DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
May 19, 2022

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

RE: CCN: 245411
Cycle Start Date: March 31, 2022

Dear Administrator:

On April 11, 2022, we notified you a remedy was imposed. On May 6, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 6, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 1, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of April 11, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 31, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered

May 19, 2022

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

Re: Reinspection Results
Event ID: V6ZG12

Dear Administrator:

On May 6, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 31, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
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
April 11, 2022

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

RE: CCN: 245411
Cycle Start Date: March 31, 2022

Dear Administrator:

On March 31, 2022, a survey was completed at your facility by the Minnesota Department of Health 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 immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On March 19, 2022, the situation of immediate jeopardy to potential health and safety cited at F600 was removed.

On March 20, 2022, the situation of immediate jeopardy to potential health and safety cited at F678 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act

and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Shirley Chapman Sholom Home East is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 31, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F"and/or an E tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services,

Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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 03/31/2022 |

| 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<br><br>On 3/29/22, through 3/31/22, an abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>The following complaints H5411122C (MN81953), H5411123C (MN81932) and H5411124C (MN81925) were found to be SUBSTANTIATED at F678 & F600 at Immediate Jeopardy at PAST NON-COMPLIANCE.<br><br>In addition, the complaint H5411121C (MN81926) was SUBSTANTIATED at F684.<br><br>The Immediate Jeopardy began on 3/16/22, when R4's hand was rubbing R3's thigh and R4's hand went up R3's thigh and began tugging on R3's shirt as though wanting to go under the shirt. Facility staff failed to report the incident of sexual abuse and no interventions or protections were put into place to prevention further abuse. On 3/17/22, a second incident of sexual abuse occurred when R4's hand was observed by staff under R3's shirt. The Chief Operating Officer (COO), the Corporate Director of Clinical Services and administrator intern were notified of the IJ on 3/30/22, at 2:38 p.m. The facility had implemented corrective action to prevent recurrence by 3/19/22, prior to the start of the survey therefore the deficiency is being cited as past non-compliance.<br><br>In addition, a second IJ began on 3/19/22, at approximately 5:40 a.m. when the facility failed to provide CPR for R1 after R1 was found | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 04/19/2022 |

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 000 | Continued From page 1<br>unresponsive without a pulse or respirations, and CPR was not initiated. The Chief Operating Officer, the Corporate Director of Clinical Services and administrator intern were notified of the IJ on 3/29/22, at 2:18 p.m. The facility had implemented corrective action to prevent recurrence by 3/20/22, therefore the deficiency is being cited as past non-compliance.<br><br>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.<br><br>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 600 SS=J | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or | F 600 | | |

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| F 600 | Continued From page 2<br>involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and document review the facility failed to protect 1 of 1 resident (R3) from resident to resident sexual abuse when R3 had an incident of sexual touch without consent occurred. The facility failed to report the abuse and implement interventions to prevent further abuse, as a result a second incident of sexual touch occurring one day later. This resulted in an Immediate Jeopardy.<br><br>The Immediate Jeopardy began on 3/16/22, when R4's hand was rubbing R3's thigh and R4's hand went up R3's thigh and began tugging on R3's shirt as though wanting to go under the shirt. Facility staff failed to report the incident of sexual abuse and no interventions or protections were put into place to prevention further abuse. On 3/17/22, a second incident of sexual abuse occurred when R4's hand was observed by staff under R3's shirt. The Chief Operating Officer (COO), the Corporate Director of Clinical Services and administrator intern were notified of the IJ on 3/30/22, at 2:38 p.m. The facility had implemented corrective action to prevent recurrence by 3/19/22, prior to the start of the survey therefore the deficiency is being cited as past non-compliance.<br><br>Findings include:<br><br>R3's diagnoses include Encephalopathy, disorientation, vascular dementia with behavioral disturbance and abnormalities of gait and mobility obtained from the quarterly Minimum Data Set (MDS) dated 1/12/22. In addition, the MDS identified R3 had severely impaired cognition and | F 600 | Past noncompliance: no plan of correction required. | |

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| F 600 | Continued From page 3 | F 600 | | |

was dependent of staff for all activities of daily living (ADL's) including mobility using a wheelchair in and out of the unit.

R3's psychosocial well-being care plan dated 2/28/22, identified R3 was a vulnerable adult and needed assistance to remain safe within the community and was vulnerable to abuse from others. The care plan directed staff, "You will report and investigate any allegations of suspected abuse, neglect, or exploitation."

R4's diagnoses included dementia without behavioral disturbances and traumatic hemorrhage of right cerebrum without loss of consciousness obtained from the 5-day admission MDS dated 1/22/22. In addition, the MDS indicated R4 had moderately impaired cognition.

R4's cognitive loss/dementia care plan dated 10/26/2021, identified R4 had diagnoses of mild cognitive impairment, major neurocognitive diagnosis, dementia, Alzheimer's disease and periods of confusion. The care plan directed staff to provide redirection.

During review of a facility reported incident (FRI) dated 3/17/22 revealed R3 was observed seated on the wheelchair outside of the Beauty Salon when R4 approached R3 and staff observed R4's hand under R3's shirt. The staff immediately intervened and removed R3. At this time nursing assistant (NA)-A made note of this encounter and she notified nurse manager immediately, and then the administrator was updated. The report also indicated R3 was confused at baseline and was unable to provide consent for this encounter and the immediate interventions included putting

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| F 600 | Continued From page 4 | F 600 | | |

R4 on 1:1 for staff to always monitor his where about's and a psych referral was made for both residents involved. In addition, when interviewed R4 indicated he was adjusting R3's shirt and did not feel that he was acting inappropriately. In addition, after the incident on 3/17/22, during the investigation when staff were asked if they had noted any inappropriate touching, or behaviors between R4 and R3, NA-B acknowledged on the evening of 3/16//22, R4 was observed putting his hand up R3's shirt. NA-B stated she separated the residents immediately at that time and thought she reported the incident to the nurse.

During interview on 3/30/22, at 10:45 a.m. NA-B stated on 3/16/22, she was down the hallway putting residents to bed and R4 had been going up and down the hallway. NA-A stated when she approached R3 and R4 she observed R4's hand was on R3's thigh rubbing and R4's hand went up R3's thigh and was tugging R3's shirt. NA-B stated R4 "was yanking and pulling on the hem of the shirt" as though wanting to go under but R4's fingers were visible and there was no skin-to-skin contact. NA-B stated she turned R4 around, took R3 to get her ready for bed and reported to the nurse as she thought it was suspicious because R3 had her eyes closed at the time. NA-B stated she had reported the incident to the nurse to make sure he had documented it. NA-B also stated she had not thought of reporting to the supervisor because she had been told to report to the nurse she was working with.

During interview on 3/30/22, at 10:35 a.m. the Corporate director of clinical services stated staff was supposed to have reported the first incident to ensure R3 was provided protection from R4 and the second incident was avoidable. She

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| F 600 | Continued From page 5 | F 600 | | |

stated education had been initiated and completed for all the staff on abuse and a referral had been completed for R4 to be transferred to a all male facility and R4 was waiting to be transferred once things were in place.

During interview on 3/30/22, at 2:38 p.m. COO stated she had been updated about the investigation and she would have expected the staff to reach out to the administrator when they had seen observations or suspected any verbal interaction which was not appropriate, then the administrator was supposed to follow through by investigating and making sure the resident was protected.

During interview on 3/30/22, at 5:00 p.m. R3's Family (FM)-C stated in R3's intact cognition, R3 would be appalled if she was touched by someone without consent. FM-C stated the facility had informed him of the incident which happened on 3/17/22, and later had called him to inform him there had been another incident which had come to light when staff was being interviewed which had been observed on 3/16/22.

The facility Abuse Prohibition-Vulnerable Adult Protection / Abuse Prevention Plan revised 9/16/21, directed staff it was the responsibility of all employees to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown etiology, theft or misappropriation of resident property to facility management immediately. In addition, the policy directed administrative strategies were to be developed to protecting the rights and well-being of residents and staff to reinforce protection for the resident.

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| F 600 | Continued From page 6<br>The immediate jeopardy began on 3/16/22, when the facility failed to implement immediately interventions to protect R3 from repeated occurrence of sexual touch without consent. The immediate jeopardy deficient practice was corrected by 3/19/22. Following the incidents on 3/17/22, the facility completed interviews for both staff and residents about observing or experiencing inappropriate touch or made to feel uncomfortable respectively; both R3 and R4 got referrals and were seen by psych; all staff education was completed on vulnerable adult policies and procedures, reporting abuse responsibility and examples of abuse, R4 was moved to a different unit in the facility and was put on 1:1 for staff to monitor his whereabouts and NA-B was written up and was provided education. In addition, verification of corrective action was confirmed by the interviews with a multiple staff and facility Abuse Prohibition-Vulnerable Adult Protection/Abuse Prevention Plan policy was reviewed. | F 600 | | |
| F 678 SS=J | Cardio-Pulmonary Resuscitation (CPR)<br>CFR(s): 483.24(a)(3)<br><br>§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to initiate cardiopulmonary resuscitation (CPR) in accordance with physician orders and resident wishes for 1 of 1 residents (R1) who was found unresponsive and required | F 678 | Past noncompliance: no plan of correction required. | |

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| F 678 | Continued From page 7 | F 678 | | |

emergency care. This resulted in an immediate jeopardy (IJ) situation.

The IJ began on 3/19/22, at approximately 5:40 a.m. when the facility failed to provide CPR for R1 after R1 was found unresponsive without a pulse or respirations, and CPR was not initiated. The Chief Operating Officer, the Corporate Director of Clinical Services and administrator intern were notified of the IJ on 3/29/22, at 2:18 p.m. The facility had implemented corrective action to prevent recurrence by 3/20/22, therefore the deficiency is being cited as past non-compliance.

Findings include:

R1's diagnoses included hypertensive heart disease with heart failure, acute diastolic congestive heart failure, type 1 diabetes mellitus with hypoglycemia without coma and obstructive sleep apnea obtained from the 5-day admission Minimum Data Set (MDS) dated 2/20/22. In addition, the MDS identified R1 had intact cognition.

R1's Physician Order Report signed and dated 12/23/21, by the nurse practitioner (NP) and resident was a "Full Code" status.

R1's Provider Orders for Life-Sustaining Treatment (POLST) signed by R1 and the nurse practitioner on 12/28/21, indicated R1's wishes were to "Attempt Resuscitation and Full Treatment including life support measures in the intensive care unit."

R1's progress note dated 3/19/22, at 7:24 a.m. by licensed practical nurse (LPN)-A indicated at 5:00 a.m. staff had been to resident room and had

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| **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 |
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| F 678 | Continued From page 8 | F 678 | | |

noted R1 was sleeping. Then at 5:40 a.m. "Writer entered to see patient had leg over edge of the bed, urine in the urinal. Patient had no resp [respirations], No BP [blood pressure], No signs of life. Lips cyanotic, skin mottled and cool to touch. Shook patient with no change. Verified by another licensed [lic] staff and supervisor of patient's passing." The note did not indicate CPR was initiated. Resident's record verified resident was a full code.

During interview on 3/29/22, at 9:51 a.m. LPN-A stated nursing assistant (NA)-A had completed resident round checks between 4:30 a.m. and 5:00 a.m. and she had reported R1 was asleep. LPN-A then stated when she entered R1's room at 5:30 a.m. to check R1's oxygen saturation she found R1 was unresponsive, had no respirations, no pulse, had no signs of life, was mottling in the upper arms and lips were blue. LPN-A acknowledged she did not review R1's POLST until she was calling the physician on-call and that was when she found out R1 was a Full code. LPN-A also acknowledged she did not initiate CPR but instead declared R1 was dead. LPN-A stated she informed LPN-B R1 had passed away and there was no discussion of CPR being initiated but instead she and LPN-B put R1's leg, that had been hanging on the edge of bed, up and that was it. LPN-A stated she was supposed to look at the POLST if she found a resident unresponsive first, then was supposed to follow the facility protocol which she did not follow.

During interview on 3/29/22, at 12:35 p.m. the Corporate Director of Clinical Services stated her expectation was the nurse should have followed the policy and procedure to initiate CPR as this was what was on the resident POLST. She then

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| F 678 | Continued From page 9 | F 678 | | |

stated following the incident the facility had immediately initiated training for all nurses and therapy staff. In addition, the Corporate Director of Clinical Services stated LPN-A was terminated.

During interview on 3/29/22, at 10:45 family member (FM)-A stated although R1 had medical issues, he was looking forward to discharging from the facility to the community. FM-A also stated R1 was coherent and able to make decisions about his health and still wanted to be alive.

During interview on 3/30/22, at 6:43 a.m. LPN-B stated she had worked the night shift on 3/18/22, to 3/19/22, when R1 was found unresponsive. LPN-B stated LPN-A had approached her as she assisted another resident to the bathroom and had asked her to hurry and at the time she asked what was going on and that was when LPN-A stated to her R1 had passed away. LPN-B then stated NA-C and LPN-A went into R1's room and observed one of the legs was hanging on the edge of the bed. LPN-B stated she assisted LPN-A to reposition R1 to the middle of the bed and at this time she also checked R1's pulse and did not feel anything and she did not say anything to LPN-A. LPN-B stated she then reminded LPN-A to call to report to the supervisor all three staff left R1's room. LPN-B stated she did not ask LPN-A R1's code status because she thought because LPN-A was the assigned nurse she was well aware of R1's wishes. LPN-B stated since the incident she had received training that if a resident was unresponsive, they were supposed to first check the resident POLST and code status, then initiate CPR and call 911.

During interview on 3/30/22, at 6:54 a.m. LPN-C

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night building supervisor stated LPN-A had called to report R1 had passed on and she had asked LPN-A if she needed any assistance and if she had made the necessary calls and LPN-A had stated she had. LPN-C also stated LPN-A had called her a second time and told me R1 was a full code and she again asked her if she needed any assistance and LPN-A told her "no." LPN-C stated when a resident was found unresponsive, "first of all we have to check the POLST and if they are a full code we are to call *79 and to call the code blue and start CPR and when staff start running we tell them what to assist with the procedure. We are to start CPR and call 911 and to get them out of here." LPN-C stated since the incident she had received in-service on CPR protocols. LPN-C further stated "We are to read the POLST out of the chart and then take the necessary actions."

The facility's CPR policy dated 3/19/22, directed staff working at the facility "to their best of their ability to respect the wishes of residents and follow the procedure listed below for the initiation of CPR or Do Not Resuscitate (DNR) orders for each resident, if obtained. The American Heart Association (AHA) publishes guidelines every five years for CPR and Emergency Cardiovascular Care (ECC).
The AHA urges all potential rescuers to initiate CPR unless a valid Do Not Resuscitate (DNR) order is in place; obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition) are present; or initiating CPR could cause injury or peril to the rescuer.
If a resident experiences a cardiac or respiratory arrest facility staff will provide basic life support, including CPR, prior to the arrival of emergency

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| F 678 | Continued From page 11<br>medical services, in accordance with the resident's advance directives and any related physician order, such as code status, or in the absence of advance directives or a DNR order."<br><br>The immediate jeopardy began on 3/19/22, when the facility failed to implement their policy, and the resident's directive, related to CPR for R1. The immediate jeopardy was removed and the deficient practice corrected by 3/20/22, when the facility had implemented a systemic plan of correction that included re-educating the facility's licensed nursing and therapy staff regarding the facility's CPR policy and what staff are supposed to do when they found a resident unresponsive which included checking the POLST, initiate CPR immediately and call 911; an audit of charts for other residents who had passed away was completed to ensure the staff had followed the residents wishes. In addition, LPN-A was terminated. Verification of corrective action was confirmed by the interviews with a variety of nursing and therapy staff and facility CPR policy was reviewed. | F 678 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by: | F 684 | | 5/2/22 |

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| F 684 | Continued From page 12<br>Based on interview and document review, the facility failed to investigate the cause of a skin injury and assess for appropriate treatment for 1 of 2 residents (R2) reviewed for non-pressure related skin concerns.<br><br>Findings include:<br><br>R2's diagnoses included encephalopathy, unspecified intracranial injury without loss of consciousness, vascular dementia with behavioral disturbance, delirium due to known physiological condition, abnormalities of gait and mobility, Long term (current) use of anticoagulants, and history of falling obtained from the admission Minimum Data Set (MDS) dated 2/28/22. In addition, the MDS identified R2 required physician staff assistance with all activities of daily living including transfers and R2 had severely impaired cognition.<br><br>R2's care plan dated 3/3/22, identified resident was at risk for skin breakdown related to impaired bed mobility and R2 was not always able to effectively off load self without staff assistance. The care plan directed nursing assistants (NA's) to conduct a skin observation daily and weekly by a nurse. In addition, the care plan directed staff to report any signs of skin breakdown (sore, tender, red, or broken areas), document and report to the physician, nurse practitioner as indicated.<br><br>R2's care plan dated 3/3/22, also identified R2 had the potential complication to bruising, bleeding, hemorrhage related to chronic anticoagulation use. The care plan directed staff to encourage resident to avoid situations that have a potential for injury. | F 684 | • Resident R2 was discharged to the hospital.<br>• All residents at facility have the potential to be affected by the deficient practice.<br>• All nursing staff will be educated on the policy and procedure for new non pressure skin concerns<br>• Whole house audit was completed to review all residents with current none pressure wounds to ensure there was a cause identified and appropriate treatment in place<br>• Facility will conduct audits of new skin concerns: two audits per week for four weeks, two audits per month for three months, and will review at following QA meeting. | |

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| F 684 | Continued From page 13 | F 684 | | |

R2's Event Report dated 3/10/22, at 3:42 a.m. by licensed practical nurse (LPN)-A indicated R2 had a "Skin tear on the right knee." The report also indicated the writer had been called to R2's bathroom and NA-C who was assisting resident at the time stated she had assisted R2 to the bathroom per request as resident had been up in wheelchair due to being alert, attempting to get out of bed and when she pulled R2's pants down she saw "a skin tear on patients right knee and notified writer. The skin tear on right knee was "V" shaped, 5.0 centimeter (cm) each line that made up "V." Patient was asked how it occurred and could not answer. Area cleaned with normal saline [N.S] and dry, non-adhering dressing applied." The report also indicated the building charge and the triage nurse for the physician were notified however R2's responsible party/family was to be notified in the morning [AM]. The writer also indicated a nursing order treatment for the skin tear on right knee was to cleanse with NS pat dry, apply dry, non-adhesive dressing and staff was to change the dressing daily and as needed until healed.

During progress notes review the following was revealed:
-Progress note dated 3/10/22, at 10:06 a.m. R2 had "A bruise on his right [R] knee which was noticed by night [NOC] shift, family notified and the wife stated that she still wants to understand how the patient [pt] got the bruise, the writer informed her that per NOC shift report the pt does not remember how he got the bruise, [Family member-A] said she will talk to the nurse manager tomorrow."

-Progress note dated 3/11/22, at 4:18 a.m. indicated a scant amount of dry blood was noted

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| F 684 | Continued From page 14 | F 684 | | |

around old dressing to right knee, then writer provided dressing to "skin tear on right knee" per as needed (PRN) order. No bleeding and no sign and symptoms of infection noted to right knee.

-Progress note dated 3/11/22, at 2:05 p.m. indicated R2 had "a bruise on the right knee" which was cleaned and dressed per orders.

-Progress note dated 3/12/22, at 3:48 p.m. indicated FM-A had come to the facility and decided to bring R2 to the hospital per her preference. The medical record lacked documentation of the facility staff investigating the cause of the skin injury.

During interview on 3/29/22, at 1:12 p.m. LPN-A stated on 3/10/22, NA-C had assisted R2 to the bathroom and NA-C had turned the bathroom light on and she went in then NA-C said she had just found it. LPN-A stated she felt the outside of R2's pants were wet from the blood and she thought the pants zipper may have caused the injury. LPN-A then stated she noticed bright red blood and the injury was "V shape" which at the point she got a disposable ruler to measure it then cleaned the area with normal saline, pat dried it and applied the appropriate dressing. LPN-A then stated she notified the supervisor, filed the appropriate form for the injury and thought she had called the physician triage on-call number to report the injury. LPN-A further stated the day nurse was supposed to call the family as she had reported to the day nurse R2 had "a skin tear." LPN-A stated for any skin alterations she was supposed to notify the necessary people who needed to be notified including the family and physician to get orders for treatment.

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| F 684 | Continued From page 15<br><br>During interview on 3/30/22, at 2:24 p.m. the cooperate director of clinical services stated she would expect the staff to follow the facility policy with assessing and identifying the origin of the skin injury. She also stated she would expect the staff to notify the family/representatives and physician of any change in condition. When the cooperate director of clinical services reviewed right knee picture injury she stated it was not a skin tear but looked like a deep cut into the skin which required sutures.<br><br>During interview on 3/30/22, at 1:49 p.m. FM-B stated resident had sustained a skin alteration which the staff was not able to explain how R2 got it on the knee. FM-B stated on 3/12/22, FM-A had taken R2 to the hospital to get wound treatment. FM-B stated when R2 was seen at the emergency room (ER) the doctors had told FM-A the wound needed stitches or sutures however, the physician was not able to do it because the wound had started healing "inside out." FM-B stated the reason FM-A had brought R2 to the ER was because of concerns with a high risk for infection as the wound was deep into the skin and staff was not able to explain the origin/cause of the wound.<br>During interview on 3/30/22, at 3:26 p.m. registered nurse (RN)-A stated when a resident had a skin tear or alteration nurses were supposed to assess the issue, then were to notify the responsible party and the physician/provider to get appropriate treatment orders for the skin concern.<br><br>On 3/30/22, at 4:00 p.m. the policy for non-pressure skin was requested but was not provided. | F 684 | | |

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Electronically delivered
April 11, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: V6ZG11

Dear Administrator:

The above facility was surveyed on March 29, 2022 through March 31, 2022 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

Please feel free to call me with any questions.

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

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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 3/29/22, through 3/31/22, 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<br>SUBSTANTIATED:<br>H5411121C (MN81926), with a licensing order issued at 0830.<br>H5411122C (MN81953)<br>H5411123C (MN81932)<br>H5411124C (MN81925)<br><br>The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.<br>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 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to investigate the cause of a skin injury and assess for appropriate treatment for 1 | 2 830 | The director of nursing or designee, could review all residents with none pressure wounds, to assure the cause of the injury | 5/2/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 00496 | A. BUILDING: _____ B. WING _____ | C 03/31/2022 |

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

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| 2 830 | Continued From page 2<br>of 2 residents (R2) reviewed for non-pressure related skin concerns.<br><br>Findings include:<br><br>R2's diagnoses included encephalopathy, unspecified intracranial injury without loss of consciousness, vascular dementia with behavioral disturbance, delirium due to known physiological condition, abnormalities of gait and mobility, Long term (current) use of anticoagulants, and history of falling obtained from the admission Minimum Data Set (MDS) dated 2/28/22. In addition, the MDS identified R2 required physician staff assistance with all activities of daily living including transfers and R2 had severely impaired cognition.<br><br>R2's care plan dated 3/3/22, identified resident was at risk for skin breakdown related to impaired bed mobility and R2 was not always able to effectively off load self without staff assistance. The care plan directed nursing assistants (NA's) to conduct a skin observation daily and weekly by a nurse. In addition, the care plan directed staff to report any signs of skin breakdown (sore, tender, red, or broken areas), document and report to the physician, nurse practitioner as indicated.<br><br>R2's care plan dated 3/3/22, also identified R2 had the potential complication to bruising, bleeding, hemorrhage related to chronic anticoagulation use. The care plan directed staff to encourage resident to avoid situations that have a potential for injury.<br><br>R2's Event Report dated 3/10/22, at 3:42 a.m. by licensed practical nurse (LPN)-A indicated R2 had a "Skin tear on the right knee." The report also indicated the writer had been called to R2's | 2 830 | is identified and appropriate treatment/services are obtained from the provider to promote healing. The director of nursing or designee, could conduct random audits of the delivery of care; review reports of skin concerns to ensure appropriate care and services are implemented and reduce the risk of these wounds not being cared for properly. | |

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| 2 830 | Continued From page 3<br><br>bathroom and NA-C who was assisting resident at the time stated she had assisted R2 to the bathroom per request as resident had been up in wheelchair due to being alert, attempting to get out of bed and when she pulled R2's pants down she saw "a skin tear on patients right knee and notified writer. The skin tear on right knee was "V" shaped, 5.0 centimeter (cm) each line that made up "V." Patient was asked how it occurred and could not answer. Area cleaned with normal saline [N.S] and dry, non-adhering dressing applied." The report also indicated the building charge and the triage nurse for the physician were notified however R2's responsible party/family was to be notified in the morning [AM]. The writer also indicated a nursing order treatment for the skin tear on right knee was to cleanse with NS pat dry, apply dry, non-adhesive dressing and staff was to change the dressing daily and as needed until healed.<br><br>During progress notes review the following was revealed:<br>-Progress note dated 3/10/22, at 10:06 a.m. R2 had "A bruise on his right [R] knee which was noticed by night [NOC] shift, family notified and the wife stated that she still wants to understand how the patient [pt] got the bruise, the writer informed her that per NOC shift report the pt does not remember how he got the bruise, [Family member-A] said she will talk to the nurse manager tomorrow."<br><br>-Progress note dated 3/11/22, at 4:18 a.m. indicated a scant amount of dry blood was noted around old dressing to right knee, then writer provided dressing to "skin tear on right knee" per as needed (PRN) order. No bleeding and no sign and symptoms of infection noted to right knee. | 2 830 | | |

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| 2 830 | Continued From page 4<br><br>-Progress note dated 3/11/22, at 2:05 p.m. indicated R2 had "a bruise on the right knee" which was cleaned and dressed per orders.<br><br>-Progress note dated 3/12/22, at 3:48 p.m. indicated FM-A had come to the facility and decided to bring R2 to the hospital per her preference. The medical record lacked documentation of the facility staff investigating the cause of the skin injury.<br><br>During interview on 3/29/22, at 1:12 p.m. LPN-A stated on 3/10/22, NA-C had assisted R2 to the bathroom and NA-C had turned the bathroom light on and she went in then NA-C said she had just found it. LPN-A stated she felt the outside of R2's pants were wet from the blood and she thought the pants zipper may have caused the injury. LPN-A then stated she noticed bright red blood and the injury was "V shape" which at the point she got a disposable ruler to measure it then cleaned the area with normal saline, pat dried it and applied the appropriate dressing. LPN-A then stated she notified the supervisor, filed the appropriate form for the injury and thought she had called the physician triage on-call number to report the injury. LPN-A further stated the day nurse was supposed to call the family as she had reported to the day nurse R2 had "a skin tear." LPN-A stated for any skin alterations she was supposed to notify the necessary people who needed to be notified including the family and physician to get orders for treatment.<br><br>During interview on 3/30/22, at 2:24 p.m. the cooperate director of clinical services stated she would expect the staff to follow the facility policy with assessing and identifying the origin of the skin injury. She also stated she would expect the | 2 830 | | |

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| 2 830 | Continued From page 5<br>staff to notify the family/representatives and physician of any change in condition. When the cooperate director of clinical services reviewed right knee picture injury she stated it was not a skin tear but looked like a deep cut into the skin which required sutures.<br><br>During interview on 3/30/22, at 1:49 p.m. FM-B stated resident had sustained a skin alteration which the staff was not able to explain how R2 got it on the knee. FM-B stated on 3/12/22, FM-A had taken R2 to the hospital to get wound treatment. FM-B stated when R2 was seen at the emergency room (ER) the doctors had told FM-A the wound needed stitches or sutures however, the physician was not able to do it because the wound had started healing "inside out." FM-B stated the reason FM-A had brought R2 to the ER was because of concerns with a high risk for infection as the wound was deep into the skin and staff was not able to explain the origin/cause of the wound.<br>During interview on 3/30/22, at 3:26 p.m. registered nurse (RN)-A stated when a resident had a skin tear or alteration nurses were supposed to assess the issue, then were to notify the responsible party and the physician/provider to get appropriate treatment orders for the skin concern.<br><br>On 3/30/22, at 4:00 p.m. the policy for non-pressure skin was requested but was not provided.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing or designee, could review all residents with none pressure wounds, to assure the cause of the injury is identified and appropriate treatment/services are obtained from the provider to promote healing. The director of | 2 830 | | |

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| 2 830 | Continued From page 6<br>nursing or designee, could conduct random audits of the delivery of care; review reports of skin concerns to ensure appropriate care and services are implemented and reduce the risk of these wounds not being cared for properly.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |