P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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.

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: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

Elizabeth Silkey, 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: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

Please 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,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00496	A. BUILDING: ______ B. WING ______	C 10/06/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 10/6/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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2 000	Continued From page 1 The following complaint was found to be substantiated: H#5411080C however no licensing orders were issued. The following complaint was found to be unsubstantiated: H#5411081C. However, as a result of the investigation a licensing orders issued at Statute 626.557 Subd. 4. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by:	21990		11/11/20

Minnesota Department of Health

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21990	Continued From page 2 Based on interview and document review, the facility failed to ensure allegations of abuse/neglect were reported to the State Agency (SA) timely, in accordance with established policies and procedures, for 2 of 4 residents (R3 and R4) reviewed for allegations of abuse. Findings include: R3's Resident Face Sheet printed 10/6/20, indicated diagnosis of malignant neoplasm of right breast, chronic atrial fibrillation (irregular heart beat), tremor, anxiety disorder and osteoporosis (bones become brittle and fragile) with current pathological fracture, left humerus. R3's quarterly Minimum Data Set (MDS) assessment dated 7/30/20, indicated R3 had a brief interview for mental status (BIMS) score of 15 (indicating no impairment in cognition) and was able to express her wants and needs. The MDS also indicated R3 required extensive assistance with activities of daily living (ADL's). R3's care plan, reviewed 8/10/20, indicated R3 had an alteration in mobility and required assist of one for transfers, bed mobility, dressing, toileting and R3 is a vulnerable adult with intervention to provide safe environment for resident and others. Investigate/report signs symptoms or accusations of abuse/neglect as appropriate. Review of a note, dated 9/27/20, by social services (SS)-A, indicated an interview occurred with R3 at 3:00 p.m., and stated R3 asked for assistance to read her menu and Nursing Assistant (NA)-A stormed of out of the room and didn't return. NA-A returned after supper and asked what R3 had done to get ready for bed. R3 denied doing anything and NA-A began to	21990	This facility ensures that all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately. Resident R3 was assessed at the time of notification of abuse, and re-interviewed on 10/7/20. Resident stated their were no additional concerns, and that she was satisfied with facility follow up. R4 had been discharged at time complaint survey was in place. All residents at facility are considered to be at risk to abuse, neglect and exploitation. Residents are reviewed upon admission, quarterly and as needed. . All staff were re-educated on reporting alleged violations and time frames to report to the administrator and state agency. Policy and procedure related to vulnerable adult reporting was reviewed and is current. Social services or designee will audit 3 concern forms and 3 resident progress notes weekly for one month and then 3 concerns forms and 3 resident progress notes monthly for 3 months to ensure all potential abuse concerns were reported immediately to the facility administrator and not documented elsewhere. Audit results will be reported to the QA committee and action plans developed as needed.	

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21990	Continued From page 3	21990		

issue orders as to what to do. R3 said NA-A was rough with helping R3 with her pants and indicated NA-A should not treat residents this way. R3 also indicated that NA-A called her the turtle because she moves so slow.

During interview on 10/6/20, at 11:51 a.m., R3 indicated NA-A entered her room approximately 8:00 p.m. and asked what I had done to get ready for bed and then yelled at me and slammed the pajamas around and the bedside table. R3 further indicated she was rough when NA-A assisted R3 into her bed, and NA-A was rude and short tempered indicating she was tired and wanted to go home and R3 was not helping her out. R3 indicated she used to call her turtle but that stopped after she told someone about it, but was not able to identify the staff member she told.

During interview on 10/6/20, at 12:54 p.m., SS-A indicated she was made aware of this issue upon investigation of a separate vulnerable adult report. Upon interview with R3 and after discussion with the administrator, SS-A indicated it was determined this was bad customer service and not abuse. SS-A stated she asked R3 if she could check her for bruises and R3 indicated there weren't any. SS-A indicated she completes vulnerable adult reports if it is clear such as bruises or the resident is acting different, but discusses any "gray" or questionable issues with the administrator before she files a vulnerable adult report. When questioned about further follow-up on this complaint, SS-A indicated it was part of the initial vulnerable adult report.

During interview 10/6/20, at 3:00 p.m., the administrator indicated a team approach is used to determine what is reportable and what is dignity or customer service issues. The

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21990	Continued From page 4	21990		

administrator further indicated she looks for trigger terms such as someone is abusive to me or someone slapped me across the face and listen for words such as rough or nasty and does further investigation as to what that means to the resident. The administrator further indicated SS-A did talk through some concerns R3 had brought forward and there was a lack of follow through.

R4's admission Minimum Data Set (MDS) assessment dated 9/7/20, indicated R4 was cognitively intact with moderate difficulty hearing requiring a hearing aid, vision was impaired requiring corrective lenses, speech was clear, she understood and was able to understand. R4 required extensive assistance for bed mobility, transfers, locomotion on the unit and dressing. R4 required limited assistance of one staff when walking.

Sholom Concern Form dated 9/16/20, indicated R4 had reported that trained medication assistant (TMA)-A was very rough with her that morning, pulling her pants up/down aggressively and seemed very rushed. According to the document, R4 indicated "I feel like maybe I was doing something wrong, or that it was my fault I wasn't already dressed." This allegation was determined to be a customer service issue. According to the form, TMA-A was questioned and stated she did not rush R4 when she grabbed her to pull her pants up while R4 was standing at her walker.

According to the concern form, R4 was immediately interviewed by social worker (SW)-B who asked R4 if her report was more of a customer service issue or if R4 felt the actions were abusive in nature. SW-B explained the definition of abuse in which R4 indicated she felt

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21990	Continued From page 5 safe, but hurried through her cares, adding that it wasn't abuse and it wasn't a big deal. R4 told SW-B that she felt safe and was not opposed to having this same TMA continue to care for her. As a plan of action after this allegation, staff were reminded and encouraged to be more patient next time and to give R4 time to participate in cares. During an interview on 10/6/20, at 12:54 p.m., when asked how a customer service issue versus abuse is determined, (SW)-A stated she looked at how upset the resident is; "I ask the resident if we can check for bruises." SW-A went on to say "if it is clear, I make the report, such as bruises or the resident is acting different. If it is gray and questionable whether it is customer service related, I talk to the administrator and get guidance from her. In this case it was decided it was more customer service related." During an interview on 10/6/20, at 1:40 p.m., the director of nursing (DON) was given R4's Sholom Concern Form dated 9/16/20, to review. DON stated she vaguely remembered it and didn't deal with it hands on. She stated "when a resident reports being handled roughly, whomever receives that information tells the nurse, then someone, such as the nurse manager, or social worker gets more details. In this case, when more details were obtained, it didn't seem reportable and that it was more of a customer service issue. That is my interpretation." When asked how it is determined whether what a resident says is a reportable allegation or a grievance, DON replied that "some are obvious, but when some are on the fence, the administrator and the social worker discuss them." During an interview on 10/6/20, at 2:35 p.m.,	21990		

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21990	Continued From page 6 SW-B stated she started at the facility in July 2020; it was her first job post graduate. SW-B stated she was familiar with the facility abuse policy, stating she was sure she went over it at orientation and added she was a mandated reporter. SW-B stated she did not have specific training on interviewing residents; she used her knowledge and experience. SW stated she interviews residents at the direction of the administrator or DON and had only interviewed R4 since working at the facility. SW-B stated when she spoke to R4, R4 indicated she felt this was blown out of proportion, that it wasn't abuse but rather too fast and rushed for that time of the morning. SW-B had not seen the completed Concern Form and after reading it, stated she did not ask R4 what abuse was. "The questions I asked were: this is what I heard and do you feel that is what happened? Then I followed up with did you get hurt? I never told her the definition of abuse." During a telephone interview on 10/6/20, at 3:05 p.m., the concern form for R4 was read to the administrator who stated "I think it was written more to clarify what happened." "We asked R4 if she felt safe and she did." "We asked what she meant by rough as everyone's definition is different and the word 'rough' triggers to ask more questions." Administrator stated when R4 was interviewed, R4 stated she felt more rushed than rough. When asked if this should have been reported and an investigation completed, administrator stated "R4 saying she just felt rushed made her think it was more customer service", but added "I can see what you are reading to me, this would have seemed like it should be reported." Facility policy titled, Abuse Prohibition-Vulnerable	21990		

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21990	Continued From page 7	21990		

Adult Protection/Abuse Prevention Plan, revision date 2/24/20, included:
- It is the policy of this organization that "abuse" allegations are reported per Federal and State Law.
- The facility will ensure that all alleged violations involving abuse...are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious body injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures.

SUGGESTED METHOD OF CORRECTION: The administrator or designee could provide additional training to staff on reporting incident of potential abuse and neglect to designated state agency (SA). Administrator or designee could perform audits to ensure state agency (SA) reports are submitted timely.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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F 000	INITIAL COMMENTS On 10/6/20, an abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was found to be substantiated with no deficiencies cited due to actions implemented by the facility prior to survey: H#5411080C The following complaint was found to be unsubstantiated: H#5411081C However, as a result of the investigation a deficiency was identified at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		11/11/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — 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.

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	245411	A. BUILDING ______ B. WING ______	C 10/06/2020

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F 609	Continued From page 1 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 ensure allegations of abuse/neglect were reported to the State Agency (SA) timely, in accordance with established policies and procedures, for 2 of 4 residents (R3 and R4) reviewed for allegations of abuse. Findings include: R3's Resident Face Sheet printed 10/6/20, indicated diagnosis of malignant neoplasm of	F 609	This facility ensures that all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately. Resident R3 was assessed at the time of notification of abuse, and re-interviewed on 10/7/20. Resident stated their were no additional concerns, and that she was satisfied with facility follow up. R4 had been discharged at time complaint survey was in place.	

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F 609	Continued From page 2 right breast, chronic atrial fibrillation (irregular heart beat), tremor, anxiety disorder and osteoporosis (bones become brittle and fragile) with current pathological fracture, left humerus. R3's quarterly Minimum Data Set (MDS) assessment dated 7/30/20, indicated R3 had a brief interview for mental status (BIMS) score of 15 (indicating no impairment in cognition) and was able to express her wants and needs. The MDS also indicated R3 required extensive assistance with activities of daily living (ADL's). R3's care plan, reviewed 8/10/20, indicated R3 had an alteration in mobility and required assist of one for transfers, bed mobility, dressing, toileting and R3 is a vulnerable adult with intervention to provide safe environment for resident and others. Investigate/report signs symptoms or accusations of abuse/neglect as appropriate. Review of a note, dated 9/27/20, by social services (SS)-A, indicated an interview occurred with R3 at 3:00 p.m., and stated R3 asked for assistance to read her menu and Nursing Assistant (NA)-A stormed of out of the room and didn't return. NA-A returned after supper and asked what R3 had done to get ready for bed. R3 denied doing anything and NA-A began to issue orders as to what to do. R3 said NA-A was rough with helping R3 with her pants and indicated NA-A should not treat residents this way. R3 also indicated that NA-A called her the turtle because she moves so slow. During interview on 10/6/20, at 11:51 a.m., R3 indicated NA-A entered her room approximately 8:00 p.m. and asked what I had done to get ready for bed and then yelled at me and slammed the	F 609	All residents at facility are considered to be at risk to abuse, neglect and exploitation. Residents are reviewed upon admission, quarterly and as needed. . All staff were re-educated on reporting alleged violations and time frames to report to the administrator and state agency. Policy and procedure related to vulnerable adult reporting was reviewed and is current. Social services or designee will audit 3 concern forms and 3 resident progress notes weekly for one month and then 3 concerns forms and 3 resident progress notes monthly for 3 months to ensure all potential abuse concerns were reported immediately to the facility administrator and not documented elsewhere. Audit results will be reported to the QA committee and action plans developed as needed.	

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pajamas around and the bedside table. R3 further indicated she was rough when NA-A assisted R3 into her bed, and NA-A was rude and short tempered indicating she was tired and wanted to go home and R3 was not helping her out. R3 indicated she used to call her turtle but that stopped after she told someone about it, but was not able to identify the staff member she told.

During interview on 10/6/20, at 12:54 p.m., SS-A indicated she was made aware of this issue upon investigation of a separate vulnerable adult report. Upon interview with R3 and after discussion with the administrator, SS-A indicated it was determined this was bad customer service and not abuse. SS-A stated she asked R3 if she could check her for bruises and R3 indicated there weren't any. SS-A indicated she completes vulnerable adult reports if it is clear such as bruises or the resident is acting different, but discusses any "gray" or questionable issues with the administrator before she files a vulnerable adult report. When questioned about further follow-up on this complaint, SS-A indicated it was part of the initial vulnerable adult report.

During interview 10/6/20, at 3:00 p.m., the administrator indicated a team approach is used to determine what is reportable and what is dignity or customer service issues. The administrator further indicated she looks for trigger terms such as someone is abusive to me or someone slapped me across the face and listen for words such as rough or nasty and does further investigation as to what that means to the resident. The administrator further indicated SS-A did talk through some concerns R3 had brought forward and there was a lack of follow through.

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R4's admission Minimum Data Set (MDS) assessment dated 9/7/20, indicated R4 was cognitively intact with moderate difficulty hearing requiring a hearing aid, vision was impaired requiring corrective lenses, speech was clear, she understood and was able to understand. R4 required extensive assistance for bed mobility, transfers, locomotion on the unit and dressing. R4 required limited assistance of one staff when walking.

Sholom Concern Form dated 9/16/20, indicated R4 had reported that trained medication assistant (TMA)-A was very rough with her that morning, pulling her pants up/down aggressively and seemed very rushed. According to the document, R4 indicated "I feel like maybe I was doing something wrong, or that it was my fault I wasn't already dressed." This allegation was determined to be a customer service issue. According to the form, TMA-A was questioned and stated she did not rush R4 when she grabbed her to pull her pants up while R4 was standing at her walker.

According to the concern form, R4 was immediately interviewed by social worker (SW)-B who asked R4 if her report was more of a customer service issue or if R4 felt the actions were abusive in nature. SW-B explained the definition of abuse in which R4 indicated she felt safe, but hurried through her cares, adding that it wasn't abuse and it wasn't a big deal. R4 told SW-B that she felt safe and was not opposed to having this same TMA continue to care for her. As a plan of action after this allegation, staff were reminded and encouraged to be more patient next time and to give R4 time to participate in cares.

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During an interview on 10/6/20, at 12:54 p.m., when asked how a customer service issue versus abuse is determined, (SW)-A stated she looked at how upset the resident is; "I ask the resident if we can check for bruises." SW-A went on to say "if it is clear, I make the report, such as bruises or the resident is acting different. If it is gray and questionable whether it is customer service related, I talk to the administrator and get guidance from her. In this case it was decided it was more customer service related."

During an interview on 10/6/20, at 1:40 p.m., the director of nursing (DON) was given R4's Sholom Concern Form dated 9/16/20, to review. DON stated she vaguely remembered it and didn't deal with it hands on. She stated "when a resident reports being handled roughly, whomever receives that information tells the nurse, then someone, such as the nurse manager, or social worker gets more details. In this case, when more details were obtained, it didn't seem reportable and that it was more of a customer service issue. That is my interpretation." When asked how it is determined whether what a resident says is a reportable allegation or a grievance, DON replied that "some are obvious, but when some are on the fence, the administrator and the social worker discuss them."

During an interview on 10/6/20, at 2:35 p.m., SW-B stated she started at the facility in July 2020; it was her first job post graduate. SW-B stated she was familiar with the facility abuse policy, stating she was sure she went over it at orientation and added she was a mandated reporter. SW-B stated she did not have specific training on interviewing residents; she used her

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F 609	Continued From page 6 knowledge and experience. SW stated she interviews residents at the direction of the administrator or DON and had only interviewed R4 since working at the facility. SW-B stated when she spoke to R4, R4 indicated she felt this was blown out of proportion, that it wasn't abuse but rather too fast and rushed for that time of the morning. SW-B had not seen the completed Concern Form and after reading it, stated she did not ask R4 what abuse was. "The questions I asked were: this is what I heard and do you feel that is what happened? Then I followed up with did you get hurt? I never told her the definition of abuse." During a telephone interview on 10/6/20, at 3:05 p.m., the concern form for R4 was read to the administrator who stated "I think it was written more to clarify what happened." "We asked R4 if she felt safe and she did." "We asked what she meant by rough as everyone's definition is different and the word 'rough' triggers to ask more questions." Administrator stated when R4 was interviewed, R4 stated she felt more rushed than rough. When asked if this should have been reported and an investigation completed, administrator stated "R4 saying she just felt rushed made her think it was more customer service", but added "I can see what you are reading to me, this would have seemed like it should be reported." Facility policy titled, Abuse Prohibition-Vulnerable Adult Protection/Abuse Prevention Plan, revision date 2/24/20, included: - It is the policy of this organization that "abuse" allegations are reported per Federal and State Law. - The facility will ensure that all alleged	F 609		

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F 609	Continued From page 7 violations involving abuse...are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious body injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures.	F 609		