STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	03/13/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 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 [DATE]. 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. - 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 [DATE], 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.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** 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 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.

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

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.