DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 2, 2020

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

RE: CCN: 245574
Cycle Start Date: March 13, 2020

Dear Administrator:

During this period of pandemic COVID-19 outbreak, the Centers for Medicare and Medicaid Services (CMS) has directed the State Agencies (MDH) to change the process for survey prioritization and enforcement remedies. CMS is delaying revisit surveys and are exercising enforcement discretion during this prioritization period, beginning March 23, 2020. As a result, the below enforcement actions resulting from this survey cycle will be suspended until revisits are again authorized.

This letter also requests that your facility submit an electronic plan of correction (ePOC). Although revisit surveys will not be conducted during the prioritization period, you may still submit your facility's ePOC during this time and the case will be held. Your facility may delay submission of an ePOC until the prioritization period is over.

On March 13, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793

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 June 13, 2020 (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 September 13, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	245574	A. BUILDING _____ B. WING _____	C 03/13/2020

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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F 000	INITIAL COMMENTS On March 10, 11, 12 and 13, 2020, 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. The following complaints were found to be SUBSTANTIATED. H5574115C and as a result of the investigation a deficiency was identified at F677. H5574121C and as a result of the investigation a deficiency was identified at F677. H5574120C and as a result of the investigation deficiencies were identified at F880. The following complaints were found to be SUBSTANTIATED with NO deficiencies cited due to actions implemented by the facility prior to survey. H5574116C, H5574117C, H5574118C and HH5574119C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/10/2020

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 conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine personal grooming and cleanliness for 2 of 3 residents (R400, R275) dependent on staff for urinary incontinence care. Findings include: On 3/12/20, from 9:00 a.m. to 12:45 p.m. R400 was observed sitting in a Broda chair without being provided urinary incontinence care as directed by nursing assistant care sheets and the care plan. - At 9:00 a.m. R400 was at breakfast in the dining room - At 9:35 a.m. staff took R400 from the dining room to an area across from the nursing station, where R400 remained until 9:51 a.m. when therapy staff took R400 to the therapy room. - At 10:22 a.m. therapy staff brought R400 to an area across from the nursing station, where R400 remained until 12:37 p.m. when nursing assistant (NA)-A wheeled R400 to the bedroom. At 12:37 p.m. NA-A stated R400 had been asked	F 677	All residents that are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R400 has had his care plan reviewed and updated as needed in the area of toileting needs. R275 has had their care plan reviewed and updated as needed in the area of toileting needs. All other residents that are dependent in toileting needs will be reviewed and care plans updated following the RAI process. The policies and procedure for toileting per the plan of care was reviewed and remains current. Nursing staff have been re-educated on following the plan of care for toileting to meet the needs of the residents per the comprehensive assessment. The Nurse Managers will be responsible for auditing that residents are toileted per the plan of care for 3 dependent residents weekly per unit for 1 month then random audits monthly for 3 months. Audit results	4/22/20

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F 677	Continued From page 2 at approximately 10:30 a.m. if R400 needed to use the bathroom and NA-A stated R400 had stated "no". However, based on observation no staff had approached R400 at 10:30 a.m. and NA-A had been in another room providing cares to another resident. At 12:39 p.m. licensed practical nurse (LPN)-B stated R400 had difficulty verbally communicating and did not know her own name. At 12:45 p.m. NA-A stated she had been looking for assistance and the proper mechanical lift sling with which to transfer R400 from the Broda chair to the bed. Upon further interview NA-A stated R400 can tell staff of the need to be toileted or changed; and that NA-A had told LPN-B she would check R400 upon returning from lunch break. At 12:50 p.m. the surveyor attempted to interview R400. R400 was asked if R400 needed to use the toilet and R400 nodded in the affirmative. R400 was then asked if the incontinent product being worn was wet or dry and R400 did not understand the question. R400 also when asked had no response when asked if special undergarments were worn. After being transferred via mechanical lift and two nursing assistants, incontinent care was provided to R400. The incontinent product was observed to be wet and the condition of the product was verified by NA-A. At 1:00 p.m. LPN-B verified that NA-A had told her she would check and change R400 upon returning from lunch break. However, LPN- B	F 677	will be sent to the QA committee and action plans developed as needed.	

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F 677	Continued From page 3 stated that NA-A had to be reminded after returning from lunch break, to check/change R400. LPN-B could not recall the time of the interaction. On 3/12/20, at 1:23 p.m. LPN-C stated R400 was cognitively impaired, but the degree of impairment depended on the time of day and at times R400 was "very alert." R400's undated nursing assistant assignment sheet indicated R400 was to be checked and changed every two hours. The Baseline Resident Care Plan dated 2/28/20, revealed R400 was admitted to the facility on 2/28/20. The care plan indicated R400 was incontinent of urine and wore incontinent briefs; and required the assistance of one to be checked and changed. The care plan did not indicate the frequency of the check and change. R275, on 3/12/20, from 9:00 a.m. to 12:35 p.m., was observed sitting in a wheelchair without being provided the opportunity to use the toilet. - At 9:00 a.m. R275 was observed sitting in a wheelchair across from the nursing desk, where R275 remained until 9:09 a.m. when R275 was wheeled into the dining room by a nursing assistant. - At 9:51 a.m. R275 was wheeled out of the dining room by a nursing assistant and placed in an area across from the nursing station, where R275 remained until 11:30 a.m. when a therapist took R275 to her room for therapy. The physical therapy assistant stated she had not attempted to toilet R275.	F 677		

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F 677	Continued From page 4 - At 12:10 p.m. therapy was finished and the therapist placed R275 across from the nursing desk. R275 had not been toileted during the therapy session. At 12:35 p.m. RN-B approached R275 and asked R275 about using the toilet. RN-B asked NA-A if the NA was assigned to R275 and NA-A replied it was the other aide on the unit who was responsible. RN-B stated he was not aware of how long it had been since R275 had been toileted. When informed by the surveyor it had been approximately 3.5 hours, RN-B stated the time was "Nearly double what we're looking for." At 12:35 p.m. RN-B and LPN-D performed a two person transfer from the wheelchair to the toilet for R275. R275's incontinence brief was dry. At 1:27 p.m. LPN-C stated the expectation was that the NA would ask therapy if therapy had toileted R275 during the therapy session. R275's undated nursing assistant assignment sheet indicated staff were to provide prompted toileting every two hours while awake for R275. R275's Baseline Resident Care Plan dated 3/6/20, indicated R275 was admitted to the facility on 3/6/20, and had occasional urinary incontinence, required assist of one to use the toilet, toileting was to be prompted and that R275 wore incontinence briefs. The facility's 5/17, revised policy titled Bladder and Bowel Care Protocol, indicated "All residents will be toileted or changed at a minimum of every	F 677		

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F 677	Continued From page 5 two hours during waking hours unless an individualized plan has been established."	F 677		
F 880 SS=E	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 §483.70(e) 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 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	F 880		4/22/20

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F 880	Continued From page 6 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 review, the facility failed to ensure infection control practices were maintained throughout the facility. This had the potential to affect 6 of 134	F 880	The facility does have established infection prevention and control program designed to provide a safe sanitary and comfortable environment and to help	

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F 880	Continued From page 7 residents (R100, R125, R175, R200, R300, P275) residing in the facility. Findings include: During a tour of resident bathrooms on 3/10/20, from 2:00 to 2:30 p.m. the following infection control breaches were noted. - R100's room had a brown stained towel on the bathroom floor by the toilet. - R125's shared bathroom had a wet wash cloth on the sink -R175 and R200's shared bathroom, at 2:15 p.m., had washcloths on the floor in the corner of the bathroom. Interview with R175 at 2:20 p.m., R175 stated the nursing assistants may have thrown the washcloths on the floor,and that R175 and R200 were not aware of how or why the washcloths were on the bathroom floor. -R275 and R300's shared bathroom had two emesis basins on each side of the bathroom sink, as well as toothbrushes and toothpaste. None of the oral hygiene products were marked with a resident's name. During interview with R275's family member (FM), FM questioned the surveyor, at this time, as to which oral hygiene products belonged to R275. Interview with R300, when asked which oral hygiene products belonged to R300; R300 did not know which products belonged to her. On 3/11/20, at 8:04 a.m. registered nurse (RN)-A was observed having finished passing medications for a resident. RN-A then blew her nose with a Kleenex and threw the tissue away. Then without performing hand hygiene, RN-A touched the computer mouse and medication	F 880	prevent the development and transmission of communicable diseases and infections. R100, R125, R175, R200, R300, R275-Rooms are being randomly auditing for linen on the floor in the bathrooms. The policies and procedures related to linen handling, hand hygiene and oral hygiene have been reviewed and updated. Nursing staff have been re-educated on policies and procedures. Nurse Managers will be responsible for auditing each area 3 times a week for one month and then weekly for one month. Hand hygiene audits will be conducted more often. Audit results will be sent to the QA committee and action plans developed as needed.	

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F 880	Continued From page 8 computer; and then left the medication cart and entered a resident's room. On 3/11/20, at 11:44 a.m. in the shared bathroom of R175 and R200 there were wet washcloths found again on the floor in the corner of the bathroom. 3/12/20, at 1:50 p.m. the director of nurses (DON) was interviewed regarding wet/soiled washcloths being left on the floor or sinks in resident bathrooms. The DON stated that was not an acceptable practice. The facility's 8/15, revised policy titled Handwashing/Hand Hygiene indicated hand hygiene was the primary means to prevent the spread of infections. And all staff were to follow handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The policy did not specify the instances where hand hygiene was to be performed. There was also no policy provided indicating how oral hygiene products were to be identified in shared resident bathrooms.	F 880		

Electronically delivered
April 2, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: OZ0K11

Dear Administrator:

The above facility was surveyed on March 10, 2020 through March 13, 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:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793

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 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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	00380	A. BUILDING: _____ B. WING _____	C 03/13/2020

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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 March 10, 11, 12 and 13, 2020, a complaint investigation was conducted to investigate complaints H5574115C, H5574116C, H5574117C, H5574118C, H5574119C, H5574120C and H5574121C to determine compliance for state licensure. The following correction orders are issued.	2 000		

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2 000	Continued From page 1 H5574115C and as a result of the investigation a deficiency was identified at State tag 0920. H5574121C and as a result of the investigation a deficiency was identified at State tag 0920. H5574120C and as a result of the investigation deficiencies were identified at State tag 1375. The following complaints were found to be SUBSTANTIATED with NO deficiencies cited due to actions implemented by the facility prior to survey. H5574116C, H5574117C, H5574118C and HH5574119C. Please indicate on your electronic plan of correction that you have reviewed these orders, and identify the date when they will be corrected.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine personal grooming and cleanliness for 2 of 3 residents (R400, R275) dependent on staff for	2 920	All residents that are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral	4/22/20

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2 920	Continued From page 2 urinary incontinence care. Findings include: On 3/12/20, from 9:00 a.m. to 12:45 p.m. R400 was observed sitting in a Broda chair without being provided urinary incontinence care as directed by nursing assistant care sheets and the care plan. - At 9:00 a.m. R400 was at breakfast in the dining room - At 9:35 a.m. staff took R400 from the dining room to an area across from the nursing station, where R400 remained until 9:51 a.m. when therapy staff took R400 to the therapy room. - At 10:22 a.m. therapy staff brought R400 to an area across from the nursing station, where R400 remained until 12:37 p.m. when nursing assistant (NA)-A wheeled R400 to the bedroom. At 12:37 p.m. NA-A stated R400 had been asked at approximately 10:30 a.m. if R400 needed to use the bathroom and NA-A stated R400 had stated "no". However, based on observation no staff had approached R400 at 10:30 a.m. and NA-A had been in another room providing cares to another resident. At 12:39 p.m. licensed practical nurse (LPN)-B stated R400 had difficulty verbally communicating and did not know her own name. At 12:45 p.m. NA-A stated she had been looking for assistance and the proper mechanical lift sling with which to transfer R400 from the Broda chair to the bed. Upon further interview NA-A stated R400 can tell staff of the need to be toileted or changed; and that NA-A had told LPN-B she	2 920	hygiene. R400 has had his care plan reviewed and updated as needed in the area of toileting needs. R275 has had their care plan reviewed and updated as needed in the area of toileting needs. All other residents that are dependent in toileting needs will be reviewed and care plans updated following the RAI process. The policies and procedure for toileting per the plan of care was reviewed and remains current. Nursing staff have been re-educated on following the plan of care for toileting to meet the needs of the residents per the comprehensive assessment. The Nurse Managers will be responsible for auditing that residents are toileted per the plan of care for 3 dependent residents weekly per unit for 1 month then random audits monthly for 3 months. Audit results will be sent to the QA committee and action plans developed as needed.	

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2 920	Continued From page 3 would check R400 upon returning from lunch break. At 12:50 p.m. the surveyor attempted to interview R400. R400 was asked if R400 needed to use the toilet and R400 nodded in the affirmative. R400 was then asked if the incontinent product being worn was wet or dry and R400 did not understand the question. R400 also when asked had no response when asked if special undergarments were worn. After being transferred via mechanical lift and two nursing assistants, incontinent care was provided to R400. The incontinent product was observed to be wet and the condition of the product was verified by NA-A. At 1:00 p.m. LPN-B verified that NA-A had told her she would check and change R400 upon returning from lunch break. However, LPN- B stated that NA-A had to be reminded after returning from lunch break, to check/change R400. LPN-B could not recall the time of the interaction. On 3/12/20, at 1:23 p.m. LPN-C stated R400 was cognitively impaired, but the degree of impairment depended on the time of day and at times R400 was "very alert." R400's undated nursing assistant assignment sheet indicated R400 was to be checked and changed every two hours. The Baseline Resident Care Plan dated 2/28/20, revealed R400 was admitted to the facility on 2/28/20. The care plan indicated R400 was incontinent of urine and wore incontinent briefs;	2 920		

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2 920	Continued From page 4 and required the assistance of one to be checked and changed. The care plan did not indicate the frequency of the check and change. R275, on 3/12/20, from 9:00 a.m. to 12:35 p.m., was observed sitting in a wheelchair without being provided the opportunity to use the toilet. - At 9:00 a.m. R275 was observed sitting in a wheelchair across from the nursing desk, where R275 remained until 9:09 a.m. when R275 was wheeled into the dining room by a nursing assistant. - At 9:51 a.m. R275 was wheeled out of the dining room by a nursing assistant and placed in an area across from the nursing station, where R275 remained until 11:30 a.m. when a therapist took R275 to her room for therapy. The physical therapy assistant stated she had not attempted to toilet R275. - At 12:10 p.m. therapy was finished and the therapist placed R275 across from the nursing desk. R275 had not been toileted during the therapy session. At 12:35 p.m. RN-B approached R275 and asked R275 about using the toilet. RN-B asked NA-A if the NA was assigned to R275 and NA-A replied it was the other aide on the unit who was responsible. RN-B stated he was not aware of how long it had been since R275 had been toileted. When informed by the surveyor it had been approximately 3.5 hours, RN-B stated the time was "Nearly double what we're looking for." At 12:35 p.m. RN-B and LPN-D performed a two person transfer from the wheelchair to the toilet for R275. R275's incontinence brief was dry.	2 920		

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2 920	Continued From page 5 At 1:27 p.m. LPN-C stated the expectation was that the NA would ask therapy if therapy had toileted R275 during the therapy session. R275's undated nursing assistant assignment sheet indicated staff were to provide prompted toileting every two hours while awake for R275. R275's Baseline Resident Care Plan dated 3/6/20, indicated R275 was admitted to the facility on 3/6/20, and had occasional urinary incontinence, required assist of one to use the toilet, toileting was to be prompted and that R275 wore incontinence briefs. The facility's 5/17, revised policy titled Bladder and Bowel Care Protocol, indicated "All residents will be toileted or changed at a minimum of every two hours during waking hours unless an individualized plan has been established." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and	21375		4/22/20

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21375	Continued From page 6 sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control practices were maintained throughout the facility. This had the potential to affect 6 of 134 residents (R100, R125, R175, R200, R300, P275) residing in the facility. Findings include: During a tour of resident bathrooms on 3/10/20, from 2:00 to 2:30 p.m. the following infection control breaches were noted. - R100's room had a brown stained towel on the bathroom floor by the toilet. - R125's shared bathroom had a wet wash cloth on the sink -R175 and R200's shared bathroom, at 2:15 p.m., had washcloths on the floor in the corner of the bathroom. Interview with R175 at 2:20 p.m., R175 stated the nursing assistants may have thrown the washcloths on the floor,and that R175 and R200 were not aware of how or why the washcloths were on the bathroom floor. -R275 and R300's shared bathroom had two emesis basins on each side of the bathroom sink, as well as toothbrushes and toothpaste. None of the oral hygiene products were marked with a resident's name. During interview with R275's family member (FM), FM questioned the surveyor, at this time, as to which oral hygiene products belonged to R275. Interview with R300, when asked which oral hygiene products belonged to R300; R300 did not know which	21375	The facility does have established 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. R100, R125, R175, R200, R300, R275-Rooms are being randomly auditing for linen on the floor in the bathrooms. The policies and procedures related to linen handling, hand hygiene and oral hygiene have been reviewed and updated. Nursing staff have been re-educated on policies and procedures. Nurse Managers will be responsible for auditing each area 3 times a week for one month and then weekly for one month. Hand hygiene audits will be conducted more often. Audit results will be sent to the QA committee and action plans developed as needed.	

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21375	Continued From page 7 products belonged to her. On 3/11/20, at 8:04 a.m. registered nurse (RN)-A was observed having finished passing medications for a resident. RN-A then blew her nose with a Kleenex and threw the tissue away. Then without performing hand hygiene, RN-A touched the computer mouse and medication computer; and then left the medication cart and entered a resident's room. On 3/11/20, at 11:44 a.m. in the shared bathroom of R175 and R200 there were wet washcloths found again on the floor in the corner of the bathroom. 3/12/20, at 1:50 p.m. the director of nurses (DON) was interviewed regarding wet/soiled washcloths being left on the floor or sinks in resident bathrooms. The DON stated that was not an acceptable practice. The facility's 8/15, revised policy titled Handwashing/Hand Hygiene indicated hand hygiene was the primary means to prevent the spread of infections. And all staff were to follow handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The policy did not specify the instances where hand hygiene was to be performed. There was also no policy provided indicating how oral hygiene products were to be identified in shared resident bathrooms. Suggested Method of Correction The DON (Director of Nursing) or designee could review/revise facility policies to ensure they	21375		

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21375	Continued From page 8 contain all components of an infection control program, including tracking/trending of all illnesses in the facility as well as an antibiotic stewardship program and that a facility assessment and plan are written for water borne pathogens. In addition, the DON or designee could review/revise policies on infection control regarding oxygen tubing. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21375		