

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 7, 2021

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

RE: CCN: 245411

Cycle Start Date: March 30, 2021

Dear Administrator:

On March 30, 2021, 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:

Jamie Perell, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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 June 30, 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 September 30, 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,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 7, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: 2YII11

Dear Administrator:

The above facility was surveyed on March 30, 2021 through March 30, 2021 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 "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.

Shirley Chapman Sholom Home East April 7, 2021 Page 2

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:

Jamie Perell, Unit Supervisor Metro A District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: jamie.perell@state.mn.us

Office: (651) 245-8094

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.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 04/16/2021 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/09/21 **Electronically Signed**

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Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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Minnesota Department of Health

STATE FORM 6899 2YII11 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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Minnesota Department of Health STATE FORM

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

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

PRINTED: 04/16/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

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	conducted at your f to be NOT in compl 42 CFR 483, Subpa Term Care Facilities	dard abbreviated survey was acility. Your facility was found liance with the requirements of art B, Requirements for Long s.					
	SUBSTANTIATED:						
	as your allegation on Departments accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 609 SS=D	onsite revisit of you	d Violations	F 6	09			4/14/21
		onse to allegations of abuse, n, or mistreatment, the facility					
	involving abuse, ne mistreatment, include source and misappe are reported immediately	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					
	DIRECTOR'S OR PROVIDICALLY Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE			(X6) DATE 04/09/2021

(X2) MULTIPLE CONSTRUCTION

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

Facility ID: 00496

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245411	B. WING _			30/2021
	PROVIDER OR SUPPLIER	M HOME EAST		STREET ADDRESS, CITY, STATE, ZIP OF 740 KAY AVENUE SAINT PAUL, MN 55102		30,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 609	that cause the alle serious bodily injur the events that cause and do not in the administrator cofficials (including adult protective se for jurisdiction in loaccordance with Sprocedures. §483.12(c)(4) Reprinvestigations to the designated representations and if the appropriate corrections REQUIREMED by: Based on interview facility failed to immadministrator and inthe State agency (fallegations of abuse reviewed for abuse reviewed for abuse Findings include: R3's quarterly Mini 1/8/21, indicated Rdiagnoses included Review of the facil Concern Form, dareported trained more ponded to R3's upon entering R3's upon entering R3's upon entering R3's abuse of the facil Concern Form, dareported trained more ponded to R3's upon entering R3's upon enter	gation involve abuse or result in y, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to f the facility and to other to the State Survey Agency and rvices where state law provides ing-term care facilities) in tate law through established ort the results of all e administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. NT is not met as evidenced w and document review, the mediately report to the failed to immediately report to SA) no later than 2 hours, we for 1 of 3 residents (R3)	F 60	This facility ensures that a violations involving abuse, exploitation or mistreatmen immediately. Resident R3 was interviewed on 3/30 form was identified as poss Resident felt that the conceadequately addressed back and had no further concern member involved. Resident she continues to feel safe a knows how to report conce Observations of staff interaresident were completed at concerns. All residents at facility are of	neglect, at are reported O when concern sible VA. ern was a in February as with staff t voiced that at facility and rns. ections with and showed no	

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			74. BOILD				с
		245411	B. WING			03/3	30/2021
	PROVIDER OR SUPPLIER CHAPMAN SHOLOI	M HOME EAST		74	TREET ADDRESS, CITY, STATE, ZIP CODE 40 KAY AVENUE AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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	TMA-A turned off the room. R3 attempted not due to staff talk hallway. R3 turned and TMA-A again in hell do you have your reported she was held due to the noise. To turned off R3's call when interviewed verified TMA-A had stated, "why the heart on, its 6:30 am?" Reported her so she facility. R3 stated Towas "rough" and she language, but she was "rough" and she registered nurse (R"bothered" by seve comments. SS-A stated she had VA report but verified mandated reporter. When interviewed licensed practical in been informed of the during a team mee and TMA-A to investigate and TMA-A to investigate the staff of the staf	the call light and exited the d to go back to sleep but could sing and laughing loudly in the her call light on to report this esponded and stated, "why the bur call light on again?" R3 having trouble falling asleep MA-A stated, "Well it isn't me", light, and exited the room. On 3/30/21, at 11:22 a.m. R3 if come into her room and sell do you have your call light the stated the interaction of the filed a grievance with the filed and other staff language he often overheard this was used to it now as "it's their sconcerns and conducted an with R3 about the allegations. Ported the concern to RN)-A. SS-A stated R3 was ral of TMA-A's alleged tated the administrator and vulnerable adult (VA) reports. In the filed the stated the administrator and the filed the stated the administrator and the filed the filed the administrator and the filed the stated the administrator and the filed the filed the administrator and the filed the filed the administrator and the filed the	F 6	609	be at risk for abuse, neglect and exploitations. Residents are review upon admissions, quarterly and as needed. All staff were reeducated on report alleged violations and time frames report to the administrator and stat agency. Policy and procedure relativulnerable adult reporting was reviewed in a current. Social service or designee will audiconcern forms and three progress weekly for one month and then three concern forms and three resident progress notes monthly for three material to ensure all potential abuse concern were reported immediately to the far administrator and not documented elsewhere. Audits will be reported dot the QA committee and action plans developmeded.	ing to e ed to ewed it three notes ee nonths erns accility	

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245411	B. WING		03	/30/2021
	PROVIDER OR SUPPLIER CHAPMAN SHOLON	I HOME EAST		STREET ADDRESS, CITY, STATE, ZII 740 KAY AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 609	was reportable as a from my understand reported, but I didn' reported." LPN-A st done by SS. When interviewed overified SS-A had rehowever, she was rethat time, so she th LPN-A who was resverified the incident don't think anyone so werified there had be she remembered hidd not recall details grievance and state SS-B verified she was reported.	abuse and stated, "I guess ding this should have been I't know that this needed to be tated reporting was usually on 3/30/21, at 1:40 p.m. RN-A eported the incident to her, not responsible for R3's unit at en reported the incident to sponsible for R3's unit. RN-A t was reportable and stated, "I should be sworn at." on 3/30/21, at 1:58 p.m. SS-B eeen a grievance filed by R3, earing about the incident but is. SS-B reviewed the ed, "it sounds reportable". I was a designated reporter for ryone in the building is a	F 6	509		
	orientation." SS-B f is that it should have when interviewed administrator verification about verbal abuse reported and stated the cracks, when I recall of it." The administrator verification of it." The administrator would have expected is a mandated reported and the protection of A 2/24/2020, indicate language that was a significant or some content of the protection o	on 3/30/21, at 2:10 p.m. the ed R3 had filed a grievance by TMA-A which was not d, "This one slipped through saw it I did not even have any ministrator further stated, "I ed that be reported. Everyone				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245411	B. WING			C / 30/2021
	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP C 740 KAY AVENUE SAINT PAUL, MN 55102		100/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 609	distance. The police ensure that all alleg neglect, exploitation injuries of unknown of resident property but not later than 2 made." The policy the employees are maintained.	y indicated the facility "will ged violations involving abuse, or mistreatment, including a source and misappropriation or, are reported immediately, hours after the allegation is further indicated "all and ated reporters and must diately report abuse, neglect,	F 6	09		