

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered August 23, 2021

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

RE: CCN: 245411

Cycle Start Date: July 12, 2021

Dear Administrator:

On August 20, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mittig

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 July 20, 2021

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

RE: CCN: 245411

Cycle Start Date: July 12, 2021

Dear Administrator:

On July 12, 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:

Sarah Grebenc, Unit Supervisor Metro B 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: sarah.grebenc@state.mn.us Office: (651) 201-3792

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 October 12, 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 January 12, 2022 (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,

Kumalu Fishe Downing

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

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

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

PRINTED: 08/05/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

		245411	B. WING _		07/12/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SHIRLEY	CHAPMAN SHOLON	M 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	
F 000	INITIAL COMMENT	гѕ	F 00	00	
	conducted at your f to be NOT in compl	ndard abbreviated survey was facility. Your facility was found liance with the requirements of art B, Requirements for Long s.			
	The following comp SUBSTANTIATED:	plaints were found to be			
	deficiency cited at (460 and MN73987), with a F584 and F677). 397), with no deficiency cited.			
	as your allegation of Departments acception enrolled in ePOC, yat the bottom of the	f correction (POC) will serve of compliance upon the otance. 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 584 SS=D	onsite revisit of you validate that substa regulations has been	table/Homelike Environment	F 58	34	8/16/21
	comfortable and ho	right to a safe, clean, melike environment, including ceiving treatment and			
		ovide- e, clean, comfortable, and ent, allowing the resident to			
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
⊨lectron	ically Signed				07/29/2021

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245411	B. WING			C 12/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 740 KAY AVENUE SAINT PAUL, MN 55102	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 584	possible. (i) This includes en receive care and sphysical layout of independence and (ii) The facility shat the protection of the or theft. §483.10(i)(2) House services necessar and comfortable in §483.10(i)(3) Clea in good condition; §483.10(i)(4) Privaresident room, as §483.10(i)(5) Adeceded in all areas; §483.10(i)(6) Complevels in all areas; §483.10(i)(6) Complevels. Facilities in 1990 must mainta 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMED by: Based on observareview, the facility was cleaned and in the sound in the so	sonal belongings to the extent assuring that the resident can services safely and that the the facility maximizes resident I does not pose a safety risk. Il exercise reasonable care for the resident's property from loss sekeeping and maintenance y to maintain a sanitary, orderly,	F 5	• Resident R2 had their to cleaned by housekeeping of facility conducted whole how resident bathrooms to ensurable All nursing staff were re-edicleaning visibly soiled toilet away, if further more detailed.	on 7.12.21, use audit on ure cleanliness. ucated on seats right	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED C	
		245411	B. WING			12/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE SAINT PAUL, MN 55102	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	ULD BE	(X5) COMPLETION DATE
F 584	R2's annual Minim 05/04/21, indicated Mental Status (BIN indicated moderat MDS further indica assistance of staff Review of R2's metime R2 had a bow at 5:33 p.m. On 07/12/21, at 10 (FM)-E was intervistains on the toilet visited and staff di would clean it if should clean it if should clean it if should also a pack of bevon 07/12/21, at 11 (NA)-A was interviseat was soiled withousekeeping had NA-A also confirm beverages behind know who put it the housekeeping wou and walked away. On 07/12/21, at 11 nurse (LPN)-A was toilet seat had a dishe was sure the Ithe room yet. LPN beverages should	dum Data Set (MDS) dated d R2 had a Brief Interview for MS) score of 12, which e cognitive impairment. R2's ated R2 required extensive with transfers and toileting. Redical record revealed, the last wel movement was on 07/11/21, D:12 a.m., family member ewed and stated she saw feces seat all the time whenever she d not clean it. She said staff	F 584	All residents at facility have potential to be affected by the dispractice. All nursing staff were re-edu housekeeping policy and proced expectations of cleaning when the visibly soiled. Nursing staff will of disinfect a toilet if visibly soiled appossible. If more detailed cleaning required, then housekeeping with notified. Facility will conduct five audited week for four weeks, five audited month for three months, and with following QA meeting. •	eficient ucated on dure and oilet is clean and as soon as ing is Il be lits per	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
	245411		B. WING		C 07/12/2021		
	PROVIDER OR SUPPLIER	M HOME EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 740 KAY AVENUE SAINT PAUL, MN 55102		12021	
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 584	on 07/12/21, at 12: stated that she had no one had told her said that she would notified her. She us bathroom once a dono 07/12/21, at 12: the toilet seat was on had not cleaned the pack of beverage bathroom next to to bedroom and store	walked out of the room and did rages to another area nor it. 10 p.m., housekeeper (HK)-A not cleaned the room yet and the toilet seat was dirty. HK-A I clean it right away if staff sually cleaned the resident's	F 58	4			
F 677 SS=D	(DON) stated that is to clean the toilet of to clean it right away. The Facility Disinferupdated 6/2/21, indiction touch points and we ADL Care Provided CFR(s): 483.24(a)(S) A resout activities of dail services to maintain personal and oral has REQUIREMED by:	cting and Cleaning policy was licated toilet seat was high ould be disinfected regularly. If for Dependent Residents 2) sident who is unable to carry y living receives the necessary in good nutrition, grooming, and bygiene;	F 67			8/16/21	
	Based on observa	tion, interview and document		Facility nurse cleaned the f	iinger nails		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245411	B. WING			C 12/2021	
NAME OF F	PROVIDER OR SUPPLIE	ir.	1	STREET ADDRESS, CITY, STATE, ZIP CO	•	12/2021	
				740 KAY AVENUE			
SHIRLEY	CHAPMAN SHOLO	OM HOME EAST		SAINT PAUL, MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From	page 4	F 6	577			
F 677	review, the facility hygiene specific t (R2, R1) reviewer (ADL's). Further, therapy recommeresidents (R2) reviewed (R2) requirements (R2) requ	y failed to provide personal to nail care to 2 of 3 resident of on activities of daily living the facility failed to implement a ended walking program for 1 of 3 viewed for rehabilitation. Record dated 02/11/20, indicated included chronic obstructive se, coronary artery disease, placed fracture left lower leg. The mum Data Set (MDS) dated and R2 had a Brief Interview of IMS) score of 12, indicated we impairment. R2's MDS further uired extensive assistance with the date of 19/20, identified R2 had care ability and an activities of problem related to chronic onary disease, dementia, and falls. The care plan et to be done weekly with bath the care plan also directed staff daily following lunch." 11/02/20, indicated nursing reded to walk with resident four-wheel walker twice a day	F6	of Resident R2 on 7.12.21, a R2 has been added to the list by in house podiatry at next of Resident R2 is currently work therapy. Resident daughter a psychological services are interested to ambulating and wo therapy. Facility was not made aware regarding resident R1 until 25 received. Resident R1 until 25 received. Resident R1 has si discharged. Per 2567 RN wa was going to send NAR in to nails. • All residents at facility wh assistance with activities of d have the potential to be affect deficient practice. • On 7/22/21, a whole hous conducted on current resider an ambulation recommendat therapy. Education was provi licensed and non-licensed cli regarding proper nail care an implementation of recommer program. Education was prov nurse management on the pr for implementing therapy recommendations. Education provided to all nursing staff o and changes in ADL status. N bath day was added to admis set and for all in house reside • Nail Care-Facility will con	t to be seen visit. king with ind in house volved to not behavior rking with of concern 567 was note in require aily living ted by the se audit was its who have ion from ded to all nical staff dodd walking vided to roper steps in was in refusals vail care on ssion order ents.		
	medical record la was on a restorat	edical record revealed R2's cked documentation that R2 tive nursing program, per (PT) recommendation at		audits per week for four week per month for three months, a review at following QA meetir Therapy Recommended Wal	ks, five audits and will ng.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMI	E SURVEY PLETED
		245411	B. WING				C 1 2/2021
	PROVIDER OR SUPPLIER			74	TREET ADDRESS, CITY, STATE, ZIP CODE 40 KAY AVENUE AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 677	discharge in Novemedical record lad assisted to walk/a discharged from Frecord for the mor NA charted not ap On 07/12/21, at 10 (FM)-E was intervnot do nail care fo and her fingernails FM-E visited R2. Frecently because toes hurt when he said the staff did roffered to walk with On 07/12/21, at 10 was observed to bunder eight out of On 07/12/21, at 11 (NA)-A stated R2 used the EZ stands and R2 would have could not remembed one. He stated he gave her bath the gave her bath the rails were dirt. On 07/12/21, at 11 (LPN)-A stated the care on their bath not tell when the lass confirmed that needed to be clear difficulty to walk at the care of the confirmed that needed to walk at the care difficulty to walk at the care of the confirmed that needed to walk at the care of the care of the care of the care difficulty to walk at the care of the care of the care difficulty to walk at the care of the care o	ember 2020. Further, the cked evidence R2 had been mbulate per order since R2 was PT. Review of the medical of the foliation of June and July indicated oplicable for 21 days. 10:12 a.m., family member iewed and stated the staff did or R2. R2's toenails were long, is had dirt underneath every time FM-E had to cut her toenails they were too long and R2's or shoes were on. FM-E also not walk R2 per order or even the her. 10:15 a.m., the resident's nail one short and dirty. She had dirt ten of her finger nails. 11:32 a.m., nursing assistant was not able to walk, and he is to get her up all the time. NA-A we nail care on her bath day but over when she had her nail care edid not do her nail care when two weeks ago. He confirmed	F 6	677	Program-Facility will conduct three per week for four weeks, five audits month for three months, and will refollowing QA meeting.	s per	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	TIPLE CONSTRUCTION	` ´con	(X3) DATE SURVEY COMPLETED	
		245411	B. WING			C / 12/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 740 KAY AVENUE SAINT PAUL, MN 55102		12/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 677	shower day or anythe long or dirty. LP worked with PT betwint. LPN-B confirm stated she would a them. On 07/12/21, at 1:0 (OT)-F was interviet to the toilet and bachursing staff had us She said usually if condition, staff wou however she had mobility about R2 usually about the until today. She staneeded to use EZ since the last time 2020. On 07/12/21, at 1:3 walk, and she had times to the bathrobother to do her nature of the confirmed she had	age 6 uld do nail care for resident on time the nails were noticed to N-B was not sure if R2 had fore she transferred to that med R2's nails were dirty and sk nursing assistant to clean O3 p.m., occupational therapist ewed and confirmed R2 walked ck to bed . OT-F did not know sed EZ stand to get R2 up. there was a change of uld alert OT for evaluation, not heard any change of until today (07/12/21). In p.m., PT-G stated when she september 2020, R2 was on walk in hallway. R2's m was 3 times a week and up me with someone follow with liker. PT-G confirmed she had at R2's mobility had declined at R2's mobility had declined at R2's mobility had declined at R2's mobility had selented that she did not know R2 stand, and it was a big change PT-G saw R2 in September O3 p.m., NA-B stated R2 could been walked with him couple om. NA-B confirmed he did not uils even on her shower day. O1 p.m., NA-C stated staff used rup but R2 could walk. She not walked R2 after meals.	F6	577			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED C	
		245411	B. WING		07	/12/2021
	PROVIDER OR SUPPLIER	M HOME EAST		STREET ADDRESS, CITY, STATE, Z 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		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 677	not walk with her and do any nail care for have her nail care of did not know when On 07/12/21, at 2:1 (DON) stated the non shower day. If the themselves and the expected staff wou On 07/14/21, at 3:0 documentation for program. DON state refusals were a bar walking therapy. Downs to follow the cawas unable or unwassistant should upsteps. R1 admission Minif 6/26/21, indicated for Mental Status (BIM moderate cognitive identified medical capsis (the body's identified medical capsis (the body's identified assistance fro and incontinence computing an observate R1 was in fully dresmatted in back and dark crusted mater around the cuticles	all. He confirmed he did not her. NA-D guessed R2 would done on her shower day but her shower day was. 2 p.m., director of nursing ail care should be done weekly he resident could not speak for eir nails were dirty, DON did clean them for residents. 9 p.m., DON provided R2 and her restorative ed R2 refused to walk, and her rrier for staff to help her with DN's expectation from staff are plan/orders. If a resident dilling to participate the nursing date the nurse on this for next mum Data Set (MDS) dated R1 had a Brief Interview of S) score of 10, indicated impairment. The MDS diagnoses included stroke, response to an infection sues) and pneumonia. 2 d 7/5/21, identified R1 needed m staff for dressing, grooming ares. 3 ion on 7/12/21, at 11:25 a.m. ased for the day, hair was appeared greasy. R1 had ial under her fingernails and		777		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
	245411 B.					C 07/12/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 740 KAY AVENUE SAINT PAUL, MN 55102		12/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 677	reported she was e appearance. State nail technician, and let her hair be great unable to do so her care." R1 reported was that she had di had bowel movemeright hand and in the reported that she as fingernails since the completed. On 7/12/21, at 11:4 (RN)-A entered the have nails cleaned she would send a nRN-A stated hands meals and after toil. The facility's Activitinail care policy revi	mbarrassed of her d she was a hairdresser and stated she never would have sy and uncombed, but was self. "The staff skips over hair what was "very bothersome" farrhea the prior evening and ent under her fingernails on the e cuticle crevasses. R1 sked staff to soak her e prior day and it was not 5 a.m. registered nurse room and R1 asked to please before lunch. RN-A stated tursing assistant in right away, were to be cleaned prior to all eting. Tes of Daily Living (ADL's) for sed July 2017, indicated nail d weekly on bath days and as	F6	577			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 20, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: Q68611

Dear Administrator:

The above facility was surveyed on July 12, 2021 through July 12, 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.

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:

Sarah Grebenc, Unit Supervisor Metro B 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: sarah.grebenc@state.mn.us

Office: (651) 201-3792

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit

Health Regulation Division

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

Email: Kamala.Fiske-Downing@state.mn.us

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	l` ′c	X3) DATE SURVEY COMPLETED	
		00496	B. WING		C 07/12/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
SHIRLE	Y CHAPMAN SHOLON	M HOME FAST	Y AVENUE PAUL, MN 55	102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surve found that the deficiency found that the deficiency for the matter of the Minnesota Deputer of the Minnesota Deputer of the Minnesota Deputer of the Minnesota Deputer of the Minnesota Opposite of the number and MN Ruwhen a rule contains comply with any of lack of compliance. The result in the assess	hether a violation has been	m			
	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 t hin 15 days of receipt of a ent for non-compliance.				
/linnesota Γ	at your facility by su Department of Hea found NOT in comp Licensure. Please i of correction you ha	TS: nplaint survey was conducted urveyors from the Minnesota lith (MDH). Your facility was coliance with the MN State indicate in your electronic place are reviewed these orders also they will be completed.	n	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwar Tag numbers have been assigned to Minnesota state statutes/rules for Nursir Homes.		
		DER/SUPPLIER REPRESENTATIVE'S	SIGNATURE	TITLE	(X6) DATE	

Electronically Signed

07/29/21

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		00496	B. WING		1	2/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLON	1 HOME EAST 740 KAY A SAINT PA	AVENUE UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ntinued From page 1 2 000				
	SUBSTANTIATED: H5411099C (MN74 licensing order issu H5411100C (MN74 issued. The facility is enroll Correction (ePoC) a not required at the l State form. Although	460 and MN73987) with a led at 0860 and 1695 and 397) with no licensing order led in the electronic Plan of and therefore a signature is bottom of the first page of the gh no plan of correction is led that you acknowledge		The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. To column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the surfindings are the Suggested Metho Correction and the Time Period For Correction.	Tag." I the sites" ply" his s which after the s veyors d of	
				PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTAS STATUTES/RULES.	TO THIS O ON FOR	
2 860	Subp. 2. Criteria for proper care. The cadequate and proper. per care and att	or determining adequate and riteria for determining	2 860			8/16/21

Minnesota Department of Health

STATE FORM 6899 Q68611 If continuation sheet 2 of 10

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE S	
				 .	С	
		00496	B. WING		07/1	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLON	# HOME EAST 740 KAY #	_	••		
	0.0000000000000000000000000000000000000		UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 860	Continued From pa	ige 2	2 860			
	by: Based on observatireview, the facility for hygiene specific to (R2, R1) reviewed for (ADL's). Further, the therapy recommentersidents (R2) reviews Findings include: R2's Admission Rerective diagnoses included pulmonary disease hypertension, displayed R2's annual Minimu 05/04/21, indicated Mental Status (BIM moderate cognitive	ent is not met as evidenced ion, interview and document ailed to provide personal nail care to 2 of 3 resident for activities of daily living e facility failed to implement a ded walking program for 1 of 3 ewed for rehabilitation. cord dated 02/11/20, indicated luded chronic obstructive, coronary artery disease, acced fracture left lower leg. um Data Set (MDS) dated R2 had a Brief Interview of S) score of 12, indicated impairment. R2's MDS further		The director of nursing and/or des will educate responsible staff to pr care to residents' dependent on fa staff, based on residents' comprehassessed needs. The DON or descould conduct audits of dependent resident cares to ensure their pershygiene needs are met consistent.	ovide cility nensively ignee t sonal	
	transfers. R2's care plan date alteration in self-ca daily living (ADL) probstructive pulmon neuropathic pain arindicated nail care than as needed. The to "walk resident date 11 assistant (NA) need 100-150 feet with for and follow with whe Review of the medialteration in self-care plants."	I/02/20, indicated nursing ded to walk with resident our-wheel walker twice a day				

Minnesota Department of Health

STATE FORM G899 Q68611 If continuation sheet 3 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
00496		B. WING			C 1 2/2021		
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
SHIRLE	Y CHAPMAN SHOLON	I HOME EAST	740 KAY A SAINT PA	AVENUE .UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED I SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 860	Continued From pa was on a restorative physical therapy (P' discharge in Novem medical record lack assisted to walk/amdischarged from PT record for the mont NA charted not app On 07/12/21, at 10: (FM)-E was intervient do nail care for and her fingernails FM-E visited R2. FN recently because the toes hurt when her said the staff did no offered to walk with On 07/12/21, at 10: was observed to be under eight out of the Condition of the EZ stand the staff did not remembed done. He stated he he gave her bath two her nails were dirty. On 07/12/21, at 11: (LPN)-A stated the care on their bath do not tell when the lass he confirmed that needed to be cleaned difficulty to walk and difficulty to walk and the confirmed that needed to walk and the confirmed that needed to walk and difficulty to walk and the confirmed that needed t	e nursing program. T) recommendation ber 2020. Further ded evidence R2 habulate per order some for 20 a.m., family measured and stated the R2. R2's toenails who was a stated the R2. R2's toenails who was were too long a shoes were on. Flut walk R2 per order her. 15 a.m., the reside the short and dirty. Sleen of her finger nail as not able to walk to get her up all the enail care on her bur when she had he did not do her nail wo weeks ago. He dest time R2 has her R2's nails were direct.	n at , the ad been ince R2 was edical indicated	2 860			

Minnesota Department of Health STATE FORM

6899 Q68611 If continuation sheet 4 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00496		B. WING			C 12/2021
	PROVIDER OR SUPPLIER CHAPMAN SHOLON	I HOME EAST	740 KAY	, ,	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 860	Continued From particles of the NA coushower day or anytiple long or dirty. LPI worked with PT befunit. LPN-B confirms tated she would as them. On 07/12/21, at 1:0 (OT)-F was intervied to the toilet and backnursing staff had us She said usually if the condition, staff wou however she had not mobility about R2 ure on 07/12/21, at 1:1 discharged R2 in Swalking program to 100 feet each time wheelchair and wall not heard about the until today. She start needed to use EZ since the last time if	13 p.m., (LPN)-B sauld do nail care for rime the nails were rime the nails were rime the nails were rime. B was not sure if ore she transferred ned R2's nails were sk nursing assistant. 3 p.m., occupational wed and confirmed sk to bed . OT-F did sed EZ stand to get here was a change lid alert OT for evaluation to the ard any changentil today (07/12/21). 1 p.m., PT-G stated eptember 2020, R2 walk in hallway. R2 was 3 times a week with someone folker. PT-G confirment R2's mobility had ted that she did not stand, and it was a ball was	esident on noticed to R2 had to that dirty and to clean at the apist R2 walked not know R2 up. of uation, e of). I when she was on 's ek and up llow with d she had declined know R2 pig change	2 860	DEFICIENC	Υ)	
	On 07/12/21, at 1:3 walk, and she had times to the bathroobother to do her na	peen walked with hi om. NA-B confirmed	m couple d he did not				
	On 07/12/21, at 7:0 EZ stand to get her confirmed she had	up but R2 could wa	alk. She				
	On 07/12/21, at 7:4	7 p.m., NA-D stated	d he had				

Minnesota Department of Health

STATE FORM G899 Q68611 If continuation sheet 5 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				С		
		00496	B. WING		07/1	2/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHIRLE	CHAPMAN SHOLON	M HOME EAST 740 KAY A	WENUE UL, MN 551	02		
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
2 860	Continued From pa	ge 5	2 860			
	do any nail care for have her nail care of did not know when On 07/12/21, at 2:1 (DON) stated the non shower day. If themselves and the expected staff would not on 07/14/21, at 3:0 documentation for program. DON state refusals were a bar walking therapy. Do was to follow the car was unable or unwing the state of the	all. He confirmed he did not her. NA-D guessed R2 would done on her shower day but her shower day was. 2 p.m., director of nursing ail care should be done weekly he resident could not speak for eir nails were dirty, DON ld clean them for residents. 9 p.m., DON provided R2 and her restorative ed R2 refused to walk, and her rier for staff to help her with DN's expectation from staff are plan/orders. If a resident lling to participate the nursing date the nurse on this for next				
	6/26/21, indicated R Mental Status (BIM moderate cognitive identified medical d sepsis (the body's i damages its own tis R1's care plan date total assistance fro and incontinence companding an observat R1 was in fully dres matted in back and dark crusted mater around the cuticles	ion on 7/12/21, at 11:25 a.m. esed for the day, hair was appeared greasy. R1 had ial under her fingernails and				

Minnesota Department of Health

STATE FORM G899 Q68611 If continuation sheet 6 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				С		
		00496	D. WING		07/1	2/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLON	M HOME EAST 740 KAY A	WENUE UL, MN 551	02		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	COMPLETE DATE	
2 860	Continued From pa	ige 6	2 860			
	reported she was e appearance. State nail technician, and let her hair be greatunable to do so her care." R1 reported was that she had dihad bowel movemeright hand and in the reported that she as fingernails since the completed. On 7/12/21, at 11:4 (RN)-A entered the have nails cleaned she would send a nails cleaned and response to the complete sent the sent that the sent the sent that the sent that the sent that the sent that the sent the sent that the sent that the sent the sent that the sent the sent that the sent	Imbarrassed of her d she was a hairdresser and stated she never would have sy and uncombed, but was reelf. "The staff skips over hair what was "very bothersome" iarrhea the prior evening and ent under her fingernails on the le cuticle crevasses. R1 sked staff to soak her e prior day and it was not 5 a.m. registered nurse room and R1 asked to please before lunch. RN-A stated nursing assistant in right away, were to be cleaned prior to all				
	The facility's Activities of Daily Living (ADL's) for nail care policy revised July 2017, indicated nail care will be provided weekly on bath days and as needed unless contraindicated.					
	SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently.					
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
21695	MN Rule 4658.1419 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			8/16/21

6899

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:					
		00496		B. WING		07/1	; 2/2021
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHIRLE	CHAPMAN SHOLON	M HOME EAST	740 KAY A SAINT PA	AVENUE .UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
21695	Continued From pa	nge 7		21695			
	provide housekeep necessary to maint comfortable interior	eeping. A nursing ho ing and maintenand ain a clean, orderly, r, including walls, fl fixtures, equipment,	e services and oors,				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a toilet seat was cleaned and in sanitary condition for 1 of 3 residents (R2) reviewed for homelike environment. Findings include:			The director of nursing (DON) or designee, will educate staff regard importance of a safe, clean, functi homelike environment. The DON designee, will coordinate and conception audits of areas residents to ensure a safe, clean, functional homelike environment is maintain extent possible.	onal and or duct frequent and		
	05/04/21, indicated Mental Status (BIM indicated moderate MDS further indicated	Minimum Data Set (MDS) dated licated R2 had a Brief Interview for s (BIMS) score of 12, which derate cognitive impairment. R2's indicated R2 required extensive f staff with transfers and toileting.			extent possible.		
		dical record reveale el movement was o					
	(FM)-E was interviews	:12 a.m., family mer ewed and stated she seat all the time who I not clean it. She sa e notified them.	e saw feces enever she				
	On 07/12/21, at 10:15 a.m., R2's toilet seat was observed and soiled with dried bowel. There was also a pack of beverages stored next to the toilet.						

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		C		
		00496	B. WING		07/1	2/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLON	M HOME EAST 740 KAY A SAINT PA	WENUE UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	(X5) COMPLETE DATE	
21695	On 07/12/21, at 11: (NA)-A was intervie seat was soiled with housekeeping had NA-A also confirme beverages behind to know who put it the housekeeping woul and walked away. On 07/12/21, at 11: nurse (LPN)-A was toilet seat had a dri she was sure the housekeeping would and walked away. On 07/12/21, at 11: nurse (LPN)-A was toilet seat had a dri she was sure the housekeeping would be was sure the housekeeping would and walked away. On 07/12/21, at 11: stated that she beverages should receive the beverage should receive the beverage bathroom." LPN-A was toilet seat "It is disguished between the toilet seat was donotified her. She us bathroom once a distribution on the said that she would notified her. She us bathroom once a distribution on the pack of beverage bathroom next to to be droom and store walked away and donotified the HK-A.	32 a.m., nursing assistant wed and confirmed R2's toilet in dried bowel. NA-A stated that not cleaned the room yet. In die the toilet seat, and he did not ire. He stated that indicted clean R2's bathroom later. 45 a.m., license practical interviewed and confirmed the ed bowel on it and stated that ousekeeping had not cleaned A stated the pack of not be stored behind the toilet. Insting to store food in the walked out of the room and did rages to another area nor it. 10 p.m., housekeeper (HK)-A not cleaned the room yet and in the toilet seat was dirty. HK-A clean it right away if staff stally cleaned the resident's lay. 13 p.m., (LPN)-B confirmed dirty and the housekeeping eroom yet. LPN-B also stated ges should not be stored in the diet seat. She moved it to the dit under R2's dresser. She id not clean the toilet seat and	21695			
	On 07/12/21, at 2:12 p.m., director of nursing (DON) stated that she expected the nursing staff to clean the toilet or at least notify housekeeping					

Minnesota Department of Health

STATE FORM G899 Q68611 If continuation sheet 9 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00496	B. WING		07/1	2/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE	·		
SHIRLEY CHAPMAN SHOLOM HO	OME EAST 740 KAY A SAINT PAU	VENUE JL, MN 551	02			
PREFIX (EACH DEFICIENCY MUS	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
updated 6/2/21, indicate touch points and would SUGGESTED METHO The director of nursing educate staff regarding clean, functional and he DON or designee, could maintenance and house periodic audits of areas ensure a safe, clean, further environment is maintain	ng and Cleaning policy was ted toilet seat was high d be disinfected regularly. DD OF CORRECTION: (DON) or designee, could g the importance of a safe, nomelike environment. The alld coordinate with sekeeping staff to conduct s residents frequent to	21695				

6899

Minnesota Department of Health STATE FORM