

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 23, 2020

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

RE: CCN: 245411 Cycle Start Date: October 6, 2020

Dear Administrator:

On October 6, 2020, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

Shirley Chapman Sholom Home East October 23, 2020 Page 2

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

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, MN 56001 Email: <u>elizabeth.silkey@state.mn.us</u> Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

Shirley Chapman Sholom Home East October 23, 2020 Page 3

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 6, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by April 6, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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.

Shirley Chapman Sholom Home East October 23, 2020 Page 4 Feel free to contact me if you have questions.

Sincerely,

Durentes Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 23, 2020

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

Re: State Nursing Home Licensing Orders Event ID: KU0311

Dear Administrator:

The above facility was surveyed on October 6, 2020 through October 6, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

Shirley Chapman Sholom Home East October 23, 2020 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, MN 56001 Email: <u>elizabeth.silkey@state.mn.us</u> Office: (507) 344-2742 Mobile: (651) 368-3593

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

Please 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,

Doverte Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit

Shirley Chapman Sholom Home East October 23, 2020 Page 3 Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00496	B. WING		10/0	C 6/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	-	
		740 KAY	AVENUE			
SHIRLE	CHAPMAN SHOLON	SAINT P	AUL, MN 551	02		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted to detern Licensure. Your fac compliance with the indicate in your elec you have reviewed date when they will	reviated survey was mine compliance with State ility was found to be NOT in MN State Licensure. Please ctronic plan of correction that these orders, and identify the				
Vinnesota D _ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE
Electron	ically Signed					10/29/20

STATE FORM

If continuation sheet 1 of 8

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE		E SURVEY PLETED		
			A. BUILDING:				
		00496	B. WING			C 10/06/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
HIRLEY	CHAPMAN SHOLON	HOME EAST 740 KAY	-				
		SAINT PA	UL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From pa	ge 1	2 000				
		plaint was found to be 411080C however no licensing					
	unsubstantiated: H	laint was found to be #5411081C. However, as a gation a licensing orders 26.557 Subd. 4.					
		ed in ePOC and therefore a uired at the bottom of the first					
21990	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4 Reporting - Inerable Adults	21990			11/11/2	
	immediately make entry point. Use of for the deaf or othe considered an oral point may not requi extent possible, the content to identify the caregiver, the natur maltreatment, any of maltreatment, the r reporter, the time, of incident, and any of reporter believes m the suspected malt reporter may disclo in section 13.02, ar	g. A mandated reporter shall an oral report to the common a telecommunications device r similar device shall be report. The common entry re written reports. To the e report must be of sufficient he vulnerable adult, the re and extent of the suspected evidence of previous name and address of the date, and location of the ther information that the ight be helpful in investigating reatment. A mandated se not public data, as defined ad medical records under the extent necessary to bdivision.					
	This MN Requirem	ent is not met as evidenced					

If continuation sheet 2 of 8

	ota Department of He IT OF DEFICIENCIES			LE CONSTRUCTION		
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SU COMPLE	
		00496	B. WING		C 10/06/2020	
	PROVIDER OR SUPPLIER	STREET AF		STATE, ZIP CODE		
	NOVIDEN ON OUT FIEN	740 KAY		STATE, ZII GODE		
SHIRLEY	CHAPMAN SHOLON		AUL, MN 55	102		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLET DATE
21990	Continued From pa	age 2	21990			
	Based on interview	and document review, the		This facility ensures that all alleg	her	
	facility failed to ens			violations involving abuse, negle		
		e reported to the State Agency		exploitation or mistreatment are		
		ordance with established		immediately.		
		dures, for 2 of 4 residents (R3		Resident R3 was assessed at th	ne time of	
		or allegations of abuse.		notification of abuse, and re-inte		
	,	C C		on 10/7/20. Resident stated their	r were no	
	Findings include:			additional concerns, and that sh	e was	
	_			satisfied with facility follow up. R	4 had	
	R3's Resident Face	e Sheet printed 10/6/20,		been discharged at time compla	int survey	
		of malignant neoplasm of		was in place.		
		c atrial fibrillation (irregular				
		, anxiety disorder and		All residents at facility are consid	dered to	
		es become brittle and fragile)		be at risk to abuse, neglect and		
	with current patholo	ogical fracture, left humerus.		exploitation. Residents are revie		
				admission, quarterly and as nee	ded	
		mum Data Set (MDS)				
		7/30/20, indicated R3 had a		All staff were re-educated on rep		
		nental status (BIMS) score of npairment in cognition) and		alleged violations and time fram		
		s her wants and needs. The		report to the administrator and s	late	
		R3 required extensive		agency. Policy and procedure related to	vulnerable	
		ivities of daily living (ADL's).		adult reporting was reviewed an		
				current.	u 15	
	•	iewed 8/10/20, indicated R3		Control complete an electron of the		
		mobility and required assist of		Social services or designee will		
		ed mobility, dressing, toileting able adult with intervention to		concern forms and 3 resident pr		
		nment for resident and others.		notes weekly for one month and concerns forms and 3 resident p		
	•	signs symptoms or accusations		notes monthly for 3 months to e		
	of abuse/neglect as			potential abuse concerns were r		
				immediately to the facility admin		
	Review of a note. d	lated 9/27/20, by social		and not documented elsewhere		
		dicated an interview occurred				
		i., and stated R3 asked for		Audit results will be reported to	he QA	
		her menu and Nursing		committee and action plans dev		
		ormed of out of the room and		needed.	•	
		returned after supper and				
		I done to get ready for bed.				
	R3 denied doing ar	nything and NA-A began to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		00496	B. WING			C 10/06/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
		740 KAY	AVENUE				
SHIKLET	CHAPMAN SHOLON	SAINT P	AUL, MN 5510)2			
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From pa	ige 3	21990				
	rough with helping l indicated NA-A sho	what to do. R3 said NA-A was R3 with her pants and uld not treat residents this ated that NA-A called her the moves so slow.					
During interview on 10/6/20, at 11 indicated NA-A entered her room 8:00 p.m. and asked what I had d for bed and then yelled at me and pajamas around and the bedside further indicated she was rough w assisted R3 into her bed, and NA- short tempered indicating she was wanted to go home and R3 was n out. R3 indicated she used to cal that stopped after she told someo was not able to identify the staff m During interview on 10/6/20, at 12 indicated she was made aware of investigation of a separate vulnera report. Upon interview with R3 an discussion with the administrator, it was determined this was bad cu and not abuse. SS-A stated she a could check her for bruises and R there weren't any. SS-A indicated vulnerable adult reports if it is clea bruises or the resident is acting di discusses any "gray" or questiona the administrator before she files adult report. When questioned at follow-up on this complaint, SS-A part of the initial vulnerable adult re	ered her room approximately ed what I had done to get ready elled at me and slammed the ad the bedside table. R3 we was rough when NA-A r bed, and NA-A was rude and icating she was tired and and R3 was not helping her she used to call her turtle but she told someone about it, but						
	indicated she was r investigation of a se report. Upon interv discussion with the it was determined th and not abuse. SS could check her for there weren't any. vulnerable adult rep bruises or the resid discusses any "gray the administrator be adult report. When follow-up on this co part of the initial vul	made aware of this issue upon eparate vulnerable adult riew with R3 and after administrator, SS-A indicated his was bad customer service -A stated she asked R3 if she bruises and R3 indicated SS-A indicated she completes ports if it is clear such as lent is acting different, but y" or questionable issues with efore she files a vulnerable of questioned about further implaint, SS-A indicated it was lnerable adult report.					
	administrator indicato determine what i	/6/20, at 3:00 p.m., the ated a team approach is used s reportable and what is service issues. The					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED	
		00496	B. WING		C 10/06/2020		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
SHIRLE	CHAPMAN SHOLON	A HOME FAST	AVENUE AUL, MN 5510	2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21990	trigger terms such a or someone slappe listen for words suc further investigation resident. The adm SS-A did talk throug brought forward an through. R4's admission Mir assessment dated cognitively intact wi requiring a hearing requiring corrective she understood and required extensive transfers, locomotio R4 required limited walking. Sholom Concern F R4 had reported tha (TMA)-A was very r pulling her pants up	inge 4 er indicated she looks for as someone is abusive to me ad me across the face and th as rough or nasty and does in as to what that means to the inistrator further indicated gh some concerns R3 had d there was a lack of follow himum Data Set (MDS) 9/7/20, indicated R4 was th moderate difficulty hearing aid, vision was impaired elenses, speech was clear, d was able to understand. R4 assistance for bed mobility, on on the unit and dressing. assistance of one staff when orm dated 9/16/20, indicated at trained medication assistant rough with her that morning, o/down aggressively and d. According to the document,					
	R4 indicated "I feel something wrong, of already dressed." T to be a customer so form, TMA-A was of not rush R4 when s	like maybe I was doing or that it was my fault I wasn't This allegation was determined ervice issue. According to the juestioned and stated she did she grabbed her to pull her was standing at her walker.					
	immediately intervie who asked R4 if he customer service is were abusive in na	oncern form, R4 was ewed by social worker (SW)-B or report was more of a ssue or if R4 felt the actions ture. SW-B explained the in which R4 indicated she felt					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:		с		
		00496	B. WING			10/06/2020	
AME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	HAPMAN SHOLON	I HOME EAST	AVENUE AUL, MN 5510	12			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE	
21990 🕻	Continued From pa	ge 5	21990				
v S h A r n	vasn't abuse and it SW-B that she felt s aving this same TI as a plan of action eminded and enco	rough her cares, adding that it wasn't a big deal. R4 told safe and was not opposed to MA continue to care for her. after this allegation, staff were uraged to be more patient ve R4 time to participate in					
v a v tt q r g	when asked how a buse is determined thow upset the re- ve can check for br if it is clear, I make he resident is actin juestionable wheth elated, I talk to the	on 10/6/20, at 12:54 p.m., customer service issue versus d, (SW)-A stated she looked sident is; "I ask the resident if ruises." SW-A went on to say the report, such as bruises o g different. If it is gray and er it is customer service administrator and get In this case it was decided it r service related."					
d C s v r r r s v d a T d d r t t t	lirector of nursing (Concern Form date tated she vaguely vith it hands on. Sh eports being handl eceives that inform omeone, such as t vorker gets more d letails were obtained and that it was more that is my interpret letermined whethe eportable allegation hat "some are obvi	on 10/6/20, at 1:40 p.m., the (DON) was given R4's Sholom of 9/16/20, to review. DON remembered it and didn't dea ne stated "when a resident ed roughly, whomever nation tells the nurse, then the nurse manager, or social letails. In this case, when more ed, it didn't seem reportable e of a customer service issue. ration." When asked how it is r what a resident says is a n or a grievance, DON replied ious, but when some are on nistrator and the social worker	Ð				
Г) During an interview	on 10/6/20, at 2:35 p.m.,					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		СОМ	E SURVEY PLETED	
		00496	B. WING			C 10/06/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
SHIRLEY	CHAPMAN SHOLON	A HOME FAST	AVENUE AUL, MN 5510	2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From pa	age 6	21990				
	stated she was fam policy, stating she w orientation and add reporter. SW-B stat training on interview knowledge and exp interviews residents administrator or DC R4 since working a when she spoke to was blown out of pr but rather too fast a morning. SW-B had Concern Form and not ask R4 what ab asked were: this is that is what happen	st job post graduate. SW-B hiliar with the facility abuse was sure she went over it at led she was a mandated ted she did not have specific wing residents; she used her berience. SW stated she s at the direction of the DN and had only interviewed t the facility. SW-B stated R4, R4 indicated she felt this roportion, that it wasn't abuse and rushed for that time of the d not seen the completed after reading it, stated she did ouse was. "The questions I what I heard and do you feel hed? Then I followed up with never told her the definition of					
	p.m., the concern for administrator who is more to clarify what she felt safe and sh meant by rough as different and the wo questions." Administ interviewed, R4 stat rough. When asked reported and an inv administrator stated rushed made her th service", but added	interview on 10/6/20, at 3:05 orm for R4 was read to the stated "I think it was written t happened." "We asked R4 if ne did." "We asked what she everyone's definition is ord 'rough' triggers to ask more strator stated when R4 was ted she felt more rushed than d if this should have been vestigation completed, d "R4 saying she just felt nink it was more customer I "I can see what you are	2				
	should be reported.	would have seemed like it " , Abuse Prohibition-Vulnerable					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUILDING: _			C	
		00496	B. WING			06/2020	
AME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
HIRLE	CHAPMAN SHOLON	M HOME EAST 740 KAY SAINT P	AVENUE AUL, MN 5510	2			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF			
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21990	Continued From pa	age 7	21990				
	date 2/24/20, include It is the policy of "abuse" allegations State Law. The facility will violations involving immediately, but no allegation is made, allegation involve a injury or not later the cause the allegation not result in serious administrator of the (including the State protective services jurisdiction in long the accordance with State procedures. SUGGESTED MET administrator or de training to staff on the abuse and neglect (SA). Administrator audits to ensure state submitted timely.	puse Prevention Plan, revision ded: of this organization that a are reported per Federal and ensure that all alleged abuseare reported of later than 2 hours after the if the events that cause the buse or result in serious body an 24 hours if the events that n do not involve abuse and do s bodily injury to the e facility and to other officials e Survey Agency and adult where state law provides for term care facilities) in tate law through established THOD OF CORRECTION: The signee could provide additiona reporting incident of potential to designated state agency or designee could perform ate agency (SA) reports are R CORRECTION: Twenty-one					

	CENTERS FOR MEDICARE & MEDICAID SERVICES				0		APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPI F	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` '			СОМ	IPLETED
		245411	B. WING				C 06/2020
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 10/	00/2020
				740	0 KAY AVENUE		
SHIRLET	CHAPMAN SHOLON	I HOME EAST		SA	NNT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 0	00			
	completed at your f Department of Hea was not in compliar CFR Part 483, Sub Long Term Care Fa The following comp	laint was found to be					
	actions implemente H#5411080C	no deficiencies cited due to ed by the facility prior to survey:					
	The following comp unsubstantiated: H#5411081C	laint was found to be					
	However, as a resu deficiency was iden	It of the investigation a tified at F609.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 609	on-site revisit of you validate that substa regulations has bee your verification. Reporting of Allege		F 6	09			11/11/20
SS=D	§483.12(c) In respo	1)(4) onse to allegations of abuse, n, or mistreatment, the facility					
	Y DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 10/29/2020

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.

DEDADTMENT OF LIEALTH AND LIUMAN CEDVICES

		AND HUMAN SERVICES				FORM	11/09/2020 APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION		0938-0391 E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _			PLETED
		245411	B. WING				C 06/2020
NAME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLON	I HOME EAST			40 KAY AVENUE AINT PAUL, MN 55102		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
F 609	Continued From pa	ae 1	F 6	09			
	must:	90 .	10				
	involving abuse, ne mistreatment, inclus source and misapp are reported immed hours after the alleg that cause the alleg serious bodily injury the events that caus abuse and do not re the administrator of officials (including to adult protective ser- for jurisdiction in lor	re that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events jation involve abuse or result in /, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established					
	designated represe accordance with Sta Survey Agency, with incident, and if the a appropriate correct This REQUIREMEN by: Based on interview facility failed to ensu abuse/neglect were (SA) timely, in acco	e administrator or his or her intative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced and document review, the ure allegations of a reported to the State Agency irdance with established			This facility ensures that all alleged violations involving abuse, neglect, exploitation or mistreatment are rep immediately.	ported	
		lures, for 2 of 4 residents (R3 or allegations of abuse.			Resident R3 was assessed at the t notification of abuse, and re-intervi- on 10/7/20. Resident stated their w additional concerns, and that she w satisfied with facility follow up. R4 h	ewed ere no /as	
		Sheet printed 10/6/20, of malignant neoplasm of			been discharged at time complaint was in place.		

Facility ID: 00496

		AND HUMAN SERVICES			PRINTED: 11/09/2020 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245411	B. WING		C 10/06/2020
	PROVIDER OR SUPPLIER	I HOME EAST	STREET ADDRESS, CITY, STA 740 KAY AVENUE SAINT PAUL, MN 55102		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE COMPLÉTION D THE APPROPRIATE DATE
F 609	right breast, chronic heart beat), tremor, osteoporosis (bone with current patholo R3's quarterly Minir assessment dated brief interview for m 15 (indicating no im was able to express MDS also indicated assistance with act R3's care plan, revi had an alteration in one for transfers, b and R3 is a vulnera provide safe enviro Investigate/report s of abuse/neglect as Review of a note, d services (SS)-A, ind with R3 at 3:00 p.m assistance to read Assistant (NA)-A st didn't return. NA-A asked what R3 had R3 denied doing ar issue orders as to v rough with helping indicated NA-A sho way. R3 also indica turtle because she During interview on indicated NA-A enta 8:00 p.m. and aske	c atrial fibrillation (irregular , anxiety disorder and s become brittle and fragile) ogical fracture, left humerus. mum Data Set (MDS) 7/30/20, indicated R3 had a nental status (BIMS) score of apairment in cognition) and s her wants and needs. The I R3 required extensive ivities of daily living (ADL's). weed 8/10/20, indicated R3 mobility and required assist of ed mobility, dressing, toileting able adult with intervention to nment for resident and others. igns symptoms or accusations appropriate. lated 9/27/20, by social dicated an interview occurred a., and stated R3 asked for her menu and Nursing ormed of out of the room and returned after supper and I done to get ready for bed. hything and NA-A began to what to do. R3 said NA-A was R3 with her pants and uld not treat residents this ated that NA-A called her the	F 6	All residents at facility a be at risk to abuse, neg exploitation. Residents admission, quarterly an All staff were re-educat alleged violations and t report to the administra agency. Policy and procedure re adult reporting was revi current. Social services or desig concern forms and 3 re notes weekly for one m concerns forms and 3 re notes monthly for 3 mo potential abuse concern immediately to the facil and not documented el Audit results will be rep committee and action p needed.	glect and are reviewed upon and as needed ted on reporting time frames to ator and state elated to vulnerable iewed and is gnee will audit 3 esident progress nonth and then 3 resident progress onths to ensure all ns were reported lity administrator Isewhere.

If continuation sheet Page 3 of 8

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/09/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245411	B. WING			(10/0) 06/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLON	I HOME EAST			40 KAY AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	pajamas around an further indicated sh assisted R3 into he short tempered indi wanted to go home out. R3 indicated s that stopped after s was not able to ider During interview on indicated she was r investigation of a se report. Upon interv discussion with the it was determined th and not abuse. SS could check her for there weren't any. vulnerable adult rep bruises or the resid discusses any "gray the administrator be adult report. When follow-up on this co part of the initial vul During interview 10 administrator indicated to determine what is dignity or customer administrator further trigger terms such a or someone slappe listen for words suc further investigation resident. The admi	ge 3 d the bedside table. R3 e was rough when NA-A r bed, and NA-A was rude and cating she was tired and and R3 was not helping her he used to call her turtle but he told someone about it, but ntify the staff member she told. 10/6/20, at 12:54 p.m., SS-A nade aware of this issue upon eparate vulnerable adult iew with R3 and after administrator, SS-A indicated his was bad customer service -A stated she asked R3 if she bruises and R3 indicated SS-A indicated she completes oorts if it is clear such as ent is acting different, but y" or questionable issues with efore she files a vulnerable questioned about further mplaint, SS-A indicated it was nerable adult report. /6/20, at 3:00 p.m., the ted a team approach is used s reportable and what is service issues. The er indicated she looks for as someone is abusive to me d me across the face and h as rough or nasty and does a st o what that means to the nistrator further indicated gh some concerns R3 had d there was a lack of follow	F 6	609			

Facility ID: 00496

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		AND HUMAN SERVICES				FORM	11/09/2020 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
245411			B. WING			C 10/06/2020				
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
SHIRLE	CHAPMAN SHOLON	I HOME EAST	740 KAY AVENUE SAINT PAUL, MN 55102							
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 609	Continued From pa	ge 4	F 6	09						
	assessment dated a cognitively intact wi requiring a hearing requiring corrective she understood and required extensive a transfers, locomotio R4 required limited walking. Sholom Concern Fo R4 had reported tha (TMA)-A was very r pulling her pants up seemed very rushe R4 indicated "I feel something wrong, o already dressed." T to be a customer set form, TMA-A was q not rush R4 when s pants up while R4 w According to the co immediately intervie who asked R4 if he customer service is were abusive in nat definition of abuse i safe, but hurried thi wasn't abuse and it SW-B that she felt a having this same Ti As a plan of action reminded and enco	imum Data Set (MDS) 9/7/20, indicated R4 was th moderate difficulty hearing aid, vision was impaired lenses, speech was clear, d was able to understand. R4 assistance for bed mobility, on on the unit and dressing. assistance of one staff when orm dated 9/16/20, indicated at trained medication assistant ough with her that morning, o/down aggressively and d. According to the document, like maybe I was doing or that it was my fault I wasn't his allegation was determined ervice issue. According to the uestioned and stated she did the grabbed her to pull her was standing at her walker. Incern form, R4 was ewed by social worker (SW)-B r report was more of a usue or if R4 felt the actions ture. SW-B explained the in which R4 indicated she felt rough her cares, adding that it wasn't a big deal. R4 told safe and was not opposed to MA continue to care for her. after this allegation, staff were uraged to be more patient ve R4 time to participate in								

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	MENT OF HEALTH		FORM APPROVED OMB NO. 0938-0391					
		& MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BUILDI	ING	·			
24541		245411	B. WING			C 10/06/2020		
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
	CHAPMAN SHOLON	A HOME EAST		7	740 KAY AVENUE			
SHIKLET		HOME EAST		S	SAINT PAUL, MN 55102			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE	
TAG	REGULATORT OR E		TAG		DEFICIENCY)			
			1		-			
F 609	Continued From pa	ae 5	F 6	na				
1 000	Continued i Tom pa	ge 5	ΓŬ	09	1			
	During an interview	on 10/6/20, at 12:54 p.m.,						
		customer service issue versus						
		d, (SW)-A stated she looked						
		sident is; "I ask the resident if						
		ruises." SW-A went on to say						
	,	e the report, such as bruises or						
		g different. If it is gray and						
		er it is customer service						
		administrator and get In this case it was decided it						
	was more custome							
		service related.						
	During an interview	on 10/6/20, at 1:40 p.m., the						
		(DON) was given R4's Sholom						
		ed 9/16/20, to review. DON						
		remembered it and didn't deal						
		e stated "when a resident						
		ed roughly, whomever						
		nation tells the nurse, then the nurse manager, or social						
		letails. In this case, when more						
		ed, it didn't seem reportable						
		e of a customer service issue.						
		ation." When asked how it is						
		r what a resident says is a						
		n or a grievance, DON replied						
		ous, but when some are on						
	,	nistrator and the social worker						
	discuss them."							
	During an interview	on 10/6/20, at 2:35 p.m.,						
		tarted at the facility in July						
		st job post graduate. SW-B						
		iliar with the facility abuse						
		vas sure she went over it at						
		ed she was a mandated						
	reporter. SW-B stat	ed she did not have specific						
	training on interview	ving residents; she used her						

Facility ID: 00496

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		AND HUMAN SERVICES					FORM	11/09/2020 APPROVED 0938-0391			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C						
245411		B. WING			10/06/2020						
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE						
SHIRLE	Y CHAPMAN SHOLON	I HOME EAST	740 KAY AVENUE SAINT PAUL, MN 55102								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD	BE	(X5) COMPLETION DATE			
F 609	knowledge and exp interviews residents administrator or DC R4 since working a when she spoke to was blown out of pr but rather too fast a morning. SW-B had Concern Form and not ask R4 what ab asked were: this is that is what happen did you get hurt? I r abuse." During a telephone p.m., the concern for administrator who s more to clarify what she felt safe and sh meant by rough as different and the wo questions." Adminis interviewed, R4 sta rough. When asked reported and an inv administrator stated rushed made her th service", but added reading to me, this should be reported. Facility policy titled, Adult Protection/Ab date 2/24/20, include It is the policy of "abuse" allegations State Law.	berience. SW stated she s at the direction of the DN and had only interviewed t the facility. SW-B stated R4, R4 indicated she felt this roportion, that it wasn't abuse and rushed for that time of the d not seen the completed after reading it, stated she did use was. "The questions I what I heard and do you feel hed? Then I followed up with hever told her the definition of interview on 10/6/20, at 3:05 form for R4 was read to the stated "I think it was written t happened." "We asked R4 if he did." "We asked what she everyone's definition is ord 'rough' triggers to ask more strator stated when R4 was ted she felt more rushed than d if this should have been restigation completed, d "R4 saying she just felt hink it was more customer "I can see what you are would have seemed like it " Abuse Prohibition-Vulnerable use Prevention Plan, revision	F	609							

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		AND HUMAN SERVICES				FORM	11/09/2020 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
245411		B. WING _		10/06/2020					
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE				
SHIRLEY	CHAPMAN SHOLON	I HOME EAST	740 KAY AVENUE SAINT PAUL, MN 55102						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD	BE	(X5) COMPLETION DATE		
F 609	immediately, but no allegation is made, allegation involve a injury or not later th cause the allegation not result in serious administrator of the (including the State protective services jurisdiction in long t	abuseare reported of later than 2 hours after the if the events that cause the buse or result in serious body an 24 hours if the events that n do not involve abuse and do	F 60						