DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 28, 2022

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

RE: CCN: 245411
Cycle Start Date: December 1, 2021

Dear Administrator:

On January 5, 2022, 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 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
December 21, 2021

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

RE: CCN: 245411
Cycle Start Date: December 1, 2021

Dear Administrator:

On December 1, 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 March 1, 2022 (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 June 1, 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 12/01/2021

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 11/29/21, 11/30/21 and 12/1/21 a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5411105C (MN78817), H5411106C (MN78815), H5411107C (MN78812), H5411108C (MN78811), H5411104C (MN78821), H5411109C (MN78780), H5411110C (MN78769), H5411111C (MN78768) The following complaint was found to be UNSUBSTANTIATED: H54111112C (MN78704). The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the rights of 8 of 9	F 602	• Residents R1, R7, and R8 were assessed for pain upon being identified as	12/31/21

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

Electronically Signed | 12/28/2021

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F 602	Continued From page 1 residents (R1, R2, R3, R4, R5, R6, R7, R8) reviewed were free from financial exploitation-drug diversion when a licensed practical nurse (LPN)-C diverted 946 as needed (PRN) narcotic medications over an eleven-month period. Findings include: R1's electronic physician orders printed on 11/23/21, noted R1 had physician orders for hydrocodone-acetaminophen 5-325mg (opioid controlled substance) 1 tab every 4 hours as needed that began on 10/28/21, and orders for oxycodone 5mg (opioid controlled substance) 1 tab every 3 hours as needed that began on 11/9/21. R2's electronic physician orders printed on 11/23/21, noted R2 had physician orders for Tramadol 50mg (opioid controlled substance) 1 tab up to 4 times a day as needed that began on 10/29/20. R2 was transferred to the hospital on 8/25/21 and expired. R3's electronic physician orders printed on 11/23/21, noted R3 had physician orders for oxycodone 10mg every hour as needed for pain that began on 7/18/21, and was discontinued on 7/20/21. R3 had orders for oxycodone 20mg every hour as needed. R3 expired at the facility on 7/24/21. R4's electronic physician orders printed on 11/23/21, noted R4 had physician orders for oxycodone 2.5mg every 6 hours as needed that began on 12/29/20. R4 expired at the facility on 4/9/21.	F 602	being effected by the diversion. All three residents were noted to have adequate pain management with no ill effects. All 3 residents will be assessed weekly for pain for four weeks. • Residents R2, R3, R4, R5 and R6 expired prior to 11/23/21, when the suspected drug diversion was reported to the state agency. • All residents who have current physician orders for controlled substance(s) would have the potential to be affected by the same deficient practice. • On 11/23/21, the facility reconciled all current, expired and hospitalized residents with controlled medications from January 2021 to current. • Facility provided education to all licensed clinical staff and trained medical assistants regarding handling, counting and destruction of controlled substances. • Facility will conduct audits of the controlled substance and reconciling the counts weekly for four weeks, monthly for 3 months and then will be reviewed in QA. • Facility will look for discrepancies or odd patterns of medication administration; this will be done twice a week for four weeks, monthly for 3 months, and will then be reviewed in QA. • Director of Nursing will audit four resident samples per month of residents receiving PRN controlled substance medications and compare the narcotic sign out log to the eMAR administration history, this will be reviewed quarterly in QA.	

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F 602	Continued From page 2	F 602		

R5's electronic physician orders printed on 11/23/21, noted R5 had physician orders for oxycodone 2.5mg every 6 hours as needed that began on 9/14/21. R5 expired at the facility on 10/9/21.

R6's electronic physician orders printed on 11/23/21, noted R6 had physician orders for oxycodone 5mg every hour as needed that began on 1/18/21. R6 expired at the facility on 8/13/21.

R7's electronic physician orders printed on 11/24/21, noted R7 had physician orders for oxycodone 2.5mg every 2 hours as needed that began on 2/23/21.

R8's electronic physician orders printed on 11/23/21, noted R8 had physician orders for oxycodone 2.5mg twice a day as needed that began on 12/16/20 and was discontinued on 6/17/21. R8 had orders for 5mg 3 times a day as needed that began on 6/17/21.

The administrator and director of nurses (DON) filed reports with the state agency (SA) regarding drug diversion on 11/23/21 involving LPN-C and 8 identified residents. The report noted upon arrival to the facility on 11/23/21, the administrator and DON both had envelopes under their office doors that contained pages of the narcotic count book from 2 residents. The pages noted that LPN-C was the only nurse that was administering narcotic pain medication to the 2 residents. The administrator and DON began an investigation and looked back to January of 2021 as LPN-C had worked in the facility for 30 years.

The facility investigation was completed on 11/24/21, the investigative file noted LPN-C

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F 602	Continued From page 3	F 602		

diverted a total of 946 doses of narcotic medications from 8 identified residents since January of 2021. LPN-C signed narcotic medications out of the narcotic count book but did not document administration of the medications. The facility investigation also noted LPN-C had taken narcotic medications from the medication cart for destruction the morning of 11/23/21, LPN-C did not destroy medications in the presence of another nurse.

A review of the controlled substance dispensing history from 1/1/2021 through 11/23/2012 indicated:

A review of R1's narcotic medication in the narcotic count book from November of 2021, noted LPN-C diverted 12 total narcotic doses. LPN-C did not document administration of the medications to R1 in the medication administration record (MAR).

A review of R2's narcotic medication in the narcotic count book from January of 2021 to 11/23/21, noted LPN-C diverted a total of 157 narcotic doses. LPN-C did not document administration of the medication to R2 in the MAR.

A review of R3's narcotic medication in the narcotic book from July of 2021, noted LPN-C diverted 6 narcotic doses, LPN-C did not document administration of the medication to R3 in the MAR.

A review of R4's narcotic medication in the narcotic book from January to March of 2021, LPN-C diverted a total of 26 narcotic doses, LPN-C did not document administration of the

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F 602	Continued From page 4	F 602		

medication to R4 in the MAR.

A review of R5's narcotic medication in the narcotic book from September to October of 2021, LPN-C diverted a total of 30 narcotic doses, LPN-C did not document administration of the medication to R5 in the MAR.

A review of R6's narcotic medication in the narcotic book from January to July of 2021, LPN-C diverted a total of 185 narcotic doses, LPN-C did not document administration of the medication to R6 in the MAR.

A review of R7's narcotic medication in the narcotic book from January to November of 2021, LPN-C diverted a total of 221 narcotic doses, LPN-C did not document administration of the medication to R7 in the MAR.

A review of R8's narcotic medication in the narcotic book from January to November of 2021, LPN-C diverted 309 narcotic doses, LPN-C did not document administration of the medication to R8 in the MAR.

During review of records for R1-R8 there were no adverse outcomes related to the diversion of PRN medications.

When interviewed on 11/30/21, at 12:56 p.m. LPN-C stated she did not divert medications, she administered the medications as ordered by the physician. LPN-C stated many times she was the only nurse on the unit, was overworked and extremely busy so she was unable to document administration of the PRN narcotic medications. LPN-C stated she did not follow facility policy with medication administration as she did not

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F 602	Continued From page 5	F 602		

document administration of the medication along with time of administration, the reason for medication, pain rating (if applicable) and the response to PRN medications. LPN-C further stated she did not follow facility policy regarding narcotic medication destruction, she destroyed narcotic medications without another nurse present.

When interviewed on 11/30/21, at 2:12 p.m. the DON stated she was made aware of the drug discrepancies on 11/23/21, upon arrival to the facility that morning. An envelope was on the floor of her office that contained photocopies of 3 pages from the narcotic drug count book on 2 current residents with a typed note that read, "I'll let you decide." The DON stated she was curious immediately as she noticed LPN-C had been the only nurse to sign out narcotics to the residents. The DON stated LPN-C was a nurse manager on the Grand unit and had been an employee at the facility for 30 years. The DON stated she then went through the electronic MAR and noticed the narcotic medications the LPN-C signed out were not administered per facility policy. A full internal investigation identified 8 total residents on the Grand unit from January until the present date were affected by LPN-C's drug diversion. The DON further discovered LPN-C had also taken narcotic medications from the medication cart to be destroyed without another nurse present that morning. The DON and administrator filed the reports with the SA, notified the MN Board of Nursing, the St Paul police department and their contracted pharmacy officials along with the medical director and the affected resident's family members of the drug diversion. The DON stated in an interview with LPN-C, she stated the facility was too short staffed and she did not have time to

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F 602	Continued From page 6 document PRN medication administration. When interviewed on 12/1/21, at 9:33 a.m. the DON stated the nurse managers are doing weekly audits of the narcotic book, medication carts and counts, and they have the book to look through. The DON will go behind them to audit the narcotic book and counts. Since it was a nurse manager, that is why she will do the 2nd check, it will be done twice a week for each cart. When questioned that this process did not identify the drug diversion before, the DON stated she plans to do spot checks of residents (a few) that are on narcotics, look at eMAR and compare to the narcotic book and carts for discrepancies and will report at QA quarterly. A facility policy titled, Abuse Prohibition-Vulnerable Adult Protection / Abuse Prevention Plan noted it is the responsibility of all staff to assure residents are free from abuse including misappropriation of a residents property.	F 602		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 21, 2021

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

Re: Event ID: C23D11

Dear Administrator:

The above facility survey was completed on December 1, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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	00496	A. BUILDING: _____ B. WING _____	C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments	2 000		

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

NH LICENSING CORRECTION ORDER

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

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

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

INITIAL COMMENTS:
On 11/29/21, 11/30/21, 12/1/21 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.

The following complaints were found to be

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2 000	Continued From page 1 SUBSTANTIATED: H5411105C (MN78817), H5411106C (MN78815), H5411107C (MN78812), H5411108C (MN78811), H5411104C (MN78821), H5411109C (MN78780), H5411110C (MN78769), H5411111C (MN78768). The following complaint was found to be UNSUBSTANTIATED: H54111112C (MN78704). The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		