STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245411	A. BUILDING _____ B. WING _____	08/12/2020

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

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 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a baseline care plan included directions to care for urinary incontinence care for 1 of 3 residents (R2) reviewed for urinary incontinence. Findings include: R2's admission Minimum (MDS) data set [DATE], included moderate cognitive impairment, was always incontinent of urine, had an external catheter and was totally dependent upon 2 staff for toileting. R2's Bladder Observation dated 7/21/20, indicated R2 used a urinal, had impaired mobility, cognition and communication and had mixed urinary incontinence and functional incontinence. The assessment indicated R2 was not appropriate for a toileting plan with a rationale indicated as, N/A (not applicable), but did not indicate why. R2 had a Urinary incontinence Care Area Assessment (CAA), dated 7/31/20, included, CAA triggered d/t (due to) resident requiring total assistance with toileting and being always incontinent of bladder during the reference period. Resident has impaired mobility r/t (related to) stroke. He receives medications which may affect his bladder functioning. He is at risk for skin breakdown and UTI (urinary tract infection). Hx (history) of UTI's. The assessment did not indicate how R2's urinary incontinence would be treated. R2's baseline care plan, undated, did not include any goals or interventions related to urinary incontinence. R2's July and August 2020 medication and treatment administration record revealed no directions to care for R2's urinary incontinence. R2's progress notes, dated 7/16/20, revealed R2 was admitted with a condom catheter, but declined to use it. R2's nursing assistant care guide, undated, included, Condom cath (catheter) (Condom catheters are external urinary catheters that are worn like a condom. They collect urine as it drains out of the bladder and send it to a collection bag strapped to the leg). When interviewed on 8/11/20, at 9:50 a.m. the nursing assistant (NA)-A reviewed R2's nursing assistant care sheet which included the condom catheter. NA-A stated R2 uses an incontinent brief and staff change him when he requests, about every two hours. When interviewed on 8/11/20, at 9:53 a.m. licensed practical nurses and unit managers (LPN)-B and (LPN)-C reported R2 did not have a condom catheter anymore. LPN-C and LPN-B reported the baseline care plan should be completed within 24 hours after admission. LPN-B and LPN-C reported the baseline care plan was not completed for R2 until 8/11/20, after asked about it by the surveyor. LPN-B and LPN-C reported the nurse manager or charge of building created the baseline care plan, depending on when the new resident was admitted . During observation of R2 on 8/11/20, at 11:15 a.m. with registered nurse (RN)-B, R2 was noted to be wearing an incontinent brief and did not have a condom catheter. When interviewed on 8/11/20, at 3:50 p.m. the director of nursing stated a baseline care plan should be created by the nurse manager or charge of building within 24 hours of resident admission and include information on incontinence care. The care planning policy, updated 11/12/18, directed staff 1) Upon admission, a baseline care plan is initiated in conjunction with admission information and completed within 48 hours by each department within the IDT. The initial goal of care will be discussed with the resident by therapy staff or nursing if goal is related to a clinical issue. Communication of the goal is documented in the medical record.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to revise the care plan for 1 of 3 residents (R3) reviewed for [MEDICAL CONDITION] (the small bowel was surgically diverted to an opening in the abdomen for stool evacuation) care to reflect current physician orders. Findings include: R3's quarterly Minimum Data Set ((MDS) dated [DATE], included, moderate cognitive impairment, had an [MEDICAL CONDITION] and required extensive assistance of one person for toilet use. R3's care plan dated 6/16/20, included, Alteration in elimination r/t (related to) ostomy ([MEDICAL CONDITION]) for bowel management. Changes ostomy independently, sits on bathroom floor to change. Staff were directed to monitor and document bowel movements every shifts and observe for signs and symptoms of problems or changes. Was independent with toileting and changed ostomy independently. R3's nursing assistant (NA) care guide dated 8/10/20, included, R3 sat on bathroom floor to change [MEDICAL CONDITION]. The toileting section indicated R3 required assistance of one to use the bedpan and empty [MEDICAL CONDITION]. R3's physician orders [REDACTED]. R3's July and August 2020 treatment administration record (TAR) included the physician order [REDACTED]. However, this was only scheduled and signed out as completed twice a week instead of every 1-2 hours. When interviewed on 8/11/20, at 8:40 A.M. R3 stated she will put on call light when the ostomy bag needs to be emptied, if no one comes she will empty it herself. When interviewed on 8/11/20, at 9:07 A.M. NA-C stated the nurse aides will usually goes into R3 room to check on R3's [MEDICAL CONDITION] bag every morning, lunch time, and at the end of the shift. When interviewed on 8/11/20, at 9:12 A.M. licensed practical nurse (LPN)-D stated the nurse aides empty R3's [MEDICAL CONDITION] and have a care guide that shows how often. LPN-D verified the current nurse aide care sheet did not direct staff to check every 1-2 hours. When interviewed on 8/11/20, at 9:26 a.m. registered nurse (RN)-A stated care plans and nurse aid care sheets are updated every morning with any new orders and verified this had been missed for R3's [MEDICAL CONDITION] care. When interviewed on 8/11/20, at 3:50 P.M. director of nursing (DON) indicated the care plans and care guide should be updated with any new order and the nurse manager is the one to update the care plan and care guide sheet. The DON verified this had been missed for R3's July physician order [REDACTED]. The care planning policy, updated 11/2/2018, directed staff to update the care plan routinely with changes in resident condition by the nurse manager and other members of the interdisciplinary team. The policy further indicated the resident care plan is reviewed for accuracy, updated, and/or revised by the nurse assessment coordinator.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the safety of 1 of 3 residents (R1) reviewed for accidents. R1 was harmed when she fell /rolled out of bed and sustained a fractured right hip requiring surgical repair. However, the facility implemented corrective action on 8/10/20, therefore the deficiency is being cited at past non-compliance. Findings include: R1's quarterly Minimum Data Set ((MDS) dated [DATE], included, severe cognitive impairment with a [DIAGNOSES REDACTED]. The MDS indicated R1 had not fallen in the last quarter. R1's mobility care plan dated 1/28/20 directed staff to utilize a full mechanical lift with 2 assistants for transfers. R1's falls care plan, dated

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245411	A. BUILDING _____ B. WING _____	**08/12/2020**

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

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) 12/9/19, identified a risk for falling related to not being aware of safety needs and directed staff to use a bed that goes to the floor with a mat along side of the bed. R1's Safety Events-Falls reports dated 10/25/20 through 3/12/20, indicated R1 had fallen or rolled out of bed thirteen times. R1's progress note dated 8/4/20, at 2:51 p.m. indicated nursing assistant (NA)-A reported R1 was on the floor at 9:20 a.m. R1 was observed, Lying on her back with legs stretched towards the foot of the bed and her head an inch beneath the night stand. R1 was able to move upper extremities and the right leg, however, Resident put her hand on her left hip and moaned in pain. Care Specialist reported that she was getting Resident ready for a shower, took the floor mat off the floor and went to get the hoyer lift (full body mechanical lift). Coming in with the lift, she witnessed Resident rolled from the bed to the floor hitting her left side. Resident unable to verbalize what happened due to dx (diagnosis) of dementia. Alert with confusion. Resident's Bp's (blood pressure) ranged from 128/58 and increased to 185/100 (normal under 120/80). Resident denies dizziness and writer took BP every 15-30 mins. R1's progress note dated 8/4/20, at 1:15 p.m. included, X-ray result identified an acute [MEDICAL CONDITION]. R1 was transported by paramedics to the hospital for surgical repair of the left hip. R1's post fall investigation dated 8/4/20, included the bed was 17 inches off the floor, but the mat was not on the floor to cushion any fall as directed in R1's care plan. R1's interdisciplinary team review, dated 8/6/20, indicated all staff had been re-educated to follow the care plan specific to each resident. An Education for Following the POC (plan of care), showed nursing staff were being re-trained on following the resident individual plan of care. The education sign in was started on 8/4/20, and continued prior to the start of each shift until all staff were trained 8/10/20. The specific direction was while providing care If a hi-low bed and /or fall mat are to be in place and not to leave the resident in bed unattended without these things in place for any amount of time. Nurses and nursing assistants were interviewed on 8/11/20, and verified they had received the training prior to starting their shift. A facility audit form dated 8/10/20, indicated the facility began routine audits on the placement of floor mats for all residents who required them. When interviewed on 8/11/20 at 1:30 p.m. the director of nursing (DON) verified All staff were trained prior to the start of each shift for following the plan of care and fall mat was to be in place and the audits began on 8/10/20, and would continue to ensure fall mats were in place as care planned. A facility policy titled, Fall Prevention and Management, updated 1/29/19, read Upon admission, quarterly, annually and with significant change all residents will be assessed for their risk for falls. All falls will be investigated and new interventions put in place and care planned.