Electronically delivered
December 29, 2020

Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

RE: CCN: 245574
Cycle Start Date: December 11, 2020

Dear Administrator:

On December 11, 2020, 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.

Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

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, Sholom Home West is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 11, 2020. 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" tag), i.e., the plan of correction should be directed to:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	C 12/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426**

(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 12/9/20, through 12/11/20, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) at past non-compliance to resident health and safety. An IJ at F684 began on 11/30/20, when a resident (R1) had an unwitnessed fall. The facility failed to ensure licensed practical nurse (LPN)-A properly assessed and notified the provider of a resident's change of condition following a fall, which resulted in death. The administrator and director of nursing (DON) were notified of the IJ for R1 on 12/10/20, at 3:13 p.m. The above findings constituted substandard quality of care, and an extended survey was conducted on 12/11/20. At the time of the abbreviated survey, an onsite investigation was completed and the following complaint was found to be substantiated: H5574127C with deficiencies cited at F684. No plan of correction is required. 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.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25	F 684		

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

Electronically Signed

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 684	Continued From page 1 § 483.25 Quality of care 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. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure proper assessment and notification of the primary care provider following a fall for 1 of 4 residents (R1) reviewed for change of condition following a fall, which resulted in death. This resulted in an immediate jeopardy. The immediate jeopardy (IJ) began on 11/30/20, at 11:30 p.m. when R1 had an unwitnessed fall in her room. Neuro checks were initiated, but were not followed per facility policy. During the 12:30 a.m. neuro check, R1 had a change of condition which included increased drowsiness and sluggish pupils. R1's provider was not notified of R1's change of condition, and no further assessments were completed. R1 subsequently died. The administrator and director of nursing (DON) were notified of the IJ on 12/10/20, at 3:13 p.m.. The IJ was issued at past non-compliance due to corrective actions taken by the facility. On 12/2/20, the facility provided training to all licensed and unlicensed staff on neuro checks, assessments, change in condition, falls, and notification of change. Findings include:	F 684	Past noncompliance: no plan of correction required.	

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F 684	Continued From page 2 R1's Face Sheet printed on 12/11/20, indicated R1's diagnoses included hypertensive heart disease with heart failure, chronic combined systolic and diastolic heart failure (a chronic condition in which the heart does not pump blood as well as it should), giant cell arteritis (an inflammation of blood vessels, called arteries, in and around the scalp), paroxysmal atrial fibrillation (an irregular often rapid heart rate that causes poor blood flow), and long term (current) use of anticoagulants (medicines that prevent the blood from clotting as quickly or as effectively as normal). R1's care plan dated 11/27/20, indicated R1 was at risk for falls. The care plan directed staff to place call light within reach and answer promptly, remind resident to ask for assistance with transfers and ambulation as appropriate, and observe for changes in cognition. R1's Provider Orders for Life-Sustaining Treatment (POLST) dated 11/27/20, indicated R1 wanted CPR performed if patient had no pulse and was not breathing. R1's Observation Detail List dated 11/27/20, at 9:01 p.m. indicated R1 had no history of multiple falls, had a decline in functional status, required assist with elimination, and was not steady, but able to stabilize without human assistance for moving seated to standing, moving on and off toilet, and surface to surface transfers. On 11/20/20, R1 was seen by nurse practitioner (NP)-A. R1's orders at that time included warfarin (blood thinner) two milligrams (mg) take mg on Monday, Wednesday, and Friday, and 1 mg	F 684		

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F 684	Continued From page 3 Tuesday, Thursday. Saturday, and Sunday. On 12/1/20, at 12:11 a.m. a progress note (edited at 5:43 a.m. with more data available) indicated R1 had been discovered sitting on the floor next to her bed at 11:30 p.m.. The progress note indicated she was trying to get up, she was extremely confused, agitated, was unaware of where she was, could only say she was getting out of the pool. The note further indicated R1 was not able to be reoriented, neuro checks were started, and she had no signs of head trauma. The progress note indicated R1 was lifted back into bed with the assist of two staff and a mechanical lift. NP-A was notified by a message left on voice mail. The noted further indicated 30 minute checks were done, and R1 was breathing and more alert at 12 a.m. and able to answer questions. On 11/30/20, R1's Neurological Assessment Flowsheet indicated R1's first neuro check was at 11:30 p.m. R1's level of consciousness was alert, pupils were equal and responsive to light, equal hand grasps and moves all extremities, and appropriate pain response. On 12/1/20, at 12:00 a.m. there was no change documented in the checklist. At 12:30 a.m. R1's level of consciousness was documented as drowsy, pupils as sluggish, equal hand grasps and moves all extremities, and appropriate pain response. R1's medical record lacked indication R1's primary care provider was notified of this change in condition. No further neuro checks were completed on R1. There was no plan for ongoing monitoring of R1, despite the change in her neurological status. On 12/1/20, at 3:36 a.m. a progress note written	F 684		

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F 684	Continued From page 4	F 684		

by licensed practical nurse (LPN)-A indicated R1 was found at 2:30 a.m. and "resident wasn't breathing. No pulse, no heart beat, called 2N nurse and brought the crash cart to resident's room. Started CPR right away, resident was still warm to the touch. Other nurse from upstairs called 911 right away. They came and took over CPR from me. Preformed (sic) CPR for 25 min. then they came and told me that they called it [pronounced R1 dead]. Son was called before and after. Son was told of our aforts (sic) to bring her back. Also that she had fallen at 11:30 pm."

On 12/10/20, at 10:01 a.m. R1's family member (FM)-A was interviewed. FM-A stated he would have expected staff to follow their procedures after a resident fall. FM-A was aware that R1 was on blood thinners, and would have expected the facility to complete neuro checks if there was a possibility of a head injury.

-at 10:52 a.m. LPN-C was interviewed. LPN-C stated she was the nurse on call on 11/30/20, through 12/1/20, until 6:00 a.m. LPN-C stated she was not called about R1's fall. LPN-C stated if a fall is unwitnessed and the resident cannot say for certain if they hit their head, neuro checks should be started. LPN-C also stated if there was a change in a resident's condition, she should also have been notified.

-at 11:10 a.m. the NP-A was interviewed. NP-A stated she was not notified of R1's change of condition at 12:30 a.m. on 12/1/20. NP-A stated a resident's change of condition "would warrant a call" and she would expect the facility to follow their policies and procedures.

-at 12:31 p.m. the administrator and the director

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F 684	Continued From page 5	F 684		

of nursing (DON) were interviewed. The DON stated LPN-A did not complete the skill area Change of Condition/Focused Assessment during her orientation. The DON stated this should have been completed.

-at 1:53 p.m. LPN-A was interviewed. LPN-A stated after R1 fell she did half hour checks on R1. LPN-A stated she should have completed neuro checks every 15 minutes. LPN-A stated if someone was sleeping and you woke them to do a neuro check "there is no real reaction to their eyes." LPN-A stated she would expect someone to have a sluggish reaction to light shined in their eyes. LPN-A stated her training for neuro checks was "quite a bit," but was stated it was because she had been a nurse for 25 years. LPN-A stated sluggish pupils "is a bad sign." LPN-A stated she knew she should have been completing neuro checks every 15 minutes for the first hour, then every 30 minutes for the next hour, but did not do this because she was "too busy." When asked if she called the on call nurse, the DON, or other nurses in the building for help she responded with no. LPN-A verified R1 had a sluggish pupil reaction and was drowsy at 12:30 a.m. and that she did not notify R1's medical provider.

-at 2:40 p.m. nursing assistant (NA)-A was interviewed. NA-A stated she was called to the unit to assist R1 to the commode sometime between 11:00 p.m. and 12:00 a.m. on 11/30/20, through 12/1/20. R1 transferred to the commode with an assist of two. NA-A stated R1 seemed "quite weak," seemed in pain, and was not able to stay seated upright without assistance.

On 12/11/20, at 8:53 a.m. the DON was interviewed. The DON stated she would expect

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F 684	Continued From page 6	F 684		

staff to follow the facility policy after a resident falls, she would expect staff to call the on-call nurse for help if she was not able to follow through because she to busy to complete needed assessments, and she would have expected LPN-A to call the on-call physician for sluggish pupils and drowsiness.

LPN-A's Employee Corrective Action Form dated 12/3/20, indicated the facility elected to terminate employment as performance did not meet their standards of practice.

The facility policy Fall Prevention and Management updated 12/2/20, directed staff following a fall, if the resident is not able to state if they hit their head to do the following: perform neuro checks per neuro check policy and form and to alert the physician or NP with any changes.

The facility policy Neurological Assessment revision date 1/19, directed staff to complete a neurological assessment for unwitnessed falls, if the resident is not competent to recall if they hit their head and there is no evidence of head trauma. The frequency of neuro checks was as follows: every 15 minutes times one hour, every 30 minutes times one hour, every one hour times two hours, every four hours times 20 hours to cover 24 hours. Then day two and day three once a shift. The policy also indicated symptoms of closed head injury are often not immediately apparent. Pupil size and reaction to light is often a late sign of increased intracranial pressure. The policy further directed, "The physician will be notified of changes in physical and mental states including head trauma and neurological symptoms. Changes found in follow-up

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F 684	Continued From page 7 assessments will be communicated to the physician." The facility policy Resident Change in Condition-Notification of Physician/Surrogate Decision Maker dated 7/18, directed staff to notify physician immediately for, "Falls with any suspected serious injury, i.e. fracture, incidents involving trauma to the head, i.e. hematoma, lacerations, recurrent falls, any other symptom (using nursing judgement) that is causing discomfort or that may jeopardize health and/or safety. Education provided to licensed and unlicensed staff included staff were educated as of 12/2/20. Training included fall policy review and fall education, interventions for high fall-risk patients, neurological assessment policy, neurological assessment form revision, reporting to the administrator, change of condition, fall education work flow review, interdisciplinary team (IDT) review process. The training was verified through interviews with staff about education relating to falls, neurological changes, and updating providers.	F 684		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 12, 2021

Revised Letter

Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

Re: Event ID: FI4P11

Dear Administrator:

This letter will replace the letter dated December 29, 2020. The deficiency cited is past noncompliance. No Plan of Correction (POC) is required.

The above facility survey was completed on December 11, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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. The following complaint was found to be SUBSTANTIATED: H5574127C at past non-compliance.

Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 29, 2020

Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: FI4P11

Dear Administrator:

The above facility was surveyed on December 9, 2020 through December 11, 2020 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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	C 12/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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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 12/9/20, through 12/11/20, dates, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5574127C at past non-compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		12/2/20

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2 265	Continued From page 2 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview, and document review the facility failed to ensure proper assessment and notification of the primary care provider following a fall for 1 of 4 residents (R1) reviewed for change of condition following a fall, which resulted in death. This resulted in an immediate jeopardy. The immediate jeopardy (IJ) began on 11/30/20, at 11:30 p.m. when R1 had an unwitnessed fall in her room. Neuro checks were initiated, but were not followed per facility policy. During the 12:30 a.m. neuro check, R1 had a change of condition which included increased drowsiness and sluggish pupils. R1's provider was not notified of R1's change of condition, and no further assessments were completed. R1 subsequently died. The administrator and director of nursing (DON) were notified of the IJ on 12/10/20, at 3:13 p.m.. The IJ was issued at past non-compliance due to corrective actions taken by the facility. On 12/2/20, the facility provided training to all licensed and unlicensed staff on neuro checks, assessments, change in condition, falls, and notification of change. Findings include: R1's Face Sheet printed on 12/11/20, indicated R1's diagnoses included hypertensive heart disease with heart failure, chronic combined systolic and diastolic heart failure (a chronic condition in which the heart does not pump blood as well as it should), giant cell arteritis (an	2 265	Corrected	

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2 265	Continued From page 3	2 265		

inflammation of blood vessels, called arteries, in and around the scalp), paroxysmal atrial fibrillation (an irregular often rapid heart rate that causes poor blood flow), and long term (current) use of anticoagulants (medicines that prevent the blood from clotting as quickly or as effectively as normal).

R1's care plan dated 11/27/20, indicated R1 was at risk for falls. The care plan directed staff to place call light within reach and answer promptly, remind resident to ask for assistance with transfers and ambulation as appropriate, and observe for changes in cognition.

R1's Provider Orders for Life-Sustaining Treatment (POLST) dated 11/27/20, indicated R1 wanted CPR performed if patient had no pulse and was not breathing.

R1's Observation Detail List dated 11/27/20, at 9:01 p.m. indicated R1 had no history of multiple falls, had a decline in functional status, required assist with elimination, and was not steady, but able to stabilize without human assistance for moving seated to standing, moving on and off toilet, and surface to surface transfers.

On 11/20/20, R1 was seen by nurse practitioner (NP)-A. R1's orders at that time included warfarin (blood thinner) two milligrams (mg) take mg on Monday, Wednesday, and Friday, and 1 mg Tuesday, Thursday. Saturday, and Sunday.

On 12/1/20, at 12:11 a.m. a progress note (edited at 5:43 a.m. with more data available) indicated R1 had been discovered sitting on the floor next to her bed at 11:30 p.m.. The progress note indicated she was trying to get up, she was extremely confused, agitated, was unaware of

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2 265	Continued From page 4	2 265		

where she was, could only say she was getting out of the pool. The note further indicated R1 was not able to be reoriented, neuro checks were started, and she had no signs of head trauma. The progress note indicated R1 was lifted back into bed with the assist of two staff and a mechanical lift. NP-A was notified by a message left on voice mail. The noted further indicated 30 minute checks were done, and R1 was breathing and more alert at 12 a.m. and able to answer questions.

On 11/30/20, R1's Neurological Assessment Flowsheet indicated R1's first neuro check was at 11:30 p.m. R1's level of consciousness was alert, pupils were equal and responsive to light, equal hand grasps and moves all extremities, and appropriate pain response. On 12/1/20, at 12:00 a.m. there was no change documented in the checklist. At 12:30 a.m. R1's level of consciousness was documented as drowsy, pupils as sluggish, equal hand grasps and moves all extremities, and appropriate pain response. R1's medical record lacked indication R1's primary care provider was notified of this change in condition. No further neuro checks were completed on R1. There was no plan for ongoing monitoring of R1, despite the change in her neurological status.

On 12/1/20, at 3:36 a.m. a progress note written by licensed practical nurse (LPN)-A indicated R1 was found at 2:30 a.m. and "resident wasn't breathing. No pulse, no heart beat, called 2N nurse and brought the crash cart to resident's room. Started CPR right away, resident was still warm to the touch. Other nurse from upstairs called 911 right away. They came and took over CPR from me. Preformed (sic) CPR for 25 min. then they came and told me that they called it

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2 265	Continued From page 5 [pronounced R1 dead]. Son was called before and after. Son was told of our aforts (sic) to bring her back. Also that she had fallen at 11:30 pm." On 12/10/20, at 10:01 a.m. R1's family member (FM)-A was interviewed. FM-A stated he would have expected staff to follow their procedures after a resident fall. FM-A was aware that R1 was on blood thinners, and would have expected the facility to complete neuro checks if there was a possibility of a head injury. -at 10:52 a.m. LPN-C was interviewed. LPN-C stated she was the nurse on call on 11/30/20, through 12/1/20, until 6:00 a.m. LPN-C stated she was not called about R1's fall. LPN-C stated if a fall is unwitnessed and the resident cannot say for certain if they hit their head, neuro checks should be started. LPN-C also stated if there was a change in a resident's condition, she should also have been notified. -at 11:10 a.m. the NP-A was interviewed. NP-A stated she was not notified of R1's change of condition at 12:30 a.m. on 12/1/20. NP-A stated a resident's change of condition "would warrant a call" and she would expect the facility to follow their policies and procedures. -at 12:31 p.m. the administrator and the director of nursing (DON) were interviewed. The DON stated LPN-A did not complete the skill area Change of Condition/Focused Assessment during her orientation. The DON stated this should have been completed. -at 1:53 p.m. LPN-A was interviewed. LPN-A stated after R1 fell she did half hour checks on R1. LPN-A stated she should have completed neuro checks every 15 minutes. LPN-A stated if	2 265		

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2 265	Continued From page 6	2 265		

someone was sleeping and you woke them to do a neuro check "there is no real reaction to their eyes." LPN-A stated she would expect someone to have a sluggish reaction to light shined in their eyes. LPN-A stated her training for neuro checks was "quite a bit," but was stated it was because she had been a nurse for 25 years. LPN-A stated sluggish pupils "is a bad sign." LPN-A stated she knew she should have been completing neuro checks every 15 minutes for the first hour, then every 30 minutes for the next hour, but did not do this because she was "too busy." When asked if she called the on call nurse, the DON, or other nurses in the building for help she responded with no. LPN-A verified R1 had a sluggish pupil reaction and was drowsy at 12:30 a.m. and that she did not notify R1's medical provider.

-at 2:40 p.m. nursing assistant (NA)-A was interviewed. NA-A stated she was called to the unit to assist R1 to the commode sometime between 11:00 p.m. and 12:00 a.m. on 11/30/20, through 12/1/20. R1 transferred to the commode with an assist of two. NA-A stated R1 seemed "quite weak," seemed in pain, and was not able to stay seated upright without assistance.

On 12/11/20, at 8:53 a.m. the DON was interviewed. The DON stated she would expect staff to follow the facility policy after a resident falls, she would expect staff to call the on-call nurse for help if she was not able to follow through because she to busy to complete needed assessments, and she would have expected LPN-A to call the on-call physician for sluggish pupils and drowsiness.

LPN-A's Employee Corrective Action Form dated 12/3/20, indicated the facility elected to terminate employment as performance did not meet their

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2 265	Continued From page 7 standards of practice. The facility policy Fall Prevention and Management updated 12/2/20, directed staff following a fall, if the resident is not able to state if they hit their head to do the following: perform neuro checks per neuro check policy and form and to alert the physician or NP with any changes. The facility policy Neurological Assessment revision date 1/19, directed staff to complete a neurological assessment for unwitnessed falls, if the resident is not competent to recall if they hit their head and there is no evidence of head trauma. The frequency of neuro checks was as follows: every 15 minutes times one hour, every 30 minutes times one hour, every one hour times two hours, every four hours times 20 hours to cover 24 hours. Then day two and day three once a shift. The policy also indicated symptoms of closed head injury are often not immediately apparent. Pupil size and reaction to light is often a late sign of increased intracranial pressure. The policy further directed, "The physician will be notified of changes in physical and mental states including head trauma and neurological symptoms. Changes found in follow-up assessments will be communicated to the physician." The facility policy Resident Change in Condition-Notification of Physician/Surrogate Decision Maker dated 7/18, directed staff to notify physician immediately for, "Falls with any suspected serious injury, i.e. fracture, incidents involving trauma to the head, i.e. hematoma, lacerations, recurrent falls, any other symptom (using nursing judgement) that is causing discomfort or that may jeopardize health and/or	2 265		

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2 265	Continued From page 8 safety. Education provided to licensed and unlicensed staff included staff were educated as of 12/2/20. Training included fall policy review and fall education, interventions for high fall-risk patients, neurological assessment policy, neurological assessment form revision, reporting to the administrator, change of condition, fall education work flow review, interdisciplinary team (IDT) review process. The training was verified through interviews with staff about education relating to falls, neurological changes, and updating providers.	2 265		