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: ZN74
Facility ID: 00496

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **09/10/2014** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Supervisor 09/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/20/2014** (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 24-5411

September 16, 2014

Ms. Ann Thole, Administrator
Shirley Chapman Sholom Home East
740 Kay Avenue
Saint Paul, Minnesota 55102

Dear Ms. Thole:

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

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

Effective September 2, 2014, the above facility is certified for:

108 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 108 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

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

*Protecting, Maintaining and Improving the Health of Minnesotans*

September 16, 2014

Ms. Ann Thole, Administrator
Shirley Chapman Sholom Home East
740 Kay Avenue
Saint Paul, Minnesota 55102

RE: Project Number S5411024

Dear Ms. Thole:

On July 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 24, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 10, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 2, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 24, 2014, effective September 2, 2014 and therefore remedies outlined in our letter to you dated July 29, 2014, 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.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

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

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245411 | A. Building<br>B. Wing | 9/10/2014 |

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

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

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix F0225<br>Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) -<br>LSC | 09/02/2014 | ID Prefix F0226<br>Reg. # 483.13(c)<br>LSC | 09/02/2014 | ID Prefix F0329<br>Reg. # 483.25(l)<br>LSC | 09/02/2014 |
| ID Prefix F0428<br>Reg. # 483.60(c)<br>LSC | 09/02/2014 | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| Reviewed By State Agency | SR/AK | 09/16/2014 | 16022 | 09/10/2014 |
| Reviewed By CMS RO | | | | |

**Followup to Survey Completed on:** 7/24/2014

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

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

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(L3) **SHIRLEY CHAPMAN SHOLOM HOME EAST**
(L4) **740 KAY AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55102**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/24/2014** (L34)

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

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

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

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

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X 1. Acceptable POC

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

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

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Vidya Tomar, HFE NE II 08/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 08/20/2014 (L20)

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

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____ 2. Facility is not Eligible
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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**02/01/1987**
(L24)

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(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

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

30. REMARKS
Posted 08/20/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7013 2250 0001 6356 5293

July 29, 2014

Mr. Timothy Meyer, Administrator
Shirley Chapman Sholom Home East
740 Kay Avenue
Saint Paul, Minnesota 55102

RE: Project Number S5411024

Dear Mr. Meyer:

On July 24, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**
>
> **<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.**

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

**DEPARTMENT CONTACT**

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

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

Telephone: (651) 201-3793
Fax: (651) 201-3790

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

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 2, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

**PLAN OF CORRECTION (PoC)**

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made

timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

**Original deficiencies not corrected**

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

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

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original

deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

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

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

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

If substantial compliance with the regulations is not verified by October 24, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 24, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

PRINTED: 07/29/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245411 | A. BUILDING ____ B. WING ____ | 07/24/2014 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS | F 000 | | |
| | The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.<br><br>Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | | | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS | F 225 | | |
| | The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged | | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245411 | A. BUILDING ______ B. WING ______ | 07/24/2014 |

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

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**F 225**

Continued From page 1

violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to immediately report allegations of misappropriation of personal property for 1 of 3 residents (R145).
Findings include:
R145's family reported missing personal property and it was not reported immediately.
Review of a "Report of Reasonable Suspicion of a Crime", was completed by the staff on 7/6/13. The report revealed that on 7/5/13 (no time given) the family reported a gold chain with a male wedding band on it was missing. There were no progress notes in the medical record for 7/5/13 and the first report was entered on 7/6/13 at 7:34 a.m. which indicated the evening nurse reported the missing gold chain and wedding band to the night nurse. The night nurse reported it to the night supervisor. The progress note indicated the supervisor and night nurse looked in the residents room but were unsuccessful in finding the necklace and wedding band. The evening nurse on 7/5/13 and the night nurse on 7/5/13 did not immediately notify the administrator or other state

**F 225**

**F-225-D**
**INVESTIGATIVE REPORT**
**ALLEGATIONS/INDIVIDUALS**

It is the Policy of Sholom Home East to immediately report any suspected or actual abuse, including misappropriation of resident property, injuries of unknown origin, neglect, mistreatment or abuse immediately to the Nursing Home Administrator as well as to the state reporting agencies.

All staff will be re-educated regarding the reporting guidelines for all types of actual or suspected abuse, which includes misappropriation of personal property.

All staff will have completed the re-education By ~~08/01/14~~. 9/1/14

The Director of Nursing will review and audit all reportable incidents for compliance with the reporting guidelines for timeliness of notifying the Nursing Home Administrator immediately as well as to the State reporting agencies (OHFC/CEP).

**Responsible Person:**
Director of Nursing

**Completion date:**
~~08/01/14~~ 9/1/14

(X5): 9/1/14

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| F 225 | Continued From page 2<br>agencies.<br>On 7/24/14 at 10:55 a.m., the director of nursing (DON) and the Licensed practical nurse manager (LPN)-A were interviewed and indicated the administrator and the state agencies were not immediately notified of the incident. The DON indicated the report should have been made immediately and that both the evening and the night nurse did not do that. | F 225 | | |
| F 226<br>SS=D | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to implement their written policy to immediately report allegations of misappropriation of personal property for 1 of 3 residents (R145).<br><br>Findings include:<br><br>R145's family reported missing personal property and it was not reported immediately according to the facility policy.<br>Review of facility policy and procedure revised 6/12 and titled, Abuse Prohibition-Vulnerable Adult Protection/Abuse Prevention Plan indicated incidents are to be reported immediately to the administrator and to other state agencies. Incidents included misappropriation of residents property. | F 226 | **F-226-D**<br>**DEVELOP/IMPLEMENT ABUSE/ NEGLECT, ETC, POLICIES**<br><br>It is the Policy of Sholom Home East to notify the Nursing Home Administrator immediately with all suspected or actual cases of misappropriation of resident's personal property according to the facilities policy "Abuse Prohibition-Vulnerable Adult Protection /Abuse Prevention Plan.<br><br>The Policy for "Abuse Prohibition-Vulnerable Adult Protection/Abuse Prevention Plan has been reviewed.<br><br>All staff will be re-educated on the facilities reporting guidelines that are established in the "Abuse-Prohibition-Vulnerable Adult Protection/Abuse Prevention Plan" policy.<br><br>**Responsible Person:**<br>Director of Nursing<br><br>**Completion Date:**<br>~~08/01/14~~ 9/12/14 | 9/12/14 |

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| F 226 | Continued From page 3<br><br>Review of a "Report of Reasonable Suspicion of a Crime", was completed by the staff on 7/6/13. The report revealed that on 7/5/13 (no time given) the family reported a gold chain with a male wedding band on it was missing. There were no progress notes in the medical record for 7/5/13 and the first report was entered on 7/6/13 at 7:34 a.m. which indicated the evening nurse reported the missing gold chain and wedding band to the night nurse. The night nurse reported it to the night supervisor. The progress note indicated the supervisor and night nurse looked in the residents room but were unsuccessful in finding the necklace and wedding band. The evening nurse on 7/5/13 and the night nurse on 7/5/13 did not immediately notify the administrator or other state agencies<br>On 7/24/14 at 10:55 am the director of nursing (DON) and the Licensed practical nurse manager (LPN)-A were interviewed and indicated the administrator and the state agencies were not immediately notified of the incident. The DON indicated the report should have been made immediately and that both the evening and the night nursedid not do that. | F 226 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. | F 329 | | |

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

PRINTED: 07/29/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 329 | Continued From page 4<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and interview the facility failed to adequately identify, assess and monitor potential side effects of antipsychotic medications for 2 of 5 residents (R96, R136) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R96's orthostatic blood pressures were not consistently checked monthly, as monitoring related to the use of an antipsychotic medication and the potential side effect of orthostatic hypotension.<br><br>Record review on 7/23/14 revealed a physician's order, dated 11/25/13, for Seroquel 25 mg. twice daily. A new order, dated 7/24/14, changed the dosage to 25 mg. once daily. The medication administration record for July 2014 showed the resident received this medication daily. | F 329 | **F-329-D**<br>**DRUG REVIEW IS FREE FROM UNESSESSARY DRUGS**<br><br>It is the Policy of Sholom Home East to monitor all Psychoactive Medications following the regulatory guidelines for each type of medication used in that category which includes monitoring the<br><br>orthostatic blood pressures every week for four weeks, and then monthly unless there is a dosage increase and/or a new medication.<br><br>Orthostatic blood pressures were obtained In the month of July for R-96 and R-136.<br><br>Re-education will be provided for the Licensed Nurses on completing the Physician orders to complete the Orthostatic blood pressure, as well as documenting the results of the blood pressure's in the resident's medical record.<br><br>All current resident's with orders for a Psychoactive Medication will be reviewed to ensure that Orthostatic Blood Pressures have been set up according to Policy, and completed.<br><br>Audits of all Psychoactive Medications will be completed each month for three months, at which time random audits will be completed monthly for compliance. | 9/1/14 |

The Policy and Procedure for the use of Psychoactive Medications has been reviewed.

Education will take place for the Licensed Nurses by September 1st, 2014.

**Responsible Person:**
DON
**Date of Completion:** ~~08/01/14~~ 9/1/14

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| F 329 | Continued From page 5<br>Monitoring for the side effect of orthostatic hypotension, which is done by taking lying and sitting blood pressures (orthostatic blood pressure), was documented in the record monthly-- only for the months of 7/14, 5/14, and 12/13 since the 11/25/13 medication order. The monthly consulting pharmacist's review forms in the record, from 11/2013 to 7/13, did not contain any information related to the monitoring of orthostatic blood pressures.<br>When interviewed on 7/24/14, at 10:15 a.m. licensed practical nurse (LPN)-A, the clinical manager of this resident's unit, acknowledged that she could not locate documentation for orthostatic blood pressures for the missing months, and monthly monitoring for orthostatic hypotension had been missed on some months. She was asked if the consulting pharmacist advised her of this omission, and she stated that the consulting pharmacist had not advised her of the missing orthostatic blood pressures.<br><br>R136's orthostatic blood pressures were not consistently checked monthly per physician orders related to use of Risperdal (antipsychotic) and the potential side effects of orthostatic hypotension.<br><br>R136's annual Minimum Data Set dated 5/29/14, indicated non-Alzheimer's type dementia.<br><br>R136's physician orders dated 7/14/14, indicated Risperdal 0.5 mg at bedtime for dementia with delusional/paranoia since 12/30/13. The physician orders also indicated, "Ortho static B/P (blood pressure) monthly once a day on 1st Tue of the month." | F 329 | | |

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| F 329 | Continued From page 6<br>R136's psych visit note dated 3/31/14, indicated "Res. is followed for cognitive decline, anxiety, strained relationshipe with other resident esp. (especially) roommate, disrupted sleep pattern, and medication management. Numerous episodes of paranoia, did not want to be left alone and Risperdone increased d/t (due to) frequent behaviors."<br><br>R136's psych nurse practitioner progress note dated 7/14/14, indicated "has much anxiety about her life, thinks staff does not like her, worried about herself and getting help. Falls/balance/mobility issue when tries to transfer on own."<br><br>R136's paper/electronic record reviewed with the nurse manager indicated multiple falls dated 7/17/14, 5/24/14, 5/21/14, 4/18/14, and 3/29/14, related to attempts at self transfers. The nurse manager confirmed no orthostatic blood pressures were taken at the time of each fall and although R136 might not cooperate with standing would expect at least a lying and sitting blood pressure at the time of the falls.<br><br>R136's medication/treatment administration records were reviewed with the nurse manager on 7/23/14, at 10:54 a.m. from 12/1/13 through 7/23/14, for evidence of orthostatic blood pressures. Although orthostatic blood pressures were recorded for the months of 12/13, 2/14, 3/14, and 5/14, there was no recorded data for the months of 1/14, 4/14, 6/14, and 7/14. After this was brought to the attention of the nurse manager, orthostatic blood pressures were taken on 7/23/14, for the month of July.<br><br>On 7/23/14, at 1:47 p.m. an interview conducted | F 329 | | |

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| F 329 | Continued From page 7<br>with the nurse manager revealed the expectation of monthly orthostatic blood pressures for R136 related to the use of Risperdal and also after each fall related to the potential adverse side effect of orthostatic hypotension.<br><br>Orthostatic (Postural) Hypotension Monitoring/Assessment policy and procedure dated 9/94, indicated "Orthostatic hypotension will be identified and/or monitored on at least a monthly basis unless the resident is bedfast. The routine monitoring will be completed the first week of a new month (Monday)." Conditions necessitating monitoring included, "use of psychoactive medications including a new medication or increase in dosing: Q Week x four weeks, then monthly thereafter; change in mental status; after any fall unless prior assessments are within normal; and with the first week vital signs each month."<br><br>On 7/23/14, at 3:10 p.m. via phone an interview conducted with the facility pharmacist revealed the expectation of orthostatic blood pressures checked monthly with an antipsychotic like Risperdal. | F 329 | | |
| F 428<br>SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. | F 428 | | |

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| F 428 | Continued From page 8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and record review, the facility failed to assure that drug regimen irregularities are reported by the pharmacist to the attending physician and the director of nursing for 2 of 5 residents in the sample (R96, R136) who required recommendations from the monthly pharmacist drug regimen review.<br><br>Findings include:<br><br>The facility's consulting pharmacist did not advise the facility that R96's orthostatic blood pressures were not consistently checked monthly, as monitoring related to the use of an antipsychotic medication and the potential side effect of orthostatic hypotension.<br><br>Record review on 7/23/14 revealed a physician's order, dated 11/25/13, for Seroquel 25 mg. twice daily. A new order, dated 7/24/14, changed the dosage to 25 mg. once daily. The medication administration record for July 2014 showed the resident received this medication daily. Monitoring for the side effect of orthostatic hypotension, which is done by taking lying and sitting blood pressures (orthostatic blood pressure), was documented in the record monthly-- only for the months of 7/14, 5/14, and 12/13 since the 11/25/13 medication order. The consulting pharmacist's Medication Regimen Review forms in the record did not contain any recommendation related to the monitoring of orthostatic blood pressures.<br>When interviewed on 7/24/14, at 10:15 a.m. | F 428 | **F-428-D**<br>**DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON**<br>It is the Policy of Sholom Home East to have a Consulting Pharmacist review and identify regular monitoring and analysis of the use of Psychoactive medications , including monitoring the Orthostatic blood pressures for each of these types of medications monthly.<br><br>The Consulting Pharmacist will review all residents who are currently on a Psychoactive medication in the Drug Reviews conducted for August for compliance of the the required side effect monitoring, and will continue monthly as part of the Drug Review process and requirements, which will include monitoring for the completion of Orthostatic blood pressures.<br><br>Resident R-96 and R-136 did have Orthostatic Blood Pressures set up on the TAR and were completed for the month of July,<br><br>Recommendations from the Consulting Pharmacist are given to the Director of Nursing for follow through and compliance.<br><br>Consulting Pharmacy reviews will be reviewed by the Director of Nursing monthly after completion to ensure that all residents with prescribed psychoactive medications have been thoroughly reviewed to meet compliance expectations.<br><br>Audits will be conducted randomly to review medical records to ensure that if a resident receives an psychoactive medication, that it has been reviewed at least monthly by the Consulting pharmacist.<br><br>**Person Responsible:**<br>Director of Nursing<br>**Date of Completion: ~~08/15/14~~** 9/2/14 | 9/2/14 |

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| F 428 | Continued From page 9<br>licensed practical nurse (LPN)-A, the clinical manager of this resident's unit, acknowledged that she could not locate documentation for orthostatic blood pressures for the missing months, and monthly monitoring for orthostatic hypotension had been missed on some months. She was also asked if the facility's consulting pharmacist advised her of this omission, and she stated that the consulting pharmacist had not advised her of the missing orthostatic blood pressures.<br><br>R136's orthostatic blood pressures were not consistently monitored monthly per physician orders related to use of Risperdal (antipsychotic) and the potential side effects of orthostatic hypotension. The facility pharmacist failed to pick up on the missing orthostatic blood pressures for R136.<br><br>R136's annual Minimum Data Set dated 5/29/14, indicated non-Alzheimer's type dementia.<br><br>R136's physician orders dated 7/14/14, indicated Risperdal 0.5 mg at bedtime for dementia with delusional/paranoia since 12/30/13. The physician orders also indicated, "Ortho static B/P (blood pressure) monthly once a day on 1st Tue of the month."<br><br>R136's psych visit note dated 3/31/14, indicated "Res. is followed for cognitive decline, anxiety, strained relationshipe with other resident esp. (especially) roommate, disrupted sleep pattern, and medication management. Numerous episodes of paranoia, did not want to be left alone and Risperdone increased d/t (due to) frequent behaviors." | F 428 | | |

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| F 428 | Continued From page 10<br>R136's psych nurse practitioner progress note dated 7/14/14, indicated "has much anxiety about her life, thinks staff does not like her, worried about herself and getting help.<br>Falls/balance/mobility issue when tries to transfer on own."<br><br>R136's paper/electronic record reviewed with the nurse manager indicated multiple falls dated 7/17/14, 5/24/14, 5/21/14, 4/18/14, and 3/29/14, related to attempts at self transfers. The nurse manager confirmed no orthostatic blood pressures were taken at the time of each fall and although R136 might not cooperate with standing would expect at least a lying and sitting blood pressure at the time of the falls.<br><br>R136's medication/treatment administration records were reviewed with the nurse manager on 7/23/14, at 10:54 a.m. from 12/1/13 through 7/23/14, for evidence of orthostatic blood pressures. Although orthostatic blood pressures were recorded for the months of 12/13, 2/14, 3/14, and 5/14, there was no recorded data for the months of 1/14, 4/14, 6/14, and 7/14. After this was brought to the attention of the nurse manager, orthostatic blood pressures were taken on 7/23/14, for the month of July.<br><br>On 7/23/14, at 1:47 p.m. an interview conducted with the nurse manager revealed the expectation of monthly orthostatic blood pressures for R136 related to the use of Risperdal and also after each fall related to the potential adverse side effect of orthostatic hypotension.<br><br>Orthostatic (Postural) Hypotension Monitoring/Assessment policy and procedure dated 9/94, indicated "Orthostatic hypotension will | F 428 | | |

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| F 428 | Continued From page 11 be identified and/or monitored on at least a monthly basis unless the resident is bedfast. The routine monitoring will be completed the first week of a new month (Monday)." Conditions necessitating monitoring included, "use of psychoactive medications including a new medication or increase in dosing: Q Week x four weeks, then monthly thereafter; change in mental status; after any fall unless prior assessments are within normal; and with the first week vital signs each month."<br><br>R136's pharmacy reviews 8/19/13 through 7/21/14, indicated no gradual dose reduction (GDR) second to paranoia related to need for Risperdal. Pharmacy consult dated 4/24/24, related to no documentation of increased behaviors since Risperdal was decreased in January to 0.5 mg at bedtime. The physician's response dated 5/28/14, indicated "no GDR at this time for Risperdal or Paxil continues to have some paranoia, delusion thinking about her body." The pharmacy reviews did not address orthostatic blood pressure monitoring.<br><br>R136's care plan 9/19/13, indicated psychotropic med use; Risperdal, Paxil, and Trazadone. Monitor for increased paranoia; one-one to redirect, and observe for adverse side effects. Orthostatic hypotension was a potential adverse side effect of antipsychotic (Risperdal) medication use.<br><br>On 7/23/14, at 3:10 p.m. via phone an interview conducted with the facility pharmacist revealed the expectation of orthostatic blood pressures checked monthly with an antipsychotic. The pharmacist also stated would note on the green pharmacy review form or in a consult note the | F 428 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245411 | A. BUILDING ______<br>B. WING ______ | 07/24/2014 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 428 | Continued From page 12<br>need for monitoring orthostatic blood pressures and if it was documented then it was missed. | F 428 | | |

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

FS411024

FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245411 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SHIRLEY CHAPMEN SHOLOM HOME EAST B. WING ______ | (X3) DATE SURVEY COMPLETED 07/22/2014 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, SHIRLEY CHAPMAN SHOLOM HOME EAST was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New health Care.<br><br>SHIRLEY CHAPMAN SHOLOM HOME EAST is a 4-story building with a full basement. The building was constructed in 2008, and was determined to be of Type II(222) construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and all resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 98 beds and had a census of 82 at the time of the survey.<br><br>The rèquirement at 42 CFR, Subpart 483.70(a) is MET.<br><br>*TEAM COMPOSITION*<br>Tom Linhoff, Life Safety Code Spc. | K 000 | | |

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

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.