DEPARTMENT OF HEALTH

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
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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,

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245411	A. BUILDING _____ B. WING _____	C 07/12/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 07/12/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5411099C (MN74460 and MN73987), with a deficiency cited at (F584 and F677). H5411100C (MN74397), with no deficiency cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		8/16/21

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

Electronically Signed | 07/29/2021

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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F 584	Continued From page 1 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This 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:	F 584	• Resident R2 had their toilet thoroughly cleaned by housekeeping on 7.12.21, facility conducted whole house audit on resident bathrooms to ensure cleanliness. All nursing staff were re-educated on cleaning visibly soiled toilet seats right away, if further more detailed cleaning.	

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F 584	Continued From page 2 R2's annual Minimum Data Set (MDS) dated 05/04/21, indicated R2 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. R2's MDS further indicated R2 required extensive assistance of staff with transfers and toileting. Review of R2's medical record revealed, the last time R2 had a bowel movement was on 07/11/21, at 5:33 p.m. On 07/12/21, at 10:12 a.m., family member (FM)-E was interviewed and stated she saw feces stains on the toilet seat all the time whenever she visited and staff did not clean it. She said staff would clean it if she notified them. 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. On 07/12/21, at 11:32 a.m., nursing assistant (NA)-A was interviewed and confirmed R2's toilet seat was soiled with dried bowel. NA-A stated that housekeeping had not cleaned the room yet. NA-A also confirmed there was a pack of beverages behind the toilet seat, and he did not know who put it there. He stated that housekeeping would clean R2's bathroom later and walked away. On 07/12/21, at 11:45 a.m., license practical nurse (LPN)-A was interviewed and confirmed the toilet seat had a dried bowel on it and stated that she was sure the housekeeping had not cleaned the room yet. LPN-A stated the pack of beverages should not be stored behind the toilet. She said "It is disgusting to store food in the	F 584	• All residents at facility have the potential to be affected by the deficient practice. • All nursing staff were re-educated on housekeeping policy and procedure and expectations of cleaning when toilet is visibly soiled. Nursing staff will clean and disinfect a toilet if visibly soiled as soon as possible. If more detailed cleaning is required, then housekeeping will be notified. • Facility will conduct five audits per week for four weeks, five audits per month for three months, and will review at following QA meeting. •	

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F 584	Continued From page 3 bathroom." LPN-A walked out of the room and did not move the beverages to another area nor clean the toilet seat. On 07/12/21, at 12:10 p.m., housekeeper (HK)-A stated that she had not cleaned the room yet and no one had told her the toilet seat was dirty. HK-A said that she would clean it right away if staff notified her. She usually cleaned the resident's bathroom once a day. On 07/12/21, at 12:13 p.m., (LPN)-B confirmed the toilet seat was dirty and the housekeeping had not cleaned the room yet. LPN-B also stated the pack of beverages should not be stored in the bathroom next to toilet seat. She moved it to the bedroom and stored it under R2's dresser. She walked away and did not clean the toilet seat and notified the HK-A. 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 to clean it right away. The Facility Disinfecting and Cleaning policy was updated 6/2/21, indicated toilet seat was high touch points and would be disinfected regularly.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 677	• Facility nurse cleaned the finger nails	8/16/21

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F 677	Continued From page 4 review, the facility failed to provide personal hygiene specific to nail care to 2 of 3 resident (R2, R1) reviewed for activities of daily living (ADL's). Further, the facility failed to implement a therapy recommended walking program for 1 of 3 residents (R2) reviewed for rehabilitation. Findings include: R2's Admission Record dated 02/11/20, indicated R2's diagnoses included chronic obstructive pulmonary disease, coronary artery disease, hypertension, displaced fracture left lower leg. R2's annual Minimum Data Set (MDS) dated 05/04/21, indicated R2 had a Brief Interview of Mental Status (BIMS) score of 12, indicated moderate cognitive impairment. R2's MDS further indicated R2 required extensive assistance with transfers. R2's care plan dated 02/19/20, identified R2 had alteration in self-care ability and an activities of daily living (ADL) problem related to chronic obstructive pulmonary disease, dementia, neuropathic pain and falls. The care plan indicated nail care to be done weekly with bath and as needed. The care plan also directed staff to "walk resident daily following lunch." R2's order dated 11/02/20, indicated nursing assistant (NA) needed to walk with resident 100-150 feet with four-wheel walker twice a day and follow with wheelchair. Review of the medical record revealed R2's medical record lacked documentation that R2 was on a restorative nursing program, per physical therapy (PT) recommendation at	F 677	of Resident R2 on 7.12.21, and resident R2 has been added to the list to be seen by in house podiatry at next visit. Resident R2 is currently working with therapy. Resident daughter and in house psychological services are involved to assist with R2's non-compliant behavior related to ambulating and working with therapy. Facility was not made aware of concern regarding resident R1 until 2567 was received. Resident R1 has since discharged. Per 2567 RN was notified and was going to send NAR in to clean R1 nails. • All residents at facility who require assistance with activities of daily living have the potential to be affected by the deficient practice. • On 7/22/21, a whole house audit was conducted on current residents who have an ambulation recommendation from therapy. Education was provided to all licensed and non-licensed clinical staff regarding proper nail care and implementation of recommended walking program. Education was provided to nurse management on the proper steps for implementing therapy recommendations. Education was provided to all nursing staff on refusals and changes in ADL status. Nail care on bath day was added to admission order set and for all in house residents. • Nail Care-Facility will conduct five audits per week for four weeks, five audits per month for three months, and will review at following QA meeting. Therapy Recommended Walking	

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F 677	Continued From page 5 discharge in November 2020. Further, the medical record lacked evidence R2 had been assisted to walk/ambulate per order since R2 was discharged from PT. Review of the medical record for the month of June and July indicated NA charted not applicable for 21 days. On 07/12/21, at 10:12 a.m., family member (FM)-E was interviewed and stated the staff did not do nail care for R2. R2's toenails were long, and her fingernails had dirt underneath every time FM-E visited R2. FM-E had to cut her toenails recently because they were too long and R2's toes hurt when her shoes were on. FM-E also said the staff did not walk R2 per order or even offered to walk with her. On 07/12/21, at 10:15 a.m., the resident's nail was observed to be short and dirty. She had dirt under eight out of ten of her finger nails. On 07/12/21, at 11:32 a.m., nursing assistant (NA)-A stated R2 was not able to walk, and he used the EZ stand to get her up all the time. NA-A said R2 would have nail care on her bath day but could not remember when she had her nail care done. He stated he did not do her nail care when he gave her bath two weeks ago. He confirmed her nails were dirty. On 07/12/21, at 11:45 a.m.,license practical nurse (LPN)-A stated the NA's usually did resident's nail care on their bath day or as needed. LPN-A could not tell when the last time R2 has her nail done. She confirmed that R2's nails were dirty and needed to be cleaned. LPN-A said R2 had difficulty to walk and refused to walk. On 07/12/21, at 12:13 p.m., (LPN)-B said either	F 677	Program-Facility will conduct three audits per week for four weeks, five audits per month for three months, and will review at following QA meeting.	

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F 677	Continued From page 6	F 677		

nurse or the NA could do nail care for resident on shower day or anytime the nails were noticed to be long or dirty. LPN-B was not sure if R2 had worked with PT before she transferred to that unit. LPN-B confirmed R2's nails were dirty and stated she would ask nursing assistant to clean them.

On 07/12/21, at 1:03 p.m., occupational therapist (OT)-F was interviewed and confirmed R2 walked to the toilet and back to bed . OT-F did not know nursing staff had used EZ stand to get R2 up. She said usually if there was a change of condition, staff would alert OT for evaluation, however she had not heard any change of mobility about R2 until today (07/12/21).

On 07/12/21, at 1:11 p.m., PT-G stated when she discharged R2 in September 2020, R2 was on walking program to walk in hallway. R2's ambulation program was 3 times a week and up to 100 feet each time with someone follow with wheelchair and walker. PT-G confirmed she had not heard about that R2's mobility had declined until today. She stated that she did not know R2 needed to use EZ stand, and it was a big change since the last time PT-G saw R2 in September 2020.

On 07/12/21, at 1:37 p.m., NA-B stated R2 could walk, and she had been walked with him couple times to the bathroom. NA-B confirmed he did not bother to do her nails even on her shower day.

On 07/12/21, at 7:01 p.m., NA-C stated staff used EZ stand to get her up but R2 could walk. She confirmed she had not walked R2 after meals.

On 07/12/21, at 7:47 p.m., NA-D stated he had

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F 677	Continued From page 7	F 677		

not walk with her at all. He confirmed he did not do any nail care for her. NA-D guessed R2 would have her nail care done on her shower day but did not know when her shower day was.

On 07/12/21, at 2:12 p.m., director of nursing (DON) stated the nail care should be done weekly on shower day. If the resident could not speak for themselves and their nails were dirty, DON expected staff would clean them for residents.

On 07/14/21, at 3:09 p.m., DON provided documentation for R2 and her restorative program. DON stated R2 refused to walk, and her refusals were a barrier for staff to help her with walking therapy. DON's expectation from staff was to follow the care plan/orders. If a resident was unable or unwilling to participate the nursing assistant should update the nurse on this for next steps.

R1 admission Minimum Data Set (MDS) dated 6/26/21, indicated R1 had a Brief Interview of Mental Status (BIMS) score of 10, indicated moderate cognitive impairment. The MDS identified medical diagnoses included stroke, sepsis (the body's response to an infection damages its own tissues) and pneumonia.

R1's care plan dated 7/5/21, identified R1 needed total assistance from staff for dressing, grooming and incontinence cares.

During an observation on 7/12/21, at 11:25 a.m. R1 was in fully dressed for the day, hair was matted in back and appeared greasy. R1 had dark crusted material under her fingernails and around the cuticles.

During an interview on 7/12/21, at 11:26 a.m. R1

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F 677	Continued From page 8	F 677		

reported she was embarrassed of her appearance. Stated she was a hairdresser and nail technician, and stated she never would have let her hair be greasy and uncombed, but was unable to do so herself. "The staff skips over hair care." R1 reported what was "very bothersome" was that she had diarrhea the prior evening and had bowel movement under her fingernails on the right hand and in the cuticle crevasses. R1 reported that she asked staff to soak her fingernails since the prior day and it was not completed.

On 7/12/21, at 11:45 a.m. registered nurse (RN)-A entered the room and R1 asked to please have nails cleaned before lunch. RN-A stated she would send a nursing assistant in right away. RN-A stated hands were to be cleaned prior to all meals and after toileting.

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.

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 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:

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

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00496	A. BUILDING: _____ B. WING _____	C 07/12/2021

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 *****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 07/12/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000	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.	

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5411099C (MN74460 and MN73987) with a licensing order issued at 0860 and 1695 and H5411100C (MN74397) with no licensing order issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed.	2 860		8/16/21

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2 860	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene specific to nail care to 2 of 3 resident (R2, R1) reviewed for activities of daily living (ADL's). Further, the facility failed to implement a therapy recommended walking program for 1 of 3 residents (R2) reviewed for rehabilitation. Findings include: R2's Admission Record dated 02/11/20, indicated R2's diagnoses included chronic obstructive pulmonary disease, coronary artery disease, hypertension, displaced fracture left lower leg. R2's annual Minimum Data Set (MDS) dated 05/04/21, indicated R2 had a Brief Interview of Mental Status (BIMS) score of 12, indicated moderate cognitive impairment. R2's MDS further indicated R2 required extensive assistance with transfers. R2's care plan dated 02/19/20, identified R2 had alteration in self-care ability and an activities of daily living (ADL) problem related to chronic obstructive pulmonary disease, dementia, neuropathic pain and falls. The care plan indicated nail care to be done weekly with bath and as needed. The care plan also directed staff to "walk resident daily following lunch." R2's order dated 11/02/20, indicated nursing assistant (NA) needed to walk with resident 100-150 feet with four-wheel walker twice a day and follow with wheelchair. Review of the medical record revealed R2's medical record lacked documentation that R2	2 860	The director of nursing and/or designee will educate responsible staff to provide care to residents' dependent 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.	

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2 860	Continued From page 3 was on a restorative nursing program, per physical therapy (PT) recommendation at discharge in November 2020. Further, the medical record lacked evidence R2 had been assisted to walk/ambulate per order since R2 was discharged from PT. Review of the medical record for the month of June and July indicated NA charted not applicable for 21 days. On 07/12/21, at 10:12 a.m., family member (FM)-E was interviewed and stated the staff did not do nail care for R2. R2's toenails were long, and her fingernails had dirt underneath every time FM-E visited R2. FM-E had to cut her toenails recently because they were too long and R2's toes hurt when her shoes were on. FM-E also said the staff did not walk R2 per order or even offered to walk with her. On 07/12/21, at 10:15 a.m., the resident's nail was observed to be short and dirty. She had dirt under eight out of ten of her finger nails. On 07/12/21, at 11:32 a.m., nursing assistant (NA)-A stated R2 was not able to walk, and he used the EZ stand to get her up all the time. NA-A said R2 would have nail care on her bath day but could not remember when she had her nail care done. He stated he did not do her nail care when he gave her bath two weeks ago. He confirmed her nails were dirty. On 07/12/21, at 11:45 a.m.,license practical nurse (LPN)-A stated the NA's usually did resident's nail care on their bath day or as needed. LPN-A could not tell when the last time R2 has her nail done. She confirmed that R2's nails were dirty and needed to be cleaned. LPN-A said R2 had difficulty to walk and refused to walk.	2 860		

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2 860	Continued From page 4 On 07/12/21, at 12:13 p.m., (LPN)-B said either nurse or the NA could do nail care for resident on shower day or anytime the nails were noticed to be long or dirty. LPN-B was not sure if R2 had worked with PT before she transferred to that unit. LPN-B confirmed R2's nails were dirty and stated she would ask nursing assistant to clean them. On 07/12/21, at 1:03 p.m., occupational therapist (OT)-F was interviewed and confirmed R2 walked to the toilet and back to bed . OT-F did not know nursing staff had used EZ stand to get R2 up. She said usually if there was a change of condition, staff would alert OT for evaluation, however she had not heard any change of mobility about R2 until today (07/12/21). On 07/12/21, at 1:11 p.m., PT-G stated when she discharged R2 in September 2020, R2 was on walking program to walk in hallway. R2's ambulation program was 3 times a week and up to 100 feet each time with someone follow with wheelchair and walker. PT-G confirmed she had not heard about that R2's mobility had declined until today. She stated that she did not know R2 needed to use EZ stand, and it was a big change since the last time PT-G saw R2 in September 2020. On 07/12/21, at 1:37 p.m., NA-B stated R2 could walk, and she had been walked with him couple times to the bathroom. NA-B confirmed he did not bother to do her nails even on her shower day. On 07/12/21, at 7:01 p.m., NA-C stated staff used EZ stand to get her up but R2 could walk. She confirmed she had not walked R2 after meals. On 07/12/21, at 7:47 p.m., NA-D stated he had	2 860		

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2 860	Continued From page 5	2 860		

not walk with her at all. He confirmed he did not do any nail care for her. NA-D guessed R2 would have her nail care done on her shower day but did not know when her shower day was.

On 07/12/21, at 2:12 p.m., director of nursing (DON) stated the nail care should be done weekly on shower day. If the resident could not speak for themselves and their nails were dirty, DON expected staff would clean them for residents.

On 07/14/21, at 3:09 p.m., DON provided documentation for R2 and her restorative program. DON stated R2 refused to walk, and her refusals were a barrier for staff to help her with walking therapy. DON's expectation from staff was to follow the care plan/orders. If a resident was unable or unwilling to participate the nursing assistant should update the nurse on this for next steps.

R1 admission Minimum Data Set (MDS) dated 6/26/21, indicated R1 had a Brief Interview of Mental Status (BIMS) score of 10, indicated moderate cognitive impairment. The MDS identified medical diagnoses included stroke, sepsis (the body's response to an infection damages its own tissues) and pneumonia.

R1's care plan dated 7/5/21, identified R1 needed total assistance from staff for dressing, grooming and incontinence cares.

During an observation on 7/12/21, at 11:25 a.m. R1 was in fully dressed for the day, hair was matted in back and appeared greasy. R1 had dark crusted material under her fingernails and around the cuticles.

During an interview on 7/12/21, at 11:26 a.m. R1

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2 860	Continued From page 6 reported she was embarrassed of her appearance. Stated she was a hairdresser and nail technician, and stated she never would have let her hair be greasy and uncombed, but was unable to do so herself. "The staff skips over hair care." R1 reported what was "very bothersome" was that she had diarrhea the prior evening and had bowel movement under her fingernails on the right hand and in the cuticle crevasses. R1 reported that she asked staff to soak her fingernails since the prior day and it was not completed. On 7/12/21, at 11:45 a.m. registered nurse (RN)-A entered the room and R1 asked to please have nails cleaned before lunch. RN-A stated she would send a nursing assistant in right away. RN-A stated hands were to be cleaned prior to all meals and after toileting. 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.	2 860		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance	21695		8/16/21

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21695	Continued From page 7 Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. 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: R2's annual Minimum Data Set (MDS) dated 05/04/21, indicated R2 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. R2's MDS further indicated R2 required extensive assistance of staff with transfers and toileting. Review of R2's medical record revealed, the last time R2 had a bowel movement was on 07/11/21, at 5:33 p.m. On 07/12/21, at 10:12 a.m., family member (FM)-E was interviewed and stated she saw feces stains on the toilet seat all the time whenever she visited and staff did not clean it. She said staff would clean it if she notified them. 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.	21695	The director of nursing (DON) or designee, will educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, will coordinate and conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible.	

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21695	Continued From page 8 On 07/12/21, at 11:32 a.m., nursing assistant (NA)-A was interviewed and confirmed R2's toilet seat was soiled with dried bowel. NA-A stated that housekeeping had not cleaned the room yet. NA-A also confirmed there was a pack of beverages behind the toilet seat, and he did not know who put it there. He stated that housekeeping would clean R2's bathroom later and walked away. On 07/12/21, at 11:45 a.m., license practical nurse (LPN)-A was interviewed and confirmed the toilet seat had a dried bowel on it and stated that she was sure the housekeeping had not cleaned the room yet. LPN-A stated the pack of beverages should not be stored behind the toilet. She said "It is disgusting to store food in the bathroom." LPN-A walked out of the room and did not move the beverages to another area nor clean the toilet seat. On 07/12/21, at 12:10 p.m., housekeeper (HK)-A stated that she had not cleaned the room yet and no one had told her the toilet seat was dirty. HK-A said that she would clean it right away if staff notified her. She usually cleaned the resident's bathroom once a day. On 07/12/21, at 12:13 p.m., (LPN)-B confirmed the toilet seat was dirty and the housekeeping had not cleaned the room yet. LPN-B also stated the pack of beverages should not be stored in the bathroom next to toilet seat. She moved it to the bedroom and stored it under R2's dresser. She walked away and did not clean the toilet seat and notified the HK-A. 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	21695		

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21695	Continued From page 9 to clean it right away. The Facility Disinfecting and Cleaning policy was updated 6/2/21, indicated toilet seat was high touch points and would be disinfected regularly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		