

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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc">https://mdhprovidercontent.web.health.state.mn.us/ltc</a> 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: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 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 Fish 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		C
NAME OF F	PROVIDER OR SUPPLIER	270711		STREET ADDRESS, CITY, STATE, ZIP CODE	07/12/2021
SHIRI EV	CHAPMAN SHOLON	M HOME FAST		740 KAY AVENUE	
OTHICLET	OTIAL MIAN OFFICEOR	THOME EACT		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 (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENT	ΓS	F 00	0	
	conducted at your f to be NOT in comp	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 the 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 bee Safe/Clean/Comfor	table/Homelike Environment	F 58	4	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	IATURE	TITLE	(X6) DATE
Electron	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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG	` ′сом	E SURVEY PLETED
		245411	B. WING_			C 12/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 740 KAY AVENUE SAINT PAUL, MN 55102		12/2021
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F 584	possible. (i) This includes en receive care and s physical layout of t independence and (ii) The facility shall the protection of thor theft.  §483.10(i)(2) Hous services necessary and comfortable in §483.10(i)(3) Clear in good condition;  §483.10(i)(4) Privaresident room, as s §483.10(i)(5) Adeq levels in all areas;  §483.10(i)(6) Complevels. Facilities ini 1990 must maintai 81°F; and  §483.10(i)(7) For the sound levels. This REQUIREME by: Based on observareview, the facility in the sound levels.	resonal belongings to the extent insuring that the resident can ervices safely and that the he facility maximizes resident does not pose a safety risk. I exercise reasonable care for the resident's property from loss rekeeping and maintenance by to maintain a sanitary, orderly, terior; In bed and bath linens that are the closet space in each specified in §483.90 (e)(2)(iv); the puate and comfortable lighting fortable and safe temperature tially certified after October 1, in a temperature range of 71 to the maintenance of comfortable in some maintenance in some maintenance of comfortable in some maintenance in	F 58	Resident R2 had their cleaned by housekeeping facility conducted whole houseident bathrooms to ens All nursing staff were re-ed.	on 7.12.21, buse audit on ure cleanliness. ducated on	
	Findings include:			cleaning visibly soiled toile away, if further more detail		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
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F 584	R2's annual Minim 05/04/21, indicated Mental Status (BIN indicated moderate MDS further indicated 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 bevoor On 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 Nather than the Nather	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.  Edical 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 h potential to be affected by the practice.     All nursing staff were rehousekeeping policy and prexpectations of cleaning whe visibly soiled. Nursing staff we disinfect a toilet if visibly soil possible. If more detailed chrequired, then housekeeping notified.     Facility will conduct five week for four weeks, five aumonth for three months, and following QA meeting.  •	re deficient reducated on ocedure and en toilet is will clean and led as soon as eaning is g will be audits per	

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CHAPMAN SHOLOM	I HOME EAST		STREET ADDRESS, CITY, STATE, ZIP COE 740 KAY AVENUE SAINT PAUL, MN 55102		12/2021
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION DATE
coathroom." LPN-A value move the beverage the toilet seat On 07/12/21, at 12: stated that she had no one had told her said that she would notified her. She us coathroom once a dath of the toilet seat was on the toilet seat was on the pack of beverage out the totoled on the totoled on the pack of beverage out the totoled on the totoled on the totoled out the totole	valked out of the room and did ages to another area nor.  10 p.m., housekeeper (HK)-A not cleaned the room yet and the toilet seat was dirty. HK-A clean it right away if staff ually cleaned the resident's ay.  13 p.m., (LPN)-B confirmed lirty and the housekeeping a room yet. LPN-B also stated yes should not be stored in the ilet seat. She moved it to the dit under R2's dresser. She	F 58	4		
On 07/12/21, at 2:1: DON) stated that so clean the toilet or o clean it right awa. The Facility Disinfedupdated 6/2/21, indicouch points and work DL Care Provided CFR(s): 483.24(a)(2) A response of daily services to maintain personal and oral hypois.	the expected the nursing staff of at least notify housekeeping by.  In the state of the nursing staff of at least notify housekeeping by.  In the state of the st	F 67		finger poils	8/16/21
	continued From parathroom." LPN-A woot move the bever lean the toilet seat on 07/12/21, at 12: tated that she had to one had told her aid that she would otified her. She us athroom once a day on 07/12/21, at 12: the toilet seat was considered the pack of beverage athroom next to to edroom and stored ralked away and distributed the HK-A.  On 07/12/21, at 2:1. OON) stated that so clean the toilet or or clean it right awas the Facility Disinfer potential points and wood of the points and or all the points are points and or all the points are points and the points are points are points are points.	on 07/12/21, at 12:10 p.m., housekeeper (HK)-A tated that she had not cleaned the room yet and o one had told her the toilet seat was dirty. HK-A aid that she would clean it right away if staff otified her. She usually cleaned the resident's athroom once a day.  On 07/12/21, at 12:13 p.m., (LPN)-B confirmed ne toilet seat was dirty and the housekeeping ad not cleaned the room yet. LPN-B also stated ne pack of beverages should not be stored in the athroom next to toilet seat. She moved it to the edroom and stored it under R2's dresser. She ralked away and did not clean the toilet seat and otified the HK-A.  On 07/12/21, at 2:12 p.m., director of nursing DON) stated that she expected the nursing staff or clean the toilet or at least notify housekeeping or clean it right away.  The Facility Disinfecting and Cleaning policy was podated 6/2/21, indicated toilet seat was high buch points and would be disinfected regularly. DL Care Provided for Dependent Residents of FR(s): 483.24(a)(2)  483.24(a)(2) A resident who is unable to carry ut activities of daily living receives the necessary ervices to maintain good nutrition, grooming, and ersonal and oral hygiene; his REQUIREMENT is not met as evidenced	continued From page 3 athroom." LPN-A walked out of the room and did of move the beverages to another area nor lean the toilet seat.  On 07/12/21, at 12:10 p.m., housekeeper (HK)-A lated that she had not cleaned the room yet and one had told her the toilet seat was dirty. HK-A laid that she would clean it right away if staff of otified her. She usually cleaned the resident's lathroom once a day.  On 07/12/21, at 12:13 p.m., (LPN)-B confirmed le toilet seat was dirty and the housekeeping and not cleaned the room yet. LPN-B also stated le pack of beverages should not be stored in the lathroom next to toilet seat. She moved it to the ledroom and stored it under R2's dresser. She lated away and did not clean the toilet seat and otified the HK-A.  On 07/12/21, at 2:12 p.m., director of nursing DON) stated that she expected the nursing staff of clean the toilet or at least notify housekeeping of clean it right away.  The Facility Disinfecting and Cleaning policy was potated 6/2/21, indicated toilet seat was high buch points and would be disinfected regularly. DL Care Provided for Dependent Residents of daily living receives the necessary error leaned the room and oral hygiene; his REQUIREMENT is not met as evidenced by:	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Tontinued From page 3  athroom." LPN-A walked out of the room and did of move the beverages to another area nor lean the toilet seat.  In 07/12/21, at 12:10 p.m., housekeeper (HK)-A tated that she had not cleaned the room yet and to one had told her the toilet seat was dirty. HK-A aid that she would clean it right away if staff otified her. She usually cleaned the resident's athroom once a day.  In 07/12/21, at 12:13 p.m., (LPN)-B confirmed he toilet seat was dirty and the housekeeping and not cleaned the room yet. LPN-B also stated he pack of beverages should not be stored in the athroom next to toilet seat. She moved it to the edroom and stored it under R2's dresser. She raiked away and did not clean the toilet seat and otified the HK-A.  In 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 or clean it right away.  The Facility Disinfecting and Cleaning policy was padated 6/2/21, indicated toilet seat was high puch points and would be disinfected regularly. DL Care Provided for Dependent Residents FR(s): 483.24(a)(2)  483.24(a)(2) A resident who is unable to carry ut activities of daily living receives the necessary ervices to maintain good nutrition, grooming, and ersonal and oral hygiene; his REQUIREMENT is not met as evidenced by the control of the precision of t	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FEGULATORY OR LSC IDENTIFY INFORMATION  FE

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SHIRLEY	CHAPMAN SHOLO	OM HOME EAST		SAINT PAUL, MN 55102		
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F 677	Continued From	page 4	F6	577		
F 677	review, the facility hygiene specific t (R2, R1) reviewer (ADL's). Further, therapy recommeresidents (R2) reviewed (R2's Admission R2's diagnoses in pulmonary diseas hypertension, diseas hypertension, diseas Mental Status (BI moderate cognitiving (ADL) obstructive pulmoneuropathic pain indicated nail card as needed. To "walk resident R2's order dated assistant (NA) need to "walk resident with and follow with with second commercial second card and second card as needed. To "walk resident R2's order dated assistant (NA) need to "walk resident with and follow with with second card card and follow with with second card and second card card as needed. To "walk resident R2's order dated assistant (NA) need follow with with second card card card card card card card car	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 sended 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 sired extensive assistance with the dated 02/19/20, 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 seded to walk with resident four-wheel walker twice a day heelchair.	F6	of Resident R2 on 7.12.21, and R2 has been added to the list by in house podiatry at next with Resident R2 is currently work therapy. Resident daughter a psychological services are invassist with R2's non-compliant related to ambulating and wotherapy.  Facility was not made aware regarding resident R1 until 25 received. Resident R1 until 25 received. Resident R1 has sit discharged. Per 2567 RN was was going to send NAR in to nails.  • All residents at facility whas assistance with activities of dhave the potential to be affect deficient practice.  • On 7/22/21, a whole hous conducted on current resident an ambulation recommendation therapy. Education was provilicensed and non-licensed cli regarding proper nail care an implementation of recommendations. Education was provinurse management on the provided to all nursing staff of and changes in ADL status. No bath day was added to admisset and for all in house residered.	to be seen isit. ing with and in house volved to at behavior rking with of concern 567 was a notified and clean R1 o require aily living ted by the se audit was ts who have on from ded to all nical staff d ded walking vided to oper steps a was a refusals lail care on sion order ents. duct five	
	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.	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING	(X3) DATE SURVEY COMPLETED C
<b>245411</b> B. WING	07/12/2021
NAME OF PROVIDER OR SUPPLIER  SHIRLEY CHAPMAN SHOLOM HOME EAST  STREET ADDRESS, CITY, STATE, 2 740 KAY AVENUE SAINT PAUL, MN 55102	· · · · · · · · · · · · · · · · · · ·
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCY MUST BE PROVIDER'S PLAN OF PROVIDER'S	TION SHOULD BE COMPLÉTION DATE
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	nduct three audits s, five audits per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245411	B. WING			1	C <b>12/2021</b>
	PROVIDER OR SUPPLIER	M HOME EAST		STREET ADDRESS, CITY, STATE, Z 740 KAY AVENUE SAINT PAUL, MN 55102	ZIP CODE	<u>,                                    </u>	12/2021
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F 677	shower day or anyt be long or dirty. LP worked with PT befunit. LPN-B confirr stated she would at them.  On 07/12/21, at 1:0 (OT)-F was interviet to the toilet and bac nursing staff had us She said usually if condition, staff wou however she had n mobility about R2 u On 07/12/21, at 1:1 discharged R2 in S walking program to 100 feet each tin wheelchair and wal not heard about that until today. She staneeded to use EZ since the last time 12020.  On 07/12/21, at 1:3 walk, and she had times to the bathroobother to do her national control of the control of th	age 6 uld do nail care for resident on ime the nails were noticed to N-B was not sure if R2 had fore she transferred to that ned R2's nails were dirty and sk nursing assistant to clean  13 p.m., occupational therapist ewed and confirmed R2 walked ok to bed . OT-F did not know sed EZ stand to get R2 up. there was a change of lid alert OT for evaluation, ot heard any change of intil today (07/12/21).  1 p.m., PT-G stated when she eptember 2020, R2 was on walk in hallway. R2's in was 3 times a week and up he with someone follow with ker. PT-G confirmed she had at R2's mobility had declined ted that she did not know R2 stand, and it was a big change PT-G saw R2 in September  17 p.m., NA-B stated R2 could been walked with him couple om. NA-B confirmed he did not ils even on her shower day.	F 6	77			
	confirmed she had	not walked R2 after meals.  7 p.m., NA-D stated he had					

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	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 740 KAY AVENUE SAINT PAUL, MN 55102		712/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677	do any nail care if have her nail care did not know whe On 07/12/21, at 2 (DON) stated the on shower day. If themselves and t expected staff wo On 07/14/21, at 3 documentation fo program. DON st refusals were a b walking therapy. I was to follow the was unable or un assistant should usteps. R1 admission Mir 6/26/21, indicated Mental Status (BI moderate cognitividentified medical sepsis (the body's damages its own R1's care plan dat total assistance fi and incontinence During an observ R1 was in fully drimatted in back ar dark crusted mataround the cuticles.	at all. He confirmed he did not or her. NA-D guessed R2 would e done on her shower day but in her shower day was.  2:12 p.m., director of nursing nail care should be done weekly the resident could not speak for heir nails were dirty, DON buld clean them for residents.  2:09 p.m., DON provided r R2 and her restorative ated R2 refused to walk, and her arrier for staff to help her with DON's expectation from staff care plan/orders. If a resident willing to participate the nursing update the nurse on this for next himum Data Set (MDS) dated at R1 had a Brief Interview of MS) score of 10, indicated we impairment. The MDS a diagnoses included stroke, as response to an infection tissues) and pneumonia.  Atted 7/5/21, identified R1 needed from staff for dressing, grooming cares.  attion on 7/12/21, at 11:25 a.m. essed for the day, hair was and appeared greasy. R1 had erial under her fingernails and	F6	577		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245411	B. WING			C / <b>12/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 740 KAY AVENUE SAINT PAUL, MN 55102		112/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION 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 dhad bowel movemeright hand and in the reported that she afingernails 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 l 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 hursing assistant in right away, were to be cleaned prior to all eting.  ies of Daily Living (ADL's) for sed July 2017, indicated nail ad weekly on bath days and as	F 6	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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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:		` '		(X3) DATE SURVEY COMPLETED	
		00496	B. WING		C <b>07/12/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
SHIRLE	Y CHAPMAN SHOLON	1 HOME EAST 740 KAY A	AVENUE LUL, 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 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 correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been			
	that may result fron orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.			
Minnesota D	at your facility by su Department of Hea found NOT in comp Licensure. Please i of correction you ha	rS:  applaint survey was conducted by the property of the Minnesota lith (MDH). Your facility was all of the MN State in the MN State in the modern of the property of the pro		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwa Tag numbers have been assigned to Minnesota state statutes/rules for Nursi Homes.	
		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

07/29/21

**Electronically Signed** 

STATEMEN	IT OF DEFICIENCIES 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 F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLON	M HOME EAST 740 KAY A SAINT PA	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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED:  H5411099C (MN74 licensing order issued H5411100C (MN74 issued).  The facility is enroll Correction (ePoC) anot required at the 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 red 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. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Method Correction and the Time Period For Correction.  PLEASE DISREGARD THE HEAD	Tag." the tute/rule ies" ply" nis s which after the s veyors d of	
				THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES T FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTAS' STATUTES/RULES.	THIS O O O O O O O O O O O O O O O O O O O	
2 860	Proper Nursing Car		2 860			8/16/21
	proper care. The c adequate and prope E. per care and att	or determining adequate and riteria for determining er care include: ention to hands and feet. nails must be kept clean and				

Minnesota Department of Health

STATE FORM G899 Q68611 If continuation sheet 2 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00496		B. WING		07/1	; 2/2021
NAME OF	PROVIDER OR SUPPLIER	S	TREET ADI	DRESS, CITY,	STATE, ZIP CODE		
SHIRLE	Y CHAPMAN SHOLON	I HOME FAST	40 KAY A AINT PA	WENUE UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 860	This MN Requirements: Based on observation review, the facility fa	ent is not met as evide on, interview and docuralled to provide personanil care to 2 of 3 reside for activities of daily living efacility failed to impler ded walking program for ewed for rehabilitation.  Cord dated 02/11/20, included chronic obstructive, coronary artery disease acced fracture left lower am Data Set (MDS) data R2 had a Brief Interview S) score of 12, indicate impairment. R2's MDS and extensive assistance and 02/19/20, identified Rare ability and an activities oblem related to chronicary disease, dementia, and falls. The care plan are be done weekly with a care plan also directed following lunch."	ment al ent ng ment a or 1 of 3 dicated we see, leg. ed w of ed ic further e with desofic bath d staff ng nt a day	2 860	The director of nursing and/or will educate responsible staff care to residents' dependent staff, based on residents' com assessed needs. The DON or could conduct audits of deper resident cares to ensure their hygiene needs are met consist.	to provide on facility aprehensively designee adent personal	

Minnesota Department of Health

STATE FORM G899 Q68611 If continuation sheet 3 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:		C	
004	96	B. WING		1	, 2/2021
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHIRLEY CHAPMAN SHOLOM HOME EA	AST 740 KAY A SAINT PA	VENUE UL, MN 551	02		
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE P REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
was on a restorative nursing physical therapy (PT) recomm discharge in November 2020 medical record lacked evident assisted to walk/ambulate per discharged from PT. Review record for the month of June NA charted not applicable for On 07/12/21, at 10:12 a.m., for (FM)-E was interviewed and sont do nail care for R2. R2's to and her fingernails had dirt use for FM-E visited R2. FM-E had to recently because they were to toes hurt when her shoes we said the staff did not walk R2 offered to walk with her.  On 07/12/21, at 10:15 a.m., to was observed to be short and under eight out of ten of her for On 07/12/21, at 11:32 a.m., no (NA)-A stated R2 was not ablowed the EZ stand to get her said R2 would have nail care could not remember when shound done. He stated he did not do he gave her bath two weeks a her nails were dirty.  On 07/12/21, at 11:45 a.m.,lic (LPN)-A stated the NA's usual care on their bath day or as mont tell when the last time R2. She confirmed that R2's nails needed to be cleaned. LPN-A difficulty to walk and refused.	nendation at . Further, the . Further, the . Ce R2 had been r order since R2 was of the medical and July indicated 21 days.  amily member . Stated the staff did . Coenails were long, . Inderneath every time . Cout her toenails . Coolong and R2's . The	2 860			

Minnesota Department of Health

STATE FORM G899 Q68611 If continuation sheet 4 of 10

NAME OF PROVIDER OR SUPPLIER  SHIRLEY CHAPMAN SHOLOM HOME EAST  CAULD CALL SHORT OF DEPLICATION OF THE CONTROL OF THE CONTROL OF THE CANADA CONTROL OF THE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			X3) DATE SURVEY COMPLETED		
SHIRLEY CHAPMAN SHOLOM HOME EAST   T40 KAY AVENUE SAINT PAUL, MN 55102			00496		B. WING			
CALL   DESCRIPTION   SUMMARY STATEMENT OF DEFICIENCIES   DEPOSITION   PROVIDERS PLAN OF CORRECTION   CACH DEFICIENCY MUST BE PRECEDED BY PILL   PREFIX   TAG   PROVIDERS PLAN OF CORRECTION   PROVIDERS PLAN OF CORRECTION   CACH DEFICIENCY MUST BE PRECEDED BY PILL   PREFIX   TAG   PROVIDERS PLAN OF CORRECTION   PROVIDER ACTION SHOULD BE CROSS-REPERBORD TO THE APPROPRIATE   DIFFICIENCY   TAG    2 860   Continued From page 4   2 860   2 860    2 860   Continued From page 4   2 860   COMMETTE   CROSS-REPERBORD TO THE APPROPRIATE   DIFFICIENCY   TAG    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	NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  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	SHIRLEY	CHAPMAN SHOLON	M HOME EAST			02		
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confirmed she had not walked R2 after meals.	2 860	On 07/12/21, at 12: nurse or the NA corshower day or anytibe long or dirty. LPI worked with PT befunit. LPN-B confirm stated she would as them.  On 07/12/21, at 1:0 (OT)-F was intervie to the toilet and bac nursing staff had us She said usually if tondition, staff wou however she had numbility about R2 uron 07/12/21, at 1:1 discharged R2 in Swalking program to ambulation program to 100 feet each time wheelchair and wal not heard about the until today. She starneeded to use EZ since the last time Face 2020.  On 07/12/21, at 1:3 walk, and she had be times to the bathroop bother to do her naid on 07/12/21, at 7:0 EZ stand to get her	13 p.m., (LPN)-B sauld do nail care for rime the nails were rime the nails were rime the nails were rime the nails were rime the same not sure if ore she transferred ned R2's nails were sk nursing assistant as p.m., occupational wed and confirmed to be december 2020, R2 walk in hallway. R2 walk in hallway. R2 walk in hallway. R2 was 3 times a wene with someone folker. PT-G confirment R2's mobility had ted that she did not stand, and it was a bear of p.m., NA-B stated on the stand walked with his p.m., NA-B confirment is even on her shown as p.m., NA-C stated up but R2 could was a p.m., NA-C stated up b.m., NA-C st	resident on noticed to R2 had to that a dirty and to clean all therapist R2 walked not know R2 up. of uation, e of ).  If when she was on P's ek and up llow with d she had declined know R2 big change ptember at R2 could m couple d he did not wer day.  If R2 could m couple d he did not wer day.	2 860			

Minnesota Department of Health

STATE FORM G899 Q68611 If continuation sheet 5 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 <b>12/2021</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SHIRLE	Y CHAPMAN SHOLON	M HOME EAST	740 KAY A SAINT PA	AVENUE .UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE  / MUST BE PRECEDED B  SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 860	Continued From particles and incontinued From particles and incontinence carbon days in fully dres matted in back and dark crusted materiaround the cuticles.	all. He confirmed he her. NA-D guessed done on her shower her shower day was 2 p.m., director of mail care should be done resident could not be resident for staff to help DN's expectation from the resident could not be resident could not be resident for staff to help DN's expectation from the resident could not be resident could	d R2 would day but s				

Minnesota Department of Health

STATE FORM G899 Q68611 If continuation sheet 6 of 10

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.110 1 27.11			A. BUILDING:			
		00496	B. WING		07/1	2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLON	M HOME EAST 740 KAY A SAINT PA	AVENUE .UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 860	nail technician, and let her hair be grea unable to do so her care." R1 reported was that she had d had bowel movemeright hand and in the reported that she a fingernails since the completed.  On 7/12/21, at 11:4 (RN)-A entered the have nails cleaned she would send a rRN-A stated hands meals and after toil.  The facility's Activit nail care policy revicare will be provide needed unless consultations. SUGGESTED MET The director of nurseducate responsible residents' dependaresidents' comprehe DON or designee of dependent resident hygiene needs are	embarrassed of her of she was a hairdresser and a 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 ne 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 leting.  ies of Daily Living (ADL's) for ised July 2017, indicated nail ad weekly on bath days and as traindicated.  THOD OF CORRECTION: sing and/or designee could e staff to provide care to not on facility staff, based on tensively assessed needs. The could conduct audits of to cares to ensure their personal	2 860			
21695	MN Rule 4658.141 Housekeeping, Op	5 Subp. 4 Plant eration, & Maintenance	21695			8/16/21

6899

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '			3) DATE SURVEY COMPLETED	
			B. WING		C 07/12/2021		
NAME OF	PROVIDER OR SUPPLIER	00496		STATE, ZIP CODE	07/1	2/2021	
	CHAPMAN SHOLON	N HOME FAST 740 KAY A	WENUE				
	T	SAINT PA	UL, MN 551			(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
21695	Continued From pa	ige 7	21695				
	provide housekeep necessary to maint comfortable interior	eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,					
	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.			The director of nursing (DON) or designee, will educate staff regard importance of a safe, clean, functionelike environment. The DON designee, will coordinate and conception audits of areas residents to ensure a safe, clean, functional homelike environment is maintain extent possible.	ional and or duct frequent and		
	time R2 had a bow at 5:33 p.m. On 07/12/21, at 10: (FM)-E was intervie	dical record revealed, the last el movement was on 07/11/21, 12 a.m., family member ewed and stated she saw feces seat all the time whenever she					
	visited and staff did would clean it if she On 07/12/21, at 10: observed and soile	not clean it. She said staff					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00496	B. WING		07/1	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SHIRLEY	CHAPMAN SHOLON	M HOME EAST 740 KAY A	_	00		
0(1) ID	CLIMMADY CTA		UL, MN 551		ON	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ige 8	21695			
	(NA)-A was intervie seat was soiled with housekeeping had NA-A also confirme beverages behind to know who put it the housekeeping would and walked away.	ld clean R2's bathroom later				
	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					

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		00496	B. WING			C <b>12/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
SHIRLE	Y CHAPMAN SHOLON		Y AVENUE PAUL, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21695	to clean it right awa The Facility Disinferupdated 6/2/21, inditouch points and wo SUGGESTED MET The director of nurseducate staff regard clean, functional an DON or designee, of maintenance and hiperiodic audits of all ensure a safe, clean environment is maintenance.		d e, ne t			

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