DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 4, 2024

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

RE: CCN: 245411
Cycle Start Date: September 25, 2024

Dear Administrator:

On October 31, 2024, 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, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 4, 2024

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

Re: Reinspection Results
Event ID: KVKC12

Dear Administrator:

On October 31, 2024 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 September 25, 2024. 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 1, 2024

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

RE: CCN: 245411
Cycle Start Date: September 25, 2024

Dear Administrator:

On September 25, 2024, 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 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 December 25, 2024 (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 March 25, 2025 (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, 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

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 09/25/2024

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 9/24/24 through 9/25/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54118502C (MN00106652); H54116660C (MN00105454). As the result of the investigation, additional deficiencies were cited at F657 and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		10/22/24

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

Electronically Signed | 10/07/2024

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 657	Continued From page 1 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to review and revise the care plan with current interventions for the care of a new catheter and enhanced barrier precautions (EBP) for 1 of 1 residents (R2) reviewed. Findings include: R2's physician order dated 9/10/24, indicated R1 required a foley catheter related to diagnosis of urinary retention due to neurogenic bladder. R2's progress note dated 9/10/24, indicated R2 had returned to the facility following hospitalization. R2 was admitted to the hospital for septic shock due to bacteremia (blood stream infection) caused by an infected kidney stone. R2	F 657	• R2 had care plan reviewed and updated to add plan of care for Enhanced Barrier Precautions as well plan of care for urinary catheter. • All residents who have a urinary catheter and/or require Enhanced Barrier Precaution due to: Infection or colonization with an MDRO when Contact Precautions do not otherwise apply Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status, could be affected by deficient practice. • Facility will conduct whole house audit of residents to identify those that require	

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F 657	Continued From page 2 came back to the facility with a foley catheter. R2's care plan revised on 9/20/24, indicated R2 had an actual alteration in elimination related to impaired mobility, overactive bladder exhibited by frequently incontinent of bowel and bladder. R2 had a diagnosis of neurogenic bladder and was at risk for skin breakdown and urinary tract infection (UTI). Further, R2's care plan directed staff to offer toileting at start of shift, every two to three hours and as needed, complete bladder assessment quarterly or with significant change, encourage adequate fluid intake every shift, incontinence care as needed, observe condition to perineal area with incontinence care, observe for signs and symptoms of UTI, toilet with assist of two staff. However, R2's care plan lacked evidence of R2 requiring a catheter or EBP and interventions in place to direct staff on how to manage R2's catheter. During an observation on 9/24/24 at 3:59 p.m., nursing assistant (NA)-A and NA-B applied a surgical mask and entered R2's room. R2 was noted to be lying in bed and a catheter bag was noted to be hanging on the side of the bed in a blue privacy bag. NA-A and NA-B applied gloves to assist R1 with incontinent cares. NA-A grabbed a canister from R2's bathroom and emptied R2's catheter while holding the canister. NA-A then placed the canister containing urine on the carpeted floor and NA-A wiped the open end of the catheter tubing and catheter bag using an incontinent wipe. NA-A then grabbed the canister, emptied the urine into the toilet, and removed the soiled gloves. NA-A and NA-B assisted R2 from bed to her wheelchair using a mechanical lift. NA-A and NA-B then exited R2's room. NA-A and NA-B did not wear a gown while assisting R2 with	F 657	Enhanced Barrier Precautions and ensure care plan is in place. Facility will conduct whole house audit of all residents with urinary catheter and ensure care plan is in place. Education will be provided to all clinical staff regarding care planning for Enhanced Barrier Precautions and urinary catheters. Facility reviewed policy and it remains current. • Facility will audit three residents each week for four weeks, and then reduce to three residents per month for three months, and then bring results to QA for further review. • Date of Compliance: October 22, 2024	

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F 657	Continued From page 3 high contact cares. On 9/25/24 at 12:56 p.m., NA-C stated R2 required total assistance by staff for activities of daily living (ADL), was incontinent of bowel, and had a catheter that was placed about a week ago. NA-C confirmed R2 did not require the use of EBP, as there was no sign posted outside of R2's door. Further, NA-C stated if a resident required EBP a sign would have been posted outside the resident's door directing staff on what personal protective equipment (PPE) needed to be used, which would be kept in the cubby outside the resident's door. NA-C stated the resident's care plan and nursing care guide sheets would have also identified what each resident required. On 9 /25/24 at 3:08 p.m., licensed practical nurse (LPN)-A stated R2 returned to the facility from the hospital with a catheter. LPN-A confirmed R2 was not on EBP as the interdisciplinary team (IDT) must have missed implementing EBP upon returning from the hospital and LPN-A had not revised R2's care plan. On 9/25/24 at 3:28 p.m., director of nursing (DON) stated staff would know if a resident required EBP by a sign posted outside each resident's room, and DON was unsure if EBP were expected to be identified in a resident's care plan. Review of facility policy titled Care Plan Policy and Procedure revised 11/22, indicated the care plan was to be changed and updated as the care changes for the resident and as the resident changes occurred it would be updated in the electronic medical record and was to always be current. Further, policy directed staff to list all	F 657		

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F 657	Continued From page 4 care to be provided for the problem listed and the care must be necessary and appropriate to accomplish the goal stated. As well as communicate vital information to all staff providing direct resident care, list of infection control measures, list of safety measures, approaches to maintain resident's customary routine and list of preventative measures.	F 657		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		10/22/24

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F 880	Continued From page 5 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 880	• R2 had care plan reviewed and	

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F 880	Continued From page 6 review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for 1 of 1 residents (R2) reviewed who had an indwelling catheter. In addition, the facility failed to ensure appropriate infection control measures for draining a catheter bag were implemented for 1 of 1 residents (R2) reviewed. Findings include: R2's physician order dated 9/10/24, indicated R1 required a foley catheter related to diagnosis of urinary retention due to neurogenic bladder. R2's progress note dated 9/10/24, indicated R2 had returned to the facility following hospitalization. R2 was admitted to the hospital for septic shock due to bacteremia (blood stream infection) due to infected kidney stone. R2 came back with a foley catheter. R2's care plan as of 9/25/24, lacked identification R2 had a foley catheter or that R2 was on EBP. During an observation on 9/24/24 at 3:59 p.m., nursing assistant (NA)-A and NA-B applied a surgical mask and entered R2's room. R2 was noted to be lying in bed and a catheter bag was noted to be hanging on the side of the bed in a blue privacy bag. NA-A and NA-B applied gloves to assist R1 with incontinent cares. NA-A grabbed a canister from R2's bathroom and emptied R2's catheter while holding the canister. NA-A then placed the canister containing urine on the carpeted floor and NA-A wiped the open end of the catheter tubing and catheter bag using an incontinent wipe. NA-A then grabbed the canister, emptied the urine into the toilet, and removed the soiled gloves. NA-A and NA-B assisted R2 from	F 880	updated to ensure proper care plan and interventions in place for Enhanced Barrier Precautions, including signage placed on door. As well as reviewed care plan and updated to ensure appropriate infection control measures in place for urinary catheter, including wiping spigot with alcohol wipe after draining catheter bag. At the time incident, facility staff were provided education regarding the use of alcohol wipes after draining urine to prevent infection, proper hand hygiene. • All residents who have urinary catheter could be affected by deficient practice. • Facility will conduct a whole house audit of residents who have catheters to ensure proper care plan, interventions are in place per facility policy. Facility will conduct whole house audit to ensure all residents who meet criteria for Enhanced Barrier Precautions have appropriate care plan and intervention in place including signage on door. Education will be provided to clinical staff regarding cleaning of catheter spigot with alcohol wipe after emptying drainage bag, and education on definition and facility policy on Enhanced Barrier Precautions. Facility reviewed Urinary Cather and Infection Control policy related to Enhanced Barrier Precautions and both remain current. • Facility will audit three residents each week for four weeks, and then reduce to three residents per month for three months, and then bring results to QA for further review. • Date Compliance: October 22, 2024	

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F 880	Continued From page 7 bed to her wheelchair using a mechanical lift. NA-A and NA-B then exited R2's room. NA-A and NA-B did not wear a gown while assisting R1 with high contact cares. On 9/25/24 at 12:56 p.m., NA-C stated R2 required total assistance by staff for activities of daily living (ADL's), was incontinent of bowel, and had a catheter that was placed about a week ago. NA-C confirmed R2 did not require the use of EBP, as there was no sign posted outside of R2's door. Further, NA-C stated if a resident required EBP, a sign would have been posted outside the resident's door directing staff on what personal protective equipment (PPE) needed to be used, which would be kept in the cubby outside the resident's door. NA-C stated the resident's care plan and nursing care guide sheets would have identified what each resident required. In addition, NA-C stated while emptying a catheter bag, staff were required to wear gloves, place a towel on the floor and drain the urine into the container. Staff were expected to clean the open end of the catheter tubing with an alcohol wipe which were available in each resident's room. On 9/25/24 at 1:16 p.m., NA-D stated R2 had a catheter which was new upon returning from the hospital. NA-D stated R2 did not require the use of EBP as there was no signage posted outside of R2's door. Further, NA-D stated a resident would require the use of EBP if the resident had an infection, wound, or catheter and a sign would have been posted outside the resident's room. On 9/25/24 at 1:28 p.m., registered nurse (RN)-A stated R2 had a catheter and required staff assistance for ADLs. RN-A stated he was unsure if R2 was currently on EBP, however confirmed	F 880		

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F 880	Continued From page 8 R2 should have been on EBP due to having a catheter. RN-A stated if a resident required the use of EBP, there would have been a sign posted outside of the resident's room and the infection preventionist (IP) was good at implementing EBP as required. On 9/25/24 at 2:01 p.m., IP stated either herself or the director of nursing (DON) would implement EBP for a resident if they had a wound, catheter, or active infection. Further, IP confirmed R2 returned from the hospital on 9/10/24, with a catheter and required EBP. In addition, IP stated R2 was on her "flow sheet" for tracking purposes and IP completed random audits to ensure all EBP were implemented, however had not completed an audit since R2's return. On 9 /25/24 at 3:08 p.m., licensed practical nurse (LPN)-A stated R2 returned to the facility from the hospital with a catheter. LPN-A confirmed R2 was not on EBP as the interdisciplinary team (IDT) must have missed implementing EBP upon returning from the hospital. In addition, LPN-A stated staff were expected to empty a resident's catheter into the cylinder and clean the open tip with an alcohol wipe. On 9/25/24 at 3:28 p.m., DON stated EBP were required for residents who had a catheter, tube feeding, external medical devices, and wounds. DON stated EBP signs were to be placed outside of the resident's room and IP tracked the individuals who required EBP. DON confirmed R2 had a catheter and required EBP. Further, DON stated staff were expected to apply gloves, place a barrier on the floor, empty the catheter into the cylinder and then wipe the open tip of the catheter with an alcohol wipe to kill any bacteria or germs	F 880		

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 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 9 present on the exterior of the tubing. On 9/25/24 at 4:27 p.m., NA-A stated staff were expected to apply gloves, place a towel on the floor, empty the catheter into the canister and use an alcohol wipe to wipe the end of the open tip of the catheter tubing. However, NA-A stated he utilized an incontinent wipe yesterday since there were no alcohol wipes available in R2's room yesterday. In addition, NA-A stated he forgot to bring a towel in to place the canister on. Review of facility policy titled Urinary Catheter Care revised 7/8/24, directed staff to wipe spigot with an alcohol wipe after drainage was completed prior to closing the system and keep the collection container off the floor or use a barrier between the floor and the collection container. Review of facility policy titled Isolation-Categories of Transmission-Based Precautions revised 7/12/22, indicated enhanced barrier precautions were an infection control intervention designed to reduce transmission of multi-drug organisms (MDROs) in the facility. Enhanced barrier precautions involved gown and glove use during high-contact resident care activities for resident known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (residents with wounds or indwelling medical devices). Further, policy indicated when a resident was placed on transmission-based precautions, appropriate notification would be placed on the room entrance door and on the front of the chart so that personnel and visitors were aware of the need for and the type of precaution. The signage informed staff of the type of precautions, instructions for use of PPE, and/or	F 880		

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F 880	Continued From page 10 instruction to see a nurse before entering the room.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 1, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: KVKC11

Dear Administrator:

The above facility was surveyed on September 24, 2024 through September 25, 2024 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00496	A. BUILDING: _____ B. WING _____	C 09/25/2024

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SHIRLEY CHAPMAN SHOLOM HOME EAST	740 KAY AVENUE SAINT PAUL, MN 55102

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/24/24 through 9/25/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54118502C (MN00106652); H54116660C (MN00105454). As a result of the investigation, a licensing order was issued at 1390. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as	21390		10/22/24

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21390	Continued From page 3 disinfectants, antiseptics, gloves, and incontinence products; and l. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for 1 of 1 residents (R2) reviewed who had an indwelling catheter. In addition, the facility failed to ensure appropriate infection control measures for draining a catheter bag were implemented for 1 of 1 residents (R2) reviewed. Findings include: R2's physician order dated 9/10/24, indicated R1 required a foley catheter related to diagnosis of urinary retention due to neurogenic bladder. R2's progress note dated 9/10/24, indicated R2 had returned to the facility following hospitalization. R2 was admitted to the hospital for septic shock due to bacteremia (blood stream infection) due to infected kidney stone. R2 came back with a foley catheter. R2's care plan as of 9/25/24, lacked identification R2 had a foley catheter or that R2 was on EBP. During an observation on 9/24/24 at 3:59 p.m., nursing assistant (NA)-A and NA-B applied a surgical mask and entered R2's room. R2 was noted to be lying in bed and a catheter bag was noted to be hanging on the side of the bed in a blue privacy bag. NA-A and NA-B applied gloves to assist R1 with incontinent cares. NA-A grabbed	21390	Corrected	

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21390	Continued From page 4 a canister from R2's bathroom and emptied R2's catheter while holding the canister. NA-A then placed the canister containing urine on the carpeted floor and NA-A wiped the open end of the catheter tubing and catheter bag using an incontinent wipe. NA-A then grabbed the canister, emptied the urine into the toilet, and removed the soiled gloves. NA-A and NA-B assisted R2 from bed to her wheelchair using a mechanical lift. NA-A and NA-B then exited R2's room. NA-A and NA-B did not wear a gown while assisting R1 with high contact cares. On 9/25/24 at 12:56 p.m., NA-C stated R2 required total assistance by staff for activities of daily living (ADL's), was incontinent of bowel, and had a catheter that was placed about a week ago. NA-C confirmed R2 did not require the use of EBP, as there was no sign posted outside of R2's door. Further, NA-C stated if a resident required EBP, a sign would have been posted outside the resident's door directing staff on what personal protective equipment (PPE) needed to be used, which would be kept in the cubby outside the resident's door. NA-C stated the resident's care plan and nursing care guide sheets would have identified what each resident required. In addition, NA-C stated while emptying a catheter bag, staff were required to wear gloves, place a towel on the floor and drain the urine into the container. Staff were expected to clean the open end of the catheter tubing with an alcohol wipe which were available in each resident's room. On 9/25/24 at 1:16 p.m., NA-D stated R2 had a catheter which was new upon returning from the hospital. NA-D stated R2 did not require the use of EBP as there was no signage posted outside of R2's door. Further, NA-D stated a resident would require the use of EBP if the resident had	21390		

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21390	Continued From page 5 an infection, wound, or catheter and a sign would have been posted outside the resident's room. On 9/25/24 at 1:28 p.m., registered nurse (RN)-A stated R2 had a catheter and required staff assistance for ADLs. RN-A stated he was unsure if R2 was currently on EBP, however confirmed R2 should have been on EBP due to having a catheter. RN-A stated if a resident required the use of EBP, there would have been a sign posted outside of the resident's room and the infection preventionist (IP) was good at implementing EBP as required. On 9/25/24 at 2:01 p.m., IP stated either herself or the director of nursing (DON) would implement EBP for a resident if they had a wound, catheter, or active infection. Further, IP confirmed R2 returned from the hospital on 9/10/24, with a catheter and required EBP. In addition, IP stated R2 was on her "flow sheet" for tracking purposes and IP completed random audits to ensure all EBP were implemented, however had not completed an audit since R2's return. On 9 /25/24 at 3:08 p.m., licensed practical nurse (LPN)-A stated R2 returned to the facility from the hospital with a catheter. LPN-A confirmed R2 was not on EBP as the interdisciplinary team (IDT) must have missed implementing EBP upon returning from the hospital. In addition, LPN-A stated staff were expected to empty a resident's catheter into the cylinder and clean the open tip with an alcohol wipe. On 9/25/24 at 3:28 p.m., DON stated EBP were required for residents who had a catheter, tube feeding, external medical devices, and wounds. DON stated EBP signs were to be placed outside of the resident's room and IP tracked the	21390		

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21390	Continued From page 6 individuals who required EBP. DON confirmed R2 had a catheter and required EBP. Further, DON stated staff were expected to apply gloves, place a barrier on the floor, empty the catheter into the cylinder and then wipe the open tip of the catheter with an alcohol wipe to kill any bacteria or germs present on the exterior of the tubing. On 9/25/24 at 4:27 p.m., NA-A stated staff were expected to apply gloves, place a towel on the floor, empty the catheter into the canister and use an alcohol wipe to wipe the end of the open tip of the catheter tubing. However, NA-A stated he utilized an incontinent wipe yesterday since there were no alcohol wipes available in R2's room yesterday. In addition, NA-A stated he forgot to bring a towel in to place the canister on. Review of facility policy titled Urinary Catheter Care revised 7/8/24, directed staff to wipe spigot with an alcohol wipe after drainage was completed prior to closing the system and keep the collection container off the floor or use a barrier between the floor and the collection container. Review of facility policy titled Isolation-Categories of Transmission-Based Precautions revised 7/12/22, indicated enhanced barrier precautions were an infection control intervention designed to reduce transmission of multi-drug organisms (MDROs) in the facility. Enhanced barrier precautions involved gown and glove use during high-contact resident care activities for resident known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (residents with wounds or indwelling medical devices). Further, policy indicated when a resident was placed on transmission-based precautions, appropriate notification would be	21390		

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21390	Continued From page 7 placed on the room entrance door and on the front of the chart so that personnel and visitors were aware of the need for and the type of precaution. The signage informed staff of the type of precautions, instructions for use of PPE, and/or instruction to see a nurse before entering the room. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed related to Enhanced Barrier Precautions as well as assisting with catheter cares. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	21390		