited at F280, F282, F312, F314 and F353. Investigation of complaint numbers H5574081, H5574082 and H5574084 were completed. These complaints were unsubstantiated.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us

Telephone: (651) 201-3792 Fax: (651) 215-9697

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

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 21, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 21, 2016 the following remedy will be imposed:

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

### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

### Original deficiencies not corrected

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

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

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

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

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

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

If substantial compliance with the regulations is not verified by November 12, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 12, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 09/07/2016 FORM APPROVED OMB NO. 0938-0391

	MENT OF DEFICIENCIES AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245574	B. WING _		08/	12/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426			
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F 000	INITIAL COMMENT	ΓS	F 00	0			
	The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.						
	Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.						
	was completed. The	complaint number H5574083 e complaint was substantiated ere cited at F241, F312, F314,					
	was completed. The	complaint number H5574085 e complaint was substantiated ere cited at F280, F282, F312,					
F 157 SS=D	H5574082 and H55		F 15	7		9/21/16	
	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial						
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE	

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

(X6) DATE

**Electronically Signed** 

09/07/2016

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 157	clinical complication significantly (i.e., a existing form of treatment); or a decitive treatment); or a decitive treatment); or a decitive resident from the \$483.12(a).  The facility must also and, if known, the ror interested family change in room or especified in \$483.1 resident rights under regulations as specified in section.  The facility must resident rights under regulations as specified in section.  The facility must restrict address and phological representative.  This REQUIREMENT by:  Based on interview facility failed to notion a medication error.  Findings include:	chreatening conditions or chs); a need to alter treatment need to discontinue an atment due to adverse of commence a new form of cision to transfer or discharge the facility as specified in the so promptly notify the resident resident's legal representative member when there is a troommate assignment as 5(e)(2); or a change in the federal or State law or cified in paragraph (b)(1) of the cord and periodically update one number of the resident's error interested family member.  Note that the federal or the service of the resident's error interested family member.  The service of the resident of the nurse practitioner (NP) or for 1 of 1 resident (R12).	F 15	F000 This plan and response to these st findings is written solely to maintain certification in the Medicare and M Assistance programs. These writter responses do constitute an admission of the service	n edical en	
	5/17/16, indicated F impairment, experie when walking, and MDS indicated R12	inimal Data Set (MDS) dated R12 had mild cognitive enced shortness of breath received diuretics daily. R12's l's diagnoses included ilure, hypertension, and		noncompliance with any neither requirement nor an agreement with finding. We wish to preserve our r dispute these findings in their entire any time and in any legal action. V submit a separate request for Infor Dispute Resolution for certain finding and determinations.	ight to ety at Ve may mal	

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F 157	(MAR) for 6/1/16 th had a Lasix (a diure Lasix 20 milligrams order was changed mg now and increa On 6/13/16, the Lasix 30 mg every mornin new Lasix order was Lasix 40 mg twice a transcribed on the la day at 8:00 a.m.,  During interview on registered nurse (R from 6/17/16 throug Lasix 40 mg a day given, except for 6/days only two dose the square for the 2 On 6/28/16, two doses dot was placed in th 6/30/16, two doses stated a dot was so when the medication initials are placed of medication has been say if the medication dot had been given  During interview on said, "I was not told three times a day. If given Lasix three times a day. If given Lasix three times a day of the started R12 on dox continued Duo Neb	on Administration Record rough 6/30/16, indicated R12 etic) order dated 5/22/16, for (mg) twice a day. R1's Lasix on 6/2/16, to give Lasix 20 se Lasix to 40 mg twice a day. Six order was changed to Lasix ng and 20 mg every evening. A se written on 6/16/16, to give a day. The order was MAR to give Lasix 40 mg twice 2:00 p.m. and 4:00 p.m.  8/10/16, at 4:33 p.m. 8/10/16, at 4:33 p.m. 8/10/16, three doses of were signed as having been 19/16 and 6/21/16. On those se were signed for. On 6/19/16, 2:00 p.m. dose had a dot in it. ses were signed as given and a ne 4:00 p.m. square. On were signed as given and a ne 4:00 p.m. square. On were signed as given. RN-D ometimes placed in a square on was prepared and then over the dot when the en given. RN-D was unable to ons that were marked with a	F 1	F157 The facility will continue to resident, physician and legal representative of an medical involving the resident. R12 SNP has been notified medication error of 6/17-6/2 Medication errors for past 3 been reviewed and provider already completed. Policy and procedure for no provider of changes in condimedication errors has been is current. Nursing staff have been edupolicy and procedure. Nurse Managers are responsauditing of all medication error Audit results will be reported committee and action plans needed.  Correction date for certificat September 21, 2016	ation error d of the 27. months have r notified if no diffication of dition including reviewed and ucated on the ensible for crors ongoing d to the QA developed a	t d

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F 157	not informed of him a day." NP-A said, 'impacted [R12]. It clevel. NP-A said, "I expected to be told before nine days." If interview with NP-A the passport (medic dispense reports be the staff had given RN-B said he did not trained medication three doses when the Passport dispense error reports were reported in the expect them to not practitioner." The More requested and the later was a medical medication error por received.	said, "To my knowledge, I was being given Lasix three times 'I don't think it negatively lid not impact his potassium am not happy. I would have about a medication error RN-B also present during at RN-B stated he would get cation dispensing machine) ecause he did not think that three doses of Lasix a day. To know why they (nurses or aides) would sign for giving wo doses were given. The reports and the Medication requested but not provided.  8/12/16, at 11:06 a.m. the (DON) said, "If they signed it, it he medication. They should ation error report. I would fy the doctor or nurse ledication error report was DON said she did not believe ation error report. The	F 15	7			
F 225 SS=E	been found guilty or mistreating residen had a finding enterer registry concerning of residents or miss	PORT	F 22	5		9/21/16	

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F 225	indicate unfitness for other facility staff to or licensing authorical The facility must en involving mistreatm including injuries of misappropriation of immediately to the to other officials in through established State survey and control of the facility must have violations are thorough event further potential in the administrator representative and with State law (includertification agency incident, and if the appropriate correct This REQUIREMED by:  Based on interview facility failed to report the staff of the potential in the staff of the appropriate correct the staff of the sta	t an employee, which would or service as a nurse aide or the State nurse aide registry ties.  Insure that all alleged violations tent, neglect, or abuse, if unknown source and if resident property are reported administrator of the facility and accordance with State law diprocedures (including to the pertification agency).  Insure that all alleged and must be evidence that all alleged ughly investigated, and must cential abuse while the rogress.	F 225	F225 The facility will ensure that there is abuse prevention plan in place and alleged violations are fully investig	that all	
	staffing. In addition R55 during the inve	rohibition and sufficient , the facility failed to protect estigation of an allegation of rotect R108 from an alleged		<ul><li>and prevent the potential for further abuse.</li><li>Concern voiced by R108 was reported and investigated. No mistreatment</li></ul>	orted	

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F 225	retailation. This had residents in the fact been floated to other Findings include:  R55 was admitted diagnoses of deme disturbance, major hypertension, lung stenosis (internal nawhich may cause raand/or numbness) Sheet.  The annual Minimu 5/12/16, noted R55 impairment, moders dependent on staff, two staff for transfer assist of one staff for transfer assist of	If the potential to affect 91 dility as both aides could have er units in the facility.  In 1/27/15, with admission and without behavioral depressive disorder, disease, weakness and spinal arrowing of spinal column adiating pain, weakness, our R55's admission Face  In Data Set (MDS) dated had severe cognitive ate depression. R55 was required extensive assist of rs and toilet use, extensive or all other cares and mobility.  In 5/13/16, identified R55 as a exact and neglect due to cognitive obility, language barriers, and on staff to complete daily paired communication, ands and can be understood asian. R55 was did was adult failure to thrive.  In Plan of care sheet for R55 sist every two hours by S (bedtime) and PRN (as exto toilet at 11:00 a.m. and or barrier cream to buttocks was to attempt assist of 1 with mediately use assist of two or	F 2	225	suspected. File has been reviewed complete.  Vulnerable Adult policy and proced been reviewed and updated.  All staff will be educated on the fact Vulnerable Adult policy and proced. The Campus Administrator has implemented a review procedure to ensure the procedure is being folloom. The facility Social Worker or design periodically interview residents if the have concerns and ensure follow-ucompleted and also monitor that the procedure is being followed. Review findings will be reported to committee and action plans develoneded.  Correction date for certification is September 21, 2016	ure has ility ure. o wed. nee will ey p is e	

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F 225	a nursing assistant got you here, you a [on the toilet]." The NA-F then turned s allegedly said, "You was reported to the investigation NA-F R55, as directed by interview at the time allegation stating, "allegation of abuse 2/28/16, the investig Friday 3/4/16, and v (three days late). To f the event were resolved, the incident tracking log provided, the incident VA report was made VA report was made VA report was made variety and instrator, and in regarding abuse and stated she was the initial report for R55 why the alleged per suspended, stated of nursing (DON) we company was the preport to the SA late it had been submitting facility policy for Ab followed, R55 shou suspending NA-F (it the investigation. In	or reported she had overheard (NA)-F state to R55, "Now I've re going to sit for 30 minutes visitor further reported that aw a nurse staff member and didn't hear that." The incident SA on 2/28/16. During the was not suspended to protect the policy. NA-F during an e of the incident denied the I didn't say that." The occurred on a Sunday gative report was due on was not submitted until 3/7/16 he Progress Notes of the time equested, but not provided. An g dated February 26th was ent was not listed, although a	F 22	25		

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F 225	R108 was observed courtyard on 8/10/1 he could speak with was a dietary aide altercation with a county and possible to abuse mobility impairment others to assist with aggressive behavious a dietary aide altercation with a county and possible to abuse mobility impairment others to assist with aggressive behavious and sold speak and the county and the	d on first floor of facility by the 6, at 1:33 p.m. R108 asked if a writer. R108 stated that there (DA)-A who he had a verbal puple months ago and now the other aides to help bring 2 north dining room." R108 the kitchen manager and nurse of the other aides to help bring 2 north dining room." R108 the kitchen manager and nurse of the other aides to help bring 2 north dining room." R108 the kitchen manager and nurse of the would take care of it but do up yet. R108 stated he met and other staff after the aided they would look into the member still was not bringing stated he did not appreciate felt singled out.  I 2/23/15, with admission tage renal disease, diabetes ressive disorder, muscle fized), history of falling, per the eet.  S dated 6/10/16, indicated tive impairment, minimal signs epression. R108 needed ers and needed escort when in to and from destinations.  And 6/28/16, identified R108 as and neglect by others due to the increased reliance on the (ADLs), and verbally ors. Resident had a history of esisting cares, and becoming	F 22	5		

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		245574	B. WING		08	/12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	indicated they were conference held or status was stable a nutrition staff was appeared to have I miscommunication dietary aid and word the administrator concerns on 8/10/of the reporting do log and operational prohibition regardinal administrator state facility at the time whe would expect stand follow format, and from there it must be would not bring him had not brought him his broas the staff member would not bring him had not brought him words with him and other residents.  On 8/11/16, at 9:02 know about any issue occurred when R1	eated by RD dated 12/30/15, e late entry notes from care n 12/23/15. R108's nutritional and discussed concern that not serving him-which	F 2	25		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245574	B. WING		08	/12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 225	a "jerk" and "a****** nobody would serv their food which wa NA, licensed practi room at that time. O because her NA ha room and gave her R108 the rule was present in the dinin delivered to reside rule. DA-A stated h steam table, read r plates and then the to the residents. Do supervisor right aw which was the facil On 8/11/16, at 9:20 registered dietician incident was no lor had met with R108 concern with DA-A RD at the time of th nutrition director ar regarding R108's o conference RD do which was related would be resolved. On 8/11/16, at 11:2 the care conference unaware of a verba aide did not serve The facility would h investigated the inc and provided re-ed	n. DA-A stated R108 called him e." DA-A stated R108 stated e him and everyone else had as not true as there was not a cal nurse or RN in the dining Only one resident had food a brought her to the dining cereal. Stated he explained to a nurse or NA needs to be groom before food can be not because that is the facility is duties are to stand by the neal tickets and put food on a NAs or nursing staff served it A-A stated he told his ay about R108 being upset, ity policy.  I a.m. SW-B stated that the (RD) at the time of the ager employed at the facility but on 12/10/15, regarding his who would not serve him. The ne incident sent an email to the ad food service supervisors oncern. At the 12/23/15, care cumented resident's concern to miscommunication and	F 2	25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245574	B. WING		08	/12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		, , = , = ,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	when he was told y concerns (which w was a reportable in talk with the reside intending to talk with the his staff and thowere credible. He was the decementate complaint but he was with the resident for The next step was determine if he should be a staff and SS-B. SS-A staff and SS-B. SS-A staff and SS-B. SS-A staff and serve foothat he was not be suspended pending administrator state he responded with administrator further been filed with the Health. SS-A staff report immediately incident, they want know what happen the preliminary information for the date of the conference note wourrent. In addition	B p.m. administrator stated vesterday about R108's as 8/10/16) he did not think it incident. He would have liked to not himself and he was the him. The administrator went uight their research and reports was uncertain of the timeframe tion did not substantiate the rould have liked to have met or a preliminary investigation. To talk with resident and build report it. On 8/11/16, at nistrator stated he was going	F 22			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		245574	B. WING		08/	12/2016
	PROVIDER OR SUPPLIER  I HOME WEST		3	STREET ADDRESS, CITY, STATE, ZIP CODE 8620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Sholom Policy and Prohibition-Vulneral Prevention Plan rev Policy: 2. Residents compassionate carrothere is zero tolerar residents, section Valnvestigating/Responsible and the Director Administrator and/owith the reporter an immediate reporting regulations require to the Minnesota De	y manner once the facility was a 8/10/16.  Procedure Abuse ble Adult Protection/Abuse rised 6/1/16, noted: will receive competent and and treatment at all times. Ince for maltreatment of and treatment of and inding section E.  known or suspected -abuse the administrator immediately is "as soon as possible") then	F 225			
F 226 SS=E	A83.13(c) DEVELO ABUSE/NEGLECT The facility must de policies and proced mistreatment, negle and misappropriation  This REQUIREMEN by: Based on interview facility failed to ope	ETC POLICIES  velop and implement written	F 226	F226 Sholom West has updated and operationalized the policy and proce		9/21/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		245574	B. WING			08/-	12/2016
	PROVIDER OR SUPPLIER			36	TREET ADDRESS, CITY, STATE, ZIP CODE 520 PHILLIPS PARKWAY SOUTH AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	R108), who were re (VA) reporting, and the potential to affeboth aides could hain the facility.  Findings include:  Sholom Policy and Prohibition-Vulneral Prevention Plan revention Plan	Procedure Abuse one Adult Protection/Abuse Prohibition. This had on the facility as the been floated to other units.  Procedure Abuse one Adult Protection/Abuse one Adult Protection/Abuse one Adult Protection/Abuse one for maltreatment at all times. The formal manner of the administrator immediately is "as soon as possible") then of Nursing. 2. The or designee will review events of determine the need for the total tracilities report incidents.	F 2	26	that prohibit mistreatment, neglect abuse of residents and misapproprof resident property. Concern voiced by R108 was reported and investigated. File has been really and investigated. File has been really investigating and notification requirements. Campus Administrator is responsible auditing of concerns and VA report system per policy. All files will be a for one month and then randomly fronths. Audit results will be reported to the committee and action plans developmeded. Correction date for compliance will September 21, 2016	riation rted viewed  y and  ole for ing audited or 6  QA ped as	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245574	B. WING		08	/12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 226	a nursing assistant got you here, you a [on the toilet]." The NA-F then turned sallegedly said, " Yo incident was report 2/28/16. NA-F duri denied the allegation of a 2/28/16, the investig to protect R55, as The allegation of a 2/28/16, the invest Friday 3/4/16, and  Progress notes of requested, but not log dated February incident was not lismade to the SA on On 8/12/16, AT 8:3 director of social wworker (SW)-B, ad nurse (RN)-B regareporting. DSW-As completed the initial and when asked we not been suspended director of nursing the company was the report to the AS latit had been submit facility policy for Ab followed, R55 should suspending NA-F (the investigation. In	or reported she had overheard (NA)-F state to R55, "Now I've are going to sit for 30 minutes a visitor further reported that saw a nurse staff member and bu didn't hear that. "The ted to the State agency (SA) on any an interview on 2/29/16, on stating, "I didn't say that." ation NA-F was not suspended directed by the policy.  buse occurred on a Sunday agative report was due on was not submitted until 3/7/16. The time of the event were provided. An Incident tracking 26th was provided, the sted, although a VA report was	F 2	26		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245574	B. WING		08/	12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	courtyard on 8/10/1 he could speak wit was a dietary aide altercation with a c DA-A would not se eat is to get one of me my food in the stated he had told manager three mo the facility's execut was told by all thre no one had followe with Ombudsman a incident and was to issue but the staff food to him. R108 being ignored and Progress notes creindicated they were conference held or status was stable a nutrition staff was appeared to have a miscommunication dietary aid and wood The administrator of the reporting dool log and operational prohibition regarding administrator state facility at the time whe would expect starts.	d on first floor of facility by the 16, at 1:33 p.m. R108 asked if h writer. R108 stated that there (DA)-A who he had a verbal ouple months ago and now rive him." The only way I get to the other aides to help bring 2 north dining room." R108 the kitchen manager and nurse in this ago and wrote a letter to cive committee director and the they would take care of it but and other staff after the old they would look into the member still was not bringing stated he did not appreciate felt singled out.  Leated by RD dated 12/30/15, at late entry notes from care in 12/23/15. R108's nutritional and discussed concern that not serving him-which	F 220			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245574	B. WING _		08	/12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		, , = , = ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	and from there it m On 8/11/16, at 8:45 dining room eating brought him his bre as the staff membe would not bring him had not brought him words with him and other residents.  On 8/11/16, at 9:03 had rules that dieta serve residents and when NAs or nurse occurred when R10 wanted DA-A to ser could not serve him a "jerk" and "a****** nobody would serve their food which wa NA, licensed praction room at that time. Of because her NA ha room and gave her R108 the rule was a present in the dinin delivered to resider rule. DA-A stated hi steam table, read in plates and then the to the residents. DA supervisor right aw which was the facili On 8/11/16, at 9:20 registered dietician incident was no lon	a.m. R108 was observed in breakfast. R108 stated NA-G takfast tray and identified DA-A or he had words with and who had his meals. Also stated DA-A or any meals since having he continued to serve the a.m. DA-A stated the facility ry aides are not supposed to do the food can only be served are present. The incident are present. The incident are present. The incident are present. The incident are present and by the him and DA-A told him he had been and everyone else had as not true as there was not a cal nurse or RN in the dining and brought her to the dining cereal. Stated he explained to a nurse or NA needs to be groom before food can be not supposed to the facility is duties are to stand by the neal tickets and put food on NA's or nursing staff served it A-A stated he told his ay about R108 being upset,	F 23	26		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  3		(X3) DATE SURVEY COMPLETED	
		245574	B. WING		08.	/12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		. = / = 0 . 1 0
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	RD at the time of the nutrition director are regarding R108's of conference RD down which was related to would be resolved.  On 8/11/16, at 11:2 the care conference unaware of a verbacide did not serve a laide did not se	who would not serve him. The ne incident sent an email to the ne incident service supervisors oncern. At the 12/23/15, care cumented resident's concern to miscommunication and  7 a.m. SS-B stated that during e on 12/22/15, she was all altercation but just that an R108 so she did not report it. have suspended staff person, cident, reported, interviewed ucation. The procedure was unaware of altercation.  8 p.m. administrator stated resterday about R108's as 8/10/16) that he did not table incident. He would have be resident himself and he was the him. The administrator went ught their research and reports was uncertain of the timeframe tion did not substantiate the ould have liked to have met or a preliminary investigation. To talk with resident and ould report it. On 8/11/16, at nistrator said he was going to tigation now.  8 a.m. interview with A, and SS-B. SS-A stated they 3/11/16, in the afternoon. It was A-A did serve food to residents ne was not being served by	F 226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245574	B. WING		08/	12/2016	
NAME OF PROVIDER OR SUPPLIER  SHOLOM HOME WEST			STREET ADDRESS, CITY, STATE, ZIP CODE  3620 PHILLIPS PARKWAY SOUTH  SAINT LOUIS PARK, MN 55426				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 241 SS=E	made the call to DA some choice words stated that an incide the Minnesota Depathe facility was supprished for speak with R108 "We should have gainformation sooner facility did not preveretaliation from DA-to serve other resided did not serve R108 the incident accordinate which was data addition, the facility non-serving of mean in a timely manner aware of it on 8/10/483.15(a) DIGNITY INDIVIDUALITY  The facility must promanner and in an enhances each resifull recognition of his properties of the same supprished facility	dministrator stated that he a-A and that he responded with and that he responded with a the administrator further ent report had been filed with artment of Health. SS-A stated bosed to report immediately so and that incident, they wanted first to know what happened at hered the preliminary and then reported it." The ent potential further alleged A to R108, as DA-A continued ents in the dining room and their meals from the date of the care conference and 12/23/15, to current. In did not report the continued is to R108 by DA-A to the SA once the facility was made	F 241	F241 The facility does promote care for tresidents in a manner and in an environment that maintains or enhathe dignity and respect of each residents R59, R152, R162, R167, R176 have had their care plan review.	ances ident. , and	9/21/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245574	B. WING		08/	12/2016
NAME OF PROVIDER OR SUPPLIER SHOLOM HOME WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 241	Continued From page 18  During an observation on 8/8/16, at 5:46 p.m., nusring assistant (NA)-K was heard calling out "she is a feeder" three separate times and stated "both of these are feeders." NA-K was referring to R59 and R162.  During an observation on 8/10/16, at 12:32 p.m., licensed practical nurse (LPN)-F was passing out clothing protectors and was referring to them as "bibs." At 12:40 p.m., while staff was passing out soup a dietary staff member called out, "make sure you give the whole table except (patients name), his soup is different.  R59's quarterly Mminimum Data Set (MDS) dated 5/17/16, indicated she was severely cognitively impaired and required extensive assistance to eat. The MDS further indicated R59 was only able to communicate her needs "sometimes."  During an observation on 8/9/16, at 8:55 a.m., an unidentified nursing assistant (NA) place a bowl of hot cereal in front of R59 but left it out of R59's reach.  During an observation on 8/10/16, at 1:00 p.m., R59's table mates sat eating their soup while R59 was left with no food in front of her.  R152's annual MDS dated 5/21/16, indicated she was severely cognitively impaired, rarely understood others, but could ususally be understood, but was able to eat independently after set-up. However, a Physicians Order Report dated 8/2/16, instructed staff to assist R152 with eating. The MDS further identified an impairment		F 241	and updated as needed in the are eating assistance.  All other dependent residents that unable to communicate needs witheir care plans reviewed and upneeded.  Policy and procedure for feeding assistance per the plan of care in dignified manner has been review updated.  All staff has been educated on thand procedure.  licensed staff is responsible for a the dining experience at least daie each household at various mealtione month then once weekly for months.  Audit results will be reported to the committee and action plans deveneeded.  Correction date for compliance weekly september 21, 2016	at are Il have dated as I a ved and e policy uditing of ly on imes for 3 ne QA eloped as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245574	B. WING _		08/	12/2016	
NAME OF PROVIDER OR SUPPLIER  SHOLOM HOME WEST				STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 241	a staff member place upper right hand coreach. At 12:51 p.m of her reach. She s down. At 12:55 p.m to R152's table. At served her soup, st R152 to eat her me R152 sat at the tab food in front of her. their soup. On 8/11, the dining table from waiting for staff to a R162's quartely ME was severely cognit to communicate he extensive assistance. During an observat staff member place table, out of R162's 9:10 a.m., a staff member place table, out of R162. The spacket, placed it on mixed it with the put The bowl of cereal tasted the egg and to reach for the creatablemates and the a.m., 26 minutes aft sat with R162 and for the creatable sat	ion on 8/10/16, at 12:41 p.m., ced a bowl of soup on the rner of the table, out of R152's a., R152's soup remained out at at the table with her head . staff served the main course 12:58, 17 minutes after being aff sat down and assisted al. On 8/10/16, at 5:55 p.m., le in the dining room with no Her tablemates were eating /16, at 8:55 a.m., R152 sat at m 8:55 a.m. to 9:08 a.m. asisst her to eat.	F 24				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245574	B. WING			08/	12/2016
NAME OF PROVIDER OR SUPPLIER SHOLOM HOME WEST				STREET ADDRESS, CITY, STATE, Z 3620 PHILLIPS PARKWAY SOUT SAINT LOUIS PARK, MN 554	ГН		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 241	a staff member place R162. At 12:44 p.m the right of R162 ar soup and left. At 12 placed on the table p.m., NA-H lifted a sat down to feed an NA-H awoke R162 moved the food with of her meal after it was severely cognit extensive assistance.  During an observati R176 was seated a food in front of him. assisting him to eat and were eating the sat down and assist after his table mate.  On 8/10/16, at 1:12 resident's food shouthem unitl staff is reconsidered.  On 8/10/16, at 1:22 should not be left in help for more than will get cold.  On 8/10/16, at 1:58 not like to be fed. Sher food separated time. LPN-G stated	on on 8/10/16, at 12:38 p.m., bed a bowl of soup in front of, LPN-F stood behind and to ad fed her five spoonfuls of :55 p.m., the main course was out of R162's reach. At 1:00 chair over R162's head and other resident at the table. by speaking with her and nin her reach. R162 ate 50% was placed within her reach.  OS dated 5/28/16, indicated he ively impiared and required the to eat.  on on 8/11/16, at 8:55 a.m., at the dining room table with No staff members were R176's tablemates had food the ir meal. At 9:12 a.m., LPN-F ted R176 to eat, 17 minutes	F 2	241			

AND BLAN OF CORRECTION INDESTRUCTION NUMBER:		. ,	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245574	B. WING _	·····	08/12/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	On 8/11/16, at 3:05 fed R176. She state too long for a reside them wihout being a resident's who need stated "we have a let to 20 minutes would food in front of you.  On 8/12/16, at 11:00 (DON) stated "I don's staff in the dining residents at the san within 30 seconds to stated staff should stated staff should stated staff should stated.	p.m., LPN-F stated she had ed she did no how long was ent to sit with food in front of assistance as "Feeders" and ot of feeders." She stated 15 d be a long time to sit with your	F 24	11		
F 280 SS=D	Resident instructed resident but did not meal should sit in fr was provided. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has th incompetent or othe incapacitated under participate in planni	NNING CARE-REVISE CP e right, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 28	30		9/21/16
	A comprehensive care	are plan must be developed				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (	(X3) DATE SURVEY COMPLETED	
		245574	B. WING		08/12/2016	
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
F 280	comprehensive assinterdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent pathe resident, the re- legal representative	the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, tracticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 280			
	by: Based on observareview, the facility foondition for 1 of 5 a pressure ulcer in Findings include: During an observat licensed practical nompleted a dressi R3's right and left is and excoriated with RN-B described the redness and three LPN-A stated the work required a large previously.  The annual MDS docognitively intact, refor bed mobility, training to the same and the same a	tion, interview and document ailed to reassess skin residents (R3) who developed the facility.  ion on 8/11/16, at 7:23 a.m., urse (LPN)-A and RN-A ng change to R3's buttocks. Schial tuberosity 's were red a three separate open areas. As area as having "lots of estage II pressure ulcers." round had gotten bigger and her dressing than it had ated 6/30/16, indicated he was equired extensive assistance nsfers and toileting and was ent of bowel and bladder. A		F280 All residents have the opportunity to participate in development in their procare including changes to their plan care. Resident R3 care plan has been revand updated to reflect current status related to wound assessment and treatment. All other residents that have wounds have their care plans reviewed and updated as needed. All changes to plan of care will be communicated to resident and this will be documented the medical record. The policy and procedure for updating plan of care has been reviewed and current. The policy and procedure for Prevention and Treatment of Pressulnjury has been updated. Nursing staff have been educated opolicies and procedures for updating	an of of iewed is will the othe din in is or ire	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245574	B. WING			08/-	12/2016
_	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 620 PHILLIPS PARKWAY SOUTH 6AINT LOUIS PARK, MN 55426		
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F 280	care area assessm "high risk for pressure pressure ulcers." R identified impaired assist with bed mode assist with all assist with normal saline, skin, cover with Allea a wound covering of day.  A Facility document dated 7/27/16, iden buttock.  During an interview LPN-A stated she was assisted she wound assessed the wound nurses do the asses was responsible for an an incident report so care plan should be was responsible for and stated she would assessments to be	ent dated 6/30/16, identified a ure ulcer due to a history of 3's care plan dated 8/5/16, mobility and directed staff to bility, transfers and toileting.  Folom Home West Physician 17/22/16 through 8/22/16, 6, the nurse practitioner wrote Left buttock ulcer- cleanse apply skin prep to surrounding evyn border (Allevyn Border is Iressing), change every other titled weekly skin checklist tified an open area on R3's left on 8/10/16, at 1:01 p.m., vas aware of the open area to stated the nurse practitioner	F 2	280	plan of care and Prevention and Treatment of Pressure Injury. Nurse Managers are responsible for auditing of 3 records of residents were wounds weekly for one month and records monthly for 3 months. Audit results will be reported to the committee and action plans development and the compliance will september 21, 2016.	vith then 3 QA ped as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION (X3	) DATE SURVEY COMPLETED
		245574	B. WING		08/12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	0.7.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 280 F 282 SS=E	7/14/16.  A facility policy titled Wounds, undated, opressure ulcers dai surrounding skin, si pain is present. The initiate weekly wour of skin condition, lo wound, length, widt characteristics.  While the Physiciar Checklist identified beginning on 7/14/1 completing a dressi ulcer every other da assessment of the time between 7/14/describe, measure healing.  483.20(k)(3)(ii) SEF PERSONS/PER CATThe services provided by title of the services provided by the services p	d Prevention and Treatment of directed staff to monitor by including the status of the gns of infection and whether expolicy further directed staff to and monitoring to include onset cation of wound, stage of h, depth and wound  1 Orders and Weekly Skin an open area to R3's buttock 6 and while nursing staff were any there was no evidence an wound was completed at any 16 and 8/11/16, to stage, or track progress toward	F 28		9/21/16
	by: Based on observate review, the facility for 4 of 5 residents R24) reviewed for controls	NT is not met as evidenced ion, interview and document ailed to follow the plan of care (R180, R116, R28, R109, lialysis, activities of daily living ag, pressure ulcers, and dining		F 282 The services provided by the facility ar provided by qualified persons in accordance with the resident plan of c. Residents R180 has had care plan and assignment sheet reviewed and update	are.

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		245574	B. WING _		08/	12/2016
	PROVIDER OR SUPPLIER  1 HOME WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	, ,	
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F 282	Findings include:  Dialysis: R180's diagnoses in hypertension and e (ESRD) obtained from Set (MDS) dated 6/ indicated R180 received.  On 8/9/16, at 12:30 asked how dialysis everything was goin increased weight weating well at the tirthe facility. When a restriction resident diet and did not have surveyor noted two night stand next to the stated he had eater was observed to have and lower extremiticated how he had sknow am a little pufficulty. R180's Hospital Dis 5/18/16, directed "Eweight gain of more pounds per week."  Orders dated 6/30/50 During review of the state of	ncluded heart failure, nd stage renal disease om the 14 day Minimum Data 6/16. In addition the MDS eived dialysis.  p.m. when approached and was going R180 stated ng well. R180 stated he had hich was good as he was not me he had been admitted to sked about the diet and fluid stated he was on a regular re a fluid restrictions as glasses of water on top of the bed.  a.m. went to resident room seated at edge of bed. R180 in breakfast in his room. R180 are slight edema on the face es and appeared tired. When slept resident stated well "I fy."  scharge Summaries dated Daily weights: Call provider for than 2 pounds per day or 5 In addition, the Physician 16, directed the same.	F 28	to reflect current status including weights per MD orders. R116 has had care plan and ass sheet reviewed to include groom use of adaptive equipment and orteatment of wounds. R109 has been reassessed for appropriate texture of food and f Plan of care, meal ticket and ass sheet have been updated to reflecurrent status. R24 has had care plan and NAR assignment sheets reviewed and as needed in the areas of incont care, and alterations of skin integratement of wounds. All other care plans will be review revised per the RAI process. Nursing staff will be inserviced of individualized plan of care and for the plan of care. Nurse Manager or designee will a audits weekly on each floor to the plan of care is being followed month and then a audits monthly months to ensure follow through plan of care Audit results will be reported to the committee and action plans deveneeded.  Correction date for certification is September 21, 2016	ignment ing needs are and luids. It is ignment ect luids. It revised mence grity and luids and luids are and luids. It is ignment ect luids and luids are and luids are luids ar	

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F 282	-June 6/1/16, 6/11/6/21/16, 6/30/16 -July 7/1/16, 7/2/16 7/8/16, 7/9/16, 7/12 -August 8/2/16, 8/3 8/7/16, 8/8/16, 8/9/  During review of the Administration Rec August 2016, it was been documented in review of the interd was revealed the widocumented there.  R180's undated caron dialysis and idershortness of breath and elevated blood directed staff to moorders.  The 2 North Group 8/11/16, directed staff to moorders.  The 2 North Group 8/11/16, directed staff to moorders.  On 8/11/16, at 3:31 verified resident had the physician order vital signs tab and missing weights in was going to check and treatment adminurses carts to see weights in thereAt 3:33 p.m. RN-B checked and found RN-B stated he wo	16, 6/14/16, 6/16/16, 6/17/16, , 7/3/16, 7/4/16, 7/5/16, 7/7/16, //16, 7/15/16, 7/16/16, 7/11/16 //16, 8/4/16, 8/5/16, 8/6/16, 16, 8/10/16. The Medication and Treatment ords for May 2016, through a revealed weights had not in the record. In addition isciplinary team notes (IDT) it reights had not been	F 28	32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245574	B. WING			08/	12/2016
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F 282	would populate to M would expect the ni sure the weights would expect the ni sure the weights would expect the physician order.  On 8/12/16, at 7:45 (DON) stated she with the physician order of the physician order stated she would expect the physician order sometimes may had other medical appowhich was not document been obtained in	Matrix. RN-B further stated he urses to check daily to make	F 2	82			
	thrive and osteopor MDS dated 5/31/16 had severely impair extensive to total dron all ADLs which i and transfers.  On 8/8/16, at 6:00 presented on the Brod Observed resident approximately half area.  On 8/9/16, at 10:30 visit to the unit resident.						

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
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F 282	the nursing station noted to have the factor of the factor	with eyes closed and still acial hairs.  a.m. resident was observed a ying on her right side pillow ent remained to have the ag assistant (NA)-A was a resident stated she was a resident up and would come resident ready for the day. 9 a.m. both NA-A and NA-U vide morning care, which and washing resident up nowledged or offered to ong white facial hairs. sed practical nurse (LPN)-B el resident to room, tilted back then turned resident to ucked a pillow under. During N-B looked at resident face adged to remove the facial	F 28	32		

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F 282	-At 10:30 a.m. LPN scheduled to get a indicated because short resident had LPN-A further state many residents did showers/baths how better now as the u aide to assist with a construction of the staff was supported to have one of the staff was supported to have one of the there were two resident with cares to have one of the there were two resident with cares to have one of the staff was supported to have one of the staff as the staff should staff should should be supported to have one of the staff should staff should should be supported to have one of the staff should staff should should be supported to have one of the staff should sh	cares for that morning.  I-A stated "[R116] was shower today." LPN-A the unit had been working not received her shower yet. Indicated the unit had been working not get there scheduled ever thought it was getting init had been added a sixth cares.  In p.m. LPN-A verified the long resident lower chin area. The ched resident chin and stated used to have removed it for a LPN-A stated she was going staff remove it and thought dents in the unit who needed we the facial hairs. LPN-A the ent had received shower after that had come in early to assist short of one NA.  Islan dated 6/11/16, indicated that alteration in self-care st with behavioral are plan directed staff for e assist of one with combing	F 28	2		

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F 282		staff was supposed to follow the was not groomed according to	F 2	82			
	R116 was observe R116 was lying in k lying on her right si of the night stand v (provide comfortab sensitive skin that -At 6:56 a.m. obse she was going to going to leave R11 minutesAt 7:14 a.m. obse assignment sheet room never heard been repositioned. about resident NA-staff in the unit how up shortly. NA-A funot know residents the care planAt 7:19 a.m. NA-A linen stated she way was just getting wh NA-A never reposit room shortly.	otive euipment: d on 8/10/16, at 6:53 a.m. Ded with their eyes closed and ide pillow behind back. On top were two Posey sleeves ble protection for fragile or may bruise or tear easily). The NA-U go to room stated et resident dressed but was 6 and would be back in 45  The NA-U reviewing the with NA-A outside resident discuss the last time R116 had When approached and asked A stated she was not a regular ever was going to get resident wither stated because she did in the unit she would follow a was observed go to room with as not getting resident up but not asked resident and left the ent asleep still observed					
	wearing the arm sl on her back to the until 8:28 a.m. -At 8:29 a.m. LPN- NA-A that R116 wa every hour. When last repositioned L	eeves on both arms still lying right side. No activity to room  A stated she had informed as supposed to be repositioned asked when resident had been PN-A stated she had got to the and did not know when					

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		245574	B. WING _		08	/12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282		een repositioned. LPN-A stated	F 28	2		
	resident had an ophowever, the area same area.  -At 8:32 a.m. both observed provide puring the observared and non-blanch the coccyx was obslayer of cream. LPI scabbed area was bottom was red and resident skin was sleft heel boot was resident skin was sleft hee	en area which was improving was a recurring one in the NA-A and LPN-A were pericare and repositioned R116. Ition R116's bottom appeared hable. The area on the tail of served covered with a thick N-A wiped the area and a observed. LPN-A stated the d non-blanchable because to fragile. LPN-A verified the not on. At 8:36 a.m. NA-A informed her resident was positioned hourly however to the NA assignment sheet it to be repositioned one to two existence had been pulled from that the shift she had not been had been repositioned last. For and 39 minutes without the caused by friction, rubbing, sure that could lead to skin and splits) and Posey sleeves be on at all times. LPN-A				
	was going to add it were supposed to I lotion." -At 8:50 a.m. RN-A care plan in the corskin care plan directorside hourly wher care plan was cont	in the treatment sheet and "I didn't know. I thought they be off at night when staff put a nurse manager reviewed the imputer and verified R116's cted staff to turn resident side in bed and also verified the radicting as it directed staff to one to two hours and then				

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
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F 282	sleeves were support RN-A stated she ware any resident plan or have a word with the On 8/10/16, at 8:52 cares were observed who during the obselft and right never never put a pillow the prominences when On 8/10/16, at 10:3 stated she had revice Care sheet and had hours and every hostated she was going to reflect the hourly as this was confusing staff. At 10:42 a.m. open area that was same area where it further stated she that was a stage II (part involving epidermis superficial and president had late on Alzheimer's disease all cares and was more of the product of the pr	of the Derma and Posey osed to be on at all times. Sould expect the staff to follow of care and she was going to be staff as that was important.  If a.m. to 9:18 a.m. R116's ed provided by NA-A and NA-U erved turned resident to the placed a pillow, three times of protect the boney repositioning.  If a.m. LPN-A approached ewed the NA group Plan of donoticed both the one to two fur for repositioning. LPN-A and the sure it was update repositioning schedule onlying and misleading for the LPN-A stated R116 had an pressure related as it was the shad healed before. LPN-A shought it was healing well and ital thickness skin loss, dermis, or both. The ulcer is sents clinically as an abrasion, rater).	F 28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245574	B. WING		90	3/12/2016		
	PROVIDER OR SUPPLIER  1 HOME WEST			STREET ADDRESS, CITY, STATE, ZIP CO 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426				
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F 282	the foot rest as dire protect skin breakd R116's diagnoses i contracture, muscle thrive and osteopor MDS dated 5/31/16 had severe impaire extensive to total don all activities of don all activities of donall activities of alterdomentia, incontine dependency with A and had a chair fast bruising easy and had a chair f	a verified the pillow was not on ected by the care plan to down.  Included dementia, a weakness, anxiety, failure to rosis obtained from the annual of the MDS indicated resident ed cognition and required ependence of one to two staff laily living which included bed and transfers. In addition the 6 was at risk for pressure nave unhealed pressure area ssessment.  Intelligible of the modern of	F 282					
	expect staff to have	e repositioned resident timely, hairs and followed the plan of						

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
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F 282	plan of care minimi break down.  A facility policy titled Wounds, undated, pressure ulcers dai surrounding skin, spain is present. The initiate weekly wou of skin condition, lowound, length, wide characteristics.  Meal consistency R109 on 8/8/16, at continuously when p.m. the resident wound continuously, as an table stated repeat mouth." At 6:15 p.m. room stated R109 6:17 p.m. when as thickened as noted stated the food had and added at times would have to add that particular mea was noted to be run	age 34 It repositioned according to the ize and/or prevent further skin of defected staff to monitor illy including the status of the igns of infection and whether it is policy further directed staff to ind monitoring to include onset ocation of wound, stage of ith, depth and wound  6:13 p.m. was heard coughing standing at the desk. At 6:14 is observed coughing in the resident in the same in the same in the meal ticket, NA-P is already been pre-thickened is for example the soup staff the thickener however not for it. The pureed food on the plate any and thin. At 6:18 p.m. cough with each bite. At 6:22	F 283	,		
	going to eat all his coughed again. Sta At 6:24 p.m. reside of the runny pureed observed hold his he was having a he nod. At 6:25 p.m. N	o and asked R109 if he was food. At 6:23 p.m. R109 aff still standing over resident. In coughed again after a bite of food on the plate and was nead and NA-P asked R109 if eadache and resident would IA- asked NA-P "do you think I ce." At 6:26 p.m. another NA				

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	came into the dinninher to wheel reside -At 6:29 p.m. reside station still coughing At 6:32 p.m. observhis room and was so On 8/8/16, at 6:39 pmanager (NSM) stathat evening had lessurveyor to come be day. When asked if had been added to NSM stated she we been added to the floor for the purif NSM would contan NSM called the coopureed food cook socops of thickenerate 6:59 p.m. RN-B practitioner was wondetermine if it was at the food was pureed to be honey consist a history of aspiration was on a patch to confuse to a purce to be honey consist a history of aspiration was on a patch to confuse food two teams on the cough and loosen round the purified staff to add two teams and this was to aler needed.  -At 7:18 p.m. approximation approximation and the confee, juice and this was to aler needed.	ing room and NA-P requested int out of the dining room. In observed at the nursing gloud and holding his head. It is is interested into till cough.  In the nutritional service atted the cook who had cooked it for the night and asked ack and talk to cook the next she was familiar with what the pureed food for R109, and not exactly know what had cook before it was brought to eved food. Surveyor requested ct the cook and at this time atted he would add one to two	F 2	82		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1	PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED
	245574	B. WING		08	/12/2016
NAME OF PROVIDER OR SUPPLIER  SHOLOM HOME WEST			STREET ADDRESS, CITY, STATE, ZIP CO 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
and she had not seen the food as LPN-C had on 8/9/16, at 9:16 a.m served into a divided pof the steam table. No plate at this time. At 9 remained in the same take the sippy cups of which were already ho and added a packet of four ounce cups, then them on the tray on to NA-F was mixing the the nourishment center word. No thickener was at this time.  -At 9:39 a.m. when ap the thickened liquids came alreas showed surveyor bottle juice in the refrigerator indicated he poured the took care of the rest if thickener to the bevered. At 10:04 a.m. NA-F we grabbed the tray survey nourishment center Nassist resident and was -At 10:07 a.m. NA-F we the door went in with the protector, pulled a character of the survey and the food. When approadded thickener to the not. NA-F was then obtained the survey was the survey was then obtained the survey was the survey was the survey was then obtained the survey was	started to assist resident the LPN-C add thickener to d indicated.  In observed R109's food plate covered and sat on top of thickener was added to italian. The plate of food a spot. At 9:33 a.m. NA-F of cranberry juice and water oney thickened consistency of thickener to each of the abrought them back and set op of the steam table. As thickener LPN-C came into italian added to the pureed food opposite of the pureed food opposite of the pureed and asked about dietary aide (DA)-A stated add pre-thickened and les of honey and water and it that were opened. He he beverages and nursing if they needed to add more tages.  In observed R109's food thickener was added to the plate of the and set of the steam table. As thickener LPN-C came into the add and water and it that were opened. He he beverages and nursing if they needed to add more tages.  In observed R109's food thickener to be a steam to the dining room eager.	F 28	2		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	` '	TE SURVEY MPLETED
		245574	B. WING _		08	/12/2016
	PROVIDER OR SUPPLIER  M HOME WEST			STREET ADDRESS, CITY, STATE, ZIP C 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 282	she was not aware to be added more the fluids which she walked out of the rocoughing.  -At 10:13 a.m. NA-F who looked at the new food and stated the left the room. NA-F seen the nurse add -At 10:15 a.m. cam and NA-F in room. added the thickene another room doing directed NA-F to account of the two death of the NA-F. LPN veriformed about add LPN-C stated this has the NA-F. LPN veriformed about add LPN-C stated this has the NA-F. LPN veriformed about add LPN-C stated this has the NA-F. LPN veriformed about add LPN-C stated this has the NA-F. LPN veriformed about add LPN-C stated this has the two teaspoons of the food.  -At 10:19 a.m. RN-Lassignment sheet the two teaspoons of the food. RN-B sto implement the dosure the orders wern ursing assistants.  R109's nurse practicated for the food aspiration and responding.  Resident physician resident diet was proceed and the food the food aspiration and responding.	resident food was supposed nickener and thought was only had. As surveyor and NA foom resident was heard  went to room with the RN-B neal ticket and looked at the food consistency was good indicated to RN-B she had not thickener to the food.  back to room found LPN-C LPN-C verified she had not to the food and was in a dressing change. LPN-C ld two teaspoons to the lad two teaspoons to the lad not been communicated to fied the order was dated was a regular staff was not posed to add the thickener to	F 28	32		

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F 282	pureed diet three til for coughing. Reside meals at all times."  The 2 North Group for nursing assistar mechanical soft die plan of care did not thickener were sup three times daily.  R109's care plan dihad potential for nu diagnoses of intelle control, and dyspharesident continued with and without intand honey thickened directed staff to "Ac powder to puree die orders"  On 8/11/16, at 3:23 stated she had wor when the order had had not been able to update the meal tickened order. RD further sit to help with the coueating.  On 8/12/16, at 7:34	Idd 2 teaspoons of thickener to mes a day [TID] during meals dent should be up in chair for	F 2	282			
	and staff was to fol	low all physician orders. ted 7/26/16, identified					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245574	B. WING		08/	12/2016	
	PROVIDER OR SUPPLIER  1 HOME WEST		;	STREET ADDRESS, CITY, STATE, ZIP CODE 8620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426			
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F 282	cream to perineal a episode and observation plan further identification integrity and directed in skin and report to skin assessment do A facility document undated indicated Foreakdown in the salay R24 down in bed During an initial interested he had pain. Buttocks and stated on it.  During an observating R24's right and left to be reddened, excareas approximately four side and approximately four sides and facility of facility of facility of facility of facility for sides and facility of fa	rected staff to apply barrier rea after each incontinence re condition of skin. The care red risk for alteration in skin and staff to observe for changes of licensed staff and a weekly one by licensed staff.  titled 2 North Plan of Care, R24 had a history of skin acral area and directed staff to dor reposition in wheel chair.  erview on 8/8/16, at 3:50 p.m., do not have a pressure ulcer.  on 8/9/16, at 7:44 a.m., R24 He stated the pain was in his dit was because he had a sore inches and had five open yone centimeter x one ne red areas were inches x two inches on the left ately two inches x one inch on should not identify an tocks. The Weekly Skin R24 had an open area on his, but did not identify an tocks. The Weekly Skin O16 was not filled out for the acility's failure to complete the for R24 resulted in five new	F 282				

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F 282	A review of R24's T 8/1/16 through 8/12 - Reposition patient displace weight on of the flowsheet designature was left band August 2016 Skin assessment of the flowsheet designature was left band August 2016 Apply barrier ointructed daily with care the care plan forn in During an interview NA-Q stated she up bottom had sores a been aware of it.  During an interview stated he had the sfor a year.  During an interview RN-B stated he was alteration to the skin nurses should be pfor R24. He stated anything that was n assessment. Howe skin assessments pully even though R on his bottom for a interview on 8/11/16 described R24's bobuttock, moving to	ge 40 reatment Flowsheet dated (16, indicated the following: every two hours in order to sacral/coccyx area. The area signated for a nurses lank the entire months of July weekly on bath day. The area signated for a nurses lank the entire months of July ment to sacral coccyx area es. The facility did not follow nonitoring the skin integrity.  on 8/11/16, at 8:18 a.m., adated the nurses when R24's and stated RN-B should have  on 8/11/16, at 2:42 p.m., R24 ores on his bottom on and off  on 8/11/16, at 8:54 a.m., so not aware R24 had an on his bottom. He stated the erforming skin checks weekly the nurses should be reporting of noted on a previous of noted on a previous over, there was no evidence of performed during the month of 24 stated he has had the sore year. During a subsequent 6, at 2:57 p.m., RN-B tom as "breakdown of left the right." He stated it looked afing" and stated the skin had		282			

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F 282	Continued From pa	ge 41	F 2	82		
		on 8/11/16, at 12:29 p.m. the skin checks should have R24.				
F 309 SS=D	directed "6. The Re changing. It is to be changes in doctor's change. The Reside accuracy, updated v 483.25 PROVIDE C	CARE/SERVICES FOR	F 3	09		9/21/16
	provide the necessary or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment				
	by: Based on observat review, the facility fa for daily weights, fo reviewed for dialysis Findings include: R180's diagnoses in hypertension and e (ESRD) obtained fre	ncluded heart failure, nd stage renal disease om the 14 day Minimum Data 6/16. In addition the MDS		F309 Each resident will continue to recei necessary care and services to attamaintain the highest practicable level physical, mental, and psychosocial well-being in accordance with the picare. Resident R180 has been reassessed MD orders for daily weights. Treatmarecords are updated to reflect currecorders. All residents with orders for weights outside of facility policy for monthly	ain and vel of lan of ed for nent ent	

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	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	<u>,</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	On 8/9/16, at 12:30 asked how dialysis everything was goi increased weight weating well at the tithe facility. When a restriction resident diet and did not has surveyor noted two night stand next to  On 8/11/16, at 9:10 observed resident stated he had eate was observed to ha and lower extremitiasked how he had know am a little purity asked how he had know am a little purity gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week." dated 6/30/16, directed "I weight gain of more pounds per week."	o p.m. when approached and was going R180 stated ng well. R180 stated he had which was good as he was not me he had been admitted to asked about the diet and fluid stated he was on a regular ve a fluid restrictions as glasses of water on top of the bed.  o a.m. went to resident room seated at edge of bed. R180 n breakfast in his room. R180 ave slight edema on the face ites and appeared tired. When slept resident stated well "I ffy."  scharge Summaries dated Daily weights: Call provider for e than 2 pounds per day or 5 In addition Physician Orders cted the same.  e vital signs weight section the were noted missing according /16, 5/28/16. 16, 6/14/16, 6/16/16, 7/5/16, 7/7/16, 2/16, 7/15/16, 7/16/16, 7/11/16 8/16, 8/4/16, 8/5/16, 8/6/16,	F 309	weights have had treatment recoreviewed to ensure orders are cuare being followed per orders. Policy and procedure on follow-the physician orders has been review is current.  All nursing staff has been educated following of MD orders and document of such.  Nurse Managers or designee will responsible for auditing treatment of 3 residents per unit for follow to MD orders for daily weights for oand then monthly for 3 months. Audit results will be reported to the committee and action plans deveneeded.  Correction date for certification is September 21, 2016	arrent and nrough on wed and ed on mentation be trecords hrough of ne month ne QA eloped as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION  NG	(		E SURVEY PLETED
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F 309	review of the interdivas revealed the widocumented there of R180's nutrition Ca dated 5/26/16, indice weight loss over the weight loss was attended the weight loss was attended to the weight. On the weight loss was gliuid and actual master breakdown, higher edema, cardiac/kidde to the weight loss was and idensified to the weight loss was good to the weight loss was going to check and treatment adminurses carts to see weights in there.	in the record. In addition isciplinary team notes (IDT) it eights had not been either.  The Area Assessment (CAA) cated resident had a significant e past 180 day period and the ributed to fluid status changes with dialysis, however also with rior to and during the characteristic in weight loss is AA indicated the possible guificant weight loss of both	F 3	09			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245574	B. WING		08/	12/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
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F 312 SS=D	RN-B stated he woo assistant to get the and record the weig would populate to Nowould expect the not sure the weights we constant of the physician orders.  On 8/12/16, at 7:45 stated she would exphysician orders.  On 8/12/16, at 10:1 registered nurse to stated she would extend the physician orders sometimes may has other medical appowhich was not document been obtained in 483.25(a)(3) ADL CODEPENDENT RES	"they are not recording them." uld expect the nursing weights daily in the morning ght to Point of Care which Matrix. RN-B further stated he urses to check daily to make ere done.  a.m. the director of nursing expect the staff to follow the  1 a.m. via telephone the the primary doctor's clinic expect the care center to follow s but thought the resident ve not been weighed due to intments or dialysis days mented why the weights had in the resident medical record. EARE PROVIDED FOR	F 3			9/21/16
	by: Based on observat review, the facility f of 3 residents (R11	NT is not met as evidenced cions, interview and document ailed to provide grooming for 1 6) who was dependent for ing (ADL) reviewed for ADL.		F312 The residents that are unable to ca activities of daily living will continue receive the necessary services to maintain good nutrition, grooming personal hygiene.	e to	

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	PROVIDER OR SUPPLIER  M HOME WEST			3	TREET ADDRESS, CITY, STATE, ZIP CODE 620 PHILLIPS PARKWAY SOUTH 6AINT LOUIS PARK, MN 55426		
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F 312	seated on the Brod. Observed resident approximately half i area.  On 8/9/16, at 10:30 visit to the unit reside the nursing station noted to have the factor of the nursing station and the nursing station and the nursing station of the nursing station and the nursing stat	o.m. resident was observed a wheelchair in the DR. with multiple white facial hairs nch long on the lower chin  a.m. during another random dent was observed on her the dining room across from with eyes closed and still acial hairs.  a.m. resident was observed a ging on her right side pillow ent remained to have the agassistant (NA)- A was a resident stated she was a resident up and would come resident ready for the day.  9 a.m. both NA-A and NA-U wide morning care, which and washing resident up nowledged or offered to ong white facial hairs. sed practical nurse (LPN)-Bel resident to room, tilted back then turned resident to ucked a pillow under. During N-B looked at resident face dged to remove the facial  1 a.m. the RN-E stated a set progression of e, was dependent on staff for	F3	312	Resident R116 has had the plan of and NAR assignment sheets for those residents that are dependent in ADI have been reviewed and updated a needed.  Nurse Managers or designee will at dependent residents per unit weekl one month and then 3 residents more for 3 months to ensure assignment are being followed.  Audit results will be reported to the committee and action plans develoneeded.  Correction date for certification is September 21, 2016	Ls udit 3 y for onthly sheets	

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F 312	On 8/11/16, at 7:30 Broda chair at the of day. When approach were still not remove feet away. At 9:16 a room facial hair visis several staff by the resident was seater facial hairs.  -At 10:27 a.m. NA-1 providing resident of carrent of the carrent of the providing resident of the carrent of	a.m. was observed on the dining table dressed for the ched the white facial hairs re and visible from standing 20 a.m. resident still in the dining ble from standing 20 feet steam table close to the table d none offered to remove the d none offered to remove the drares for that morning.  -A stated "[R116] was shower today." LPN-A the unit had been working not received her shower yet. d due to insufficient staff, not get there scheduled ever thought it was getting nit had been added a sixth cares.  p.m. LPN-A verified the long resident lower chin area. The ched resident chin and stated esed to have removed it for LPN-A stated she was going staff remove it and thought dents in the unit who needed we the facial hairs. LPN-A ent had received shower after aff had come in early to assist short of one NA.	F 31:			

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F 312	dependence of one daily living which in and transfers.  R116's pressure uld dated 5/31/16, indic pressure ulcer relat dementia and bowe staff to assist with or R116's activities of 6/11/16, indicated rein self-care ability, r dressing/grooming/ to advanced demendisturbance. The care grooming to provide hair, oral care, nail.  The 3 South Weekl indicated resident with the state of the self-care action with the self-care action.  On 8/11/16, at 3:16 unit manager stated automatically remove Am totally with you. supposed to follow.  On 8/12/16, at 7:36 stated she would excare, to reposition to remove the facial his thing."	to two staff on all activities of cluded bed mobility, toilet use cer Care Area Assessment cated resident was at risk for red to impaired mobility, el incontinence. CAA directed cares.  daily living care plan dated esident had potential alteration needed assist with bathing and oral care related nation with behavioral are plan directed staff for eassist of one with combing care and shaving.  y Bath List dated 8/8/16, was scheduled to get a bath on p.m. registered nurse (RN)-A distaff should have wed the facial hairs "You think." RN further stated staff was the plan of care.  a.m. the director of nursing expect staff to follow the plan of imely and assist a resident to airs with cares "it's a dignity	F 31			
	483.25(c) TREATM PREVENT/HEAL P Based on the comp		F 31	4		9/21/16
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-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	[`	X3) DATE SURVEY COMPLETED
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F 314	who enters the faci- does not develop p individual's clinical they were unavoida pressure sores rec services to promote prevent new sores  This REQUIREMED by: Based on observareview, the facility fre-assess residents	y must ensure that a resident lity without pressure sores pressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and the healing, prevent infection and	F 314	F 314 The Facility will continue to ensure the residents admitted to the facility will develop pressure sores unless the	
	services to promote sores from develop R3, R28, R116) rev This resulted in act developed multiple (partial thickness s dermis, or both. Th	e healing and/or prevent new bing for 4 of 5 residents (R24, viewed for pressure ulcers. The stage II pressure ulcers kin loss involving epidermis, the ulcer is superficial and the san abrasion, blister, or		individual □s clinical condition demonstrate that they were unavoida and residents having pressure sores receive the necessary treatments to promote healing, prevent infection are prevent new ones from developing. Residents R 3 and R24 have been reassessed for pressure sore risk are care plans and NAR assignment she have been updated to reflect current status.  All other residents that this may affect	nd nd eets
	registered nurse (Fa pressure ulcer.  On 8/9/16, at 7:44 a stated he had pain, sore on his buttock  During an observat nursing assistant (I	a.m., R24 was interviewed and He stated the pain he had a s which caused him pain.  tion on 8/11/16, at 8:41 a.m. NA)-Q toileted R24. R24's right erosities were noted to be		include those with a Braden score of 15-19 will have assessments reviewed and care plans and NAR assignment sheets reviewed and updated as need Policy and Procedure for Prevention treatment of Pressure Injuries has be updated.  All nurses will be educated on update policy and procedure.  Nurse Managers or designee will autoresident seconds to include	ed t eded. and een

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		245574	B. WING		08/-	12/2016
	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 8620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	a bony swelling on weight of the body open areas observed approximately one. The areas of redne approximately four side and approximately four side and approximately four side and approximate right.  R24's Care Area As 4/6/16, indicated R2 ulcers due to the nebed mobility and ind Minimum Data Set indicated R24 was incontinent of bladd bowel and required mobility, toileting ar dated 7/26/16, indicincontinence and in apply a barrier creatarea after each inconserve the conditional plan further identified in skin integrity and changes in skin, to staff, and for the lice weekly skin assess R24's Treatment F1 8/12/16, indicated to be implemented: Reposition patient of displace weight on assessment weekly	riated (an ischial tuberosity is the buttocks that bears the while sitting). There were five ed which each measured centimeter (cm) x one cm. ss were noted to be inches x two inches on the left ately two inches x one inch on essessment (CAA) dated 24 was at risk for pressure ed for extensive assist with continence. A quarterly (MDS) dated 6/30/16, cognitively intact, occasionally ler, frequently incontinent of extensive assistance for bed not transfers. R24's care plan eated the resident experienced aterventions directed staff to am to the resident 's perineal continent episode, and to on of R24 's skin. The care ed R24 had a risk for alteration directed staff to observe for report changes to the licensed ensed staff to conduct a ment.	F 314	assessment, care plan and NAR assignment sheets per unit weekl month and then 3 residents month months to ensure compliance with and procedure. Repositioning audits will be compusing the same schedule. Audit results will be reported to the committee and action plans devel needed.  Correction date for certification is September 21, 2016	nly for 3 n policy leted e QA	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245574	B. WING	<del></del>	08	/12/2016
	PROVIDER OR SUPPLIER  1 HOME WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
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F 314	Checklist for Augus open area to his rig Skin Checklist did r skin on his buttocks Skin Checklist for J documentation for the Areview of the Nurdated 8/12/16, indic (multiple open area Family notified of properties of skin breakdown is staff to lay R24 down chair.  During an interview nursing assistant (Nof pain in his botton on it. NA-Q stated the better, then worse. update the nurse we to have sores on it. aware of the open as should have been as the skin on his botts should be performing and should be repobeen noted on a prothere was no evider assessments had be month of July.	document titled Weekly Skin at 2016, indicated R24 had an ht shin on 8/6/16. The Weekly not identify any alteration to the se. When reviewed, the Weekly uly 2016 had void of any the entire month.  se's Progress Note late entry cated R3 "has stage 2 ulcers son right and left buttocks)." ressure ulcers. titled 2 North Plan of Care (NAd, indicated R24 had a history in the sacral area and directed an in bed or reposition in wheel on 8/11/16 at 8:18 a.m., NA)-Q stated R24 complained in and stated he gets "rashes" the resident has stated it gets NA-Q stated she would hen R24's bottom was noted NA-Q was asked if RN-B was areas and NA-Q replied, "He aware of it."  Ton 8/11/16 at 8:54 a.m., RN-B was areas and NA-Q replied, "He aware R24 had an alteration to om. He stated the nurses ng weekly skin checks for R24 rting anything that had not evious assessment. However,	F3	14		

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F 314	checks should have stated RN-B should pressure ulcers to nurse manager on  During a follow up at 2:42 p.m., R24 shottom on and off for During a subseque 8/11/16 at 2:57 p.m bottom as "breakde the right." RN-B stated as "chabeen "sheared" off.  RN-A stated during a.m., that she was R3's skin but that she was R3's skin	(DON) stated weekly skin be been completed for R24 and dhave been aware of the R24's bottom as RN-B was the the unit.  Interview with R24 on 8/11/16 tated he'd had sores on his or a year.  Interview with RN-B on and the R24's bown of left buttock, moving to the difference of the skin had	F 31	4		

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F 314	A review of Nurses' through 8/11/16, ide open areas to the bR3 had a stage II properties and was cognitively intal assistance for bed and was frequently bladder. A CAA date "high risk for pressure ulcers."  R3's care plan date area of impaired more included for staff to transfers and toileting updated on 8/11/16 open area to his lef (centimeters) x 1.5 on 8/11/16 at 7:23 areas, a Nurses' Prindicated a messag practitioner regarding 1.2 cm) on resident A review of R3's Ph 7/22/16 through 8/2 nurse practitioner had better the stage of the same properties of Allevyn border (Allecovering dressing),	Progress Notes from 2/12/16 entified R3 had a history of uttocks. The notes indicated ressure ulcer on 2/23/16.  ated 6/30/16, indicated he ct, required extensive mobility, transfers and toileting incontinent of bowel and ed 6/30/16, indicated R3 had a are ulcer due to a history of d 8/5/16, identified a problem obility, and interventions assist with bed mobility, ang. R3's care plan had been to include identification of an at buttock measuring 1.5 cm cm. Although the observation a.m. had identified three open ogress Note dated 8/11/16, e had been left for the nurse ag: "two open areas (1.2 cm x 's left buttock."  ysician Order Report dated 2/16, indicated on 7/14/16, the ad written the following order: leanse with normal saline, urrounding skin, cover with vyn Border is a wound change every other day.	F 3	14		

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F 314	Checklist identified beginning on 7/14/ assessment of the time between 7/14 describe, measure healing.  During an interview LPN-A stated she R3's buttocks. She saw him in July an stated R3 had exp skin on his bottom  During an interview days after RN-A woulcer on R3's buttocks assessed the would nurse do the assessed the would nurse do the assessed the would nurse do the assessment to me pressure ulcers.  During an interview DON stated when an incident report scare plan should be was responsible for and stated weekly been expected to be assessment to the plan should be was responsible for and stated weekly been expected to be assessment to the plan should be was responsible for and stated weekly been expected to be assessment to the plan should be was responsible for and stated weekly been expected to be assessment to the plan should be was responsible for and stated weekly been expected to be assessment to the plan should be was responsible for and stated weekly been expected to be assessment to the plan should be was responsible for and stated weekly been expected to be assessment to the plan should be was responsible for and stated weekly be a specific plan should be assessment to the plan should be was responsible for and stated weekly be a specific plan should be a s	n Orders and Weekly Skin an open area to R3's buttock 16, there was no evidence an wound was completed at any /16 and 8/11/16 to stage, or track progress toward  of on 8/10/16 at 1:01 p.m., was aware of the open area to estated the nurse practitioner dound the area. LPN-A further erienced problems with the in the past.  of on 8/11/16, at 7:02 a.m., two as made aware of the pressure ock, RN-A stated she had not not yet. She stated, "I think the essments daily." However, of reflected there had been no asure and monitor R3's  of on 8/11/16 at 12:19 p.m., the a skin concern was identified should be filled out and the e updated. She stated RN-A or implementing the process skin assessments would have be completed since the initial covered by the nurse	F 3	14		
	R28's quarterly ME was moderately co incontinent of bow extensive assistan	OS dated 6/23/16, indicated she agnitively impaired, frequently el and bladder and required ce of two staff for bed mobility, ers. R28's care plan dated				

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F 314	7/31/16, indicated sa mechanical stand osteoarthritis and n further identified a puttocks and direct reposition with pillor relieving cushion in document titled 2 N directed staff to "be repositioning" but d Prior to inquiry by s reflected every hou tolerance tests.  A Nursing Progress indicated R28 had a present on her right.  During continuous 8:06 a.m10:07 a.m. the wheelchair with on 8/10/16, R28 was chair with a cushior R28 remained seat dining room. At 9:20 her room where show without repositionin remained in the whous and states who hours and states.	the required assistance using to transfer related to europathy. The care plan pressure ulcer to R28's right ed staff to monitor weekly, where weekly, we and provide a pressure wheel chair. A facility torth-Plan of Care undated, diligent with turning and id not identify a frequency. Europeyor, the care plan repositioning based on tissue a Noted dated 7/29/16, a stage II pressure ulcer to buttock.  Sobservation on 8/10/16 from nout repositioning. At 8:06 a.m. as seated in a standard wheel no not he seat. At 8:58 a.m., ed in the wheel chair in the 6 a.m., staff escorted R28 to be remained seated in her chair g. At 10:07 a.m. R28		114			
	8:30 a.m. and had a 10:24 a.m., NA-Q s beauty shop and ha At that time, R28 ha	seated in the dining room at not been repositioned. At tated R28 had left for the ad still not been repositioned. ad been in her wheel chair for ninutes without repositioning.					

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F 314	the bathroom after shop but did not spondid not spondi	Stated she had taken R28 to she returned from the beauty ecify an exact time.  on 8/10/16, at 10:11 a.m., N)-B stated another staff essments and the care plans care sheets (the 2 North-B stated if the care plan osition R28 every hour it on the care sheet and staff ning her every hour.  on 8/11/16 at 12:26 p.m., the would have been repositioned ted by the care plan. She es care sheets should indicate a the nursing assistants.  If on 8/10/16, at 6:53 a.m. lying side, eyes closed and a pillow wo Posey sleeves (provide ion for fragile or sensitive skin ear easily) were observed on and.  was observed to enter R116's she was going to get R116 and of minutes. At 7:14 a.m. NA-U ewing the assignment sheet R116's room. When ime, and asked about when wed care, NA-A stated she taff on the unit but would be ortly. NA-A stated because esidents in the unit she would	F3				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245574	B. WING	·		08/-	12/2016
-	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
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F 314	need ready. At that the resident. At 7:2 be asleep on the be both arms still lying right side. At 8:29 a informed NA-A that repositioned every resident had been I she had gotten to the know when R116 h LPN-A stated R116 improving however in the same area. A LPN-A were observed repositioning for R1 R116's bottom apportant the area on the taicovered with a thick the area and a scalt the bottom was red R116's skin was so R116 was suppose which was not on. A LPN-A had informe be repositioned hou looked at the NA as R116 was to be rephours, and because another unit later in told when R116 had went one hour and repositioned.  At 8:45 a.m. on 8/1 resident was supposed to the NA as R116 had went one hour and repositioned.	as just getting what she would time, NA-A did not reposition 7 a.m. R116 was observed to ed wearing the arm sleeves on on her back, positioned to her a.m. LPN-A stated she had R116 was supposed to be hour. When asked when the ast repositioned, LPN-A stated he unit at 6:30 a.m. but did not ad last been repositioned. had an open area which was the area was a recurring one at 8:32 a.m. both NA-A and red to provide pericare and 16. During the observation eared red and non-blanchable. If of the coccyx was observed and non-blanchable because fragile. LPN-A also verified to be wearing a left heel boot At 8:36 a.m., NA-A stated and non-blanchable because fragile. LPN-A stated and her R116 was supposed to arly however when she'd assignment sheet, it indicated to stitioned every one to two e she had been pulled from to the shift she had not been do been repositioned last. R116 39 minutes without being	F	314			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245574	B. WING			08/	12/2016
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F 314	care plan and verifi staff were to reposi when in bed. Howe contradictory as it at the resident every of the Posey sleeves times. RN-A stated follow the resident's On 8/10/16, R116 vto 9:18 a.m. R116's provided by NA-A afrom the left to the behind the resident On 8/10/16 at 10:36 reviewed the NA grhad noticed both th hour for repositioning going to make sure hourly repositioning confusing and misk LPN-A stated R116 pressure related as had healed before. stage II which was On 8/12/16 at 7:20 seated in a Broda of door. R116 was not feet however, did not rest. At 7:30 a pillow in place on the R116's annual MDS resident's diagnose	a.m., RN-A reviewed R116's ed R116's care plan indicated tion her side to side hourly ever, the care plan was also directed staff to reposition one to two hours. RN-A verified were supposed to be on at all she would expect staff to splan of care.  Vas observed from 8:52 a.m. cares were observed and NA-U who turned R116 right but never placed a pillow.  So a.m., LPN-A stated she had oup Plan of Care sheet and e one to two hours and everying. LPN-A stated she was it was updated to reflect the schedule as this was eading for staff. At 10:42 a.m. had an open area that was it was the same area where it LPN-A stated the area was a healing well.  a.m., R116 was observed chair in front of the dining room ted to have blue boots on both ot have a pillow placed on the .m. RN-A verified their was no	F3	14			

NAME OF PROVIDER OR SUPPLIER  SHOLOM HOME WEST  SHOLD HOME WEST  SHOLD HOME WEST  SHOLD HOME WEST  SHOLOM HOME WEST  SHOLD HO	STATEMENT OF DEFICIE  AND PLAN OF CORREC		INHIMDED:	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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steoporosis. The MDS also indicated R116 had severely impaired cognition and required extensive to total dependence of one to two staff for all activities of daily living which included bed mobility, tollet use and transfers. In addition the MDS indicated R116 was at risk for pressure ulcers, but had no unhealed pressure areas at the time of the assessment.  R116's pressure ulcer CAA dated 5/31/16, indicated the resident was at risk for pressure ulcers related to impaired mobility, dementia and bowel incontinence. The CAA directed staff to assist R116 with turning and repositioning and to observe skin daily during cares.  R116's care plan dated 7/8/16, indicated she was at risk for alteration in skin integrity related to dementia, incontinence of bowel and bladder, dependency with ADLs, poor nutritional intake, and being chair fast. The care plan further indicated R116 had a history of bruising easily and had fragile skin. Care plan interventions included: "Place pillow on foot rest when resident is in BRODA chair, elevate lower extremities when in bed above level of heart. Turn side to side hourly while in bed, use pillows to protect bony prominences when repositioning, Repositioning hourly while in BRODA chair (specialized wheelchair), Posey sleeves upper extremities (Full arm) and derma-savers to lower extremities (Full arm) and derma-savers to lower extremities at all times, remove at bedtime to apply lotion, then reapply. Heel blue boots on both feet when lying in bed and sitting up daily on all three shifts"  During review of the Event Reports assessments and the Interdisciplinary team notes (IDT) the following were revealed:	osteopo severely extensive for all accompositive mobility, MDS incompositive mobility,	porosis. The MDS also indicated rely impaired cognition and requisive to total dependence of one activities of daily living which in ity, toilet use and transfers. In a indicated R116 was at risk for its, but had no unhealed pressure of the assessment.  Its pressure ulcer CAA dated 5/3 ated the resident was at risk for its related to impaired mobility, of a related to impaired proposition in skin integrity restricts, incontinence of bowel and related R116 had a history of bruis and fragile skin. Care plan interested: "Place pillow on foot rest was a respective to the standard proposition of the responsition of the reapply. Heel blue feet when lying in bed and sitting the lated sciplinary team notes are interdisciplinary team notes are interdisciplinary team notes.	ed R116 had uired e to two staff included bed addition the pressure e areas at the staff to soning and to staff to soning easily eventions when resident tremities urn side to to protect ing, A chair eves upper edtime to boots on ing up daily on assessments	14		

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F 314	resident required ph staff with bed mobil -Skin Integrity Even Ulcer/Arterial dated stage II- partial thick presents clinically a shallow crater. The buttocks and measi 1.0 cm. The assess history of pressure interventions includ and repositioning at devices in chair and -Interdisciplinary no indicated resident p bottom measured "normal saline [NS], applied to area."  On 8/12/16, at 7:36 expect staff to have accordance with the	y dated 7/7/16, indicated hysical extensive assistance of ity and repositioning. ts Pressure Sore/Stasis 8/1/16, indicated R116 had a kness loss of skin layers that is an abrasion blister, or open area was on the left ured 1.5 centimeters (cm) by sment indicated resident had ulcer and directed ed but not limited to turning and use of pressure relieving it bed. Ite (IDT) note dated 8/4/16, ressure open area on right 1/4 cm x 1/8 cm, washed with patted dry, barrier cream	F 3	14		
F 323 SS=E	Wounds undated, or pressure ulcers dail surrounding skin, si pain is present. The initiate weekly wour of skin condition, lowound, length, widt characteristics.  483.25(h) FREE OF HAZARDS/SUPER	lirected staff to monitor by including the status of the gns of infection and whether be policy further directed staff to and monitoring to include onset cation of wound, stage of and, depth and wound  FACCIDENT	F 32	23		9/21/16

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F 323	as is possible; and adequate supervisiprevent accidents.  This REQUIREMENT by: Based on observative review, the facility factured food/fluids choking/aspiration who had been idenduring a dining obsfacility failed to ens	each resident receives on and assistance devices to NT is not met as evidenced ion, interview and document ailed to provide appropriate in order to prevent for 1 of 1 residents (R109) tified as at risk reviewed ervations. In addition, the ure grab bars on toilets were	F 323	F 323 The facility will continue to ensure the resident senvironment remains as of accident hazards as possible. Resident R109 has been reassessed appropriate texture of food and fluid Plan of care, meal ticket and assign	free ed for ls.	
	R101, R96, R176). 118 residents who I 118 residents who I 118 residents who I 118 residents who I 118 resident was sobser another resident in repeatedly, "[R109] p.m. nursing assist dining room stated every day. At 6:17 phad been thickened NA-P stated the for pre-thickened and a soup staff would had however, not for the food on the plate w At 6:18 p.m. R109	residents (R29, R58, R186, This has the potential to affect have grab bars on their toilets.  e was observed on 8/8/16, at a heard coughing continuously the desk. At 6:14 p.m. the wed coughing continuously, as the same table stated cover your mouth." At 6:15 ants (NA)-P and NA-K in the to R109 coughed like that p.m. when asked if the food of as noted in the meal ticket, and had already been added at times for example the exercise to add the thickener at particular meal. The pureed as noted to be runny and thin. Continued to cough with each A-P stood up and asked R109		sheet have been updated to reflect current status.  All other residents affected by this was reviewed and care plans and NAR assignment sheets updated as need Education has been conducted with nursing staff on following the plan of related to appropriate textures of for fluids.  Dietary servers have been educated providing appropriate textures while serving meals.  Nurse Manager or designee will cord audits weekly on each floor to ensure the plan of care is being followed for month and then 3 audits monthly for months to ensure follow through on plan of care.  Director of Culinary services or designee is responsible to audit servers to encompliance 3 times weekly for one and then 3 times monthly for 3 mon All grab bars on toilets have been a	ded. f care od and d on mplete sure r one r 3 the ignee sure month ths.	

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	if he was going to end over the resident. A coughed again after food on the plate at and NA-P asked Richeadache and resident. At 6:26 p.m. dining room and NA resident out of the control	eat all his food. At 6:23 p.m. in. Staff were still standing at 6:24 p.m. the resident r a bite of the runny pureed and was observed hold his head 109 if he was having a dent would nod. At 6:25 p.m. To you think I should give him another NA came into the A-P requested her to wheel dining room. In observed at the nursing g loud and holding his head. The reduction of the nutritional service ated the cook who had cooked fit for the night. When asked if the what had been added to the 109, NSM stated she would not had been added to the 109, NSM stated she would not had been added to the 109, NSM stated she would not had been added to the 109, NSM stated she would not had been added to the 109, NSM stated she would that time. NSM called the all the cook added one to two r to all pureed food.	F 323	for safety. All are currently in vorder.  Maintenance Director or desig responsible for routine auditing bars to ensure ongoing compli Audit results will be reported to committee and action plans deneeded.  Correction date for certification September 21, 2016	nee will be g of grab ance. o the QA eveloped as	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245574	B. WING		08	/12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 5542	P CODE H	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	had signed off on it ticket the three pac coffee, juice and so was to alert staff of -At 7:18 p.m. approassisting R109 with had watched the traserved and when s and she had not se (LPN)-C add thicke indicated.  On 8/9/16, at 9:16 a served into a divide of the steam table. plate at that time. A remained in the sar took the sippy cups (which were alread consistency) and are each of the 4 ounce back and set them table. As NA-F was came into the nouri said a word. No this pureed food at that -At 9:39 a.m. when the thickened liquid the liquids came all indicated he poured took care of the rest thickener to the bevalunder. NA-F stated resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the rest of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. NA-I the door went in with the staff of the resident and was was -At 10:07 a.m. At 10:0	RN-B stated on the meal kets of thickener were for the pup if he needed them and that what the resident needed. ached NA-P who had been eating and she stated she ay from when it had been he started to assist resident en the licensed practical nurse ner to the food as LPN-C had a.m. observed R109's food and plate covered and sat on top No thickener was added to at 9:18 a.m. the plate of food me spot. At 9:33 a.m. NA-F of cranberry juice and water y honey thickened dided a packet of thickener to be cups, then brought them on the tray on top of the steam mixing the thickener LPN-C shment center and left never ckener was added to the time. approached and asked about s dietary aide (DA)-A stated ready pre-thickened. He at the beverages and nursing the if they needed to add more verages. The went to the dining room and went into the nourishment at she was going to assist	F3	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245574	B. WING		08	/12/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3620 PHILLIPS PARKWAY SOUTH  SAINT LOUIS PARK, MN 55426				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	the food. When appreciated thickener to not. NA-F was then quick bite when surher before the seconstated she was not supposed to be add thought that was or NA-F walked out of heard coughing.  -At 10:13 a.m. NA-F who looked at the refood and stated the left the room. NA-F seen the nurse add -At 10:15 a.m. cam and NA-F in room. added the thickene another room doing directed NA-F to accompany the food.  -At 10:17 a.m. when informed about add LPN-C stated that he the NA-F. LPN veriformed about add LPN-C stated that he naver she was supthe food.  -At 10:19 a.m. RN-F aware she was supthe food.	proached and asked if she had the food NA-F stated she had observed give resident one veyor intervened and stopped and bite at 10:10 a.m. NA-F aware resident food was ded more thickener and ally the fluids which she had. As the room, the resident was went to room with the RN-B neal ticket and looked at the food consistency was good indicated to RN-B she had not thickener to the food. The back to room found LPN-C LPN-C verified she had not room to the food and was in a dressing change. LPN-C ded two teaspoons to the masked if the NA-F had been ling the thickener to the food and not been communicated to fied the order was dated was a regular staff was not posed to add the thickener to	F 3	23			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCT  A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245574	B. WING			08/	/12/2016
	PROVIDER OR SUPPLIER			36	TREET ADDRESS, CITY, STATE, ZIP CODE 620 PHILLIPS PARKWAY SOUTH AINT LOUIS PARK, MN 55426	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	edentulous and did indicated R109's dipureed and honey to have as needed be related to intake. The resident quarted dated 5/3/16, indicate extensive physical attensive practicated 7/12/16, indicated 7/12/16, indicated 7/12/16, indicated 7/12/16, indicated 7/12/16, indicated 7/12/16, directed standition, another 7/29/16, directed stand	not have dentures. CAA et had been downgraded to hickened liquids but continued cough which may or may not  erly Minimum Data Set (MDS) ated resident required assistance of one staff with ng or choking during meals or edications and was on a d diet. In addition the MDS and a diagnoses of dysphagia.  Itioner (NP) progress note exted resident was at high risk irratory infectious due to the  order dated 7/22/16, indicated ureed and honey thick liquids. physician order dated aff to "add 2 teaspoons of diet three times a day [TID] ughing. Resident should be up	F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		LE CONSTRUCTION		B) DATE SURVEY COMPLETED	
		245574	B. WING			08/-	12/2016	
	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	and honey thickened directed staff to "Ad powder to puree die orders"  On 8/11/16, at 3:23 stated she had wor when the order had had not been able tupdate the meal tic orders were part of acknowledged the implemented since order. RD further sit to help with the coue eating.  On 8/12/16, at 7:34 (DON) stated she with the staff on the order physician orders.  Grab bars R29's left grab bars observed on 8/8/16 room observations inches back and for stated she used it a been loose for a who on 8/10/16, at 11:4 grab bar resident a about letting the staff orgot something's.	ake and was on pureed diet and liquids. The care plan and 2 teaspoons of thicken at TID during meals per  p.m. registered dietician (RD) ked the kitchen the Friday been obtained 7/29/16, and to update the care plan and ket. RD stated physician the resident plan of care and order should have been nursing was aware of the tated the new order was a trial aghing resident had with  a.m. the director of nursing would expect communication to the ers and staff was to follow all affixed to the bed was a trial aghing resident to be loose moved three orth when touched. Resident and noted the grab bar had hile now.  7 a.m. when asked about the gain stated she had thought aff know to fix it but she always	F 3	323				
		ssessment dated 4/16/16,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245574	B. WING _		08	/12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 323	indicated resident r bed mobility, transfordressing, toilet use R29's quarterly MD resident had intact included Parkinson osteoarthritis obtain 8/8/16.  R29's care plan dath had an alteration in depression, arthritis fractures. Care plan extensive assist wit feet into/out of bed ambulation using a care plan did not inbars in the bed for a 2 North Group 8 as 8/9/16, indicated re The plan of care did responsible for che they were properly  On 8/10/16, at 11:5 maintenance fixed would expect the steither in paper if the computer. At 11:53 verified the left grathe thought it was a properly.  -At 12:10 p.m. NA-6 the loose grab bars to tur	equired extensive assist with ers, ambulation, locomotion, and personal hygiene.  S dated 7/9/16, indicated cognition. Resident diagnoses is tremors, osteoporosis and hed from the face sheet dated and seed 8/8/16, indicated resident mobility related to weakness, in history of falls and history of a directed staff to provide the bed mobility. Staff was to lift and extensive assistance with walker and transfer belt. The dicated resident used grab mobility.  signment sheet updated sident had safety grab bars. In not indicate who was cking the grab bars to ensure affixed to the bed frame.  2 a.m. RN-B stated the grab bars. RN- B stated he aff to put in a work order ey did not have access to the a.m. RN-B went to room and to bar was loose. He indicated loose from bolts not fitting.  O stated she had not noticed When asked if resident used in side to side when in bed or do out of the bed and during.	F 32	23		

	2/2016
NAME OF PROVIDER OR SUPPLIER  SHOLOM HOME WEST  SHOLOM HOME WEST  STREET ADDRESS, CITY, STATE, ZIP CODE  3620 PHILLIPS PARKWAY SOUTH  SAINT LOUIS PARK, MN 55426	
(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued From page 67  -112:18 p.m. RN-B stated about two weeks ago the interim DON had requested the staff to do an assessment and check if residents needed to have the grab bars in the beds. At the time resident had indicated she wanted to keep the grab bars in her bed and had been given the risks and benefits of the grab bars. RN-B stated he had not at the time checked the grab bars to make sure they were properly affixed to the bed frame and had not since completed an assessment and was getting to it. RN-B further stated maintenance had also gone through the entire unit he thought and switched out the beds if a resident had asked to have only one grab bar and was not sure if maintenance had check the grab bars to make sure they were properly affixed to the bed and directed the surveyor to the maintenance staff.  On 8/10/16, at 12:47 p.m. environmental supervisor (EVS) stated he had been in his position for the last one week. He indicated his department depended on house-keeping and nursing to report any concerns for his staff to come and fix the grab bars.  -At 12:51 maintenance staff verified the grab bar was loose. He indicated it was the bolts that needed to be tightened up. He further stated the grab bar on the left was supposed to be affixed firmly to the bed frame as the right side and that was caused due to the residents using the grab bars repeatedly.  R58's grab bars on toilet seat were observed to move the toilet seat 15 degrees to the right and left during the initial tour on 8/9/16, at 10:17 a.m.	

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		245574	B. WING		08/	12/2016	
	PROVIDER OR SUPPLIER  1 HOME WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 323	R58 was cognitively a walker with super with toileting. R58's diagnoses included hypertension, and A R58's care plan revrequired assistance dementia and impator falls. The care panticipate needs for precautions, and as off the toilet.  The Nursing assists 6/23/16, instructed minimal assist with The Progress Note was independent who in the progress of the toilet and the sesupposed to be tight wiggle.  On 8/9/16, at 10:22 the toilet and the sesupposed to be tight wiggle.  On 8/11/16, at 12:1 grab bar] needs to develop a preventar [toilet grab bar]."  R186's room was on p.m. The grab bars to be loose, allowing the sesupposed to be supposed to be loose, allowing the progress of the supposed to be loose, allowing the progress of the loose, allowing the progress of the loose, allowing the loose, allowing the progress of the loose, allowing the loose in the	DS dated 5/31/16, indicated y intact, walked in room using vision and required assistance MDS indicated R58's congestive heart failure, Alzheimer's disease.  Vised 6/17/16, indicated R58 with toileting related to ired mobility and was at risk plan instructed staff to related to ired mobility and was at risk plan instructed staff to related to ired mobility and was at risk plan instructed staff to related staff to related staff that R58 required ambulation and toileting.	F 323	3			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	` '	TE SURVEY MPLETED
		245574	B. WING _		08	/12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	R186's quarterly M R186 was severely walk in room, requi R186's MDS indica osteoarthritis, and A R186's care plan re required assistance toilet and was at ris instructed staff to a follow safety precau one to transfer on a  The Nursing Assist 8/4/16, instructed s with transfers and t  On 8/8/16, at 2:45 p the toilet with staff a seat moving might observed telling the the loose toilet grate  On 8/11/16, at 12:1 verified the toilet gr  R101's room was o p.m. and the grab b observed to be loos twist.  R101's MDS dated severely cognitively with toileting. R101 diagnoses included  The Nursing Assist	DS dated 6/23/16, indicated cognitively impaired, did not red assistance with toileting. ted R186's diagnoses included Alzheimer's disease.  Evised 8/3/16, indicated R186 eto transfer on and off the sk for falls. The care plan nticipate needs for toileting, utions, and provide assist of and off the toilet.  ant Assignment Sheet dated taff that R186 required assist coileting.  D.m. NA-K verified R186 used assistance and that the toilet cause a fall. NA-K was e health unit coordinator about to bars.	F 32	3		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION		E SURVEY PLETED
		245574	B. WING		<del></del>	08/	12/2016
	PROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	ambulation using a toileting.  R101's care plan rerequired assistance dementia and impa for falls related to u falls. The care plan needs for toileting, assist of one to transist of on	R101 required assist with front wheel walker and with wised 7/1/16, indicated R101 with toileting related to ired mobility and was at risk insteady gait and history of instructed staff to anticipate follow safety precautions, and asfer on and off the toilet.  D.m. NA-N verified R101 used I, "The seat should not wiggle Is p.m. EVS said all but one entoilet grab bar were loose.  Served on 8/8/16, at 6:13 p.m. ars on the toilet when grabbed at to twist.  S dated 6/16/16, indicated by cognitively impaired, and with toileting. R96's MDS gnoses included seizure intia.  Ant Assignment sheet dated staff that R96 required assist mechanical lift that assists a a standing position) for		323			
		s. R96 required assistance					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245574	B. WING			08/	12/2016
	PROVIDER OR SUPPLIER			36	REET ADDRESS, CITY, STATE, ZIP CODE 620 PHILLIPS PARKWAY SOUTH AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	impaired sitting bala. The care plan instrutive staff member to toilet.  On 8/8/16, at 6:25 pthe bathroom and swiggle this much.  On 8/11/16, at 12:0 bar and seat were ledepended on nursing notify maintenance.  R176's room was op.m. The grab bars to be loose, allowing side.  R176's quarterly MIR176 was severely in room using a wal required assistance indicated R176's dia (involuntary movem R176's care plan rerequired assistance muscle weakness a risk for falls. The call anticipate needs for (toilet grab bars), at use and incontinence.  The Nursing Assista 6/23/16, instructed in toilet grab bars and incontinence.	d to and cognitive changes, ance and was at risk for falls. Increased and was at risk for falls. Increased staff to provide assist of the oransfer R96 on and off the oran	F3	323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		E SURVEY PLETED
		245574	B. WING _	<del> </del>	08/	12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	meals, at bed time, needed.  On 8/8/16, at 3:35 pthe bathroom and swiggle this much.  On 8/11/16, at 12:0 seat turned 15 to 20 EVS said this was a During interview at 8/11/16, at 12:21 p. expect the nursing to notify maintenant loose grab bar." EV on the toilets were one of the grab bar a wrench. EVS stated was broken and ne stated, "If a resident hand it could move EVS stated they did maintenance programs.  On 8/11/16, at 4:41 "We do not have a maintenance but we paper and compute need to be fixed. All the systems."  On 8/12/16, at 11:0 expect the nursing report loose grab between the systems."	e bathroom upon rising, after during rounds at night and as 0.m. NA-N verified R176 used stated the seat should not 9 p.m. EVS verified the toilet 0 degrees to the left and right. a fall risk.  end of environmental tour on m. the EVS said, "I would assistants and housekeeping ce immediately if they saw a 'S verified that the grab bars not to be loose and that all but s observed could be fixed with ted one grab bar on the toilet eded to be replaced. EVS at grabbed the bar with one causing them to slip." The dot have a preventative am for checking the toilet grab p.m. the administrator stated, policy for reporting issues to be do have a process, both er for staff to report things that I staff can use at least one of 6 a.m. the DON said, "I would assistants and nurses to ars to maintenance."	F 32			
F 334	483.25(n) INFLUEN	NZA AND PNEUMOCOCCAL	F 33	4		9/21/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 8620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		. = / = 0 . 0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	) BE	(X5) COMPLETION DATE
F 334 SS=E	that ensure that (i) Before offering the each resident, or the representative recebenefits and potentimmunization; (ii) Each resident is immunization Octoberation octobera	evelop policies and procedures the influenza immunization, e resident's legal ives education regarding the ial side effects of the  offered an influenza per 1 through March 31 e immunization is medically the resident has already been this time period; the resident's legal the opportunity to refuse  medical record includes indicates, at a minimum, the tent or resident's legal provided education regarding tential side effects of influenza tent either received the tion or did not receive the tion due to medical refusal.  evelop policies and procedures	F 334			
	(ii) Each resident is	offered a pneumococcal ss the immunization is				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		245574	B. WING		08/12/2016
	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 334	already been immu (iii) The resident or representative has immunization; and (iv) The resident's r documentation that following: (A) That the reside representative was the benefits and po pneumococcal imm (B) That the reside pneumococcal imm the pneumococcal im	licated or the resident has inized; the resident's legal the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding itential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical refusal.  e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal is medically contraindicated or resident's legal representative	F 334		
	by: Based on interview facility failed to imprelated to pneumod (PCV13) for 4 of 5 R176) whose vacci reviewed. Findings include:	NT is not met as evidenced v and document review, the lement a policy and procedure coccal conjugate vaccine residents (R50, R84, R153, nation histories were		F 334 The facility policy and procedure for pneumococcal immunization has bee updated to include the conjugated va for PCV13. Nursing staff have been educated on policy and procedure. Nurse Manager or designee will audit new admissions for one month and the admissions per month to ensure	ccine t all

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245574	B. WING			08/	12/2016
	PROVIDER OR SUPPLIER  1 HOME WEST			36	TREET ADDRESS, CITY, STATE, ZIP CODE 520 PHILLIPS PARKWAY SOUTH AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	have not previously have previously red PPSV23 (pneumoc 23) should receive PCV13 should be a after the most receive R50's Immunization 102 year old reside PPSV23 on 1/1/05. had been offered the admission to the factor of the 84 year old receive but did not specify a was signed by R94 evidence she had be vaccine since her red 2/1/16.  R153's immunization the 82 year old resiindicated the 82 year old resiindicated the 82 year old resiindicated she had be vaccine since her and 1/11/16.  R176's immunization the 70 year old resiine 70 year old r	by years of age or older who received PCV13 and who eived one or more doses of occal polysaccharide vaccine a dose of PCV13. The dose of dministered at least one year of PPSV23 dose.  The record, undated indicated the entreceived the Pneumovax. There was no evidence she effect of PCV13 vaccine since her cility on 10/10/11.  The record, undated, indicated eived the Pneumovax PPSV23 and date. The undated record on 2/3/2012. There was no been offered the PCV13 enadmission to the facility on the end of the PCV13 dmission to the facility on the end of the PCV13 dmission to the facility on the end of the PCV13 dmission to the facility on the end of the PCV13 dmission to the facility on the end of the PCV13 dmission to the facility on the end of the PCV13 vaccine since his cility on 3/12/14.  The end of the Pneumovax of the end of the end of the PCV13 vaccine since his cility on 3/12/14.	F3	34	compliance. Audit results will be reported to the committee and action plans develoneeded.  Correction date for certification is September 21, 2016		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	` '	SURVEY PLETED
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	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 8620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	Continued From pa	ge 76	F 334			
F 353 SS=F	requested but not re	ENT 24-HR NURSING STAFF	F 353			9/21/16
	provide nursing and maintain the highes and psychosocial w	ve sufficient nursing staff to d related services to attain or st practicable physical, mental, rell-being of each resident, as dent assessments and care.				
	numbers of each of personnel on a 24-l	ovide services by sufficient in the following types of the following types of the four basis to provide nursing in accordance with resident				
		d under paragraph (c) of this urses and other nursing				
	section, the facility	d under paragraph (c) of this must designate a licensed charge nurse on each tour of				
	by: Based on observat review, the facility for staffing for resident	NT is not met as evidenced ion, interview and document ailed to ensure adequate s to receive the highest ng. This had the potential to ents in the facility.		F353 Current staffing patterns for all unit been reviewed daily to ensure staff appropriate for current resident new Staffing levels will be reviewed dail adjusted with changes in resident reposting of hours will be updated dail	ing is eds. y and needs.	

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 353	The task of sufficied OHFC (Office of Hiccomplaints to surve as well as family consite. In addition, that the facility with the three additional consee F282 failure to see F309 failure to practicable wellbein See F312 activities See F314 pressure.  Complaint number been short staff and 22 falls in a month, given late, wound of completed and resiminutes for call light.  Complaint number short of staff and repersonal cares conrepositioned." R116 pressure ulcers (painvolving epidermis superficial and presblister, or shallow of 8/1/16, aide sheet reposition hourly, by according to the number short of staff and presblister, or shallow of 8/1/16, aide sheet repositioned from sinitial hour 36. Resimove, totally deper R136 was a Russia cognitive impairmed.	ant staffing was triggered by an ealth Facility Complaints) by, H5574085 and H5574083, omplaints of lack of staffing on the OHFC surveyors entered survey team to investigate implaints. In follow the care plan. In provide cares for highesting. In the care of daily living. It is a result there have been in addition, medications were care treatments were not being idents were waiting up to 90 into the beautiful of the care of the care treatments were not being idents were waiting up to 90 into the care treatments were not being idents were waiting up to 90 into the care treatments were not being idents were waiting up to 90 into the answered."  H5574085 noted, "Facility esident, R116 was not getting inpleted, and not being in had recurrent stage 2 in had recurrent stage 3 in had recurrent stage 4 in had recurrent stage 5 in had recurrent stage 6 in had recurrent stage 6 in had recurrent stage 7 in had recurrent stage 8 in had recurrent stage 8 in had recurrent stage 9 in had recurrent	F 353	include changes made througho day. Audits of daily posting will be completed daily for 2 weeks and for 2 months to ensure complian All concerns/grievances related staffing/call light response will be investigated per policy.  Call light reports will be reviewed with nursing management for on and then weekly for 3 months are taken as needed.  Audit results will be reported to to committee and action plans deveneded.  Correction date for certification is September 21, 2016	weekly ce. to daily e month ad actions the QA eloped as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	` '	E SURVEY IPLETED
		245574	B. WING		08/	12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	,	
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F 353	at 3:40 p.m. family R136) Stated: "I kn weekends are shoulack of communicated tell the staff I see a watch for changes scratch), I come be and when I ask the nothing about it, or the scratch is; shoulook? It seems like the skin checks. Cl the doctor when I put thing you know he in the hospital. Just between staff and given concerns. Whave someone who review of the reside sites that worsened additional treatmer R136's daughter nothours before he was 8/9/16.  Grievances were reconsultant pharma the following concein the dining roome two of MD-A's reside ating. Requested twice and nothing if	age 78 fers, and toilet use. On 8/10/16, member (F)-D (daughter of low that people work hard, and it staffed. But there is also a ation that impacts care. When I is change in my father, or to in his skin, (a bruise or lack 3 days later and it's worse, a nurse working, they know they say it doesn't say where aldn't they lift up his shirt and it the staff are not even doing hanges don't get reported to coint them out, and the next is back on antibiotics, or back it a lack of communication doctors, staff don't listen when that about the people who don't or can come every day." A cents chart revealed wound did and required antibiotics and ints, and documentation that officed staff of changes 24 as transferred to the hospital on eviewed and revealed:  Ith, medical doctor (MD)-A and coist (CP) approached voicing erns related to resident service during lunch today. Reported dents had concerns with not aide to get a resident juice happened. MD-A then offered sauce and yogurt, which MD-A	F 35	3		
	then served to the fed a resident soup call light was on gr	patients, MD-A also physically b. Call light audits indicated one eater than 15 minutes, two call ter than 20 minutes, two call				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		I SHOULD BE	(X5) COMPLETION DATE
F 353	lights were on great call light was on grewas not requested.  On 7/25/16, spouse not getting walked fordered, "only 1 state Call light audits indigreater than 15 mirgreater than 20 mirgreater than 25 mirgreater than 30 mirgreater than 35 mir North had 2 LPN amanager working the NA. 3 North had 2 LPN and 6 NA. Evand 6 NA, 2 South and 3 NA. 3 North South had 1 LPN, 2 North had 1 LPN, 3 Staff posting was in hours, as it was not the manger working South was not cour On 7/20/16, daught 7/10/16, had not ye audits indicated two than 15 minutes, or than 20 minutes, or than 20 minutes, or than 30 minutes and than 40 minutes. O	ter than 25 minutes, and one eater than 45 minutes. Staffing to of R21 stated resident was three times per day as a ff member ever walks him." It is is cated three call light was on outes, one call light was on outes. On 7/25/16, Day shift: 2 and 6 NA. 2 South had 1 and 3 LPN and 6 NA. 3 South had 2 cening shift: 2 North had 2 LPN (1 was agency), 1 RN, 1 LPN, and 6 NA, 3 TMP and 6 NA. Night shift: 2 NA. 2 South had 1 RN and 2 LPN (agency nurse did double south had 1 RN and 2 NA. The correct for the number of LPN and a land a	F3	953		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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F 353	and 4 NA. 3 North South had 2 LPN a LPN, 2 NA. 2 Sout had 1 RN and 2 NA The staff posting w	age 80 nd 6 NA, 2 South had 2 LPN, 1 RN, 1 LPN, and 6 NA, 3 and 6 NA. Night shift: 2 North 1 h had 1 RN and 2 NA. 3 North A. 3 South had 1 RN and 2 NA. vas incorrect for the number of ours, as it was not updated	F 3	53		
	not knowing how to and residents were Call light audits ind greater than 15 min greater than 20 min 2 North had 2 LPN 1 TMA and 2 NA. 3 South had 1 RN, 1 2 North had 2 LPN 1 TMA, and 2 NA. NA, 3 South had 2 North 1 RN, 2 NA. North had 1 LPN a and 2 NA. The staff	e of R177 complained of staff of properly read meal tickets, a not getting their ordered diets. Iicated four call lights were on nutes, two call lights were on nutes. On 7/11/16, Day shift: and 6 NA. 2 South had 1 LPN, 8 North had 2 LPN and 6 NA. 3 LPN and 6 NA. Evening shift: and 6 NA, 2 South had 1 LPN, 3 North 1 RN, 2 TMA, and 5 LPN and 6 NA. Night shift: 2 2 South had 1 RN and 2 NA. 3 and 2 NA. 3 South had 1 LPN if posting was incorrect for the N and NA hours, as it was not ges.				
	residents in July. On 6/13/16, R126's approached SW to another facility due plan, not meeting of gradual weight loss resident is not receive to be successful. Call lights were on call lights were on	s of lack of food from multiple s, husband and daughter request assistance to move to to NA's not following care dietary needs, poor intake and s, an overall feeling that siving quality of care she needs call light audits indicated four greater than 15 minutes, three greater than 20 minutes, two reater than 25 minutes and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245574	B. WING _		08	/12/2016
-	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 353	one call light was o 6/13/16, Day shift: 2 South had 1 LPN had 2 LPN and 5 N NA. Evening shift: 4 NA, 2 South had RN, 1 LPN and 5 N NA. Night shift: 2 N had 1 RN and 1 RN a was incorrect for th hours, as it was not On 5/29/16, Call lig lights were on grea call light were on grea lights were on grea call light were on grea call light were on grea call light were on grea lights were on grea lights were on grea call light were on grea lights were on grea lights were on grea lights were on grea lights were on grea call light were on grea lights were on grea lights were on grea lights were on grea lights were on grea call light were on grea lights were on	ge 81 In greater than 45 minutes. On 2 North had 2 LPN and 4 NA. In TMA and 2 NA. 3 North A. 3 South had 2 LPN and 4 2 North had 1 RN, 1 LPN and 2 LPN, and 3 NA. 3 North 1 A, 3 South had 2 LPN and 4 North 1 LPN, 2 NA. 2 South In	F 35			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245574	B. WING _		08	08/12/2016	
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F 353	TMA and 2 NA. 3 N South had 2 LPN a North had 1 RN, 1 NA, 2 South had 1 2 LPN and 5 NA, 3 NA. Night shift: 2 I had 1 RN and 1 NA NA. 3 South had 1 posting was incorre	age 82 North had 2 LPN and 5 NA. 3 and 5 NA. Evening shift: 2 LPN (double from days) and 5 RN, 1 TMA and 2 NA. 3 North South had 1 RN, 1 LPN and 3 North 1 LPN, 2 NA. 2 South A. 3 North had 1 LPN and 2 LPN and 2 NA. The staff ect for the number of RN, LPN t was not updated with	F 35	3			
	dining room for 30 from dining room for inadequate staff or indicated one call I minutes, and two call 1 minutes, and two call 1 minutes. On 5/1 RN, 1 LPN and 6 NA. 3 North had 2 LPN and 5 NA. Evand 6 NA, 2 South 3 North 2 RNS and SHIFT) NA. 3 South shift: 2 North 1 LPI LPN and 1 NA. 3 North 1 N	id not take resident R135 to minutes, and did not return or 30 minutes, was told in the floor. Call light audits ight was on greater than 15 call lights were on greater than 19/16, Day shift: 2 North had 1 NA. 2 South had 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. 3 South had 2 LPN had 1 LPN, 1 TMA and 2 NA. 3 (SHORT 3 NA ON THIS th had 2 LPN and 5 NA. Night N, 2 NA. 2 South had 1 RN, 1 North had 2 NA. 3 South had 1 e staff posting was not ay.					
	physical threats ag resident adjacent, other people (no m Unfounded allegati manager meet with audits indicated tw than 15 minutes, o	letter from family verbal and ainst resident and visitor by learned he was already hitting tention of OHFC report made). It is not and response made, nurse in daughter that day. Call light to call lights were on greater ne call light was on greater ne call light was on greater					

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION			E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD I	BE	(X5) COMPLETION DATE
F 353	than 30 minutes an than 65 minutes (1) Day shift: 2 North h South had 1 RN, 1 LPN and 5 NA. 3 S Evening shift: 2 North and 2 NA. 3 North 2 1 RN, 1 LPN and 3 admit. Night shift: 2 had 1 RN and 1 NA NA. 3 South had 1 posting was incorred NA hours, as it was On 5/9/16, R500, cobringing R500 to mot toileting/changii (recorded weight loaudits indicated two than 15 minutes, or than 30 minutes. O Day shift: 2 North hhad 1 RN, 1 LPN and 1 RN, 1 LPN and 5 NA. 3 South shift: 2 North had 2 RN, 1 TMA and 2 Na and 5 NA, 3 South days) and 5 NA. N NA. 2 South had 1 LPN and 2 NA. 3 S The staff posting was LPN and NA hours, changes.	ge 83 ree call lights were on greater d one call light was on greater hour 5 minutes). On 5/17/16, ad 1 RN, 1 LPN and 6 NA. 2 TMA and 2 NA. 3 North had 2 outh had 2 LPN and 5 NA. 1th had 1 RN, 1 LPN (double A, 2 South had 1 RN, 1 TMA 2 LPN and 5 NA, 3 South had NA, and a note to take no North 1 LPN, 2 NA. 2 South a. 3 North had 1 LPN and 2 LPN and 2 NA. The staff of the number of LPN and not updated with changes.  In the staff was not eals, he had untreated pain, and of incontinent pads in May and June). Call light of call lights were on greater in 5/9/16 staff was short 1 NA, ad 2 LPN and 5 NA. 2 South and 2 LPN and 5 NA. 2 South and 2 LPN and 5 NA. 2 South and 2 LPN and 5 NA. Evening LPN and 6 NA, 2 South had 1 LPN and 2 LPN (1 doubled from 1 lA. 3 North had 1 RN, 1 LPN had 2 LPN (1 doubled from 1 lA. 3 North had 1 LPN, 2 RN and 1 NA. 3 North had 1 LPN, 2 RN and 1 NA. 3 North had 1 LPN, 2 RN and 1 LPN and 2 NA. as incorrect for the number of as it was not updated with relief of the light over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter helped. (No mention and the staff argued over aughter he	F3	53			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245574	B. WING		08/1	2/2016	
	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	, ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 353	of investigation or Call light audits incompression	report to State agency (SA). dicated one call light was on nutes, three call lights were on nutes, one call light was on nutes, one call light was on nutes and one call light was on nutes. The staffing 5/7/16, on to 1 NA for 2 North day shift, and NA. 2 South had 1 LPN and 1 Nad 2 LPN and 5 NA. 3 2 TMA and 4 NA. Evening shift: 1 and 5 NA. 2 South had 1 LPN, and 1 RN, 1 LPN, and 1 LPN and 1 NA. I and 2 NA. 3 South had 1 LPN ff posting was incorrect for the rs, as it was not updated with p.m. MD-A stated there had ver this summer, and assumed of the new nurses. Stated a challenge and that was why in shut down, they didn't have Grievance on 7/27/16).  p.m. the director of nursing ical services director for all of D) were interviewed for Stated basic staffing pattern is affing sheets. Day shift: 2 LPN and 6 NA. 2 South had 1 NA. 3 North had 2 LPN and 5 NA. Evening shift: 1 LPN and 6 NA, 2 South had 2 NA. 3 North 2 LPN and 5 NA, 2 South had 2 NA. 3 North 2 LPN and 5 NA, 2 South had 2 NA. 3 North 2 LPN and 5 NA, 2 NA, 3 North 2 LPN and 5 NA, 2 South had 2 NA. 3 North 2 LPN and 5 NA, 2 South had 2 NA. 3 North 2 LPN and 5 NA, 3 North 2 LPN and 5 NA,					

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	PROVIDER OR SUPPLIER  1 HOME WEST			STREET ADDRESS, CITY, STATE, ZIP C 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	3 South had 1 RN, North 1 LPN, 2 NA. 3 North had 1 RN a and 2 NA. The staff number of LPN and updated with change Supervisors did the in's on the off shifts Service Agencies (Sut expected the hicompleted and SNS September 1st. The starting on 8/15/16. census, also look a unit and have recer 2 North, because the (intravenous infusion manage (NM) to as behaviors, IV's, worstaffing. Staffing was census decreased.  The DCS verified siconcerns about the were divided, but no DCS stated there a in's and cannot replaround as much as load. New nurses githen leave to go to The annual turnove the Quality Assurant nursing (RN-LPN) in nursing department 5.45% to 11.67%.	1 LPN and 3 NA. Night shift: 2 2 South had 1 LPN and 1 NA. Ind 2 NA. 3 South had 1 LPN i posting was incorrect for the I NA hours, as it was not les.  staff changes and took call . Supplemental Nursing SNSA) were currently in use, ring and training to be SA nurses to be phased out by e last training class was Staffing was flexed for t acuity on transtitional care only been increasing staffing for ney had a couple of IV's ons). We expect the nurse k for more help, we look at unds, and admits to adjust as also flexed down when  staff had brought forward workload and how groups of in the last couple of months. The days that we have three call lace them, but we shuffle we can too even the work et one year of training and	F3	53		

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F 353	1.92% to 10.71%. A review of the Terrindicated: 18% SNS for misconduct, 4% Abandonment, 2% 2% Excessive Tard  When asked about above) DCS stated answering call light "would really like le communicated here tracking and trendin patterns was probabeen by the prior nowould be a focus of the DCS stated the provided the Call Li 10/15. Stated "Rescontacting staff to Call lights will be an needs will be met in Staffing interviews On 8/8/16, at 11:55 asked about staffin stated "Woo you ar problem for a while here and sometime lot of residents nee able to get the work the toilet and walkin resident I have to whave time to do it be new management I it's still bad. I can given the context of the toilet and walking resident I bad. I can given the toilet and given the toilet and given the toilet and given the toilet and walking resident I have to whave time to do it be new management I it's still bad. I can given the toilet and give	partment turnover rate ranged mination Reason report SA staff use, 13% terminated no call/no show, 3% Job terminated for performance, iness.  the call light waits (recorded the facility expectation for s was five minutes or less, ss than 10, maybe not e very well." The DCS stated no of falls and incidents for bly not done as it should have ursing leadership group, and the new nursing leadership.  ere was no staffing policy, but ght System policy, reviewed dents will have a means of obtain assistance at all times. Inswered promptly. Residents	F 35	53			

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		245574	B. WING			08/	12/2016
	PROVIDER OR SUPPLIER  # HOME WEST			STREET ADDRESS, CITY, STATE, ZIP C 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E	3E	(X5) COMPLETION DATE
F 353	gotten a lot better for was a problem. NA of new staff working was coming and go about how she was stated she was able rushed the resident done.  On 8/9/16, at 7:21 a surveyor called surveyor called surveyor called surveyor short staffed a not getting their new 16 to 20 residents are go continue to give parsome of us. It is so ambulate, toilet and residents. We have routine."  On 8/10/16, at 6:37 think I am allowed the aides at night as the census goes up we on 8/10/16, at 6:43 surveyor in the hallow we are working she if the facility was wo NA-C who appeare people" when asked stated one NA.	p.m. NA-B stated staffing had or the last two months but still -B stated she had noticed a lot in the facility as a lot of staffing right away. When asked able to provide cares NA-B to do cares however felt she is through to get all the stuff a.m. NA-E approached veyor into a resident room and then stated the facility was not thought the residents were east met. "We sometimes have and are told someone is omes. Do you want to tell me etting total cares? They sticular staff raises but not bad and we are not able to I do all the cares to the to get the residents up by	F 3	53			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245574	B. WING _		08	/12/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 353	they did not unders working short in the asked about staffin working short staffed daily thing."  On 8/11/16, at 8:12 asked who was ass LPN-B stated the generated because there was and current five state according to room resident got the car "there was a misco"	age 88 erheard in the hallway state tand why they were always a unit. When approached and g NA-U stated "we are always ad in this unit and this is almost a.m. when approached and signed to Group 1, 3 South roup was split right now not enough staff on the floor ff had been assigned numbers to ensure the re they required. LPN-B stated mmunication and we had to is is not how we like it to be	F 35	3			
	when asked is there member replied, "Not enough and the inefficient." FM-A further provide is very poor thinking of finding howould be more difficult on 8/12/16, at 12:0 stated, "I am conce at the nursing home there is a problem vactivities people he FM-C said, "When	is p.m. family member (FM)-A be enough staff to help family lo, are you kidding, there are so ones they have are very arther stated "The care they r, I am sorry to say. I am him a new place even though it cult for me to see them."  10 pm family member (FM)-C be about the amount of staff e, and their training. You know with staffing when you see the lping with the breakfast."  12 a resident needs more help to up for themselves the care is					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
<b>245574</b> B. WING	08/12/2016
SHOLOM HOME WEST	DRESS, CITY, STATE, ZIP CODE  LIPS PARKWAY SOUTH  UIS PARK, MN 55426
	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 353  Continued From page 89  On 8/08/16, at 2:45 p.m. NA-M raised eyebrows when asked do you have enough staff to get your work done and stated "it all depends, today since you are here, we have enough. We have six [aides] today. Normally it is a good day if we have five. NA-M said, "Is that enough, no. We have a lot of two people assists for turning and EZ stands [mechanical lift that helps a resident stand up]. We might have to break up a group and rearrange it. I do not normally work this floor, so I do not know the residents which makes it harder to plan my work.  On 8/08/16, at 7:04 p.m. LPN-H stated, "No we do not have enough staff. We should have six aides but normally we have only five and have to split a team. Our patients have Alzheimer's and they sundown, so when the aide is busy the nurse has to stand with the resident to ensure they do not fall. The dining room can be crazy depending on the mood."  On 8/09/16, at 8:15 a.m. anonymous licensed practical nurse (LPN) stated "the staffing here is so short. Administration has the right model but not enough staff to fill it. They did have a very big hiring fair recently but not everyone is staying. This morning 3 North had two people not show up so I had to rearrange staff. Most of the time we would have had to tell them to work short and only replace one staff member but not during survey. Sometimes the nurses cannot get everything done because they are trying to help the aides. The aides are rushing from one thing to the next which can cause problems. The aides care and try really hard. I observe staff as they are working to be sure they are following the care	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245574	B. WING _		08/12/2016		
	PROVIDER OR SUPPLIER  I HOME WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 364 SS=D	are tired."  On 8/11/16, at 2:34 at the nursing desk stated "I have group home." NA-S stated regular group if I cargoing home."  483.35(d)(1)-(2) NL PALATABLE/PREFIEach resident receif food prepared by m	p.m. NA's were heard arguing about assignments NA-R of 4 otherwise I am going I, "Not if I am here it is my nnot have my group I am ITRITIVE VALUE/APPEAR, ER TEMP  ves and the facility provides ethods that conserve nutritive opearance; and food that is	F 35			9/21/16	
	by: Based on observat review, the facility fa attractive and prope resident (R162) obs  Findings include:  During dining room a.m. an unidentified hot cereal in front o R162 was awake at -At 9:10 a.m. a nurs when they placed a eggs and pureed br -At 9:12 a.m. nursir observed to sit dow	ion, interview and document ailed to provide food in an er appearance for 1 of 1 served for dining.  observation on 8/9/16, at 8:55 I nursing assistant (NA) placed f R162 out of R162's reach. In the stared at the cereal. Sing assistant woke R162 up divided plate with scrambled read in front of R162. In assistant (NA)-E was in next to R162. NA-E put the idual jelly packet on R162.		F 364 The process for meal delivery was reviewed and staff educated on prodignity with dining. Resident R162 has been reassess appropriate interventions and care updated as appropriate. Referral to Occupational therapy will be made indicated following reassessment. Nursing staff will be educated on pra dignified dining experience. Nurse Managers or designee is responsible for auditing of the dining experience at least daily on each household at various mealtimes for month then once weekly for 3 month Audit results will be reported to the	ed for plan if roviding		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245574	B. WING		<del> </del>	08/ <sup>-</sup>	08/12/2016	
	PROVIDER OR SUPPLIER			36	REET ADDRESS, CITY, STATE, ZIP CODE 520 PHILLIPS PARKWAY SOUTH AINT LOUIS PARK, MN 55426			
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F 364	scrambled eggs. No eggs with jelly and put the plate with egand placed the crea opposite side of the reach. NA-E then le mixture of scramble then attempted to rewheelchair looking closed her eyes.  -At 9:21 a.m. NA-E moved the plate with eggs and pureed by started feeding R16 100% (percent) of the egg and bread of the egg and was remeds. R162's quarterly Min 6/8/16, indicated R16/8/16, indicated R16/8/1	A-E then mixed the scrambled pureed bread together. NA-E ggs and bread in front of R162 am of rice on the table on the e placemat, out of R162's left the table. R162 tasted the ed eggs pureed bread and each the cereal. R162 sat in at other residents and then sat down at the table and the mixture of scrambled read away from R162, and 62 cream of rice. R162 ate the cream of rice and 0% of mixture.  Inimum Data Set (MDS) dated 162 was severely cognitively arely able to communicate indicated R162's diagnoses is disease, and dysphagia gg).	F3	864	committee and action plans develoneeded.	ped as		
	indicated R162 had decline from Janua goal listed on the caweight at 125 pound instructed staff to "pmeals if res [residersome items w/[withutensils). Divided plR162's vision care R162 had impaired or identify colors. Times and the state of the state o	are plan dated 6/8/16, dysphagia and had a weight ry 2016, to April 2016. The are plan was to maintain ds or greater. The care plan provide feeding assistance at nt] accepts. May feed self fingers (does not like to use late at meals for pureed diet." plan revised 7/1/16, indicated vision and was unable to read the care plan instructed staff to to find food on plate at meals ed.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 364	6/22/16, instructed	age 92 sistant assignment sheet dated staff that R162 required assist as to be seated at a table with	F 36	64			
	instructed staff R16 diet, ok for regular scrambled eggs. It pudding, ice cream between meals bed R162 four ounces of	Order Report signed 7/5/16, 62 was to be given a pureed soft breads, gefilte fish, and also instructed staff to offer or yogurt three times a day cause of weight loss. " Give of Mighty shake (a high calorie, supplement) three times a day					
	8/5/16. Highest wei	iewed from 2/19/16 through ght recorded was 130 pounds tweight on 8/5/16, was 121.4					
	put the food in from before you are read tray is served the w	2 p.m. NA-I stated, "You do not t of a resident who needs help dy for them to eat. A resident's vay it is meant to be eaten. You with the potatoes or meat but gether."					
	mix all of a residen	2 p.m. NA-H stated "you do not t's food together before will refuse to eat it."					
	never mix a resider	p.m. NA-J stated "I would nts food together. We are nity issue and I want to treat all lignity."					
	does not like people	p.m. LPN-G stated "[R162] e to feed her. She will put her and lick it off. She likes her					

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428 SS=D	tray to have each it one and then all of within reach she ca her food is at the fa cannot reach it to fe have to wake her upher."  On 8/11/16, at 3:05 okay to mix a reside they are on a puree appeal to the reside eat it. You can add ok with their diet."  On 8/12/16 at 11:06 (DON) stated that se resident if they wan else when they browd DON said she would on scrambled eggs it. DON said it would scrambled eggs and unless the resident 483.60(c) DRUG RIRREGULAR, ACT  The drug regimen of reviewed at least of pharmacist.  The pharmacist muthe attending physicials at the case of the	em separate and will eat all of the next. If you leave her food in eat most of it by herself. If it edge of the placemat she eed herself. Sometimes we per or sit with her and talk to p.m. LPN-F stated, "It is not ent's food together, even if ediet. It would most likely not ent and they would refuse to appropriate seasoning, if it is the expected staff to ask the ted salt or pepper or anything ught the food to the table. If and they would requested the expected staff to place jelly unless the resident requested the appropriate to mix dispute the food to the table. If the expect is the resident requested the expected to the appropriate to mix dispute the food together requests it.	F 42			9/21/16

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		E SURVEY PLETED
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	PROVIDER OR SUPPLIER  1 HOME WEST			STREET ADDRESS, CITY, STATE, ZIP C 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 428	This REQUIREMEI by: Based on interview facility failed to act	NT is not met as evidenced v and document review, the on recommendations made by	F 42	F428 Pharmacist recommendation		
	the consultant phar (R147) reviewed for (R147) reviewed for Findings include:  A review of a Physic Pharmacist for R14 R147 was currently is an anti-psychotic certain mental/moo Bipolar Disorder) 10 and Divalproex (Divaring phase of bip bedtime for mixed I recommendation in nursing notes have behavior, reports of and recommended to 75mg. There was recommendation with facility.	macist for 1 of 5 residents r unnecessary medications.  cian Recommendation From 7 dated 11/25/15, indicated taking Quetiapine (Quetiapine medication used to treat d conditions associated with 00 milligrams (mg) at bed time valproex is used to treat the olar disorder) 2 tablets at Bipolar Disorder. The dicated progress notes and been reporting no changes in a hallucinations or delusions a tapering of R147's Seroquel is no evidence the as followed up on by the		11/25/15 and 8/11/16 for reshas been communicated wifollow-up has been docume Policy and procedure for phrecommendation follow up reviewed and is current. Natincluding Nurse Managers educated on the policy and Nurse Managers or designer responsible to audit all phare recommendations for approfollow-up for 2 months and monthly for 3 months. Audit results will be reported committee and action plans needed.  Correction date for certificat September 21, 2016	ith the MD and ented. harmacy has been ursing staff have been procedure. hee will be rmacy opriate then 10% do to the QA as developed as	
	dated 5/25/16, indic cognitively impaired no symptoms of de R147's care plan da potential for alterati related to diagnosis bipolar disorder. The use of psychotre	ated 8/12/16, identified a on in psychosocial well-being of Parkinson's disease and le care plan further identified opic medications, potential for and identified a sleep				

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F 428	Continued From pa		F 42	28		
	Pharmacist again re Quetiapine from 10 the progress and no	cian Recommendation from ecommended a taper of 0mg to 75mg and indicated ursing noted reported no r, no hallucinations and no				
	stated the pharmac monthly. She stated resident every quar taking certain medi	1 p.m., social worker (SW)-B ist reviews medications d she documents on each ter and reviews why they are cations. SW-B stated R147 signs of manic behaviors.				
F 441 SS=F	stated the pharmace to the physician or a follow-up. He stated based on the recon in the medication as stated there was not up on the pharmace.	p.m., registered nurse (RN)-B y recommendations are given the nurse practitioner for d if there are new orders nmendations they will show up dministration record. RN-B o process in place for following sts recommendations. I CONTROL, PREVENT	F 44	11		9/21/16
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.				
	Program under whi (1) Investigates, co in the facility;	tablish an Infection Control				

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	•	
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F 441	(3) Maintains a recactions related to in actions related to in (b) Preventing Spro (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility must communicable disc from direct contact direct contact will t (3) The facility must hands after each of hand washing is in professional practic (c) Linens Personnel must ha	to an individual resident; and ord of incidents and corrective infections.  ead of Infection tion Control Program resident needs isolation to of infection, the facility must the st prohibit employees with a rease or infected skin lesions with residents or their food, if ransmit the disease. It require staff to wash their direct resident contact for which dicated by accepted	F 4	41		
	by: Based on observareview facility failed glucometer maching R253) during a range the facility failed to analysis of infection affect all 145 resident findings include:  R5's annual Minim	NT is not met as evidenced ation, interview and document densure sanitizing of the ne for 2 of 2 residents (R5, adom observation. In addition, perform tracking, trending and ns. This had the potential to ents residing in the facility.  The document of the potential to ents residing in the facility.		F441 The policy and procedure for glucometers has been review revised. Nursing staff have been eduction policy and procedure. Nurse Managers are responsiculating 2 nurses per week for and then one week for one macality policy and procedure Control tracking has been revupdated.	eated on the sible for one month onth.	

-	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY IPLETED
		245574	B. WING _		08/	12/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	R5's MDS indicated diabetes and demosigned by physician to have blood sugar day before meals.  During random obsa.m. R5's blood sulicensed practical riglucometer (a mac sugars) while R5 whallway across from was 86. LPN-F reniglucometer on top pointed object for othe glucometer.  R253 Resident Facindicated R253's didementia, and hististaphylococcus audinfection that is vertreatment.) Diabetic indicated R253 was twice a day on Mor During a continuous 7:26 a.m. R253was hallway in front of the R253's finger with a with a lancet and the same glucometer on top plastic caddy without the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on top plastic caddy without signed the same glucometer on the s	rarely able to communicate. d R5's diagnoses included entia. Physicians Order Report in on 5/18/16, indicated R5 was ar checks done three times a servation on 8/09/16 at 7:20 gar (BS) was checked by nurse (LPN)-F with a chine for checking blood was sitting in a wheelchair in the m the nurses desk. R5's BS noved gloves and put the of the lancets (a small sharp drawing blood) without cleaning ce Sheet printed 8/5/16, iagnoses included diabetes, ory of methicillin resistant reus infection (a bacterial by resistive to antibiotic ce flow sheet dated 8/5/16, is to have BS checks done inday, Wednesday, and Friday. It is observation on 8/09/16, at its approached by LPN-F in the intended in the checked R253's BS using the that had been used to it had not been cleaned. R253's 17. LPN-F then removed solid lancet away and put the of loose lancets that were in a but cleaning the glucometer. Die to stop LPN-F before	F 44	Director of Nursing is responsauditing logs monthly and tratrending of infections to obsepatterns. Audit results will be reported committee and action plans oneeded.  Correction date for certification September 21, 2016	cking and rve for to the QA developed as	

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	the glucometer twice individual glucometer should have offered rooms but did not a not clean glucometer. On 8/09/2016, at 8 clean the glucometer sanitizing wipes. We well and wrap them two minutes and the on 8/09/16, at 8:15 stated "It was expected and after every glucometer was to specific product us wet time and some wet time. Staff shour esident's rooms under the composition of the clean the glucometer of the clean the glucometer of the clean the glucometer of the clean ing Glucose instructed staff, "To	ood sugar.  a.m. LPN-F said, "We clean be a shift. They are getting eers soon." LPN-F verified she do to take both residents to their and she acknowledge she did er between residents.  a:01 a.m. LPN-E stated, "We ers after each use with ee wipe the glucometers down in a clean wipe for at least en let them air dry."  a.m. LPN-D nurse manager cted glucometers to be time they were used. A be cleaned in accordance with ed some have a two minute products have a three minute ald do blood sugars in aless the resident refused."  a.m. the director of nurses pect them [staff] to do blood tely not out in the main stream. They [staff] have become a back to the er stated, "The staff are the glucometer between each ordered glucometers for each were just all trained on when to	F 44			

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			E SURVEY MPLETED
	245574	B. WING _		08	/12/2016
			STREET ADDRESS, CITY, STATE, ZIP COI 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
cleaned after each The Monthly Infectionorth) unit were revented through June 2016. The sident name, type prescribed, and the resolved but did not logs were available the months of July and Monthly Infection Control unit were revented through April 2016. The sident name, type prescribed, and the resolved. No logs wor June, July and Aonthly Infection Control the 2 south unit from 2016. The logs ider of infection, the ant dated the infection available from April Monthly Infection Control South unit from 2016. The logs ider 2016. The logs ider 2016. The logs ider	use." on Control Logs for the 2N (2 riewed from December 2015. The logs identified the e of infection, the antibiotic e dated the infection was t identify any organisms. No prior to December 2015 or for and August of 2016. ontrol Logs for the 3N (3 viewed From July 2015 The logs identified the e of infection, the antibiotic e dated the infection was vere available for the months ugust of 2016. ontrol Logs were reviewed for m July 2015 through March ntified the resident name, type ibiotic prescribed, and the was resolved. No logs were 2016 through August 2016. ontrol Logs were reviewed for m July 2015 through June ntified the resident name, type itidid the resident name, type intified the resident name, type	F 44	,		
on 8/12/16, at 10:3 was a plan in place and review the logs patterns exist. She doing spot checks a	was resolved. No logs were onths of July and August 2016. If a.m., the DON stated there to keep infection control logs congoing to determine if stated the facility is currently and observing staff's infection				
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WING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 99 cleaned after each use."  The Monthly Infection Control Logs for the 2N (2 north) unit were reviewed from the dated the infection was resolved. No logs were available from July 2015 through March 2016.  Monthly Infection Control Logs for the months of July and August of 2016.  Monthly Infection Control Logs were reviewed for the 2 south unit from July 2015 through March 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available from April 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were reviewed for the 2 south unit from July 2015 through March 2016. 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Monthly Infection Control Logs were reviewed for the 23 South unit from July 2015 through June 2016.  Monthly Infection Control Logs were reviewed for	PROVIDER OR SUPPLIER  245574  245574  B. WING  STREET ADDRESS. CITY, STATE. ZIP CODE 3820 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 99 cleaned after each use."  The Monthly Infection Control Logs for the 2N (2 north) unit were reviewed from December 2015 through June 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available prior to December 2015 through June 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available for many 12016 through March 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were evailed for the 2 south unit from July 2015 through March 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available from April 2016 through August 2016.  Monthly Infection Control Logs were reviewed for the 2 south unit from July 2015 through March 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available from April 2016 through June 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available for the months of July and August 2016.  Monthly Infection Control Logs were reviewed for the 3 South unit from July 2015 through June 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available for the months of July and August 2016.  Monthly Infection Control Logs were primetion ontrol logs and review the logs ongoing

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT COM	E SURVEY MPLETED
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F 441	identify resident info no evidence of ong past June 2016.  A policy for tracking	age 100 ad been keeping logs to ection and illness, there was oing tracking and trending  g and trending of resident lested, but none was received.	F 4	41		

PRINTED: 09/12/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245574 B. WING 08/09/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3620 PHILLIPS PARKWAY SOUTH SHOLOM HOME WEST SAINT LOUIS PARK, MN 55426 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 09, 2016. At the time of this survey, Sholom Home West was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street., Suite 145 St. Paul, MN 55101-5101 FAX: 651-215-0525 (X6) DATE

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

TITLE

**Electronically Signed** 

09/02/2016

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

Facility ID: 00380

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG <b>01 - MAIN BUILDING</b> 01		E SURVEY MPLETED
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		ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:				
	A description of to correct the definition	f what has been, or will be, done ciency.				
	2. The actual, or p	proposed, completion date.				
	responsible for co	for title of the person prection and monitoring to rence of the deficiency.		К		
	Type II(222) cons basement and is has a fire alarm s resident rooms, c corridor that is modepartment notific	ing was determined to be of truction. It has a partial fully fire sprinklered. The facility ystem with smoke detection in orridors and spaces open to the onitored for automatic fire cation. The facility has a eds and had a census of 145 of the survey.				
	NOT MET as evid	at 42 CFR, Subpart 483.70(a) is denced by: SAFETY CODE STANDARD	ΚO	950		9/8/16
SS=C	signal and simula conditions. Fire d times under varyi on each shift. The and is aware that	the transmission of a fire alarm tion of emergency fire rills are held at unexpected ng conditions, at least quarterly e staff is familiar with procedures drills are part of established ibility for planning and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION 6 01 - MAIN BUILDING 01		SURVEY PLETED
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K 050	persons who are questions who are questions who are questions are consisted of audible at 18.7.1.2, 19.7.1.2. This STANDARD is STANDARD in the second and the second and the second are consisted and the second are could affect that the second are could affect that the fedocumentation for the second are could affect that the fedocumentation for the second are could affect that the fedocumentation for the second are could affect that the fedocumentation for the second are could affect that the fedocumentation for the second are consistent to the second are consist	assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and nnouncement may be used alarms.  Is not met as evidenced by: Intation review and staff by could not provide the drills were conducted quarter for all staff under conditions as required by 2000 19.7.1.2. This deficient conditions as the deficient conditions as the deficient conditions as required by 2000 19.7.1.2. This deficient conditions as required by 2000 19.7.1.2. This deficient conditions are required by 2000 AM august 09, 2016, observation acility did not have fire drills being conducted ter, 3rd shift of 2016 and the	K 050	K050   FIRE DRILLS The facility did not have docume for fire drills being conducted du 1st quarter, 3rd shift of 2016 and quarter, 2nd shift of 2016. The fire drills will be conducted a shift per quarter for all staff unde times and conditions required by NFPA 101, section 19.7.1.2 This will be monitored by the Dir Maintenance or designee and co by 9/8/2016. Attachment #1	ring the I the 2nd once per er varying 2000 ector of	
K 052 SS=F	Director of Mainter NFPA 101 LIFE SA A fire alarm system be, tested, and ma NFPA 70 National National Fire Alarm available. The syst maintenance and tapplicable requirer 9.6.1.4, 9.6.1.7, This STANDARD Based on docume	tice was confirmed by the nance at the time of inspection. AFETY CODE STANDARD  In required for life safety shall intained in accordance with Electric Code and NFPA 72 in Code and records kept readily tem shall have an approved testing program complying with ment of NFPA 70 and 72.  Is not met as evidenced by: In the content of the co	K 052	K052 ⊟ FIRE ALARM SYSTEM The facility⊟s fire alarm system	ı	9/8/16

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG <b>01 - MAIN BUILDIN</b>	IG 01	(X3) DATE COMF	SURVEY
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K 054	This deficient practices residents.  Findings include:  On a facility tour beand 01:00 PM on revealed that the facumentation of a inspection.  This deficient practice of Maintenance at	age 3 cordance with NFPA 72, (99). tice could affect all 145 etween the hours of 09:00 AM August 09, 2016, observation acility could not provide a current annual fire alarm tice was verified by the Director the time of the inspection. AFETY CODE STANDARD	K O	maintenance i accordance w The facility is maintenance i Integrated Fire completed on Director of ma  Attachment #2 The annual fir maintenance by a licensed report will be o with NFPA72 The Director of will monitor fo	re alarm system inspection will be co contractor and a cop documented in acco	pt in the mpleted by of the rdance esignee	9/8/16
SS=F	activating door hol maintained, inspect with the manufact. This STANDARD Based on docume the facility has not testing of the smot system in accorda 7-3.2.1. This defic residents.  Findings include:  On a facility tour band 01:00 PM on a revealed that the first since with the first	e detectors, including those d-open devices, are approved, cted and tested in accordance urer's specifications. 9.6.1.3 is not met as evidenced by: ent review and staff interview, been documenting sensitivity ke detectors on the fire alarm nce with NFPA 72 (99), Sec. ient practice could affect all 145 etween the hours of 09:00 AM August 09, 2016, observation acility could not provide a current smoke detector		The facility has sensitivity test on the fire ala with NFPA72 The sensitivity licensed contraport will be maintenances This will be m	OKE DETECTORS as not been documenting of the smoke dearm system in accord (99), Sec. 7-3.2.1. By test will be compleined a copy of kept in the Director of soffice.  In or designee and cordinate or designee and cordinate in the Director of the the Dir	tectors lance ted by a the of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION (1) - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
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K 054 K 056 SS=F	of Maintenance at NFPA 101 LIFE SA Where required by facilities shall be papproved, superviin accordance with systems are equip switches which are the building fire also construction, alternishall be permitted protection in specific regulations prohib NPFA 13.  This STANDARD Based on observation automatic sprinkle maintained in accordance of the International system in compliant allow system beindecrease in the first the event of an entary automatic sprinkle system in compliant allow system beindecrease in the first the event of an entary automatic sprinkle system in compliant allow system beindecrease in the first the event of an entary automatic sprinkle system in compliant allow system beindecrease in the first the event of an entary automatic sprinkle system in compliant allows and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in compliant and 01:00 PM observation reveau provide document sprinkler system in	tice was verified by the Director the time of inspection. AFETY CODE STANDARD  ASSECTION 19.1.6, Health care rotected throughout by an sed automatic sprinkler system is section 9.7. Required sprinkler ped with water flow and tamper electrically interconnected to arm. In Type I and II native protection measures to be substituted for sprinkler fic areas where State or local it sprinklers. 19.3.5, 19.3.5.1, is not met as evidenced by: ations and staff interview, the er system is not installed and ordance with NAPA 13 the installation of Sprinkler Systems failure to maintain the sprinkler nce with NAPA 13 (99) could g place out of service causing a e protection system capability in hergency that could affect all are between the hours of 09:00 on August 09, 2016, led that the facility could not ration for an annual automatic	K	054	K056 : AUTOMATIC SPRINKLER SYSTEM  1. The facility could not provide documentation for an annual autom sprinkler system inspection. In comwith NFPA 13 (99).  The facilities annual automatic spring system inspection conducted by Olifice Inspection and completed on 8 will be kept in the Director of Mainter Office  Attachment #4  The annual automatic sprinkler system inspection will be completed by a licontractor and a copy of the report kept in the Director of Maintenance This will be monitored by the Director maintenance or designee and comby 9/8/2016	natic pliance nkler sen 3/21/15 enance tem censed will be office. tor of	9/8/16	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION - MAIN BUILDING 01	(X3) DATE COMF	SURVEY
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K 056	sprinkler system flo quarters of 2015 at 2016.	age 5 ation of quarterly automatic by tests for the 3rd and 4th and the 1st and 2nd quarter of tice was verified by Director of time of inspection .	KO		2. The facility could not provide documentation of quarterly autom sprinkler system flow tests for the 4th quarters of 2015 and the 1st a quarter of 2016. In compliance wi 13 (99). The facility will contract with an oulicensed sprinkler service contract ensure that four quarterly water flare conducted every 12 months. director of maintenance will monifischedule for the quarterly inspect will contact the contractor at the appropriate intervals and a copy of report will be kept in the Director maintenance office. This will be monitored by the Director by 9/8/2016.	3rd and and 2nd th NFPA utside tor to ow tests The tor the ion and of the of	
K 069 SS=D	Cooking facilities a with 9.2.3. 19.3. This STANDARD Based on observer facility failed to profacilities in accorda NFPA 101-2000 ec 9.2.3; NFPA 96-19 Findings include:  On a facility tour be and 01:00 PM on A revealed that the facilities and 10-100 PM on A revealed that the facility facilities are second on the facility facilities and 10-100 PM on A revealed that the facility facilities are second on the facilities are s	etween the hours of 09:00 AM August 09, 2016, observation acility could not provide the last two 6 month kitchen	K	069	Attachment #3  KO69   KITCHEN HOOD AND   SYSTEM.  The facility could not provide documentation of the last two 6 n kitchen hood and duct system ins in accordance with the requirement NFPA 101-2000 edition, Sections and 9.2.3; NFPA 96-1998 edition  The facility will contract with an olicensed contractor to ensure that month kitchen hood and duct sys	nonth spection ents of 3 19.3.2.6 utside t two 6	9/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G <b>01 - MAIN BUILDING 01</b>	COMPLETED			
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K 069	Continued From page of Maintenance at	ctice was verified by the Director the time of inspection.	K 06	maintenance will monitor the so the 2 every six month inspection contact the contractor at the ap intervals and a copy of the repokept in the Director of maintena This will be monitored by the Dimaintenance or designee and oby 9/8/2016.	n and will propriate rt will be nce office. rector of		



Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted August 26, 2016

Mr. Steve Fritzke, Administrator Sholom Home West 3620 Phillips Parkway South Saint Louis Park, MN 55426

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5574025 and Complaint numbers H5574081, H5574082, H5574083, H5574084 and H5574085

Dear Mr. Fritzke:

The above facility was surveyed on August 8, 2016 through August 12, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5574083 was completed. The complaint was substantiated at MN Rule 4658.0510 Subp. 1 (0800), MN Statute 144.651 Subd. 5 (1805), MN Rule 4658.0520 Subp. 2 D. (0850) and MN Rule 4658.0525 Supb. 3 A. and B. (0900). An investigation of complaint number H5574085 was completed. The complaint was substantiated at MN Rule 4658.0405 Subp. 4 (0570), MN Rule 4658.0405 Subp. 3 (0565), MN Rule 4658.0510 Subp. 1 (0800), MN Rule 4658.0520 Subp. 2 D. (0850) and MN Rule 4658.0525 Subp. 3 A. and B. (0900). An investigation of complaint numbers H5574081, H5574082, and H5574084 were conducted and found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are

Sholom Home West August 26, 2016 Page 2

delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gloria Derfus, Unit Supervisor at (651) 201-3792.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kamala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Sholom Home West August 26, 2016 Page 3

Fax: (651) 215-9697

PRINTED: 09/07/2016

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_\_ B. WING \_ 00380 08/12/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

NAME OF PROVIDER OR SUPPLIER S		STREET ADDRESS, CITY, STATE, ZIP CODE					
SHOLON	I HOME WEST	_	LLIPS PARKWAY SOUTH UIS PARK, MN 55426				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
2 000	Initial Comments	2 000					
	*****ATTENTION*****						
	NH LICENSING CORRECTION ORDER						
	In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.						
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.						
	You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.						
	INITIAL COMMENTS: 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/inrobul.htm The State licensing orders are delineated on the attached Minnesota	f					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

STATE FORM 6899 If continuation sheet 1 of 99 XY1C11

(X6) DATE

TITLE

09/07/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	12/2016
	PROVIDER OR SUPPLIER	3620 PHII	LIPS PARKV			
		SAINT LO	OUIS PARK, M	IN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. Is necessary for State enter the word "corn text. You must then State licensure proceompletion date, the corrected prior to el Minnesota Departm On August 8th throus urveyors of this Deabove provider and orders are issued. electronic plan of coreviewed these ordethey will be completed Minnesota Departmente State Licensing federal software. Ta assigned to Minnesota Nursing Homes.  The assigned tag in column entitled "ID statute/rule out of completed "Summary Statement and replaces the "Torrection order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Corplease DISREGA FOURTH COLUMN	Althorders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading edate your orders will be lectronically submitting to the nent of Health.  Augh August 12, 2016, epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted.  The Health is documenting Correction Orders using ag numbers have been onto state statutes/rules for  The Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute are wing the surveyors findings method of Correction and crection.  The The Heading Of The Which States,	2 000			
		N OF CORRECTION." THIS				

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STATE FORM KY1C11 If continuation sheet 2 of 99

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					OATE SURVEY COMPLETED		
			A. BOILDING.				
		00380	B. WING		08/1	2/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
SHOLON	SHOLOM HOME WEST 3620 PHI SAINT LC			WAY SOUTH NN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 000	Continued From page 2		2 000				
	THIS WILL APPEA	R ON EACH PAGE.					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
	was completed. The at MN Rule 4658.05 Statute 144.651 Su	complaint number H5574083 e complaint was substantiated 510 Subp. 1 (0800), MN bd. 5 (1805), MN Rule D. (0850) and MN Rule A. and B. (0900).					
	was completed. The at MN Rule 4658.04 4658.0405 Subp. 3 Subp. 1 (0800), MN	complaint number H5574085 e complaint was substantiated 405 Subp. 4 (0570), MN Rule (0565), MN Rule 4658.0510 I Rule 4658.0520 Subp. 2 D. e 4658.0525 Subp. 3 A. and B.					
		complaint numbers H5574081, 574084 were conducted and tantiated.					
2 265	MN Rule 4658.008 Resident Health Sta	5 Notification of Chg in atus	2 265			9/21/16	
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X3) MULTIPLE CONSTRUCTION  A. BUILDING:			(3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
	PROVIDER OR SUPPLIER	3620 PHIL		STATE, ZIP CODE  WAY SOUTH  MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 265	appropriate notifica  A. an accident results in injury and physician interventi  B. a significant physical, mental, o example, a deterior psychosocial status conditions or clinica  C. a need to alrexample, a need to of treatment due to begin a new form o  D. a decision tresident from the new form the new facility failed to notificate of a medication error findings include:  R12's admission M 5/17/16, indicated F impairment, experie when walking, and MDS indicated R12 congestive heart failed mentia.	tion times for: involving the resident which has the potential for requiring on; change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening al complications; ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment; o transfer or discharge the	2 265	See ePOC		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00380	B. WING	<del></del>	08/1	2/2016
	PROVIDER OR SUPPLIER  I HOME WEST	3620 PHIL		NAY SOUTH  NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	(MAR) for 6/1/16 th had a Lasix (a diure Lasix 20 milligrams order was changed mg now and increased on 6/13/16, the Lasix 30 mg every morning new Lasix order was Lasix 40 mg twice a transcribed on the National and a day at 8:00 a.m.,  During interview on registered nurse (Refrom 6/17/16 throug Lasix 40 mg a day of given, except for 6/16/16, two doses dot was placed in the 6/30/16, two doses dot was placed in the 6/30/16, two doses dot was placed in the 6/30/16, two doses stated a dot was so when the medication initials are placed of medication has been say if the medication dot had been given  During interview on said, "I was not told three times a day. Figure Lasix three times (6/13/16, 6/16/16 and control and contr	rough 6/30/16, indicated R12 etic) order dated 5/22/16, for (mg) twice a day. R1's Lasix on 6/2/16, to give Lasix 20 se Lasix to 40 mg twice a day. Six order was changed to Lasix ng and 20 mg every evening. As written on 6/16/16, to give a day. The order was MAR to give Lasix 40 mg twice 2:00 p.m. and 4:00 p.m.  8/10/16, at 4:33 p.m. N)-D verified for the period of 6/27/16, three doses of were signed as having been 19/16 and 6/21/16. On those is were signed as given. On were signed as given and a ne 4:00 p.m. square. On were signed as given and a ne 4:00 p.m. square. On were signed as given RN-D metimes placed in a square in was prepared and then wer the dot when the en given. RN-D was unable to ns that were marked with a  8/11/16, at 12:41 p.m. NP-A about the Lasix being given R12 should not have been mes a day. I saw [R12] on d 6/21/16. On 6/16/16, I	2 265			
	continued Duo Neb breathing) and the I twice a day. " NP-A	ycycline (an antibiotic), s (inhaled medication to ease Lasix was increased to 40 mg said, "To my knowledge, I f him being given Lasix three				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	M HOME WEST			WAY SOUTH		
OHOLON	THOME WEST	SAINT LO	UIS PARK, N	MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 5	2 265			
2 265	times a day." NP-A negatively impacted potassium level. NF would have expected medication error be present during inter he would get the parachine) dispense think that the staff is a day. RN-B said he (nurses or trained in for giving three dos given. The Passpor Medication error reprovided.  During interview on director on nurses (means they gave the have done a medic expect them to noti practitioner." The N requested and the I there was a medical	said, "I don't think it d [R12]. It did not impact his P-A said, "I am not happy. I ed to be told about a efore nine days." RN-B also rview with NP-A. RN-B stated assport (medication dispensing reports because he did not had given three doses of Lasix e did not know why they medication aides) would sign es when two doses were the dispense reports and the port were requested but not a 8/12/16, at 11:06 a.m. the (DON) said, "If they signed it, it he medication. They should ation error report. I would fy the doctor or nurse dedication error report was DON said she did not believe ation error report. The olicy requested but not	2 265			
	The director of nurs and revise policies audits related to No Resident Health to conducted to the ap a change in health	THOD OF CORRECTION: sing or designee, could review and procedures, conduct offication of Change in ensure proper notification is oppropriate party when there is status. The director of nursing develop ensure staff training is ngoing basis.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
		00380	B. WING		08/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	I HOME WEST			WAY SOUTH		
040.15	CLIMANA DV CTA	TEMENT OF DEFICIENCIES	UIS PARK, I		ONI	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From page	ge 6	2 565			
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			9/21/16
		omprehensive plan of care personnel involved in the				
	by: Citation Text for Tag Based on observation review the facility fat for 4 of 5 residents R24) reviewed for d	ent is not met as evidenced g 0282, Regulation FF09 on, interview and document iled to follow the plan of care (R180, R116, R28, R109, lialysis, activities of daily living g, pressure ulcers, and dining		See ePOC		
	Findings include:					
	hypertension and en (ESRD) obtained from	ncluded heart failure, nd stage renal disease om the 14 day Minimum Data 6/16. In addition the MDS eived dialysis.				
	asked how dialysis everything was goin increased weight wheating well at the tin the facility. When as restriction residents diet and did not have	p.m. when approached and was going R180 stated ag well. R180 stated he had nich was good as he was not ne he had been admitted to sked about the diet and fluid stated he was on a regular e a fluid restrictions as glasses of water on top of the ped.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLOM	I HOME WEST		LIPS PARK UIS PARK, I	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From page 7		2 565			
	On 8/11/16, at 9:10 observed resident stated he had eater was observed to ha and lower extremitic asked how he had sknow am a little puff R180's Hospital Dis 5/18/16, directed "Dweight gain of more pounds per week." Orders dated 6/30/7 During review of the following weights w to months:  -May 5/19/16, 5/27/-June 6/1/16, 6/30/16 -July 7/1/16, 7/2/16 7/8/16, 7/9/16, 7/12 -August 8/2/16, 8/3/8/7/16, 8/8/16, 8/9/10 During review of the Administration Reconstruction Reconstruction and the review of the interdition was revealed the widocumented there are R180's undated caron dialysis and identifications.	a.m. went to resident room seated at edge of bed. R180 in breakfast in his room. R180 ive slight edema on the face es and appeared tired. When slept resident stated well "I fy."  scharge Summaries dated vaily weights: Call provider for than 2 pounds per day or 5 in addition, the Physician 16, directed the same.  e vital signs weight section the ere noted missing according 16, 5/28/16.  16, 6/14/16, 6/16/16, 6/17/16, 7/3/16, 7/15/16, 7/16/16, 7/11/16 (16, 8/4/16, 8/5/16, 8/6/16, 8/10/16.  e Medication and Treatment ords for May 2016, through a revealed weights had not in the record. In addition isciplinary team notes (IDT) it eights had not been				
	and elevated blood	pressure. The care plan nitor and follow the Physician				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
SHOLON	M HOME WEST			WAY SOUTH		
(VA) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES	UIS PARK, N		<b>N</b>	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 8	2 565			
	8/11/16, directed start On 8/11/16, at 3:31 verified resident had the physician orders vital signs tab and readment adminurses carts to see weights in there.  -At 3:33 p.m. RN-B checked and found RN-B stated he word assistant to get the and record the weight would populate to Nital would expect the number of the weights were the weights were started as a signal of the signal of	a.m. the director of nursing				
		vould expect the staff to follow s and resident plan of cares.				
	registered nurse to stated she would ex the physician orders sometimes may har other medical appo which was not docu not been obtained i	a.m. via telephone the the primary doctor's clinic spect the care center to follow is but thought the resident we not been weighed due to intments or dialysis days imented why the weights had in the resident medical record. The hed according to the plan of				
	Grooming removal R116's diagnoses in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
	PROVIDER OR SUPPLIER	3620 PHIL	, ,	STATE, ZIP CODE  WAY SOUTH  MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	contracture, muscle thrive and osteopor MDS dated 5/31/16 had severely impair extensive to total do on all ADLs which in and transfers.  On 8/8/16, at 6:00 pseated on the Brodo Observed resident approximately half i area.  On 8/9/16, at 10:30 visit to the unit reside the nursing station noted to have the factor of the second properties of the second properties of the second province of t	e weakness, anxiety, failure to osis obtained from the annual. The MDS indicated resident ed cognition and required ependence of one to two staff included bed mobility, toilet use o.m. resident was observed a wheelchair in the DR. with multiple white facial hairs inch long on the lower chin a.m. during another random dent was observed on her the dining room across from with eyes closed and still	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLOM HOME WEST			LLIPS PARK\ )UIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 10	2 565			
	resident had late or Alzheimer's disease all cares and was not on 8/11/16, at 7:30 Broda chair at the coday. When approace were still not remove feet away. At 9:16 a room facial hair visis several staff by the resident was seated facial hairs.  -At 10:27 a.m. NA-10 providing resident codard to get a indicated because the short resident had resident had resident had residents did showers/baths how	a.m. was observed on the dining table dressed for the ched the white facial hairs are and visible from standing 20 a.m. resident still in the dining lible from standing 20 feet steam table close to the table do none offered to remove the close to the table do none offered to remove the close for that morning.  A stated "[R116] was shower today." LPN-A the unit had been working not received her shower yet. In do not get there scheduled rever thought it was getting nit had been added a sixth				
	white facial hair on LPN-A actually touch the staff was supported to have one of the staff were two resident with cares. The to have one of the staff were two residents assistance to remofurther stated resident has evening staff the unit was staff to the unit was staff to the s	p.m. LPN-A verified the long resident lower chin area. ched resident chin and stated used to have removed it for LPN-A stated she was going staff remove it and thought dents in the unit who needed we the facial hairs. LPN-A ent had received shower after taff had come in early to assist short of one NA.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHOLOM HOME WEST			LLIPS PARK\ DUIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 565	resident had potent ability,needed assis dressing/grooming/to advanced demer disturbance. The cagrooming to provide hair, oral care, nail.  The 3 South Weekl indicated resident was Thursdays AM.  On 8/11/16, at 3:16 stated staff should be facial hairs "You RN further stated stiplan of care. R116 was observed R116 was observed R116 was observed R116 was lying in be lying on her right sid of the night stand we (provide comfortable sensitive skin that reached and the resident was going to going to leave R116 minutes.  -At 7:14 a.m. observed assignment sheet was going to repositioned. The about resident NA-A staff in the unit how up shortly. NA-A fur	ial alteration in self-care it with bathing and oral care related itia with behavioral are plan directed staff for e assist of one with combing care and shaving.  y Bath List dated 8/8/16, vas scheduled to get a bath on  p.m. RN-A unit manager have automatically removed ithink. Am totally with you." taff was supposed to follow the was not groomed according to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00380			08/1	2/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
			WAY SOUTH		
SHOLOM HOME WEST	SAINT LO	UIS PARK, N	IN 55426		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565 Continued From pag	e 12	2 565			
-At 7:19 a.m. NA-A was linen stated she was was just getting what NA-A never reposition room shortlyAt 7:27 a.m. resident wearing the arm slees on her back to the riguntil 8:28 a.mAt 8:29 a.m. LPN-A NA-A that R116 was every hour. When as last repositioned LPN unit since 6:30 a.m. aresident had last beer resident had an oper however, the area was ame areaAt 8:32 a.m. both No observed provide per During the observation red and non-blanchat the coccyx was obsel layer of cream. LPN-scabbed area was obto bottom was red and resident skin was so left heel boot was no stated LPN-A had infinity supposed to be repowhen she looked at the directed resident to be hours and because sanother unit later into told when resident had	vas observed go to room with not getting resident up but a she would need ready. In a sleep still observed eves on both arms still lying ght side. No activity to room stated she had informed supposed to be repositioned sked when resident had been N-A stated she had got to the and did not know when en repositioned. LPN-A stated in area which was improving as a recurring one in the A-A and LPN-A were ricare and repositioned R116. On R116's bottom appeared able. The area on the tail of erved covered with a thick and wiped the area and a biserved. LPN-A stated the non-blanchable because fragile. LPN-A verified the sit on. At 8:36 a.m. NA-A formed her resident was sistioned hourly however the NA assignment sheet it be repositioned one to two she had been pulled from the shift she had not been ad been repositioned last. and 39 minutes without	2 300			

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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	M HOME WEST			WAY SOUTH		
	T		UIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 13	2 565			
	breakdowns, tears were supposed to be stated it was not on was going to add it were supposed to be lotion."  -At 8:50 a.m. RN-A care plan in the corskin care plan direct to side hourly when care plan was contreposition resident hourly. RN-A verifies sleeves were supposited to suppose the suppo	ure that could lead to skin and splits) and Posey sleeves be on at all times. LPN-A in the treatment sheet and "I didn't know. I thought they be off at night when staff put nurse manager reviewed the nputer and verified R116's sted staff to turn resident side in bed and also verified the radicting as it directed staff to one to two hours and then d the Derma and Posey seed to be on at all times. Sould expect the staff to follow if care and she was going to e staff as that was important.				
	On 8/10/16, at 8:52 a.m. to 9:18 a.m. R116's cares were observed provided by NA-A and NA-U who during the observed turned resident to the left and right never placed a pillow, three times never put a pillow to protect the boney prominences when repositioning.					
	stated she had revi- Care sheet and had hours and every ho stated she was goir to reflect the hourly as this was confusi- staff. At 10:42 a.m. open area that was same area where it further stated she the was a stage II (part involving epidermis	6 a.m. LPN-A approached ewed the NA group Plan of a noticed both the one to two ur for repositioning. LPN-A ag to make sure it was update repositioning schedule onlying and misleading for the LPN-A stated R116 had an pressure related as it was the had healed before. LPN-A mought it was healing well and ital thickness skin loss, dermis, or both. The ulcer is sents clinically as an abrasion.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00380	B. WING		08/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
SHOLOM	I HOME WEST			WAY SOUTH		
040.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	UIS PARK, I		ONI	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 14	2 565			
	blister, or shallow c	rater).				
	On 8/10/16, at 10:5 resident had late or Alzheimer's disease all cares and was n On 8/12/16, at 7:20 seated on Broda ch door noted to have however did not have rest when in Broda the care planAt 7:30 a.m. RN-A	1 a.m. the RN-E stated a set progression of a, was dependent on staff for on-verbal.  a.m. observed resident air in front of the dining room blue boots to both feet we the pillow placed on foot to protect skin as directed by verified the pillow was not on				
	the foot rest as directed by the care plan to protect skin breakdown.  R116's diagnoses included dementia, contracture, muscle weakness, anxiety, failure to thrive and osteoporosis obtained from the annual MDS dated 5/31/16. The MDS indicated resident had severe impaired cognition and required extensive to total dependence of one to two staff on all activities of daily living which included bed mobility, toilet use and transfers. In addition the MDS indicated R116 was at risk for pressure ulcers and did not have unhealed pressure area at the time of the assessment.  R116's care plan dated 7/8/16, indicated resident was at risk for alteration in skin integrity related to dementia, incontinence of bowel and bladder, dependency with ADLs, poor nutritional intake, and had a chair fast status. R116 had a history of bruising easy and had fragile skin. The care plan directed staff "Place pillow on foot rest when resident is in BRODA chair, elevate lower extremities when in bed above level of heart. Turn					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00380	B. WING	<del></del>	08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
SHOLON	I HOME WEST		LIPS PARK\ UIS PARK, N	NAY SOUTH NN 55426		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 15	2 565			
	(specialized wheeld extremities (Full arrextremities at all time to apply lotion, then to both feet when by on all three shifts'  On 8/12/16, at 7:36 expect staff to have removed the facial care. R116 was not	y while in BRODA chair chair), Posey sleeves upper m) and derma-savers to lower nes, remove at bedtime [HS] reapply. Heel blue boots on ing in bed and sitting up daily a.m. DON stated she would be repositioned resident timely, hairs and followed the plan of repositioned according to the ze and/or prevent further skin				
	Wounds, undated, or pressure ulcers dail surrounding skin, si pain is present. The initiate weekly wour	d Prevention and Treatment of directed staff to monitor by including the status of the gns of infection and whether expolicy further directed staff to monitoring to include onset cation of wound, stage of h, depth and wound				
	continuously when a p.m. the resident was continuously, as an table stated repeated mouth." At 6:15 p.m. room stated R109 c6:17 p.m. when ask thickened as noted stated the food had and added at times would have to add that particular meal	6:13 p.m. was heard coughing standing at the desk. At 6:14 as observed coughing other resident in the same edly "[R109] cover your n. NA-P and NA-K in the dining coughed like that everyday. At the diff the food had been in the meal ticket, NA-P already been pre-thickened for example the soup staff the thickener however not for . The pureed food on the plate any and thin. At 6:18 p.m.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	12/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
			LLIPS PARK\	•		
SHOLON	M HOME WEST		DUIS PARK, N			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ΓΙΟΝ	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
2 565	Continued From pa	ge 16	2 565			
	p.m. NA-P stood up going to eat all his f coughed again. Sta At 6:24 p.m. resider of the runny pureed observed hold his his he was having a he nod. At 6:25 p.m. N should give him juic came into the dinninher to wheel resideration still coughing At 6:32 p.m. observe his room and was station again.	-				
	manager (NSM) stated that evening had let surveyor to come be day. When asked if had been added to NSM stated she we been added to the fithe floor for the purif NSM would contan NSM called the coopureed food cook socops of thickener -At 6:59 p.m. RN-B practitioner was wo determine if it was at the food was pureed to be honey consist a history of aspiration was on a patch to don Mucinex (used to cough and loosen in	o.m. the nutritional service ated the cook who had cooked ft for the night and asked ack and talk to cook the next she was familiar with what the pureed food for R109, and not exactly know what had food before it was brought to feed food. Surveyor requested ct the cook and at this time sk who indicated to all the tated he would add one to two frame on resident diet order to appropriate and at that time d and liquids were supposed for pneumonia, and currently fecrease secretions and was or relieve the symptoms of fucus in the chest). At 7:06 the 7/29/16, which directed				

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NAME OF PROVIDER OR SUPPLIER SHOLOM HOME WEST  A. BUILDING:  B. WING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  3620 PHILLIPS PARKWAY SOUTH  SAINT LOUIS PARK, MN 55426	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  SHOLOM HOME WEST  3620 PHILLIPS PARKWAY SOUTH				A. BOILDING.			
SHOLOM HOME WEST 3620 PHILLIPS PARKWAY SOUTH			00380	B. WING		08/1	2/2016
SHOLOM HOME WEST	NAME OF PRO	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAINT LOUIS PARK, MN 55426	SHOLOM H	HOME WEST					
				UIS PARK, N	MN 55426		
	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETE DATE
2 565 Continued From page 17 2 565	2 565 C	Continued From pa	age 17	2 565			
staff to add two teaspoons of thickener stated the nurse had signed off on it. RN-B stated on the meal ticket the three packets of thickener were for the coffee, juice and soup if he needed them and this was to alert staff of what the resident needed.  -At 7:18 p.m. approached NA-P who had been assisting R109 with eating and she stated she had watched the tray from when it had been served and when she started to assist resident and she had not seen the LPN-C add thickener to the food as LPN-C had indicated.  On 8/9/16, at 9:16 a.m. observed R109's food served into a divided plate covered and sat on top of the steam table. No thickener was added to plate at this time. At 9:18 a.m. the plate of food remained in the same spot. At 9:33 a.m. NA-F take the sippy cups of cranberry juice and water which were already honey thickened consistency and added a packet of thickener to each of the four ounce cups, then brought them back and set them on the tray on top of the steam table. As NA-F was mixing the thickener LPN-C came into the nourishment center and left never said a word. No thickener was added to the pureed food at this time.  -At 9:39 a.m. when approached and asked about the thickened liquids dietary aide (DA)-A stated the liquids came already pre-thickened and showed surveyor bottles of honey and water and juice in the refrigerator that were opened. He indicated he poured the beverages and nursing took care of the rest if they needed to add more thickener to the beverages.  -At 10:04 a.m. NA-F went to the dining room grabbed the tray surveyor went into the nourishment center AI-F stated she was going to	st no me for an formation and an formation and an for an formation and an for an formation and an formati	staff to add two tean nurse had signed of meal ticket the threfor the coffee, juice and this was to aler needed.  -At 7:18 p.m. approful assisting R109 with had watched the traserved and when sland she had not see the food as LPN-C  On 8/9/16, at 9:16 asserved into a divide of the steam table. plate at this time. A remained in the sar take the sippy cups which were already and added a packe four ounce cups, the them on the tray on NA-F was mixing the nourishment ce word. No thickener at this time.  -At 9:39 a.m. when the thickened liquid the liquids came alreshowed surveyor be juice in the refrigeration in the refrigeration to the bevent of the bevent of the pour of the tray surveyor between the thickener to the bevent of the tray surveyor between the tray surveyor to the tray surveyor tray the tray surveyor to the tray surveyor to the tray surveyor tray the tray surveyor tray the tray surveyor tray the tray surveyor tray tray tray tray tray tray tray tra	aspoons of thickener stated the off on it. RN-B stated on the see packets of thickener were and soup if he needed them ent staff of what the resident oached NA-P who had been heating and she stated she say from when it had been she started to assist resident een the LPN-C add thickener to shad indicated.  a.m. observed R109's food ed plate covered and sat on top. No thickener was added to a 9:18 a.m. the plate of food ame spot. At 9:33 a.m. NA-F is of cranberry juice and water y honey thickened consistency et of thickener to each of the nen brought them back and set in top of the steam table. As he thickener LPN-C came into enter and left never said a rewas added to the pureed food in approached and asked about dis dietary aide (DA)-A stated dready pre-thickened and oator that were opened. He ad the beverages and nursing st if they needed to add more everages.  Fer went to the dining room urveyor went into the	2 565			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
71110 1 12711	OF CONTILECTION	IDENTIFICATION NONBERG	A. BUILDING:		O O IVIII	
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
SHOLO	SHOLOM HOME WEST			WAY SOUTH		
	OLIMANA DV. OTA		UIS PARK, N			0.50
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 565	Continued From page 18		2 565			
2 565	the door went in with protector, pulled a content of the food. When appended thickener to not. NA-F was then quick bite when surher before the seconthen came with surshe was not aware to be added more the fluids which she walked out of the roccughing.  -At 10:13 a.m. NA-F who looked at the nod and stated the left the room. NA-F seen the nurse add -At 10:15 a.m. camend NA-F in room. added the thickener another room doing directed NA-F to add pureed food.  -At 10:17 a.m. when informed about add LPN-C stated this his the NA-F. LPN veriff 7/29/16, and NA-F was aware she was sup the food.  -At 10:19 a.m. RN-F aware she was sup the food.  -At 10:19 a.m. RN-F aware she was sup the food.  -At 10:19 a.m. RN-F aware she was sup the food.  -At 10:19 a.m. she was sup the food.	h the tray, applied the clothing chair next to R109 and mixed proached and asked if she had the food NA-F stated she had observed give resident one veyor intervened and stopped and bite at 10:10 a.m. NA-F veyor out of the room stated resident food was supposed nickener and thought was only a had. As surveyor and NA from resident was heard  F went to room with the RN-B neal ticket and looked at the food consistency was good indicated to RN-B she had not thickener to the food.  E DPN-C verified she had not a dressing change. LPN-C do two teaspoons to the masked if the NA-F had been a sked if the NA-F had been ing the thickener to the food and not been communicated to fied the order was dated was a regular staff was not posed to add the thickener to	2 565			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
SHOLON	M HOME WEST		LIPS PARK UIS PARK, N	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 19	2 565			
		ated resident was at high risk iratory infectious due to the				
	resident diet was pu In addition another directed staff to "ad pureed diet three tir	order dated 7/22/16, indicated ureed and honey thick liquids physician order dated 7/29/16, d 2 teaspoons of thickener to mes a day [TID] during meals ent should be up in chair for				
	The 2 North Group 9 Plan of Care dated 8/8/16, for nursing assistants indicated R109 was on a mechanical soft diet with nectar thick liquids. The plan of care did not indicated two teaspoons of thickener were supposed to be added to the food three times daily.					
	had potential for nu diagnoses of intelle control, and dyspha resident continued t with and without into and honey thickene directed staff to "Ad	ated 8/9/16, indicated resident trition related concerns ctual disability, impulse gia. The care plan indicated to have coughing episodes ake and was on pureed diet d liquids. The care plan d 2 teaspoons of thicken et TID during meals per				
	stated she had work when the order had had not been able to update the meal tick orders were part of acknowledged the complemented since order. RD further st	p.m. registered dietician (RD) ked the kitchen the Friday been obtained 7/29/16, and o update the care plan and ket. RD stated physician the resident plan of care and order should have been nursing was aware of the ated the new order was a trial ghing resident had with				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/	12/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLON	M HOME WEST		LLIPS PARK\ DUIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 20	2 565			
	eating.					
	expect communicat	a.m. DON stated she would tion to the staff on the orders ow all physician orders.				
	incontinence and di cream to perineal a episode and observ plan further identifie integrity and directe in skin and report to	red 7/26/16, identified rected staff to apply barrier rea after each incontinence re condition of skin. The care red risk for alteration in skin red staff to observe for changes o licensed staff and a weekly one by licensed staff.				
	undated indicated F breakdown in the sa	titled 2 North Plan of Care, R24 had a history of skin acral area and directed staff to d or reposition in wheel chair.				
		erview on 8/8/16, at 3:50 p.m., d not have a pressure ulcer.				
	stated he had pain.	on 8/9/16, at 7:44 a.m., R24 He stated the pain was in his d it was because he had a sore				
	R24's right and left to be reddened, exc areas approximatel centimeter each. The approximately four side and approximately right.	inches x two inches on the left ately two inches x one inch on				
		locuments titled Weekly Skin R24 had an open area on his				

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_	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION NU					X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 33/1	_,	
SHOLON	I HOME WEST			WAY SOUTH			
(VA) ID	ST V V D V D V S T A	TEMENT OF DEFICIENCIES	UIS PARK, I	PROVIDER'S PLAN OF CORRECTI	ON	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	Continued From page 21		2 565				
	alteration to his but Checklist for July 20 entire month. The forweekly skin checks open areas to R24's						
	8/1/16 through 8/12 - Reposition patient displace weight on of the flowsheet designature was left band August 2016 Skin assessment of the flowsheet designature was left band August 2016 Apply barrier ointo twice daily with care	reatment Flowsheet dated 2/16, indicated the following: a every two hours in order to sacral/coccyx area. The area signated for a nurses blank the entire months of July weekly on bath day. The area signated for a nurses blank the entire months of July ment to sacral coccyx area es. The facility did not follow nonitoring the skin integrity.					
	NA-Q stated she up	on 8/11/16, at 8:18 a.m., odated the nurses when R24's and stated RN-B should have					
		on 8/11/16, at 2:42 p.m., R24 ores on his bottom on and off					
	RN-B stated he was alteration to the skin nurses should be p for R24. He stated anything that was n assessment. Howe skin assessments p	on 8/11/16, at 8:54 a.m., s not aware R24 had an n on his bottom. He stated the erforming skin checks weekly the nurses should be reporting ot noted on a previous ver, there was no evidence of performed during the month of 24 stated he has had the sore					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						TE SURVEY MPLETED	
		00380	B. WING		08/1	2/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
SHOLON	I HOME WEST		.LIPS PARK\ UIS PARK, I	WAY SOUTH MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 22	2 565				
	interview on 8/11/16 described R24's bo buttock, moving to like it started as "ch been "sheared" off.  During an interview	on 8/11/16, at 12:29 p.m. the					
	DON stated weekly skin checks should have been completed for R24.						
	The facility Care Plan policy reviewed 10/15, directed "6. The Resident Care Plan is constantly changing. It is to be updated routinely with changes in doctor's orders and resident condition change. The Resident Care Plan is reviewed for accuracy, updated with annual MDS"						
	The administrator of system to educate s	THOD OF CORRECTION: or designee could develop a staff and develop a monitoring taff are providing care as ten plan of care.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			9/21/16	
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/				(X3) DATE COMP	SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	<u>.</u>	STATE, ZIP CODE		
SHOLON	I HOME WEST		LIPS PARK UIS PARK, I	WAY SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 23	2 570			
		seven days of the revision of resident assessment required subpart 3, item B.				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to reassess skin residents (R3) who developed the facility.		See ePOC		
	Findings include:					
	licensed practical n completed a dressin R3's right and left is and excoriated with RN-B described the redness and three s LPN-A stated the w	ion on 8/11/16, at 7:23 a.m., urse (LPN)-A and RN-A and change to R3's buttocks. Schial tuberosity 's were red three separate open areas. A area as having "lots of stage II pressure ulcers." ound had gotten bigger and er dressing than it had				
	cognitively intact, refor bed mobility, tra frequently incontine care area assessm "high risk for pressu pressure ulcers." Ridentified impaired i	ated 6/30/16, indicated he was equired extensive assistance insfers and toileting and was ent of bowel and bladder. A ent dated 6/30/16, identified a ture ulcer due to a history of 3's care plan dated 8/5/16, mobility and directed staff to bility, transfers and toileting.				
	Order Report dated indicated on 7/14/10 the following order:	olom Home West Physician 7/22/16 through 8/22/16, 6, the nurse practitioner wrote Left buttock ulcer- cleanse apply skin prep to surrounding				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
SHOLON	I HOME WEST		.LIPS PARK\ UIS PARK, N	NAY SOUTH NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 24	2 570			
	skin, cover with Allevyn border (Allevyn Border is a wound covering dressing), change every other day.					
	A Facility document titled weekly skin checklist dated 7/27/16, identified an open area on R3's left buttock.					
	During an interview on 8/10/16, at 1:01 p.m., LPN-A stated she was aware of the open area to R3's buttocks. She stated the nurse practitioner saw him in July and found the area.					
	During an interview on 8/11/16, at 7:02 a.m., two days after RN-A was made aware of the pressure ulcer on R3's buttock, RN-A stated she had not assessed the wound yet. She stated, "I think the nurses do the assessments daily" and stated she was responsible for the measuring of the wound.					
	DON stated when a an incident report s care plan should be was responsible for and stated she wou assessments to be	on 8/11/16, at 12:19 p.m., the a skin concern was identified hould be filled out and the updated. She stated RN-A implementing that process lid have expected weekly skin completed since the initial d by the nurse practitioner on				
	Wounds, undated, or pressure ulcers dail surrounding skin, si pain is present. The initiate weekly wour	d Prevention and Treatment of directed staff to monitor by including the status of the gns of infection and whether expolicy further directed staff to and monitoring to include onset cation of wound, stage of h, depth and wound				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
	PROVIDER OR SUPPLIER  I HOME WEST	3620 PHIL		STATE, ZIP CODE WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	While the Physiciar Checklist identified beginning on 7/14/1 completing a dressi ulcer every other da assessment of the time between 7/14/describe, measure healing.  SUGGESTED MET The director of nurs staff related to the reare plans and more	ge 25 In Orders and Weekly Skin In open area to R3's buttock I 6 and while nursing staff were Ing change to R3's pressure Ing change to R3's buttock Ing change to R3's pressure Ing change to R3's pressu	2 570			
2 800	Staffing requirement Subpart 1. Staffing home must have or number of qualified registered nurses, I nursing assistants to residents at all nursing all buildings if more in all buildings if more involved. This incluand vacation replacements. This MN Requirements by:  Based on observation review the facility fastaffing for residents.	requirements. A nursing of duty at all times a sufficient nursing personnel, including icensed practical nurses, and of meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends, sements.  The is not met as evidenced on, interview and document alled to ensure adequate to receive the highest of the nursing and the potential to	2 800	See ePOC		9/21/16

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00380	B. WING	· · · · · · · · · · · · · · · · · · ·	08/1	2/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
SHOLON	M HOME WEST		LIPS PARK UIS PARK, I	WAY SOUTH MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 800	Continued From pa	ge 26	2 800				
	Findings include:  The task of sufficier OHFC (Office of He complaints to surve as well as family co site. In addition, three three additional corner See F282 failure to See F309 failure to practicable wellbeir See F312 activities See F314 pressure  Complaint number been short staff and 22 falls in a month, given late, wound a completed and resiminutes for call light.  Complaint number short of staff and repersonal cares compersonal cares compersonal cares compersonal cares compensationed." R116 pressure ulcers (Painvolving epidermis superficial and presibister, or shallow of 8/1/16, aide sheet we repositioned from 9 initial hour 36. Resimove, totally dependented.	ant staffing was triggered by an ealth Facility Complaints) by, H5574085 and H5574083, amplaints of lack of staffing on ee OHFC surveyors entered survey team to investigate inplaints. follow the care plan. provide cares for highest ing. of daily living. ulcer development.  H5574083 noted, "Facility has do as a result there have been in addition, medications were are treatments were not being dents were waiting up to 90 its to be answered."  H5574085 noted, "Facility esident, R116 was not getting inpleted, and not being in had recurrent stage 2 artial thickness skin loss, dermis, or both. The ulcer is sents clinically as an abrasion, rater), which had opened was not updated to say of ottom red and non-blanchable, rse manager. R116 was not its to 10:32 she sat, after the dent is nonverbal, unable to					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			
		00380	b. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLON	I HOME WEST		.LIPS PARK\ UIS PARK, N	NAY SOUTH NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	bed mobility, transfeat 3:40 p.m. family R136) Stated: "I knoweekends are shor lack of communicated tell the staff I see a watch for changes scratch), I come based when I ask the nothing about it, or the scratch is; shoulook? It seems like the skin checks. Che the doctor when I put thing you know he is in the hospital. Just between staff and or given concerns. Whave someone who review of the reside sites that worsened additional treatmen R136's daughter nothours before he was 8/9/16.  Grievances were recon 7/27/16, 2 Soutt consultant pharmace the following concern the dining room of two of MD-A's reside ating. Requested a twice and nothing here.	ge 27 assistance of one person for ers, and toilet use. On 8/10/16, member (F)-D (daughter of ow that people work hard, and t staffed. But there is also a cion that impacts care. When I change in my father, or to in his skin, (a bruise or ck 3 days later and it's worse, nurse working, they know they say it doesn't say where aldn't they lift up his shirt and the staff are not even doing langes don't get reported to oint them out, and the next is back on antibiotics, or back a lack of communication doctors, staff don't listen when the can come every day. " A ents chart revealed wound and required antibiotics and ts, and documentation that of the staff of changes 24 is transferred to the hospital on eviewed and revealed:  In, medical doctor (MD)-A and continue to can come every day. The continue to the hospital on eviewed and revealed:  In, medical doctor (MD)-A and continue to can continue to the hospital on eviewed and revealed:  In, medical doctor (MD)-A and continue to get a resident service during lunch today. Reported lents had concerns with not aide to get a resident juice appened. MD-A then offered auce and yogurt, which MD-A	2 800			
	fed a resident soup call light was on gre	patients, MD-A also physically . Call light audits indicated one eater than 15 minutes, two call ter than 20 minutes, two call				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.12 . 27.11	. 6. 6626		A. BUILDING:		33	
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLOM HOME WEST			.LIPS PARK UIS PARK, I	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	lights were on great call light was on great call light was on great was not requested.  On 7/25/16, spouse not getting walked to ordered, "only 1 stated Call light audits indigreater than 15 mir greater than 20 mir greater than 25 mir greater than 35 mir North had 2 LPN armanager working the NA. 3 North had 2 LPN and 6 NA. Even and 6 NA. 2 South and 3 NA. 3 North South had 1 LPN 2 North had 1 LPN, 2 NA. 3 North had 1 LPN, 2 TMA and 3 NA. 3 North had 1 RN, 2 TMA and 3 NA. 3 North had 1 RN, 2 TMA and 3 NA. 3 North had 1 RN, 1 LPN and 1 RN, 1 LPN an	ter than 25 minutes, and one eater than 45 minutes. Staffing	2 800			

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		00380	B. WING		08/1	2/2016
	SHOLOM HOME WEST 3620 PH			STATE, ZIP CODE WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	and 4 NA. 3 North 1 South had 2 LPN at LPN, 2 NA. 2 South had 1 RN and 2 NA The staff posting waren RN, LPN and NA howith changes.  On 7/11/16, spouse not knowing how to and residents were Call light audits indigreater than 15 min greater than 20 min 2 North had 2 LPN 1 TMA and 2 NA. 3 South had 1 RN, 1 2 North had 2 LPN 1 TMA, and 2 NA. 3 NA, 3 South had 2 LPN 1 TMA, and 2 NA. 3 NA, 3 South had 1 LPN ar and 2 NA. The staff number of RN, LPN updated with change Multiple complaints residents in July. On 6/13/16, R126's approached SW to another facility due plan, not meeting d gradual weight loss resident is not receit to be successful. Call lights were on gradual lights were on gradual light were on grone call light was on	I RN, 1 LPN, and 6 NA, 3 and 6 NA. Night shift: 2 North 1 had 1 RN and 2 NA. 3 North 3 South had 1 RN and 2 NA. 3 South had 1 RN and 2 NA. as incorrect for the number of burs, as it was not updated of staff properly read meal tickets, not getting their ordered diets. Cated four call lights were on outes, two call lights were on outes. On 7/11/16, Day shift: and 6 NA. 2 South had 1 LPN, North had 2 LPN and 6 NA. 3 LPN and 6 NA. Evening shift: and 6 NA, 2 South had 1 LPN, 8 North 1 RN, 2 TMA, and 5 LPN and 6 NA. Night shift: 2 2 South had 1 RN and 2 NA. 3 and 2 NA. 3 South had 1 LPN is posting was incorrect for the I and NA hours, as it was not	2 800			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLO	M HOME WEST		LIPS PARK UIS PARK, N	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	2 South had 1 LPN had 2 LPN and 5 N NA. Evening shift: 4 NA, 2 South had RN, 1 LPN and 5 N NA. Night shift: 2 N had 1 RN and 1 RN a was incorrect for th hours, as it was not On 5/29/16, Call lig lights were on great lights were on great call light were on great light were on great light were on great call light were on great call light were on great call light were on great light were on great light were on great call light were on great lights were on great call light were on great light were on great call light wa	ge 30  , 1 TMA and 2 NA. 3 North A. 3 South had 2 LPN and 4 2 North had 1 RN, 1 LPN and 2 LPN, and 3 NA. 3 North 1 A, 3 South had 2 LPN and 4 Jorth 1 LPN, 2 NA. 2 South A. 3 North had 1 RN and 1 NA. And 2 NA. The staff posting e number of RN, LPN and NA and 2 NA. The staff posting e number of RN, LPN and NA a updated with changes.  The taudits indicated seven call ter than 15 minutes, five call ter than 20 minutes, and three teater than 25 minutes.  The taudits indicated seven call ter than 20 minutes, and three teater than 25 minutes.  The taudits indicated seven call ter than 15 minutes, five call ter than 20 minutes, and three teater than 25 minutes.  The taudits indicated seven call ter than 20 minutes, and three teater than 25 minutes.  The taudits indicated seven call ter than 15 minutes, five call ter than 20 minutes, and three teater than 25 minutes.  The taudits indicated seven call ter than 20 minutes, and three teater than 25 minutes.  The taudits indicated seven call ter than 20 minutes, and three teater than 25 minutes, and three teater than 25 minutes.  The taudits indicated seven call ter than 20 minutes, and three teater than 25 minutes, and three teater than 25 minutes, and three teater than 26 minutes, and three teater than 27 minutes, and three teater than 28 minutes, five call ter than 20 minutes, and three teater than 20 minutes, and three teater than 25 minutes, five call ter than 20 minutes, and three teater than 25 minutes, five call ter than 20 minutes, and three teater than 25 minutes, and three teater than 20 minutes, and three than 20 minutes, and three teater than 20 minutes, and three teater than 20 minutes, and three teater than 20 minutes, and three than 20 minutes, and three teater than 20 minutes, and three tea	2 800			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
SHOLOM HOME WEST 3620 PHI			DRESS, CITY, S LIPS PARK\ UIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 800	NA, 2 South had 1 l2 LPN and 5 NA, 3 NA. Night shift: 2 N had 1 RN and 1 NA NA. 3 South had 1 lposting was incorre and NA hours, as it changes.  On 5/19/16, staff diddining room for 30 r from dining room for 30 r from dining room for inadequate staff on indicated one call ligminutes, and two ca 20 minutes. On 5/18 RN, 1 LPN and 6 N NA. 3 North had 2 L LPN and 5 NA. Eve and 6 NA, 2 South 3 North 2 RNS and SHIFT) NA. 3 South shift: 2 North 1 LPN LPN and 1 NA. 3 N LPN and 2 NA. The provided for that da On 5/17/16, R140, lphysical threats agaresident adjacent, le other people (no mounfounded allegatic manager meet with audits indicated two than 15 minutes, or than 20 minutes, or than 25 minutes, th than 30 minutes and	RN, 1 TMA and 2 NA. 3 North South had 1 RN, 1 LPN and 3 lorth 1 LPN, 2 NA. 2 South a 3 North had 1 LPN and 2 LPN and 2 NA. The staff of the number of RN, LPN was not updated with a minutes, and did not return or 30 minutes, was told the floor. Call light audits ght was on greater than 15 all lights were on greater than 9/16, Day shift: 2 North had 1 A. 2 South had 2 LPN and 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. 3 South had 2 LPN and 1 LPN, 1 TMA and 2 NA. 3 (SHORT 3 NA ON THIS in had 2 LPN and 5 NA. Night 1, 2 NA. 2 South had 1 RN, 1 orth had 2 NA. 3 South had 1 e staff posting was not by.  I letter from family verbal and ainst resident and visitor by earned he was already hitting ention of OHFC report made). On and response made, nurse daughter that day. Call light was on greater ne call light was on greater ree call light was on greater done call light was on greater	2 800			
	than 65 minutes (1	hour 5 minutes). On 5/17/16, ad 1 RN, 1 LPN and 6 NA. 2				

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		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLON	M HOME WEST		LLIPS PARK DUIS PARK, I	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 800	South had 1 RN, 1 LPN and 5 NA. 3 Se Evening shift: 2 North and 2 NA. 3 North 2 1 RN, 1 LPN and 3 admit. Night shift: had 1 RN and 1 NA NA. 3 South had 1 I posting was incorre NA hours, as it was On 5/9/16, R500, cobringing R500 to monot toileting/changir (recorded weight loaudits indicated two than 15 minutes, or than 30 minutes. On 2 Day shift: 2 North had 1 RN, 1 LPN and 5 NA. 3 South 1 shift: 2 North had 2 RN, 1 TMA and 2 Na and 5 NA. 3 South 1 days) and 5 NA. Ni NA. 2 South had 1 LPN and 2 NA. 3 South 1 LPN and NA hours, changes.  On 5/7/16, R146, w medication, was nowho was helping, do of investigation or rocall light audits indigreater than 15 min greater than 20 min	ge 32  TMA and 2 NA. 3 North had 2 buth had 2 LPN and 5 NA. th had 1 RN, 1 LPN (double A, 2 South had 1 RN, 1 TMA 2 LPN and 5 NA, 3 South had NA, and a note to take no 2 North 1 LPN, 2 NA. 2 South 3 North had 1 LPN and 2 LPN and 2 NA. The staff ct for the number of LPN and not updated with changes.  Implained nursing, was not eals, he had untreated pain, ng of incontinent pads as in May and June). Call light ocall lights were on greater in 5/9/16 staff was short 1 NA, ad 2 LPN and 5 NA. 2 South and 2 NA. 3 North had 2 LPN and 5 NA. Evening LPN and 6 NA, 2 South had 1 LPN and 2 LPN (1 doubled from 1 Shad 1 NA) as incorrect for the number of as it was not updated with a sit was not updated with suites, three call light was on sutes, one call light was on sutes.	2 800			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00380	B. WING		08/	12/2016	
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
SHOLOM HOME WEST		LLIPS PARKV DUIS PARK, N				
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
greater than 35 m Day shift was sho had 2 LPN and 5 TMA and 2 NA. 3 South had 1 LPN, 2 North had 2 LPI 1 TMA, and 2 NA. 5 NA. 3 South had shift: 1 LPN, 2 NA 3 North had 1 LPI and 2 NA. The sta number of RN hor changes.  On 8/8/16, at 5:30 and asked staff w positions. At 5:40 been a huge turn these were some staffing had been one wing	inutes and one call light was on inutes. The staffing 5/7/16, on it 1 NA for 2 North day shift, and NA. 2 South had 1 LPN and 1 N had 2 LPN and 5 NA. 3 2 TMA and 4 NA. Evening shift: N and 5 NA. 2 South had 1 LPN, 3 North had 1 RN, 1 LPN, and 1 RN, 1 LPN, and 1 RN, 1 LPN, and 1 RN, 1 LPN and 1 LPN and 1 LPN and 2 NA. 3 South had 1 LPN and 1 NA. I and 2 NA. 3 South had 1 LPN and 1 LPN and 2 NA. 3 South had 1 LPN and 3 South had 1 LPN and 5 NA. I was not updated with a p.m. MD-A stated there had over this summer, and assumed of the new nurses. Stated a challenge and that was why in shut down, they didn't have Grievance on 7/27/16).  p.m. the director of nursing nical services director for all of SD) were interviewed for Stated basic staffing pattern is taffing sheets. Day shift: 2 LPN and 6 NA. 2 South had 1 NA. 3 North had 2 LPN and 5 NA. 1 LPN and 5 NA. Evening shift: 1 LPN and 6 NA, 2 South had 2 NA. 3 North 2 LPN and 5 NA, 1 LPN and 3 NA. Night shift: 2 NA. 2 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 1 NA. and 2 NA. 3 South had 1 LPN and 2 NA. 3 South had 1 LPN and 2 NA. 3 South had 1 LPN and 3 NA. Night shift: 2 NA. 3 South had 1 LPN and 3 NA. Night shift: 2 NA. 3 South had 1 LPN and 3 NA. Night shift: 2 NA. 3 South had 1 LPN and 3 NA. Night shift: 3 NA. 3 South had 1 LPN and 3 NA. Night shift: 3 NA. 3 South had 1 LPN and 3 NA. Night shift:	2 800				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
	SHOLOM HOME WEST 3620 PHI			STATE, ZIP CODE WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 800	Supervisors did the in's on the off shifts Service Agencies (\$ but expected the hicompleted and SNS September 1st. The starting on 8/15/16. census, also look a recently been increabecause they had a infusions). We expeask for more help, wounds, and admits was also flexed dow.  The DCS verified siconcerns about the were divided, but no DCS stated there a in's and cannot replaround as much as load. New nurses githen leave to go to.  The annual turnove the Quality Assuran nursing (RN-LPN) woursing department 5.45%-11.67%.  The annual turnove monthly nursing de 1.92% to 10.71%. A review of the Terrindicated: 18% SNS for misconduct, 4% for some service of the short shifts and cannot replare the control of the shifts and turnove the Quality Assurant nursing (RN-LPN) would be shifted to the shifts and turnove monthly nursing de 1.92% to 10.71%. A review of the Terrindicated: 18% SNS for misconduct, 4%	staff changes and took call. Supplemental Nursing SNSA) were currently in use, ring and training to be SA nurses to be phased out by a last training class was Staffing was flexed for tracuity on TCU and have asing staffing for 2 North, a couple of IV's (intravenous et the nurse manage (NM) to we look at behaviors, IV's, as to adjust staffing. Staffing when census decreased.  Itaff had brought forward workload and how groups of in the last couple of months. The days that we have three call ace them, but we shuffle we can too even the work et one year of training and hospital jobs.  It rate which was reported at the ce (QA) meeting, for the was 82.52%, the monthly a turnover rate ranged between the safe for NA was 65.14%. The partment turnover rate ranged mination Reason report SA staff use, 13% terminated no call/no show, 3% Job terminated for performance,	2 800			

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		00380	B. WING		08/1	2/2016
				TATE, ZIP CODE VAY SOUTH IN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	When asked about above) DCS stated answering call lights "would really like less communicated here tracking and trendir patterns was probabeen by the prior nowould be a focus of The DCS stated the provided the Call Li 10/15. Stated "Resi contacting staff to call lights will be an needs will be met in Staffing interviews On 8/8/16, at 11:55 asked about staffing stated "Woo you a problem for a while here and sometime lot of residents need able to get the work the toilet and walking resident I have to whave time to do it be new management in the still bad. I can go not be done. The resident a lot better for was a problem. NAT of new staff working was coming and go about how she was	the call light waits (recorded the facility expectation for s was five minutes or less, as than 10, maybe not every well." The DCS stated and of falls and incidents for bly not done as it should have ursing leadership group, and the new nursing leadership.  The was no staffing policy, but ght System policy, reviewed dents will have a means of obtain assistance at all times. Is swered promptly. Residents in a timely manner.  The asking me this has been a here. We have 43 residents is with being a long-term unit a ded total help. We are just not a done like putting residents to a giften sometimes the ralk I will tell them I just don't ecause it's just too much. This has been doing something but on and on about this and will esidents are not getting what				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 33/1	
SHOLON	M HOME WEST			WAY SOUTH		
SAINI LO			UIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 36	2 800			
	rushed the residents through to get all the stuff done.					
	surveyor called surveyor short staffed a not getting their need 16-20 residents and but never comes. Duresidents are getting to give particular stall to give particular st	a.m. NA-T stated "I don't o say anything. We have two e census is low and when the will get more help."  a.m. NA-C approached way of 3 South unit and stated ort today again." When asked orking on replacing the staff d upset stated "we are iron d how short the unit was NA-C ed practical nurse (LPN)-A erheard in the hallway state tand why they were always unit. When approached and g NA-U stated "we are always ed in this unit and this is almost				
	asked who was ass LPN-B stated the g	a.m. when approached and signed to Group 1, 3 South roup was split right now not enough staff on the floor				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
	PROVIDER OR SUPPLIER  # HOME WEST	3620 PHII		STATE, ZIP CODE WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	and current five state according to room resident got the car "there was a misconsplit the groups. The but it is what it is."  Family members On 8/10/16, at 4:06 when asked is there member replied, "Not enough and the inefficient." FM-A furth provide is very poor thinking of finding howould be more difficient. If am conce at the nursing home there is a problem vactivities people he FM-C said, "When and does not speak not there."  Staff interviews On 8/08/16, at 2:45 when asked do you work done and state you are here, we had [aides] today. Norm five. NA-M said, "Is lot of two people as stands [mechanical up]. We might have rearrange it. I do not	ge 37  If had been assigned numbers to ensure the e they required. LPN-B stated mmunication and we had to it is is not how we like it to be p.m. family member (FM)-A e enough staff to help family o, are you kidding, there are ones they have are very rther stated "The care they r, I am sorry to say. "I am im a new place even though it cult for me to see them."  O pm family member (FM)-C rned about the amount of staff e, and their training. You know with staffing when you see the liping with the breakfast." a resident needs more help to up for themselves the care is p.m. NA-M raised eyebrows have enough staff to get your ed "it all depends, today since ave enough. We have six ally it is a good day if we have that enough, no. We have a sists for turning and EZ lift that helps a resident stand at to break up a group and out normally work this floor, so I sidents which makes it harder	2 800			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
SHOLOM HOME WEST 3620 PHII		3620 PHIL	DRESS, CITY, S LLIPS PARKV DUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 800	On 8/08/16, at 7:04 do not have enough aides but normally a split a team. Our pathey sundown, so whas to stand with the not fall. The dining on the mood."  On 8/09/16, at 8:15 practical nurse (LPI so short. Administration of enough staff to hiring fair recently be the model. This morning 3 Nor so I had to rearrang would have had to to only replace one state survey. Sometimes everything done bethe aides. The aide to the next which cacare and try really hare working to be suplan, I make sure to signs of burn out, to short staffed, that is are tired."  On 8/11/16, at 2:34 at the nursing desk stated "I have group home." NA-S stated regular group if I cate going home."  SUGGESTED MET The administrator of the survey of the sur	ge 38  p.m. LPN-H stated, "No we is staff. We should have six we have only five and have to attents have Alzheimer's and when the aide is busy the nurse is resident to ensure they do room can be crazy depending.  a.m. anonymous licensed in the staffing here is attoned the staffing here is attoned to the staff. They did have a very big but not everyone is staying. The had two people not show up ge staff. Most of the time we staff here is a they are trying to help is are rushing from one thing an cause problems. The aides are they are following the care to tell them if they are showing to take a break. When we are shard and a lot of the aides of the staff is my anot have my group I am  THOD OF CORRECTION: or director of nursing could stident care needs and	2 800			
		needs based on these needs.				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00380			08/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 337.2	
SHOLON	SHOLOM HOME WEST			WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 39	2 800			
	TIME PERIOD FOR CORRECTION: Twenty One (21) days.					
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			9/21/16
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.					
	by: Based on observati review, the facility for textured food/fluids choking/aspiration f had been identified dining observations to follow physician of	ent is not met as evidenced on, interview and record ailed to provide appropriate in order to prevent for 1 of 1 resident (R109) who as at risk reviewed during a . In addition, the facility failed orders for daily weights, for 1 ) reviewed for dialysis.		See ePOC		
	Findings include:					
	6:13 p.m. R109 was when standing at the	e was observed on 8/8/16, at sheard coughing continuously e desk. At 6:14 p.m. the yed coughing continuously, as				

Minnesota Department of Health

WIIIIII	ta Department of Tie	aitri				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00380	B. WING		08/1	2/2016
NAME OF E	PROVIDER OR SUPPLIER	CTDEET ADI	DECC CITY (	STATE, ZIP CODE		
IVAIVIL OI I	THO VIDEN ON SOLT EIEN					
SHOLON	I HOME WEST		_	WAY SOUTH		
		SAINT LO	UIS PARK, I	WN 55426		1
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		DATE
		,		DEFICIENCY)		
2 830	Continued From pa	go 40	2 830			
2 000	·		2 000			
		the same table stated				
		cover your mouth." At 6:15				
		ants (NA)-P and NA-K in the				
		to R109 coughed like that				
		o.m. when asked if the food I as noted in the meal ticket.				
		od had already been				
		added at times for example the				
	soup staff would have to add the thickener however, not for that particular meal. The pureed					
		as noted to be runny and thin.				
		continued to cough with each				
		A-P stood up and asked R109				
		at all his food. At 6:23 p.m.				
		n. Staff were still standing				
		t 6:24 p.m. the resident				
	coughed again afte	r a bite of the runny pureed				
		nd was observed hold his head				
		109 if he was having a				
		lent would nod. At 6:25 p.m.				
		o you think I should give him				
		another NA came into the				
		A-P requested her to wheel				
	resident out of the o					
	•	ent observed at the nursing				
		g loud and holding his head.				
	his room and was s	red R109 had been moved into				
	Tils Tootti attu was s	till Cough.				
	On 8/8/16 at 6:39 r	o.m. the nutritional service				
		ated the cook who had cooked				
		ft for the night. When asked if				
	_	th what had been added to the				
		09, NSM stated she would not				
		nad been added to the food				
		ht to the floor for the pureed				
		ISM to see if they would				
		that time. NSM called the				
		all the cook added one to two				

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scoops of thickener to all pureed food.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLO	M HOME WEST		.LIPS PARK\ UIS PARK, N	NAY SOUTH NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	-At 6:59 p.m. regist approached stated working on residen was appropriate an pureed and liquids consistency. RN-B aspiration pneumor patch to decrease s Mucinex (used to reand loosen mucus RN-B verified the 7 add two teaspoons had signed off on it ticket the three paccoffee, juice and so was to alert staff of -At 7:18 p.m. approassisting R109 with had watched the traserved and when s and she had not se (LPN)-C add thicke indicated.  On 8/9/16, at 9:16 a served into a divide of the steam table. plate at that time. A remained in the sar took the sippy cups (which were alread consistency) and a each of the 4 ounce back and set them table. As NA-F was came into the nouri said a word. No this pureed food at that -At 9:39 a.m. when	ered nurse (RN)-B the nurse practitioner was t diet order to determine if it d at that time the food was were supposed to be honey stated R109 had a history of nia, and currently was on a secretions and was on elieve the symptoms of cough in the chest). At 7:06 p.m. /29/16, which directed staff to of thickener stated the nurse . RN-B stated on the meal kets of thickener were for the oup if he needed them and that what the resident needed. ached NA-P who had been the eating and she stated she ay from when it had been the started to assist resident en the licensed practical nurse ner to the food as LPN-C had  a.m. observed R109's food ad plate covered and sat on top No thickener was added to at 9:18 a.m. the plate of food one spot. At 9:33 a.m. NA-F of cranberry juice and water y honey thickened dded a packet of thickener to be cups, then brought them on the tray on top of the steam on mixing the thickener LPN-C shment center and left never ockener was added to the	2 830			

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
7.1.12 . 2.1.			A. BUILDING:	<del></del> _		
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLO	M HOME WEST		LIPS PARK UIS PARK, N	NAY SOUTH NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	the liquids came all indicated he poured took care of the rest thickener to the bey-At 10:04 a.m. NA-I grabbed the tray ar center. NA-F stated resident and was wat 10:07 a.m. NA-I the door went in with protector, pulled a control that the food. When appeaded thickener to not. NA-F was then quick bite when surfier before the second stated she was not supposed to be additionally that was on NA-F walked out of heard coughing.  At 10:13 a.m. NA-I who looked at the resident he nurse additionally and NA-F in room. added the thickener another room doing directed NA-F to accomply a second control that the NA-F. LPN verification.	ready pre-thickened. He is the beverages and nursing it if they needed to add more verages.  Went to the dining room and went into the nourishment if she was going to assist farming the food.  Went to R109's room door at the the tray, applied the clothing chair next to R109 and mixed proached and asked if she had the food NA-F stated she had observed give resident one everyor intervened and stopped and bite at 10:10 a.m. NA-F aware resident food was ded more thickener and analy the fluids which she had. As the room, the resident was  went to room with the RN-B meal ticket and looked at the food consistency was good indicated to RN-B she had not a thickener to the food.  We back to room found LPN-C LPN-C verified she had not a dressing change. LPN-C did two teaspoons to the masked if the NA-F had been a sked if the NA-F had been a sked if the NA-F had been a sked if the order was dated was a regular staff was not posed to add the thickener to	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
	PROVIDER OR SUPPLIER	3620 PHIL		NAY SOUTH  NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	assignment sheet of the two teaspoons of to the food. RN-B so to implement the dosure the orders wern nursing assistants.  R109's nutrition Cardated 11/5/15, indicated 11/5/16, indicat	updated 8/8/16, did not have order for thickener to be added tated he expected the nurses octors' orders and to make re communicated to the re Area Assessment (CAA) rated the resident was on a didet, had dysphagia, was not have dentures. CAA ret had been downgraded to hickened liquids but continued cough which may or may not rely Minimum Data Set (MDS) rated resident required resistance of one staff with region choking during meals or redications and was on a didet. In addition the MDS rad a diagnoses of dysphagia. The resident was at high risk irratory infectious due to the readed and honey thick liquids. Physician order dated aff to "add 2 teaspoons of diet three times a day [TID] regions. Resident should be up that all times."	2 830			
		its indicated R109 was on a				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DAT			SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE	1 00,1	
SHOLON	I HOME WEST		LIPS PARK UIS PARK, I	WAY SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 44		2 830			
	plan of care did not indicated two teaspoons of thickener were supposed to be added to the food three times daily.					
	had potential for nu diagnoses of intelle control, and dyspha resident continued to with and without into and honey thickene directed staff to "Ac	ated 8/9/16, indicated resident trition related concerns ctual disability, impulse gia. The care plan indicated to have coughing episodes ake and was on pureed diet ad liquids. The care plan ld 2 teaspoons of thicken et TID during meals per				
	stated she had work when the order had had not been able the update the meal tick orders were part of acknowledged the complemented since order. RD further st	p.m. registered dietician (RD) ked the kitchen the Friday been obtained 7/29/16, and o update the care plan and ket. RD stated physician the resident plan of care and order should have been nursing was aware of the ated the new order was a trial ghing resident had with				
	(DON) stated she w	a.m. the director of nursing yould expect communication to ers and staff was to follow all				
	hypertension and e (ESRD) obtained fro 6/6/16. In addition to received dialysis.	ncluded heart failure, nd stage renal disease om the 14 day MDS dated he MDS indicated R180 p.m. when approached and				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION		E SURVEY PLETED
		00380	B. WING		08/	12/2016
	PROVIDER OR SUPPLIER  M HOME WEST	3620 PHI	DRESS, CITY, S' LLIPS PARKW DUIS PARK, M	AY SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	asked how dialysis everything was goir increased weight weating well at the tirthe facility. When a restriction resident diet and did not have surveyor noted two night stand next to  On 8/11/16, at 9:10 observed resident stated he had eater was observed to have and lower extremiticasked how he had sknow am a little puff weight gain of more pounds per week." dated 6/30/16, directed "During review of the following weights we to months:  -May 5/19/16, 5/27/-June 6/1/16, 6/30/16 -July 7/1/16, 7/2/16 7/8/16, 7/9/16, 7/12 -August 8/2/16, 8/3 8/7/16, 8/8/16, 8/9/-During review of the Administration Recaugust 2016, it was been documented in	was going R180 stated ng well. R180 stated he had hich was good as he was not me he had been admitted to sked about the diet and fluid stated he was on a regular re a fluid restrictions as glasses of water on top of the bed.  a.m. went to resident room seated at edge of bed. R180 in breakfast in his room. R180 are slight edema on the face es and appeared tired. When slept resident stated well "I fy."  scharge Summaries dated Daily weights: Call provider for e than 2 pounds per day or 5. In addition Physician Orders betted the same.  The vital signs weight section the ere noted missing according according (16, 5/28/16.)  The first signs weight section the ere noted missing according (16, 5/28/16, 7/15/16, 7/16/16, 7/11/16, 7/15/16, 7/16/16, 7/15/16, 7/16/16, 7/11/16, 7/15/16, 7/16/16, 7/15/16, 7/16/16, 7/11/16, 7/15/16, 7/16/16, 7/11/16, 7/15/16, 8/6/	2 830			

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D MINO	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
00380 B. WING 08/12/20		08/12/2016
NAME OF PROVIDER OR SUPPLIER  SHOLOM HOME WEST  STREET ADDRESS, CITY, STATE, ZIP CODE  3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(EACH DEFICIENCY MU	ILD BE COMPLETE
2 830  Continued From page 46  was revealed the weights had not been documented there either.  R180's nutrition CAA dated 5/26/16, indicated resident had a significant weight loss over the past 180 day period and the weight loss was attributed to fluid status changes that were planned with dialysis, however also with decreased intake prior to and during the hospitalization, which resulted in weight loss below dry weight. CAA indicated the possible complications of significant weight loss of both fluid and actual mass loss include skin breakdown, higher risk for infection, depression, edema, cardiac/kidney strain, altered labs and death.  R180's undated care plan indicated resident was on dialysis and identified resident was at risk for shortness of breath (SOB), chest pain, edema and elevated blood pressure. The care plan directed staff to monitor and follow the physician orders.  The 2 North Group 8 Plan of Care updated 8/11/16, directed staff to do a daily weight.  On 8/11/16, at 3:31 p.m. RN-B verified resident had an order for daily weights in the physician orders. RN-B then reviewed the vital signs tab and verified there were a lot of missing weights in the computer. RN-B stated he was going to check in the both the medication and treatment administration records on the nurses carts to see if the staff was recording the weights in there.  -At 3:39 p.m. RN-B approached stated he had checked and found "they are not recording them." RN-B stated he would expect the nursing assistant to get the weights daily in the morning	was revealed the weig documented there eith R180's nutrition CAA oresident had a signific past 180 day period at attributed to fluid state planned with dialysis, decreased intake prior hospitalization, which below dry weight. CAA complications of signiffluid and actual mass breakdown, higher rist edema, cardiac/kidney death.  R180's undated care pon dialysis and identifishortness of breath (Sand elevated blood prodirected staff to monitorders.  The 2 North Group 8 R8/11/16, directed staff On 8/11/16, at 3:31 puhad an order for daily orders. RN-B then revand verified there were the computer. RN-B sin the both the medical administration records if the staff was recording	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		00380	B. WING		08/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLOM	I HOME WEST		.LIPS PARK\ UIS PARK, I	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 47	2 830			
	would populate to Matrix. RN-B further stated he would expect the nurses to check daily to make sure the weights were done.					
		a.m. the DON stated she aff to follow the physician				
	the primary doctor's expect the care cer orders but thought have not been weig appointments or dia documented why the	a.m. via telephone the RN to social clinic stated she would after to follow the physician the resident sometimes may shed due to other medical alysis days which was not see weights had not been dent medical record.				
	DON or her designed procedures regarding the use of tickener her designee could and procedures. The	THOD OF CORRECTION: The ee could develop polices and ng assessing and monitoring for foods/fluids. The DON or educate staff on the policies ne DON or her designee could ng system to ensue residents riate care.				
	TIME FRAME FOR (21) Days.	CORRECTION: Twenty One				
2 850	MN Rule 4658.0520 Proper Nursing Car	O Subp. 2 D Adequate and re; Shaving	2 850			9/21/16
	proper care. The cadequate and proper D. Assistance	or determining adequate and criteria for determining er care include: with or supervision of shaving necessary to keep them clean				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 100			SURVEY LETED	
7.1.12 1 27.11	0. 0020		A. BUILDING:	:		
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	M HOME WEST			WAY SOUTH		
3110201	ITTOME WEST	SAINT LO	UIS PARK, I	MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 850	Continued From pa	ge 48	2 850			
	by: Based on observati review, the facility for 3 residents (R110)	ent is not met as evidenced ons, interview and document ailed to provide grooming for 1 6) who was dependent for ing (ADL) reviewed for ADL.		See ePOC		
	Findings include:					
	seated on the Brod Observed resident	o.m. resident was observed a wheelchair in the DR. with multiple white facial hairs inch long on the lower chin				
	visit to the unit residuhe	a.m. during another random dent was observed on her the dining room across from with eyes closed and still acial hairs.				
	sleep eyes closed Is behind back. Resid facial hairsAt 8:36 a.m. nursin observed reposition going to get anothe back in later to get -At 8:52 a.m. to 9:2 were observed provincluded oral cares however never acknowever never acknowever never acknown the visible I -At 10:32 a.m. licen was observed whee Broda chair to the back the right side and to	a.m. resident was observed a ying on her right side pillow ent remained to have the ag assistant (NA)- A was a resident stated she was a resident up and would come resident ready for the day. 9 a.m. both NA-A and NA-U vide morning care, which and washing resident up nowledged or offered to ong white facial hairs. I seed practical nurse (LPN)-B el resident to room, tilted back then turned resident to ucked a pillow under. During N-B looked at resident face				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		00380	B. WING	····	08/1	2/2016
NAME OF PROVI	DER OR SUPPLIER			STATE, ZIP CODE		
SHOLOM HOM	ME WEST		LIPS PARK UIS PARK, N	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
but hairs On a resident all company were feet room sever resident facial short and company were feet room sever resident facial short and company were feet room sever resident facial short and company feet facial short facial	8/10/16, at 10:5 dent had late on heimer's disease ares and was not a chair at the day way. At 9:16 am facial hair visileral staff by the dent was seated al hairs.  10:27 a.m. NA-Lyiding resident control of the seated because the tresident had rowers/baths hower now as the une to assist with control of the seated because the tresident had rowers/baths hower now as the une to assist with control of the seated because the tresident had rowers/baths hower now as the une to assist with control of the seated because the tresident with cares, are one of the seated resident with cares, are one of the seated resident residen	dged to remove the facial  1 a.m. the RN-E stated a set progression of e, was dependent on staff for on-verbal.  a.m. was observed on the lining table dressed for the shed the white facial hairs e and visible from standing 20 a.m. resident still in the dining ble from standing 20 feet steam table close to the table d none offered to remove the  J stated she had completed ares for that morningA stated "[R116] was shower today." LPN-A he unit had been working not received her shower yet. d due to insufficient staff, not get there scheduled ever thought it was getting nit had been added a sixth ares.  p.m. LPN-A verified the long resident lower chin area. shed resident chin and stated sed to have removed it for LPN-A stated she was going staff remove it and thought dents in the unit who needed we the facial hairs. LPN-A ent had received shower after aff had come in early to assist	2 850			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) DATE  COMF			SURVEY LETED	
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLON	I HOME WEST		LLIPS PARK\ DUIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 850	Continued From pa	ge 50	2 850			
	thrive and osteopor Minimum Data Set indicated resident h cognition and requil dependence of one daily living which inc and transfers.	e weakness, anxiety, failure to osis obtained from the annual dated 5/31/16. The MDS ad severely impaired red extensive to total to two staff on all activities of cluded bed mobility, toilet use				
	dated 5/31/16, indic pressure ulcer relat	cer Care Area Assessment cated resident was at risk for ed to impaired mobility, el incontinence. CAA directed cares.				
	6/11/16, indicated ruin self-care ability, rudressing/grooming/to advanced demendisturbance. The ca	bathing and oral care related ntia with behavioral are plan directed staff for e assist of one with combing				
		y Bath List dated 8/8/16, vas scheduled to get a bath on				
	unit manager stated automatically remove	ved the facial hairs "You think." RN further stated staff was				
	stated she would excare, to reposition t	a.m. the director of nursing xpect staff to follow the plan of imely and assist a resident to airs with cares "it's a dignity				

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	` '		X3) DATE SURVEY COMPLETED	
7.1.12 . 27.1.1	o. oo2011011		A. BUILDING:	<del></del>			
		00380	B. WING		08/1	2/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
SHOLOM	I HOME WEST		.LIPS PARK' UIS PARK, I	WAY SOUTH MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 850	Continued From pa	ge 51	2 850				
	thing."						
	director of nursing ( in-service all staff o living (such as shave	THOD OF CORRECTION: The (DON) or designee could in performing activities of daily ving) for residents. Also the or designee could monitor for					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			9/21/16	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which					
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and					
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent yeloping.					
	by: Based on observati review, the facility fa interventions to pre	ent is not met as evidenced on, interview and document ailed to implement vent skin breakdown for 4 of 5 , R28, R116) reviewed for		See ePOC			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
NAME OF PRO	VIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLOM H	OME WEST		.LIPS PARK\ UIS PARK, N	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
pr R3 pr inv subli Fi R3 the at Distribution or Di R3 iso bu sit ar ce we the inc (N co bla re to	and R24 who de ressure ulcers (par volving epidermis, uperficial and presister, or shallow crandings include:  24 did not have a re registered nurse 3:50 p.m.  uring an interview ated he had pain. uttocks and stated in it.  uring an observative and to the continuation of the right and left in the chial tuberosity is attocks that bears atting) were noted the chial tuberosity is attocks that bears are approximately eleft side and approximately interest eleft side and for extensive a continence. The quality interest eleft extensive a continence and for extensive	is resulted in actual harm for eveloped multiple stage II rtial thickness skin loss dermis, or both. The ulcer is ents clinically as an abrasion,	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		3) DATE SURVEY COMPLETED  08/12/2016	
		00380	B. WING		08/1	2/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
SHOLO	M HOME WEST		.LIPS PARK\ UIS PARK, N	WAY SOUTH MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	incontinence episod skin. The care plan alteration in skin into observe for change licensed staff and a done by licensed staff and a review of R24's T8/1/16 through 8/31 - Reposition patient displace weight on - Skin assessment - Apply barrier ointrivice daily with care A review of facility of Checklist indicated right shin on 8/6/16 alteration to his but Checklist for July 20 entire month.  A review of a Sholo Progress Note date indicated R3 "has sareas on right and I of pressure ulcers.  A facility document undated indicated Foreakdown in the salay R24 down in beauty of pain in his bottom on it. She stated it on the stated it on the stated it on the stated it on the stated she up the stated	de and observe condition of further identified risk for egrity and directed staff to s in skin and report to weekly skin assessment aff.  reatment Flowsheet dated /16, indicated the following: every two hours in order to sacral/coccyx area. weekly on bath day. nent to sacral coccyx area	2 900				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00380 B. WING			08/12/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	I HOME WEST		LIPS PARK\ DUIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 54	2 900			
		on 8/11/16, at 2:42 p.m., R24 ore on his bottom on and off				
	RN-B stated he was alteration to the skin nurses should be por for R24. He stated to anything that was nursessment. However, skin assessments pully even though Rights bottom for a year interview on 8/11/16 described R24's borbuttock, moving to the skin assessment of the skin and the skin assessment of the skin assessmen	on 8/11/16, at 8:54 a.m., as not aware R24 had an on his bottom. He stated the erforming skin checks weekly the nurses should be reporting of noted on a previous ever, there was no evidence of performed during the month of 24 stated he had the sore on ar. During a subsequent as a subsequent as "breakdown of left the right." He stated it looked afing" and stated the skin had				
	director of nursing ( checks should have She stated RN-B sh pressure ulcers on comprehensively re R24 developed five and the facility did n necessary treatmen	on 8/11/16, at 12:29 p.m. the DON) stated weekly skin been completed for R24. Hould have been aware of the R24's bottom. R24 was not r-assessed for skin integrity as open areas on the buttocks not ensure R24 received the at and services to promote the new sores from developing.				
	at 7:12 a.m., per RN unaware of any alte stated she was goir RN-A stated she ha open area present of	ny skin alterations on 8/9/16, N-A. RN-A stated she was trations to R3's skin. She ng to look at it. At 7:28 a.m., d looked at buttocks had an on his right buttock and was as a stage I pressure ulcer				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/12/2016	
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/1	2/2010
				WAY SOUTH		
SHOLON	I HOME WEST	SAINT LO	UIS PARK, N	MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 55	2 900			
	heralding lesion of swith darker skin, dis	ythema of intact skin, the skin ulceration. In individuals scoloration of the skin, duration, or hardness may also				
	licensed practical n completed a dressi R3's right and left is and excoriated with RN-B described the redness and three s LPN-A stated the w	ion on 8/11/16, at 7:23 a.m., urse (LPN)-A and RN-A ng change to R3's buttocks. schial tuberosity 's were red three separate open areas. e area as having "lots of stage II pressure ulcers." ound had gotten bigger and er dressing than it had				
	A review of Sholom Home West Resident Progress Notes dated 2/12/16 through 8/11/16, identified a history of open areas to R3's buttocks beginning on 2/16/16. (Identified as a stage II pressure ulcer on 2/23/16.)					
	cognitively intact, re for bed mobility, tra frequently incontine care area assessm	ated 6/30/16, indicated he was equired extensive assistance nsfers and toileting and was ent of bowel and bladder. A ent dated 6/30/16, identified a ure ulcer due to a history of				
	mobility and directe mobility, transfers a was updated on 8/1 on his left buttock n (centimeters) x 1.5 Sholom Home Wes dated 8/11/16, indice	d 8/5/16, identified impaired d staff to assist with bed and toileting. R3's care plan 1/16, to include an open area neasuring 1.5 cm cm. However, a review of at Resident Progress Notes eated: message left for nurseing the "two open areas (1.2)				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		00380	B. WING		08/1	2/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SHOLOM HOME WEST			.LIPS PARK\ UIS PARK, N	WAY SOUTH MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 56	2 900				
	Further, during obs	sident's (R3's) left buttock. ervation on 8/11/16, at 7:23 open areas on his buttocks.					
	Order Report dated indicated on 7/14/10 the following order: with normal saline, skin, cover with Alle	rolom Home West Physician 17/22/16 through 8/22/16, 6, the nurse practitioner wrote Left buttock ulcer- cleanse apply skin prep to surrounding evyn border (Allevyn Border is Iressing), change every other					
		titled weekly skin checklist tified an open area on R3's left					
	Checklist identified beginning on 7/14/1 assessment of the time between 7/14/	an Orders and Weekly Skin an open area to R3's buttock 6, there was no evidence an wound was completed at any 16 and 8/11/16, to stage, or track progress toward					
	LPN-A stated she w R3's buttocks. She saw him in July and	on 8/10/16, at 1:01 p.m., vas aware of the open area to stated the nurse practitioner I found the area. LPN-A further lems with his bottom in the					
	days after RN-A wa ulcer on R3's buttoo assessed the woun nurses do the asse	on 8/11/16, at 7:02 a.m., two s made aware of the pressure ck, RN-A stated she had not d yet. She stated, "I think the ssments daily" and stated she the measuring of the wound.					
	During an interview	on 8/11/16, at 12:19 p.m., the					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
1		00380	B. WING		08/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLON	I HOME WEST		LIPS PARK UIS PARK, I	WAY SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 57	2 900			
	an incident report s care plan should be was responsible for and stated she wou assessments to be	a skin concern was identified hould be filled out and the updated. She stated RN-A implementing that process lid have expected weekly skin completed since the initial d by the nurse practitioner on				
	R28's quarterly MDS dated 6/23/16, indicated she was moderately cognitively impaired, frequently incontinent of bowel and bladder and required extensive assistance of two staff for bed mobility, toileting and transfers. R28's care plan dated 7/31/16, indicated she required assistance using a mechanical stand to transfer related to osteoarthritis and neuropathy. The care plan further identified a pressure ulcer to R28's right buttocks and directed staff to monitor weekly, reposition with pillows and provide a pressure relieving cushion in wheel chair. A facility document titled 2 North-Plan of Care, undated directed staff to "be diligent with turning and repositioning" but did not identify a frequency. Prior to inquiry by surveyor, the care plan reflected every hour repositioning based on tissue tolerance tests.					
	dated 7/29/16, indic pressure ulcer pressure ulcer pressure state of the pressure ulcer pressure at the pressure of the pressu	est Resident Progress Noted cated R28 had a stage II ent on her right buttock.  Observation on 8/10/16, at seated in a standard wheel on the seat. At 8:58 a.m., ed in the wheel chair in the 6 a.m., Staff escorted R28 to be remained seated in her chair g until 10:07 a.m. At that time				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		00380	B. WING		08/12/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/1	2/2010
SHOLON	M HOME WEST			WAY SOUTH		
SAINI LO		UIS PARK, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 58	2 900			
	R28 had been seated in her wheel chair for two hours and one minute.					
	NA-Q stated she kr two hours and state a.m. However, R28 room at 8:30 a.m. a At 10:24 a.m., NA-C beauty shop and ha At that time, R28 ha two hours and 18 m During an interview registered nurse (R completed the asse and he updated the -Plan of Care). RN directed staff to rep should be reflected	on 8/10/16, at 10:15 a.m., nows to reposition R28 every ed it was last done around 8:30 was seated in the dining and had not been repositioned. It is stated R28 had left for the ad still not been repositioned. It is a still not been repositioning.  On 8/10/16, at 10:11 a.m., N)-B stated another staff resonants and the care plans are care sheets (the 2 North B stated if the care plan osition R28 every hour it on the care sheet and staff ning her every hour.				
	DON stated R28 sh every hour as direct further indicated the	on 8/11/6, at 12:26 p.m., the nould have been repositioned ted by the care plan. She e care sheets should indicate a the nursing assistants.				
	R116 was lying in b lying on her right side of the night stand w (provide comfortable sensitive skin that respective to the respective sensitive skin that respective she was going to going to leave R116 minutes.	d on 8/10/16, at 6:53 a.m. ed with their eyes closed and de pillow behind back. On top were two Posey sleeves e protection for fragile or may bruise or tear easily). ved NA-U go to room stated et resident dressed but was and would be back in 45 ved NA-U reviewing the				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  SHOLOM HOME WEST  3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	A. BUILDING: COMPLETED	(X2) MULTIPL A. BUILDING:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	
NAME OF PROVIDER OR SUPPLIER  SHOLOM HOME WEST  SHOLOM HOME WEST  STREET ADDRESS, CITY, STATE, ZIP CODE  3620 PHILLIPS PARKWAY SOUTH  SAINT LOUIS PARK, MN 55426					
SHOLOM HOME WEST  3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426	B. WING 08/12/2016	B. WING	00380		
SHOLOM HOME WEST SAINT LOUIS PARK, MN 55426	ET ADDRESS, CITY, STATE, ZIP CODE	DRESS, CITY,	STREET ADI	PROVIDER OR SUPPLIER	NAME OF
SAINT LOUIS PARK, MN 55426				M HOME WEST	SHOLON
(X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION   (X5)		UIS PARK, I			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	PREFIX	MUST BE PRECEDED BY FULL	(EACH DEFICIENCY	
2 900 Continued From page 59 2 900	2 900	2 900	ge 59	Continued From pa	2 900
assignment sheet with NA-A outside resident room never heard discuss the last time R116 had been repositioned. When approached and asked about resident NA-A stated she was not a regular staff in the unit however was going to get resident up shortly. NA-A further stated because she did not know residents in the unit she would follow the care plan.  -At 7:19 a.m. NA-A was observed go to room with linen stated she was not getting resident up but was just getting what she would need ready. NA-A never repositioned resident and left the room shortly.  -At 7:27 a.m. resident asleep still observed wearing the arm sleeves on both arms still lying on her back to the right side. No activity to room until 8:28 a.m.  -At 8:29 a.m. LPN-A stated she had informed NA-A that R116 was supposed to be repositioned every hour. When asked when resident had been last repositioned LPN-A stated she had go to to the unit since 6:30 a.m. and did not know when resident had last been repositioned. LPN-A stated resident had an open area which was improving however, the area was a recurring one in the same area.  -At 8:32 a.m. both NA-A and LPN-A were observed provide pericare and repositioned R116. During the observation R115's bottom appeared red and non-blanchable. The area on the tail of the coccyx was observed covered with a thick layer of cream. LPN-A wiped the area and a scabbed area was observed. LPN-A stated the bottom was red and non-blanchable because resident skin was so fragile. LPN-A verified the left heel boot was not on. At 8:36 a.m. NA-A stated LPN-A had informed her resident was supposed to be repositioned hourly however when she looked at the NA assignment sheet it	anad keed ular dent id viewith ut.  Ing med een the ated are ated ang in the ated are at a ten at a ten ated are at a ten at a te		with NA-A outside resident liscuss the last time R116 had When approached and asked A stated she was not a regular ever was going to get resident ther stated because she did in the unit she would follow was observed go to room with so not getting resident up but at she would need ready, oned resident and left the ent asleep still observed seves on both arms still lying ight side. No activity to room A stated she had informed as supposed to be repositioned asked when resident had been PN-A stated she had got to the and did not know when sen repositioned. LPN-A stated en area which was improving was a recurring one in the NA-A and LPN-A were ericare and repositioned R116. Sion R116's bottom appeared able. The area on the tail of erved covered with a thick I-A wiped the area and a observed. LPN-A stated the I non-blanchable because of fragile. LPN-A verified the ot on. At 8:36 a.m. NA-A informed her resident was ositioned hourly however	assignment sheet or room never heard of been repositioned. about resident NA-A staff in the unit how up shortly. NA-A fur not know residents the care plan.  -At 7:19 a.m. NA-A linen stated she was just getting who NA-A never reposition room shortly.  -At 7:27 a.m. reside wearing the arm sle on her back to the runtil 8:28 a.m.  -At 8:29 a.m. LPN-A NA-A that R116 was every hour. When a last repositioned LF unit since 6:30 a.m. resident had last be resident had an open however, the area was ame area.  -At 8:32 a.m. both Nobserved provide puring the observar red and non-blanch the coccyx was obslayer of cream. LPN scabbed area was bottom was red and resident skin was sleft heel boot was not stated LPN-A had in supposed to be rep	2 900

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
	SHOLOM HOME WEST 3620 PH			TATE, ZIP CODE /AY SOUTH IN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	hours and because another unit later in told when resident I R116 went one hou being repositionedAt 8:45 a.m. LPN-/Derma-savers (prof sustaining damage abrasion and press breakdowns, tears were supposed to be stated it was not on was going to add it were supposed to be lotion." -At 8:50 a.m. RN-A care plan in the corskin care plan direct to side hourly when care plan was contreposition resident hourly. RN-A verifies sleeves were supposed to have a word with the On 8/10/16, at 8:52 cares were observed who during the obsileft and right never never put a pillow to prominences when On 8/10/16, at 10:3 stated she had revicare sheet and had hours and every ho stated she was goir	she had been pulled from to the shift she had not been had been repositioned last. It and 39 minutes without a verified resident feet fragile skin from caused by friction, rubbing, for that could lead to skin and splits) and Posey sleeves be on at all times. LPN-A in the treatment sheet and I'l didn't know. I thought they be off at night when staff put the nurse manager reviewed to skin and posey states and nurse manager r	2 900			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3620 PHILLIPS PARKWAY SOUTH  SAINT LOUIS PARK, MN 55426    PROVIDERS PLAN OF CORRECTION   PREFIX   FACH DEFICIENCY MINESTRE PRECEDED BY ZHILL   PREFIX   FACH DEFICIENCY MINESTRE PRECEDED BY ZHILL   PREFIX   FACH DEFICIENCY MINESTRE PRECEDED BY ZHILL   PREFIX   FACH DORRECTION OF LISO (BENTEY-PING IN PORMATION)   PREFIX TAG	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
SHOLOM HOME WEST   3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426   PROVIDER'S PLAN OF CORRECTION (AS) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACIDINA SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DATE DATE (AS) TAG (AS) (EACH CORRECTIVE ACIDINA SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DATE DATE (AS) (EACH CORRECTIVE ACIDINA SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DATE DATE (AS) (EACH CORRECTIVE ACIDINA SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DATE DATE (AS) (EACH CORRECTIVE ACIDINA SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DATE DATE (AS) (EACH CORRECTIVE ACIDINA SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D			00380	B. WING		08/1	12/2016
(X4)   D   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   TAG   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   TAG   PROVIDERS PLAN OF CORRECTION (LAS)   COMPLETE   CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   COMPLETE DATE    2 900   Continued From page 61   2 900   as this was confusing and misleading for the staff. At 10:42 a.m. LPN-A stated R116 had an open area that was pressure related as it was the same area where it had healed before. LPN-A further stated she thought it was healing well and was a stage II.  On 8/10/16, at 10:51 a.m. the RN-E stated resident had late on set progression of Alzheimer's disease, was dependent on staff for all cares and was non-verbal.  On 8/12/16, at 7:20 a.m. observed resident seated on Broda chair in front of the dining room door noted to have blue boots to both feet however did not have the pillow placed on foot rest when in Broda to protect skin as directed by the care plan.  -At 7:30 a.m. RN-A verified the pillow was not on the foot rest as directed by the care plan to protect skin breakdown.  R116's diagnoses included dementia, contracture, muscle weakness, anxiety, failure to thrive and osteoporosis obtained from the annual MDS dated 5/31/16. The MDS indicated resident had severe impaired cognition and required extensive to total dependence of one to two staff on all activities of daily living which included bed mobility, toilet use and transfers. In addition the	NAME OF	PROVIDER OR SUPPLIER					
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 900  Continued From page 61  as this was confusing and misleading for the staff. At 10:42 a.m. LPN-A stated R116 had an open area that was pressure related as it was the same area where it had healed before. LPN-A further stated she thought it was healing well and was a stage II.  On 8/10/16, at 10:51 a.m. the RN-E stated resident had late on set progression of Alzheimer's disease, was dependent on staff for all carres and was non-verbal.  On 8/12/16, at 7:20 a.m. observed resident seated on Broda chair in front of the dining room door noted to have blue boots to both feet however did not have the pillow placed on foot rest when in Broda to protect skin as directed by the care plan.  -At 7:30 a.m. RN-A verified the pillow was not on the foot rest as directed by the care plan.  R116's diagnoses included dementia, contracture, muscle weakness, anxiety, failure to thrive and osteoporosis obtained from the annual MDS dated 5/31/16. The MDS indicated resident had severe impaired cognition and required extensive to total dependence of one to two staff on all activities of daily living which included bed mobility, toilet use and transfers. In addition the	SHOLON	I HOME WEST					
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ulcers and did not have unhealed pressure area at the time of the assessment.  R116's pressure ulcer CAA dated 5/31/16, indicated resident was at risk for pressure ulcer related to impaired mobility, dementia, bowel incontinence. CAA directed staff to assist with turning and repositioning and observed skin daily with cares.	2 900	as this was confusing staff. At 10:42 a.m. open area that was same area where it further stated she the was a stage II.  On 8/10/16, at 10:5 resident had late or Alzheimer's disease all cares and was not a confused to have however did not rest as dire protect skin breakd.  R116's diagnoses in contracture, muscle thrive and osteopor MDS dated 5/31/16 had severe impaire extensive to total de on all activities of dimobility, toilet use a MDS indicated R11 ulcers and did not hat the time of the as R116's pressure ulcindicated resident we related to impaired incontinence. CAA at turning and repositions and repositions are the first that was a stage II.	ng and misleading for the LPN-A stated R116 had an pressure related as it was the had healed before. LPN-A nought it was healing well and a set progression of e, was dependent on staff for on-verbal.  a.m. observed resident air in front of the dining room blue boots to both feet we the pillow placed on foot to protect skin as directed by verified the pillow was not on cted by the care plan to own.  Included dementia, weakness, anxiety, failure to osis obtained from the annual and the complete the pillow was not on cted by the care plan to own.  Included dementia, weakness, anxiety, failure to osis obtained from the annual and the complete the pillow was not on cted by the care plan to own.  Included dementia, weakness, anxiety, failure to osis obtained from the annual and the complete th	2 900			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	M HOME WEST		LIPS PARK\ UIS PARK, N	NAY SOUTH NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 62	2 900			
	was at risk for alterdementia, incontinedependency with Aland had a chair fas bruising easy and hidrected staff "Placeresident is in BROD extremities when in side to side hourly protect bony promir Repositioning hourl (specialized wheeld extremities (Full arrextremities at all tinto apply lotion, then	ated 7/8/16, indicated resident ation in skin integrity related to ence of bowel and bladder, DLs, poor nutritional intake, t status. R116 had a history of ad fragile skin. The care plane pillow on foot rest when DA chair, elevate lower bed above level of heart. Turn while in bed, use pillows to nences when repositioning, y while in BRODA chair chair), Posey sleeves upper m) and derma-savers to lower nes, remove at bedtime [HS] is reapply. Heel blue boots on ring in bed and sitting up daily				
	and the Interdisciplifollowing were reversellowing were reversellowing were reversellowing were reversellowing were reversellowing with the mobility of the stage	ry dated 7/7/16, indicated hysical extensive assistance of lity and repositioning. hts Pressure Sore/Stasis 8/1/16, indicated R116 had a kness loss of skin layers that as an abrasion blister, or open area was on the left ured 1.5 centimeters (cm) by sment indicated resident had ulcer and directed ed but not limited to turning and use of pressure relieving				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE WAY SOUTH		
SHOLOM	I HOME WEST		UIS PARK, I			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 63	2 900			
	normal saline [NS], applied to area."	patted dry, barrier cream				
	expect staff to have	a.m. DON stated she would repositioned resident timely, hairs and followed the plan of				
	A facility policy titled Prevention and Treatment of Wounds, undated, directed staff to monitor pressure ulcers daily including the status of the surrounding skin, signs of infection and whether pain is present. The policy further directed staff to initiate weekly wound monitoring to include onset of skin condition, location of wound, stage of wound, length, width, depth and wound characteristics.					
	director of nursing of residents at risk for they are receiving the treatment/services from developing, ar pressure ulcers. The designee could condelivery of care; to designee the treatment of	to prevent pressure ulcers and to promote healing of the director of nursing or aduct random audits of the the ensure appropriate care and the nented; to reduce the risk for				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 960	MN Rule 4658.0600 Food Quality	Subp. 1 Dietary Service -	2 960			9/21/16
		uality. Food must have taste, ance that encourages resident d.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/12/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	M HOME WEST			WAY SOUTH		
	OUR MAR DV OTA		UIS PARK, I		211	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 960	Continued From pa	ge 64	2 960			
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to provide food in an er appearance for 1 of 1 served for dining.		See ePOC		
	a.m. an unidentified hot cereal in front on R162 was awake a -At 9:10 a.m. a nurs when they placed a eggs and pureed brown and placed to sit down contents of an indiviscrambled eggs. Not eggs with jelly and put the plate with example and placed the creat opposite side of the reach. NA-E then lemixture of scramble then attempted to rewheelchair looking closed her eyesAt 9:21 a.m. NA-E moved the plate with eggs and pureed brown started feeding R16 100% (percent) of the egg and bread in R162's quarterly Mi	observation on 8/9/16, at 8:55 dinursing assistant (NA) placed of R162 out of R162's reach. Individed at the cereal. Sing assistant woke R162 up a divided plate with scrambled read in front of R162. In a assistant (NA)-E was an next to R162. NA-E put the ridual jelly packet on R162. A-E then mixed the scrambled pureed bread together. NA-E aggs and bread in front of R162 am of rice on the table on the explacemat, out of R162's aft the table. R162 tasted the end eggs pureed bread and each the cereal. R162 sat in at other residents and then as at down at the table and the mixture of scrambled read away from R162, and 62 cream of rice. R162 ate the cream of rice and 0% of mixture.				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	M HOME WEST		.LIPS PARK\ UIS PARK, N	NAY SOUTH NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 960	Continued From pa	ge 65	2 960			
	needs. R162's MDS	arely able to communicate 5 indicated R162's diagnoses s disease, and dysphagia g).				
	indicated R162 had decline from Janua goal listed on the caweight at 125 poundinstructed staff to "pmeals if res [reside some items w/[with utensils). Divided pR162's vision care R162 had impaired or identify colors. T	are plan dated 6/8/16, I dysphagia and had a weight ry 2016, to April 2016. The are plan was to maintain ds or greater. The care plan provide feeding assistance at nt] accepts. May feed self I fingers (does not like to use late at meals for pureed diet." plan revised 7/1/16, indicated vision and was unable to read the care plan instructed staff to to find food on plate at meals ed.				
	6/22/16, instructed	istant assignment sheet dated staff that R162 required assist as to be seated at a table with				
	instructed staff R16 diet, ok for regular s scrambled eggs. It pudding, ice cream between meals bed R162 four ounces of	Order Report signed 7/5/16, 32 was to be given a pureed soft breads, gefilte fish, and also instructed staff to offer or yogurt three times a day cause of weight loss. " Give of Mighty shake (a high calorie, upplement) three times a day				
	8/5/16. Highest wei	fewed from 2/19/16 through ght recorded was 130 pounds weight on 8/5/16, was 121.4				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00380	B. WING		08/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
SHOLON	I HOME WEST		LIPS PARK UIS PARK, I	NAY SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 960	Continued From page 66		2 960			
	put the food in front before you are read tray is served the we can mix the gravy who the mix them all togonomic of the mix them all togonomic of the mix all of a resident feeding them. They on 8/10/16, at 1:24 never mix a resident taught that is a digramy residents with don 8/10/16, at 1:58 does not like people finger into the food	p.m. NA-H stated "you do not "s food together before will refuse to eat it."  p.m. NA-J stated "I would ats food together. We are lity issue and I want to treat all ignity."  p.m. LPN-G stated "[R162] to feed her. She will put her and lick it off. She likes her				
	one and then all of within reach she ca her food is at the fa cannot reach it to fe have to wake her upher."  On 8/11/16, at 3:05	em separate and will eat all of the next. If you leave her food n eat most of it by herself. If r edge of the placemat she eed herself. Sometimes we p or sit with her and talk to p.m. LPN-F stated, "It is not				
	okay to mix a reside they are on a puree appeal to the reside	ent's food together, even if diet. It would most likely not ent and they would refuse to appropriate seasoning, if it is				
	(DON) stated that s resident if they wan else when they brou DON said she woul	S a.m. the director of nurses he expected staff to ask the ted salt or pepper or anything ught the food to the table. d not expect staff to place jelly unless the resident requested				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00380			08/12/2016		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	<u>,                                    </u>		
SHOLON	I HOME WEST		LIPS PARK UIS PARK, I	NAY SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 960	Continued From pa	ge 67	2 960				
	it. DON said it would not be appropriate to mix scrambled eggs and pureed bread together unless the resident requests it.						
	dietitian and food se policies and proced food palatability. Ap trained. Audits of fo conducted and resi satisfaction. The re	THOD OF CORRECTION: The ervice director could ensure lures are accurateand address propriate staff could be lood temperatures could be dents randomly interviewed for sults of the audits could be ty committee for review.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			9/21/16	
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.					
	by: Based on observati review, the facility fi glucometer machin	ent is not met as evidenced on, interview and document ailed ensure disinfecting of the e for 2 of 2 residents (R5, ed during a random		See ePOC			
	Findings include:						
	7/17/16, indicated F impaired and was r	um Data Set (MDS) dated R5 was severely cognitively arely able to communicate. If R5's diagnoses included					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLON	M HOME WEST		LLIPS PARK DUIS PARK, N	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 68	21375			
	diabetes and deme	ntia. Physicians Order Report on 5/18/16, indicated R5 was r checks done three times a				
	a.m. R5's blood suglicensed practical niglucometer (a mack sugars) while R5 with hallway across from was 86. LPN-F remiglucometer on top of	ervation on 8/09/16 at 7:20 gar (BS) was checked by urse (LPN)-F with a hine for checking blood as sitting in a wheelchair in the n the nurses desk. R5's BS loved gloves and put the of the lancets (a small sharp rawing blood) without cleaning				
	R253 Resident Face Sheet printed 8/5/16, indicated R253's diagnoses included diabetes, dementia, and history of methicillin resistant staphylococcus aureus infection (a bacterial infection that is very resistive to antibiotic treatment.) Diabetic flow sheet dated 8/5/16, indicated R253 was to have BS checks done twice a day on Monday, Wednesday, and Friday.					
	7:26 a.m. R253was hallway in front of the R253's finger with a with a lancet and the same glucomet check R5's BS and blood sugar was 11 gloves, threw the seglucometer on top of plastic caddy without Surveyor was unab checking R253's bloometer.	s observation on 8/09/16, at approached by LPN-F in the ne nurses desk. LPN-F wiped an alcohol wipe and stuck it ten checked R253's BS using er that had been used to had not been cleaned. R253's 7. LPN-F then removed piled lancet away and put the of loose lancets that were in a ut cleaning the glucometer. It is stop LPN-F before ood sugar.				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
	PROVIDER OR SUPPLIER	3620 PHIL	DRESS, CITY, S LLIPS PARKV			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	the glucometer twice individual glucometer should have offered rooms but did not a not clean glucomete.  On 8/09/2016, at 8 clean the glucometer sanitizing wipes. We well and wrap them two minutes and the on 8/09/16, at 8:15 stated "It was expected and after every glucometer was to specific product use wet time and some wet time. Staff shour esident's rooms ur on 8/12/16, at 11:0 (DON) stated, "I expugar checks privated I would expect to the to go to their room. task oriented group basics." DON further supposed to clean the glucometer clean the glucometer clean glucose for the glucometer clean glucose for the glucometer staff, "To blood-borne pathog cleaned after each suggested to the supposed to staff, "To blood-borne pathog cleaned after each suggested to the glucometer cleaned to the glucometer clean	the a shift. They are getting ers soon." LPN-F verified she did to take both residents to their and she acknowledge she did er between residents.  101 a.m. LPN-E stated, "We ers after each use with ewipe the glucometers down in a clean wipe for at least en let them air dry."  a.m. LPN-D nurse manager cted glucometers to be time they were used. A be cleaned in accordance with ed some have a two minute products have a three minute ald do blood sugars in alless the resident refused."  6 a.m. the director of nurses pect them [staff] to do blood tely not out in the main stream. em [staff] to ask the resident They [staff] have become a weneed to go back to the er stated, "The staff are the glucometer between each ordered glucometers for each were just all trained on when to ers."  Machine policy revised 07/16, prevent the transmission of tens glucometers will be	21375			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. Bolebind.			
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLO	M HOME WEST		LIPS PARK UIS PARK, N	NAY SOUTH NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 70	21375			
	patient use equipment contamination and	riate cleaning of multiple ent to prevent cross then monitor for compliance. R CORRECTION: Twenty One				
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control		21390			9/21/16
	control program muprocedures which pare collection to identify residents;  B. a system for control of outbreaks.  C. isolation and reduce risk of trans.  D. in-service exprevention and con.  E. a resident he immunization progration of resident in part 465 procedures of resident the prevention and.  F. the development of the procedures including defined in part 465.  G. a system for the products which affed disinfectants, antised incontinence products.	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
	PROVIDER OR SUPPLIER	3620 PHIL		STATE, ZIP CODE WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21390	This MN Requirement by: Based on interview facility failed to perfanalysis of infection to implement a policy pneumococcal conj of 5 residents (R50 vaccination histories potential to affect alfacility.  Findings include:  The Monthly Infection orth) unit were revitorough June 2016. resident name, type prescribed, and the resolved but did not logs were available the months of July at Monthly Infection C North) unit were revitorough April 2016. resident name, type prescribed, and the resolved. No logs word June, July and At Monthly Infection C the 2 south unit from 2016. The logs identification, the antidated the infection available from April	and document review, the orm tracking, trending and is. In addition, the facility failed by and procedure related to ugate vaccine (PCV13) for 4, R84, R153, R176) whose is were reviewed. This had the lil 145 residents residing in the logs identified the erof infection, the antibiotic dated the infection was it identify any organisms. No prior to December 2015 or for and August of 2016.  Control Logs for the 3N (3 viewed From July 2015 The logs identified the erof infection, the antibiotic dated the infection was viewed From July 2015 The logs identified the erof infection, the antibiotic dated the infection was vere available for the months	21390	See ePOC		
		m July 2015 through June				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00380		B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
SHOLOM HOME WEST			.LIPS PARK\ UIS PARK, N	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From page 72		21390			
	2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available for the months of July and August 2016.					
	During an interview on 8/12/16, at 10:31 a.m., the DON stated there was a plan in place to keep infection control logs and review the logs ongoing to determine if patterns exist. She stated the facility is currently doing spot checks and observing staff's infection control practiced across different shifts.					
	While the facility had been keeping logs to identify resident infection and illness, there was no evidence of ongoing tracking and trending past June 2016.					
		and trending of resident ested, but none was received.				
	Identified "Adults 65 have not previously have previously rec PPSV23 (pneumoc 23) should receive	ease Control and Prevention by years of age or older who received PCV13 and who eived one or more doses of occal polysaccharide vaccine a dose of PCV13. The dose of dministered at least 1 year nt PPSV23 dose.				
	the 102 year old res Pneumovax PPSV2 evidence she had b	n record, undated indicated sident received the 23 on 1/1/05. There was no been offered the PCV13 dmission to the facility on				
		record, undated, indicated				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
	PROVIDER OR SUPPLIER	3620 PHIL		STATE, ZIP CODE WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	was signed by R94 evidence she had by vaccine since her re 2/1/2016.  R153's immunization indicated the 82 year Pneumovax PPSV2 evidence she had by vaccine since her at 7/11/2016.  R176's immunization the 70 year old residence PPSV23 on 8/4/2011 had been offered the admission to the factor of high predictions are monital evidence of the pneumococcal of the pneumoc	a date. The undated record on 2/3/2012. There was no been offered the PCV13 de-admission to the facility on on record dated 7/5/2016 ar old resident received the 23 6/26/2008. There was no been offered the PCV13 dmission to the facility on on record, undated, indicated dent received the Pneumovax 1. There was no evidence she are PCV13 vaccine since his cility on 3/12/2014.  on 8/12/16, at 10:57 a.m., the nical specialist (RNCS)-A and not started implementing PCV13 at this time.  umococcal PCV13 was exceived.  THOD OF CORRECTION: sing (DON) or designee could d/or revise Infection Control e that resident and staff	21390			
21426	. , .	A.04 Subd. 3 Tuberculosis htrol	21426			9/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
SHOLO	SHOLOM HOME WEST			WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volumed the shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.	21426			
	by: Based on interview facility failed to ensituberculosis (TB) wemployees (E1, E2) Findings include: E1 started in the fathe First step TST (8/5/16. However, Eincomplete.  E2 received the first tread on 4/25/16.	ent is not met as evidenced and document review the ure employee evaluations for ere complete for 2 of 5 reviewed.  cility on 8/3/16. She received on 8/3/16 and had it read on 1's symptom screen was t step TST on 4/22/16 and had She had a second step TST 6, however there no evidence		See ePOC		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLOM	I HOME WEST		UIS PARK, N	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 75	21426			
	of the second step TST being given. The documentation lacked the name of person administering the test, date and time administered, location, tuberculin manufacturer, expiration date and lot number.					
	registered nurse (R responsible for the program. She state error and stated E the east campus ar have been complete.	on 8/12/16, at 10:11 a.m., IN)-F stated she was employee infection control d E2's documentation was her 1 started her employment on her symptom screen should ed there. RN-F stated she documentation and it got				
	The Director of Nur monitor to assure to procedures were de ensure staff was fre working with reside	eveloped and implemented to see of tuberculosis prior to nts.				
	(21) days.	R CORRECTION: Twenty-one				
21530	MN Rule 4658.1310	O A.B.C Drug Regimen Review	21530			9/21/16
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of I Health Care Finance This standard is income.	en of each resident must be conthly by a pharmacist by the Board of Pharmacy. The done in accordance with state Operations Manual, the sessions of Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. Corporated by reference. It is the Minitex interlibrary loan				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/12/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	M HOME WEST		.LIPS PARK UIS PARK, I	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21530	B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the acreport and the signi of nursing services  C. If the attend with the pharmacist not provide adequate pharmacist believes being adversely afferefer the matter to tif the medical direct physician. If the medical compustification for the ophysician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter to the must refer the matter to the compusion of the compusion	bject to frequent change.  cist must report any director of nursing services hysician, and these reports by the time of the next coner, if indicated by the proses of this part, "acted coeptance or rejection of the groin initialing by the director and the attending physician. In physician does not concur t's recommendation, or does te justification, and the sthe resident's quality of life is ected, the pharmacist must the medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality esurance committee required If the attending physician is or, the consulting pharmacist er directly to the quality esurance committee.	21530			
	by: Based on interview facility failed to act of the consultant phar	and document review, the on recommendations made by macist for 1 of 5 residents r unnecessary medications.		See ePOC		
	Findings include:					
		cian Recommendation From 7 dated 11/25/15, indicated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILBING.			
		00380	B. WING		08/1	2/2016
NAME OF PROVIDER OR SUF	PPLIER			STATE, ZIP CODE		
SHOLOM HOME WEST			.LIPS PARK\ UIS PARK, N	NAY SOUTH NN 55426		
PREFIX (EACH DEF	ICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
is an anti-psy certain menta Bipolar Disord and Divalprose manic phase bedtime for manic phase bedtime for manic phase bedtime for manic phase bedtime for manic phase behavior, repand recommenda facility.  R147's significated 5/25/16 cognitively immon symptoms  R147's care protential for a related to diagrate disord the use of psychemical sy pattern of "8 If the progress changes in bedelusion.  During an interviews medicuments of the progress changes in bedelusion.	rrently chotical/mooder) 10 ex (Divortion in the corts of	taking Quetiapine (Quetiapine medication used to treat do conditions associated with milligrams (mg) at bed time valproex is used to treat the olar disorder) 2 tablets at Bipolar Disorder. The dicated progress notes and been reporting no changes in f hallucinations or delusions a tapering of R147's Seroquels no evidence the as followed up on by the change Minimum Data Set cated she was moderately d, displayed no behaviors and pression.  Atted 8/12/16, identified a on in psychosocial well-being of Parkinson's disease and the care plan further identified opic medications, potential for ms and identified a sleep	21530			

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
SHOLOM HOME WEST			.LIPS PARK' UIS PARK, I	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 78	21530			
	SW-B stated R147 manic behaviors.	has not shown any signs of				
	registered nurse (R recommendations at the nurse practition there are new order recommendations to medication administ there was no proceed the pharmacists recommendations to the pharmacists recommendation with the pharmacists recommendation of the pharmacists recommendation usage. Suggested the pharmacists recommendation usage. Suggested the pharmacists recommendation usage. Suggested the pharmacists and proceed medication usage. Suggested the pharmacists and proceed medication usage. Suggested the pharmacists are proceeded to the pharmacists and proceeded the pharmacists and ph	hey will show up in the tration record. RN-B stated ss in place for following up on				
21665	MN Rule 4658.1400	) Physical Environment	21665			9/21/16
	functional, comforta environment, allowi	ust provide a safe, clean, able, and homelike physical ng the resident to use s to the extent possible.				
	by: Based on observati review, the facility fa	on, interview and record ailed to ensure grab bars on d for 6 of 10 residents (R29,		See ePOC		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/S		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	I HOME WEST			WAY SOUTH		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	UIS PARK, N	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
21665	Continued From pa	ge 79	21665			
	R58, R186, R101, R96, R176). This has the potential to affect 118 residents who have grab bars on their toilets.					
	Findings include:					
	R29's left grab bars affixed to the bed was observed on 8/8/16, at 2:51 p.m. during resident room observations to be loose moved three inches back and forth when touched. Resident stated she used it and noted the grab bar had been loose for a while now.					
	On 8/10/16, at 11:47 a.m. when asked about the grab bar resident again stated she had thought about letting the staff know to fix it but she always forgot something's.					
	R29's activities of daily living (ADL)/Functional Status Care Area Assessment (CAA) dated 4/16/16, indicated resident required extensive assist with bed mobility, transfers, ambulation, locomotion, dressing, toilet use and personal hygiene.					
	7/9/16, indicated re Resident diagnoses	imum Data Set (MDS) dated sident had intact cognition. included Parkinson's sis and osteoarthritis obtained dated 8/8/16.				
	had an alteration in depression, arthritis fractures. Care plar extensive assist wit feet into/out of bed ambulation using a	ed 8/8/16, indicated resident mobility related to weakness, s, history of falls and history of a directed staff to provide h bed mobility. Staff was to lift and extensive assistance with walker and transfer belt. The dicated resident used grab mobility.				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLON	M HOME WEST		.LIPS PARK\ UIS PARK, I	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	Continued From page 80		21665			
	8/9/16, indicated re The plan of care did responsible for che they were properly and they were properly and they were properly and they were properly and they work order either in access to the compto room and verified. He indicated he tho not fitting properly.  At 12:10 p.m. nurs she had not noticed asked if resident us to side when in bed the bed and during does."  At 12:18 p.m. RN-I the interim director requested the staff check if residents in in the beds. At the they are they are they had been given the bars. RN-B stated if the grab bars to material affixed to the bed from the beds if a resone grab bar and whad check the grab	signment sheet updated sident had safety grab bars. It not indicate who was cking the grab bars to ensure affixed to the bed frame.  2 a.m. registered nurse tenance fixed the grab bars. Buld expect the staff to put in a paper if they did not have buter. At 11:53 a.m. RN-B went of the left grab bar was loose. Bught it was a loose from bolts are in the loose grab bar. When seed the grab bars to turn side for when she got in and out of cares NA-O stated by the grab bars in and out of cares NA-O stated by the grab bars in her bed and to do an assessment and eeded to have the grab bars ime resident had indicated to the grab bars in her bed and risks and benefits of the grab bars in her bed and risks and benefits of the grab bars in her bed and risks and benefits of the grab bars in her bed and risks and bars in her bed and sident had asked to have only as not sure if maintenance bars to make sure they were he bed and directed the intenance staff.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	00380	B. WING		08/1	2/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHOLOM HOME WEST		LIPS PARK UIS PARK, N	NAY SOUTH NN 55426		
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
supervisor (EVS) staposition for the last of department did not he preventative routine department dependent of the preventative routine department dependent of the preventative routine department dependent of the preventative report and come and fix the grace of the preventation of the preventation of the preventation of the preventation of the left of the preventation of the preventation of the preventation of the preventation of the last possible preventation of the last preventation of the prevent	7 p.m. environmental ated he had been in his one week. He indicated his have grab bars on a routine plan to be checked and his ed on house-keeping and y concerns for his staff to ab bars. Incestaff verified the grab bar ated it was the bolts that hed up. He further stated the was supposed to be affixed me as the right side and that the residents using the grab toilet seat were observed to 15 degrees to the right and tour on 8/9/16, at 10:17 a.m.  OS dated 5/31/16, indicated intact, walked in room using vision and required assistance MDS indicated R58's congestive heart failure,	21665			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLON	I HOME WEST		.LIPS PARK\ UIS PARK, N	NAY SOUTH NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	Continued From page 82		21665			
	Progress Note dated 6/29/16, indicated R58 was independent with toileting.					
	During interview on 8/9/16, at 10:22 a.m. NA-L verified R58 used the toilet and the seat/grab bar combination are supposed to be tight and the seat should not wiggle.					
	During interview on 8/11/16, at 12:13 p.m. EVS said, "This [toilet grab bar] needs to be replaced. We need to develop a preventative program for checking this [toilet grab bar]."					
	R186's room was observed on 8/8/16, at 2:41 p.m. The grab bars on toilet seat were observed to be loose, allowing the toilet seat to move side to side. On 8/9/16, at 10:50 a.m. toilet grab bars were still loose.					
	R186's quarterly MDS dated 6/23/16, indicated R186 was severely cognitively impaired, did not walk in room, required assistance with toileting. R186's MDS indicated R186's diagnoses included osteoarthritis, and Alzheimer's disease.					
	required assistance toilet and was at ris instructed staff to a	evised 8/3/16, indicated R186 to transfer on and off the k for falls. The care plan nticipate needs for toileting, utions, and provide assist of and off the toilet.				
		ant Assignment Sheet dated taff that R186 required assist oileting.				
	verified R186 used	8/8/16, at 2:45 p.m. NA-K the toilet with staff assistance eat moving might cause a fall.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	I HOME WEST		.LIPS PARK\ UIS PARK, N	NAY SOUTH NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 83	21665			
		d telling the health unit ne loose toilet grab bars.				
	During interview on 8/11/16, at 12:17 p.m. the administrator verified the toilet grab bar was loose.					
	R101's room was observed on 8/8/16, at 5:19 p.m. and the grab bars on the toilet seat were observed to be loose, allowing the toilet seat to twist.					
	R101's MDS dated 6/1/16, indicated R101 was severely cognitively impaired, required assistance with toileting. R101's MDS indicated R101's diagnoses included hypertension, and dementia.					
	The Nursing Assistant Assignment Sheet dated 6/23/16, indicated R101 was a fall risk and instructed staff that R101 required assist with ambulation using a front wheel walker and with toileting.					
	required assistance dementia and impa for falls related to u falls. The care plan needs for toileting,	evised 7/1/16, indicated R101 with toileting related to ired mobility and was at risk insteady gait and history of instructed staff to anticipate follow safety precautions, and insfer on and off the toilet.				
		8/8/16, at 5:25 p.m. NA-N the toilet and stated, "The gle this much."				
		8/11/16, at 12:13 p.m. EVS that secured the toilet grab				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHOLO	I HOME WEST		LIPS PARK\ DUIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 84	21665			
		served on 8/8/16, at 6:13 p.m. ars on the toilet when grabbed at to twist.				
	R96 was moderatel required assistance	S dated 6/16/16, indicated y cognitively impaired, and with toileting. R96's MDS gnoses included seizure ntia.				
	The Nursing Assistant Assignment sheet dated 6/23/16, instructed staff that R96 required assist with of EZ Stand (a mechanical lift that assists a resident to come to a standing position) for transfers with toileting.					
	impaired range of n both hips and kneed with toileting related impaired sitting bala The care plan instru	ised 7/1/16, indicated R96 had notion due to contractures in s. R96 required assistance I to and cognitive changes, ance and was at risk for falls. Ucted staff to provide assist of o transfer R96 on and off the				
		8/8/16, at 6:25 p.m. NA-N ne bathroom and stated the gle this much.				
	verified toilet grab b stated he depended	8/11/16, at 12:07 p.m. EVS par and seat were loose. EVS d on nursing and to notify maintenance that a				
	p.m. The grab bars	bserved on 8/8/16, at 3:31 on toilet seat were observed g the toilet seat to twist side to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHOLON	M HOME WEST		LLIPS PARK\ DUIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 85	21665			
	side.					
	R176 was severely in room using a wal required assistance indicated R176's dia	DS dated 5/28/16, indicated cognitively impaired, walked lker with assistance and with toileting. R176's MDS agnoses included Parkinson 'ement disorder), and				
	required assistance muscle weakness a risk for falls. The ca anticipate needs for	evised 6/17/16, indicated R176 with toileting related to and Parkinson's and was at are plan instructed staff to r safety, toilet safety frame assist of one staff for toilet ce care.				
	The Nursing Assistant Assignment sheet dated 6/23/16, instructed staff that R176 required assist of two staff to transfer and reposition. Staff were to assist R176 to the bathroom upon rising, after meals, at bed time, during rounds at night and as needed.					
		8/8/16, at 3:35 p.m. NA-N the bathroom and stated the gle this much.				
	verified the toilet se	8/11/16, at 12:09 p.m. EVS eat turned 15 to 20 degrees to VS said this was a fall risk.				
	8/11/16, at 12:21 p. expect the nursing to notify maintenand loose grab bar." EV on the toilets were in	end of environmental tour on m. the EVS said, "I would assistants and housekeeping ce immediately if they saw a 'S verified that the grab bars not to be loose and that all but s observed could be fixed with				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00380	B. WING		08/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
SHOLOM	I HOME WEST		LIPS PARK UIS PARK, M	NAY SOUTH NN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	Continued From page 86		21665			
	toilet was broken at EVS stated, "If a re one hand it could m EVS stated they did	stated one grab bar on the and needed to be replaced. sident grabbed the bar with nove, causing them to slip." If not have a preventative am for checking the toilet grab				
	During interview on 8/11/16, at 4:41 p.m. the administrator stated, "We do not have a policy for reporting issues to maintenance but we do have a process, both paper and computer for staff to report things that need to be fixed. All staff can use at least one of the systems."					
	During interview on 8/12/16, at 11:06 a.m. the DON said, "I would expect the nursing assistants and nurses to report loose grab bars to maintenance."					
	The administrator a director could moni conditions periodical	THOD FOR CORRECTION: and environmental services tor the status of physical plant ally to insure that a routine in place is being effectively				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			9/21/16
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				

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	ENT OF DEFICIENCIES N OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00380	B. WING	<del></del>	08/1	2/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SHOLON	I HOME WEST		LIPS PARK OUIS PARK, I	WAY SOUTH MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21805	Continued From pa	ge 87	21805				
	by: Based on observati review, the facility fa dining experience fo	ent is not met as evidenced on, interview and record ailed to provide a dignified or 5 of 24 residents (R59, R176) who required		See ePOC			
	Findings include:						
	nusring assistant (N "she is a feeder" thr	ionon 8/8/16, at 5:46 p.m., IA)-K was heard calling out ree separate times and stated eeders." NA-K was referring					
	LPN-F was passing was referring to the while staff was pass member called out,	fon on 8/10/16, at 12:32 p.m., out clothing protectors and m as "bibs." At 12:40 p.m., sing out soup a dietary staff "make sure you give the (patients name), his soup is					
	5/17/16, indicated s impaired and requireat. The MDS further	inimum Data Set (MDS) dated the was severely cognitively red extensive assistance to er indicated R59 was only able r needs "sometimes."					
	unidentified nursing	ion on 8/9/16, at 8:55 a.m., an assistant (NA) place a bowl t of R59 but left it out of R59's					
		ion on 8/10/16, at 1:00 p.m., eat eating their soup while R59 d in front of her.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00380	B. WING		08/1	12/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
SHOLON	M HOME WEST		LLIPS PARKV DUIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 88	21805			
	was severely cognitunderstood others, understood, but was after set-up. Howe Report dated 8/2/16 R152 with eating. Timpairment to R152 During an observatia staff member placupper right hand coreach. At 12:51 p.m of her reach. She sidown. At 12:55 p.m to R152's table. At served her soup, st R152 to eat her me R152 sat at the table food in front of her. their soup. On 8/11/	S dated 5/21/16 indicated she lively impaired, rarely but could ususally be able to eat independently ver, a Physicians Order of instructed staff to assist he MDS further identified an elementary she in the manner of the table, out of R152's in, R152's soup remained out at at the table with her head at the dining room with no Her tablemates were eating at the sist of th				
	was severely cognit	eS dated 6/8/16, indicated she tively impaired, was rarely able r needs and required se to eat.				
	staff member place table, out of R162's 9:10 a.m., a staff m containing scramble front of R162. The s packet, placed it on mixed it with the pu	ion on 8/9/16, at 8:55 a.m., a d a bowl of hot cereal on the reach and walked away. At ember placed a plate ed eggs and pureed bread in staff member opened a jelly R162's scrambled eggs and reed bread and left the table. remined out of reach. R162				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
SHOLON	HOME WEST		LIPS PARK\ DUIS PARK, N	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 89	21805			
	to reach for the cre tablemates and the a.m, 26 minutes aft sat with R162 and f cereal but did not e bread.	bread mixture and attempted al. She looked at her n closed her eyes. At 9:21 er receiving her food, NA-E ed her. She ate 100% of her at the mixture of eggs and				
	During an observation on 8/10/16, at 12:38 p.m., a staff member placed a bowl of soup in front of R162. At 12:44 p.m., licensed practical nurse (LPN)-F stood behind and to the right of R162 and fed her five spoonfuls of soup and left. At 12:55 p.m., the main course was placed on the table out of R162's reach. At 1:00 p.m., NA-H lifted a chair over R162's head and sat down to feed another resident at the table. NA-H awoke R162 by speaking with her and moved the food within her reach. R162 ate 50% of her meal after it was placed within her reach.					
		OS dated 5/28/16 indicated he tively impiared and required se to eat.				
	R176 was seated a food in front of him. assisting him to eat and were eating the	ion on 8/11/16, at 8:55 a.m., t the dining room table with No staff members were . R176's tablemates had food eir meal. At 9:12 a.m., LPN-F ted R176 to eat, 17 minutes s.				
	resident's food sho	p.m., NA-I stated the uld not be place in front of eady to assist them to eat.				
		p.m., NA-H stated food front of a resident who needs				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHOLOM HOME WEST		.LIPS PARK\ UIS PARK, N	WAY SOUTH MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 90	21805			
	help for more than will get cold.	"five minutes tops" or the food				
	not like to be fed. Sher food separated time. LPN-G stated front of her she will LPN-G further state the residents as neon too long for a resident them without being a resident's who need stated "we have a left too long for the stated".	p.m., LPN-G stated R162 did he stated R162 likes to have and will eat one thing at a if R162's food is placed in eat most of it by herself. It destaff need to sit and assist eded after trays are passed.  p.m., LPN-F stated she had ed she did no how long was ent to sit with food in front of assisted. LPN-F referred to the did assistance as "Feeders" and ot of feeders." She stated 15 did be a long time to sit with your				
	(DON) stated "I dor staff in the dining ro stated she expected 15 minutes of the s residents at the sar within 30 seconds t stated staff should	6 a.m., the director of nursing n;t know if we have enough from at this time." She further d the food to be served within cheduled meal time and all me table should be served o a minute of each other. She sit down and assist the y so their food does not get				
	Resident instructed resident but dis not	policy titled Feeding A staff on how to feed a address how long a residents ront of them before assistance				
	The DON or design	HOD OF CORRECTION: lee could educate staff on The DON or designee could				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00380	B. WING		08/1	12/2016
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
SHOLOM HOME WEST			UIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 91	21805			
		ents routinely to ensure dignity and respect are being				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
22000		5.557 Subd. 14 (a)-(c) tment of Vulnerable Adults	22000			9/21/16
	facility, except hompersonal care atten establish and enformerevention plan. The assessment of the environment, and it factors which may early and a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility, agency and person providers, shall deverevention plan for residing there or reconstruction plan for residing there are the plan shall contain	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan licensing agency. Including a home health care all care attendant services elop an individual abuse each vulnerable adult ceiving services from them. In an individualized the person's susceptibility to viduals, including other (2) the person's risk of abusing ults; and (3) statements of the obe taken to minimize the tosses of this paragraph, the				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET			STATE, ZIP CODE		
SHOLOM HOME WEST			.LIPS PARK' UIS PARK, I	WAY SOUTH MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	violent crime or an toward others, the i plan must detail the minimize the risk the reasonably be experimentally and persons unsupervised. Under a vulnerable aduration misconduct or physical information from authority or through another facility, and	erable adult has committed a act of physical aggression individual abuse prevention at the vulnerable adult might exted to pose to visitors to the outside the facility, if the ler this section, a facility knows lt's history of criminal sical aggression if it receives om a law enforcement a medical record prepared by other health care provider, or grassessments of the	22000			
	by: Based on interview facility failed to ope Prohibition policy for R108), who were re (VA) reporting, and Findings include: Sholom Policy and Prohibition-Vulnera Prevention Plan revention Plan reventions are compassionate care.	Procedure Abuse ble Adult Protection/Abuse vised 6/1/16, noted: s will receive competent and e and treatment at all times. unce for maltreatment of I. Reporting and		See ePOC		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00380	B. WING		08/1	2/2016
				TATE, ZIP CODE		
SHOLON	WITHOME WEST	SAINT LO	UIS PARK, N	MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	Notification: 1. Any must be reported to (Immediately mean contact the Director Administrator and/o with the reporter an immediate reporting regulations require to the Minnesota De immediately (immediately).  R55 was admitted diagnoses of demedisturbance, major hypertension, lung of stenosis (internal nawhich may cause raand/or numbness) pusheet.  On 2/28/16, a visito a nursing assistant got you here, you a [on the toilet]." The NA-F then turned saallegedly said, "Yo incident was reported 2/28/16. NA-F during the investigation protect R55, as of the allegation of ab 2/28/16, the investigation protect R55, and Progress notes of the same contact and the same contact and the same contact R55, as of the allegation of ab 2/28/16, the investigation of ab 2/28/16, the investigation of ab 2/28/16, and we have contact R55, and the same contact R55, and the same contact R55, and the same contact R55, and R5/28/16, the investigation of ab 2/28/16, the investigation of ab 2/28/16, the investigation of ab 2/28/16, and we have contact R55, and R5/28/16, the investigation of ab 2/28/16, and we have contact R55, and R5/28/16, the investigation of ab 2/28/16, the investigation of ab 2/2	known or suspected -abuse the administrator immediately s "as soon as possible") then of Nursing. 2. The or designee will review events d determine the need for g to external agencies. b: The that facilities report incidents	22000			
	requested, but not p					

Minnesota Department of Health STATE FORM

DRM State of 
Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00380	B. WING		08/1	12/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
SHOLO	M HOME WEST		LLIPS PARKV DUIS PARK, M			
0// 15	CLIMMADV CTA	TEMENT OF DEFICIENCIES			IONI	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 94	22000			
	made to the SA on					
	director of social wo worker (SW)-B, adr nurse (RN)-B regar reporting. DSW-A s completed the initia and when asked wh not been suspende director of nursing ( the company was the report to the AS late it had been submitted facility policy for Ab followed, R55 shou suspending NA-F (to the investigation. In	3 a.m. an interview with the ork services (DSW)-A, social ministrator, and registered ding abuse and timely stated she was the person who all report for R55 on 2/28/16, my the alleged perpetrator had d, stated "good question." The (DON) who was no longer with the person who submitted the e, and DSW-A was not aware ed late. DSW-A verified the use Prohibition was not ld have been protected by the alleged perpetrator), during addition, the five day should have been submitted				
	courtyard on 8/10/1 he could speak with was a dietary aide (altercation with a could not sere eat is to get one of me my food in the 2 stated he had told to manager three more the facility's execution was told by all three no one had followed with Ombudsman a incident and was to issue but the staff no	d on first floor of facility by the 6, at 1:33 p.m. R108 asked if a writer. R108 stated that there (DA)-A who he had a verbal cuple months ago and now ve him." The only way I get to the other aides to help bring 2 north dining room." R108 he kitchen manager and nurse of the would take care of it but dup yet. R108 stated he met and other staff after the lid they would look into the nember still was not bringing stated he did not appreciate				

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		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHOLO	SHOLOM HOME WEST			WAY SOUTH MN 55426		
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22000	being ignored and f Progress notes creatindicated they were conference held on status was stable an nutrition staff was nappeared to have be miscommunication dietary aid and wou.  The administrator was concerns on 8/10/10 of the reporting doctor log and operational prohibition regarding administrator stated facility at the time whe would expect stated facility at the time whe would expect stated facility at the time when would expect stated for the would expect stated for the would expect stated for the would expect stated from there it means the staff member would not bring him had not brought him words with him and other residents.  On 8/11/16, at 9:03 had rules that dietal serve residents and when NAs or nurse occurred when R10 wanted DA-A to ser could not serve him a "jerk" and "a*******	elt singled out.  ated by RD dated 12/30/15, late entry notes from care 12/23/15. R108's nutritional nd discussed concern that ot serving him-which een related to a between nursing and the	22000			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  22000 Continued From page 96  their food which was not true as there was not a NA, licensed practical nurse or RN in the dining room at that time. Only one resident had food because her NA had brought her to the dining room and gave her cereal. Stated he explained to R108 the rule was a nurse or NA needs to be present in the dining room before food can be delivered to residents because that is the facility rule. DA-A stated his duties are to stand by the steam table, read meal tickets and put food on plates and then the NA's or nursing staff served it to the residents. DA-A stated he told his supervisor right away about R108 being upset, which was the facility policy.		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
SHOLOM HOME WEST  3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  22000  Continued From page 96  their food which was not true as there was not a NA, licensed practical nurse or RN in the dining room at that time. Only one resident had food because her NA had brought her to the dining room and gave her cereal. Stated he explained to R108 the rule was a nurse or NA needs to be present in the dining room before food can be delivered to residents because that is the facility rule. DA-A stated his duties are to stand by the steam table, read meal tickets and put food on plates and then the NA's or nursing staff served it to the residents. DA-A stated he told his supervisor right away about R108 being upset, which was the facility policy.  (X5) PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY  (EACH COR			00380	B. WING	<del></del>	08/1	2/2016
SAINT LOUIS PARK, MN 55426	NAME OF	PROVIDER OR SUPPLIER			<i>'</i>		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  22000  Continued From page 96  their food which was not true as there was not a NA, licensed practical nurse or RN in the dining room at that time. Only one resident had food because her NA had brought her to the dining room and gave her cereal. Stated he explained to R108 the rule was a nurse or NA needs to be present in the dining room before food can be delivered to residents because that is the facility rule. DA-A stated his duties are to stand by the steam table, read meal tickets and put food on plates and then the NA's or nursing staff served it to the residents. DA-A stated he told his supervisor right away about R108 being upset, which was the facility policy.	SHOLO	M HOME WEST					
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On 8/11/16, at 9:20 a.m. SW-B stated that the registered dietician (RD) at the time of the incident was no longer employed at the facility but had met with R108 on 12/10/15, regarding his concern with DA-A who would not serve him. The RD at the time of the incident sent an email to the nutrition director and food service supervisors regarding R108's concern. At the 12/23/15, care conference RD documented resident's concern which was related to miscommunication and would be resolved.  On 8/11/16, at 11:27 a.m. SS-B stated that during the care conference on 12/22/15, she was unaware of a verbal altercation but just that an aide did not serve R108 so she did not report it. The facility would have suspended staff person, investigated the incident, reported, interviewed and provided re-education. The procedure was there but staff was unaware of altercation.  On 8/11/16, at 4:23 p.m. administrator stated when he was told yesterday about R108's concerns (which was 8/10/16) that he did not	22000	their food which wa NA, licensed practic room at that time. Obecause her NA har room and gave her R108 the rule was a present in the dining delivered to resident rule. DA-A stated his team table, read many plates and then the to the residents. DA supervisor right away which was the facility on 8/11/16, at 9:20 registered dietician incident was no long had met with R108 concern with DA-A RD at the time of the nutrition director and regarding R108's conference RD door which was related to would be resolved.  On 8/11/16, at 11:21 the care conference unaware of a verbal aide did not serve Facility would he investigated the incommon and provided re-edit there but staff was some conference on 8/11/16, at 4:23 when he was told years.	s not true as there was not a cal nurse or RN in the dining only one resident had food d brought her to the dining cereal. Stated he explained to a nurse or NA needs to be groom before food can be its because that is the facility s duties are to stand by the neal tickets and put food on NA's or nursing staff served it a-A stated he told his ay about R108 being upset, ty policy.  a.m. SW-B stated that the (RD) at the time of the ger employed at the facility but on 12/10/15, regarding his who would not serve him. The e incident sent an email to the d food service supervisors oncern. At the 12/23/15, care umented resident's concern or miscommunication and  7 a.m. SS-B stated that during e on 12/22/15, she was I altercation but just that an R108 so she did not report it. ave suspended staff person, ident, reported, interviewed ucation. The procedure was unaware of altercation.				

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STATE FORM KY1C11 If continuation sheet 97 of 99

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00380	B. WING		08/1	2/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/1	2/2010
				WAY SOUTH		
SHOLOI	M HOME WEST	SAINT LO	UIS PARK, N	MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	liked to talk with the intending to talk wit to his staff and thou were credible. He was but the documentate complaint but he wowith the resident for The next step was determine if he sho 4:34 p.m. the admir complete the invest On 8/12/16, at 8:33 administrator, SS-Amet with R108 on 8 determined that DA and R108 felt that h DA-A. DA-A was su investigation. The amade the call to DA some choice words stated that an incide the Minnesota Department of the Minnesota Department o	e resident himself and he was h him. The administrator went aght their research and reports was uncertain of the timeframe ion did not substantiate the ould have liked to have met r a preliminary investigation. To talk with resident and uld report it. On 8/11/16, at histrator said he was going to digation now.  a.m. interview with a, and SS-B. SS-A stated they lightly lig	22000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
00380	B. WING		08/	12/2016
	ADDRESS, CITY, S			
I SHOLOM HOME WEST	HILLIPS PARKV LOUIS PARK, M			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
Z2000 Continued From page 98  The administrator could in-service all staff on the need to immediately reporting suspected abuse/neglect to the designated state agency/common entry point according to the facility's policy. The director of nurses' could monitor incident reports for implementation of th requirement.  TIME PERIOD FOR CORRECTION: Fourteen (14) days.		DETICIENCY)		

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