

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Shirley Chapman Sholom Home East		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure multi-dose medications were labeled upon opening and discarded in accordance with professional standards for 1 of 2 medications rooms reviewed and 1 of 5 medication carts reviewed for medication storage. Findings include: R92's entry tracking Minimum Data Set (MDS), indicated R92 admitted for short term rehabilitation on 7/16/26. An observation and interview on 7/20/26 at 5:19 p.m., registered nurse (RN)-E was preparing to administer Lispro insulin to R92. When R92's insulin pen was removed, the open date and initials label was blank. RN-E stated all insulin pens were supposed to be dated with the open date, but on the transitional care unit (TCU) residents were not here for very long so it gets missed sometimes. R42's quarterly MDS dated [DATE], indicated R42 had severe cognitive impairment and received hospice services. R25's significant change MDS dated [DATE], indicated R25 had severe cognitive impairment and received hospice services. An observation of the third-floor medication room refrigerator on 7/22/26 at 12:51 p.m., contained two open bottles of liquid Ativan for R42 and two open bottles of liquid Ativan for R25. The bottles of Ativan for R42 and R25 had open date and initial labels; however, they were all blank. All bottles of Ativan for R42 and R25 contained medication and were not full. The bottles had a label that started to discard after 60 days. RN-F verified the bottles and the missing opening dates. RN-F further stated they should be dated when opened and whichever one was older should have been discarded when the newer one opened. RN-F wasn't sure why there were two open bottles and why they were not labeled. An interview on 7/22/26 at 1:01 p.m., licensed practical nurse (LPN)-A had entered the medication room and stated they should be labeled when opened and it was important to know because they are good for only so long. When interviewed on 7/23/26 at 9:21 a.m., RN-B expected insulin pens to be dated when opened. When interviewed on 7/23/26 at 12:09 p.m., the Director of Nursing (DON) stating multiple bottles of opened medications should not be happening. With hospice residents they typically have more than one medication vial in stock, however, staff should be dating them and not opening a new one until needed. A facility policy titled Storage and Expiration Dating of Medications revised 6/30/25, directed staff to follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Furthermore, staff should record the date opened on the primary medication container. If a multidose vial of an injectable medication has been opened, it should be dated and discarded within 28 days unless manufacture guidelines say differently.		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, document review, the facility failed to ensure a proper sanitization technique was used to obtain food temperatures from ready-to-serve meals from the steam table. This finding had the potential to increase the risk of cross contamination and affect 17 residents who resided on the fourth floor. Findings include: During observation on 7/21/26 at 11:50 a.m., on the fourth floor, dietary aid (DA)-A placed stainless steel trays containing food on the steam table. DA-A washed her hands, put on gloves, got a food thermometer and started to check the food temperatures. DA-A checked the soup temperature first and wiped the thermometer with a napkin, then she checked the steamed vegetables temperature and once again used the same napkin to wipe the thermometer. DA-A stated she always used a napkin to clean the thermometer before she checked the next food item. DA-A stated she was never told to do otherwise. During interview on 7/21/26 at 1:16 p.m., DA-B was cleaning the kitchenette after serving lunch to residents on the second floor. DA-B explained he used a napkin to clean the food thermometer between food items and used a sanitizer solution before he put away the thermometer. During interview on 7/21/26 at 1:57 p.m., culinary services director (CSD) stated she expected the dietary aids will check the food temperature before the food is placed on the steam table. CSD stated the dietary aids needed to check the temperature, write down the temp, wipe off the thermometer with the sanitizing solution, and use a paper towel to dry the thermometer before they checked the next food item. CSD stated they used Ecolab Oasis 146 Multi-Quat Sanitizer diluted following manufacturer's recommendations. CSD stated she had new employees and will need further education. During interview on 7/21/26 at 3:36 p.m., Ecolab district manager (EDM) stated the Ecolab Oasis 146 multi-quat sanitizer was a food surface sanitizer. EDM stated the sanitizer was used to clean tables, and it was also used to wash dishes and silverware. EDM stated if the solution was diluted to sanitize the thermometer it could be safe, but the use of a napkin was concerning because the napkin might be contaminated. During interview on 7/23/26 at 10:52 a.m., director of nursing (DON) stated the expectation was for staff to follow proper sanitization procedures to clean the food thermometers to prevent cross contamination and reduce the risk of foodborne illnesses. Facility's policy titled Food Temperatures: Correct Use of Thermometer dated 10/24/25, indicated all foods were prepared in accordance with the FDA Food code. The policy also indicated the thermometer will be sanitized using a thermometer wipe in between foods of different types to also prevent cross contamination.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure self-administration of medications was assessed and determined to be appropriate for 1 of 1 resident (R9) reviewed for self-administration of medications. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R9 was cognitively intact and required varying levels of assistance with activities of daily living and mobility. Diagnoses included low blood pressure when standing, heart failure, chronic kidney disease, lung disease, and a pacemaker. R9's Self-Administration of Medications (SAM) assessment dated [DATE], indicated R9 responded No when asked whether he wanted to self-administer medications or treatments. R9's care plan dated 6/26/26, failed to identify interventions related to bedside storage or self-administration of eye medications. R9's medical record, reviewed on 07/21/26, lacked evidence of provider orders for Systane Complete or ketotifen fumarate eye drops or authorization for the medications to be kept at the bedside. During observation on 7/20/26 at 4:03 p.m., two bottles of eye drops, Systane Complete and ketotifen fumarate, were observed unsecured on R9's bedside table. The medications lacked pharmacy prescription labels. During interview at that time, R9 stated the eye drops were not facility medications and reported facility staff administered the eye drops at his request. During observation on 7/21/26 at 8:36 a.m., the two eye drop medications remained on R9's bedside table. During interview on 7/21/26 at 8:54 a.m., registered nurse (RN)-C observed the eye drop medications at R9's bedside and verified they lacked pharmacy prescription labels. RN-C stated the medications may have been brought from home, staff administered them at R9's request, and a SAM assessment was required before medications could be kept in a resident's room. RN-C removed the medications and stated she would notify the unit manager. During interview on 7/21/26 at 9:17 a.m., registered nurse (RN)-D stated staff were required to verify the resident's assessment, provider order, medication, and the rights of medication administration before giving medications. During interview on 7/21/26 at approximately 4:00 p.m., the Director of Nursing (DON) stated residents needed to be able to safely self-administer medications, have a completed assessment, and have a provider's order before keeping medications in their room. The DON stated medications kept in resident rooms required a provider's order and a way to identify the medication. The DON expected staff to remove medications not listed on the Medication Administration Record (MAR) and notify the unit manager. Facility's policy titled Self-Administration of Medications dated 11/2018, indicated residents capable of self-administering medications could keep medications at bedside with a physician's order stating the medication may be kept at bedside for self-administration. The policy required a SAM assessment, identification of bedside medications on the MAR and care plan, and resident education regarding medication use, frequency, storage, and notification of nursing staff when a dose was taken. Nursing staff were required to document self-administration and assess medication effectiveness.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure the use of as needed (i.e., PRN) psychotropic medication was limited to 14 days or extended to a certain date with supporting rationale provided by the medical provider for 1 of 5 residents (R8) reviewed for unnecessary medication use. Findings include: R8's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R8 had severe cognitive impairment, received hospice services, and had diagnoses of atrial fibrillation, congestive heart failure, renal failure, Alzheimer's disease, depression and psychotic disorder. R8's medical orders dated 7/22/26, included an order for lorazepam (anti-anxiety medication) 0.5 milligrams (mg) orally every 6 hours as needed (PRN) for anxiety, with a discontinuation date of 9/2026. R8's medical administration records (MAR) indicated R8 did not receive any doses of lorazepam between 3/2026 and 7/2026. R8's medical record lacked supporting rationale for the lorazepam order. During interview on 7/23/26 at 10:07 a.m., requested documentation supporting rationale to the corporate director of clinical services (DCS) stated a psychotropic medication ordered PRN, couldn't be ordered for more than 14 days at the time. DCS stated a doctor needed to do a face-to-face visit and provide a rationale for a psychotropic medication ordered PRN for longer than 14 days. During interview on 7/23/26 at 10:19 a.m., director of nursing (DON) the expectation depended on the situation but initially a psychotropic medication to be used PRN couldn't be ordered for longer than 14 days. After the initial 14 days, the use of the medication needed to be reviewed, and the doctor could re-write the order for an additional 14 days or schedule the medication if necessary. DON added an order for a PRN psychotropic medication should be a red flag for the nurses. Nurses should know the CMS regulations. Facility's policy titled Unnecessary Drugs/Psychotropic Medications dated 3/16/25, indicated the resident will be free from chemical restraints and unnecessary medications. The policy also indicated PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure that a discharge notice was sent to the Office of the State Long-Term Care Ombudsman (OOLTC) for 2 of 2 resident (R87, R89) reviewed for discharge. Findings include: R87 R87's admission Minimum Data Set (MDS) dated [DATE], indicated R87 was cognitively intact and had diagnoses of hepatic encephalopathy (a brain condition caused by severe liver disease), chronic liver failure, cirrhosis (scarring of the liver), systolic congestive heart failure, and chronic kidney disease. R87's face sheet reviewed on 7/23/26, indicated R87 was admitted to the facility on [DATE] and transferred to United hospital on 4/27/26. R87's progress notes dated 4/27/26, indicated R87 had a change in condition. The nurse notified the provider, who ordered transfer to United Hospital for further evaluation. R87 left the facility with paramedics at 10:50 p.m. A facility document titled Monthly Notice to MN Office of Ombudsman for Long-Term Care of Emergency Acute Care Transfers and Discharges dated 5/1/26, failed to include R87's 4/27/26 facility-initiated hospital transfer. During interview on 7/23/26 at approximately 11:00 a.m., the Corporate Director of Clinical Services (DCS) confirmed R87 was transferred from the facility to the hospital on 4/27/26. DCS confirmed the transfer was not listed on the facility's April Ombudsman notification log and should have been included. R89 R89's admission Minimum Data Set (MDS) dated [DATE], indicated R89 had intact cognition with no hallucinations, delusions, or behaviors. R89's Census information dated 4/28/26, indicated that R89 was admitted to the facility on [DATE] and discharged on 4/29/26. R89's progress note dated 4/29/26 at 1:54 p.m., stated that R89 left the facility against medical advice (AMA) around 10:30 a.m. In an email correspondence dated 7/17/26 at 12:33 p.m., the OOLTC stated that no transfer and discharge notices from the facility have been received for approximately two years. The OOLTC identified that the last transfer and discharge notice received from the facility was from May 2024. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Monthly Notice to Minnesota OOLTC of Emergency Acute Care Transfers and Discharges dated 5/1/26, indicated that the ombudsman had been notified of 18 resident hospital transfers during the month of April. The document did not include any record of ombudsman notification of discharges including that of R89. Record of ombudsman notification of R89's discharge was requested and not received. During an interview on 7/22/26 at 1:44 p.m., when notified that record of ombudsman notification of R89's discharge was not found in the Monthly Notice to MN OOLTC of Emergency Acute Care Transfers and Discharges, the Director of Clinical Services (DCS) stated that ombudsman notification of AMA discharges may be kept in a different file and she would provide this if able. The DCS stated that the ombudsman should be notified by the Social Services Director (SSD) of all unplanned discharges, including residents who discharge AMA. The SSD was on vacation during survey and unavailable for interview. During an interview on 7/23/26 at 9:38 a.m., the administrator stated that after reviewing their records, she did not have evidence of ombudsman notification for R89's discharge from the facility. A facility policy titled Transfer and Discharge from the Facility updated 4/5/25, indicated the facility should forward a copy of all discharge notices to the OOLTC and required state agencies.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure provider orders were followed to put on leg wraps for 1 of 1 resident (R6) reviewed for edema. In addition, the facility failed to ensure effective collaboration between the facility and the hospice agency for 1 of 1 resident (R8) reviewed who received hospice services. Findings include: R6 R6's quarterly Minimum Data Set (MDS) dated [DATE], indicated R6 had intact cognition, had no behaviors and did not reject cares. MDS indicated R6 needed moderate assistance with dressing, putting her shoes on, and showers. R6's Profile form dated 7/23/26, identified diagnoses of essential hypertension, non-rheumatic aortic stenosis, diabetes type II, prosthetic heart valve replacement, morbid obesity, and metabolic encephalopathy. R6's medical orders form dated 7/23/26 included an order to apply leg wraps to bilateral lower extremities; on in the morning and off at night. This order was dated 11/10/25. R6's July treatment medication record (TAR) included the order for leg wraps. During observation and interview on 7/20/26 at 3:25 p.m., R6 was in her room, sitting in her wheelchair. R6 was not wearing the leg wraps, she said she needed help to put them on. R6 said sometimes the staff got busy and didn't wrap her legs. During observation and interview on 7/21/26 at 9:11 a.m., R6 was in her room putting on makeup. R6's leg wraps were on top of her bedside table. R6 stated the staff will help her later to wrap her legs. During interview on 7/21/26 at 10:30 a.m., registered nurse (RN)-G stated he was running behind but would try to wrap R6 legs as soon as possible. During observation on 7/22/26 at 9:05 a.m., R6 was in the dining room and did not have leg wraps on. During observation and interview on 7/22/26 at 12:26 p.m., nurse manager (RN)-H stated the nurses needed to apply leg wraps to resident's legs early in the morning. RN-H stated. If for some reason the nurse on duty got behind with their morning medication pass or other duties, they could let her know as she was willing to support the nurses. RN-H stated the facility needed to follow the doctor's orders and update them as necessary. RN-H verified R6 legs were not wrap, she said she would do it. During interview on 7/23/26 at 10:45 a.m., director of nursing (DON) stated the leg wraps and compression stockings should be applied first thing in the morning. DON stated if the wraps or compression stockings were not applied, the resident's edema could worsen, cause fluid overload, worsened cardiac related symptoms, and possibly have a negative effect on residents' wellbeing. A policy regarding edema and following doctor's orders was requested but none was received. R8 R8's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R8 had severe cognitive impairment, had no behaviors, did not refuse cares, and needed maximal assistance with toileting hygiene and lower extremity dressing. MDS also indicated R8 needed moderate assistance with upper body dressing and was dependent to put on and take off footwear. MDS indicated diagnoses of stroke, a-fib, congestive heart failure, hypertension, Alzheimer's disease, and received hospice services. R8's orders report dated 7/23/26, indicated orders for hospice evaluation and treatment, this order was dated 1/16/26. R8's progress notes between 7/1/26 and 7/21/26 included only one hospice nurse progress note dated 7/16/26. During observation and interview on 7/20/26 at 4:49 p.m., R8 was visiting with one of her daughters. R8 was confused, was able to answer yes/no questions, but after answering the second question she said she didn't want to share any information. R8 appeared to be physically comfortable. Per daughter, R8's didn't trust new people. During interview on 7/21/26 at 9:20 a.m., R8 was in her room, sitting on her wheelchair folding and putting clothes away in her closet. A hospice massage therapist arrived and stayed with the resident for about one hour. During interview on 7/21/26 at 9:28 a.m., RN-G stated he believed the hospice staff visited R8 on Tuesdays. RN-G said the hospice nurses (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	usually talked to him after they visited R8. RN-G stated he knew R8 had a hospice nursing assistant, a nurse, social worker, spiritual worker, massage therapist, and volunteers, but he didn't know when they were scheduled to visit R8. RN-G stated he believed the schedule was on the hospice binder, or in the electronic medical record (EMR). RN-G was unable to find the hospice binder, and the hospice schedule was not on her EMR. During interview on 7/21/26 at 9:32 a.m., RN-H stated R8's hospice information was in front of the resident's hard chart. During document review on 8/21/26 at 9:35 a.m., R8's hard chart had the following hospice documents: a form that identified the medications covered by hospice, a form with the hospice contact information, and a schedule. However, there was not a care plan and/or the current hospice certification. The July hospice schedule indicated the following visits: Spiritual care: 7/14 and 7/28 Skilled nursing: 7/8, 7/15, 7/22 Massage therapy: 7/8, 7/15, 7/22 Volunteer: 7/1, 7/8, 7/15, 7/22 HHA (home health aide): 7/2, 7/9, 7/16, 7/23 Social worker: 7/17 During interview on 4/21/26 at 9:50 a.m., RN-H verified R8's hard chart didn't include a hospice care plan and/or the hospice certification. RN-H also verified there was only one hospice progress note for the month of July. RN-H stated the hospice manager brought both the care plan and the current certification and she would put it on R8's hard chart. During interview on 7/21/26 at 12:16 p.m., nursing assistant (NA)-C stated she was not sure what hospice did for R8. NA-C stated she had seen volunteers. NA-C stated she had never seen or talked to the hospice nurse or seen the hospice NA. NA-C was not aware if hospice had a schedule and didn't know when they were coming. NA-C added The nurse and the nurse manager should know. I am sure they know. During interview on 7/22/26 at 12:52 p.m., RN-H stated she expected the nurses knew when hospice visited R8. RN-C said she expected the nursing staff to communicate with hospice members before and after their visits and call them to report any changes in condition and to re-order medications. During interview on 7/22/26 at 12:59 p.m., hospice program manager (HPM) stated the hospice program had their own electronic medical record. HPM stated the hospice nurse needed to copy and paste her progress note into R8's EMR after each visit. HPM stated the rest of the team needed to document their visits on the hospice communication book kept in R8's room. HPM verified there was not a hospice certification or care plan until yesterday. HPM stated she was working with management about implementing hospice binders which will be more accessible to the facility's nursing staff. HPM stated the hospice and facility's social workers and nurse managers met on a weekly basis to review changes of condition, but the facility's floor staff was not necessarily aware what hospice did for the hospice patients. During interview on 7/23/26 at 10:31 a.m., director of nursing (DON) stated the facility staff should know what services were provided by hospice. DON stated sometimes the facility's NAs needed to know the services provided by the hospice NA were additional services. DON stated hospice needed to provide a schedule and the resident's hospice care plan to coordinate our resident's cares and to provide continuity of care, we integrate our care plan with hospice. DON stated we will need to do an in-service to educate the staff about where to look for information. DON stated he expected hospice to add their progress notes to the resident's EMR. Facility's policy titled Hospice Care for Nursing Facility Residents- Coordination of services dated 5/23/16, indicated the hospice program ensures that mechanisms are in place to provide for the coordination of all hospice services provided to patients residing in facilities.		

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F 0689 Level of Harm - Minimal harm or potential for 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 observation, interview and document review, the facility failed to ensure fall interventions were implemented for 1 of 3 residents (R90) who were at risk of falls. Findings include: R90's face sheet printed 7/22/26, indicated R90 was recently admitted and had diagnoses of stroke with aphasia (trouble finding words to speak), dementia with mood disturbance, and a history of falling. R90's Comprehensive Nursing assessment dated [DATE], indicated R90 had short and long-term memory problems, had severely impaired cognitive skills for daily decision making, and had a history of falling prior to admission. R90's care plan revised 7/20/26, indicated: -R90 had a self-care deficit with mobility and required assist of 1 staff with a gait belt and four wheeled walker for transfers and mobility. - R90 was at risk for falls related to dementia and wandering. Interventions included keeping bed at transferring height, call light in reach and to ensure R90 wore appropriate footwear. R90's medical record lacked indication R90 did not like or refused grip socks. An observation on 7/20/26 at 11:06 a.m., R90 was sitting on the bed in his room. R90 was barefoot with shoes on the floor near the bed. R90 got up and started walking towards the door. R90 was barefoot and was not using his walker. R90 made it outside into the hallway a few steps and stood there for a short time. Unidentified nursing assistant (NA) rushed from the other side and escorted R90 back to his room. An observation on 7/21/26 at 9:08 a.m., R90 was sleeping in bed. R90 had a transfer belt around him and was wearing socks without grips. An observation on 7/21/26 at 10:07 a.m., R90's family member (FM)-A was with him in the hallway. Unknown physical therapy staff and FM-A were walking with R90 in the hallway. R90 was wearing plain socks without grips and no shoes. An observation on 7/21/26 at 11:52 a.m., R90 was lying in bed sleeping. R90 was wearing plain socks without grips. An interview on 7/20/26 at 3:17 p.m., FM-B stated R90 had recently been admitted to the facility and was so confused. R90 had fallen once, and family was trying to be here as much as possible for support. An interview on 7/21/26 at 3:04 p.m., nursing assistant (NA)-B stated R90 was a fall risk and had had a fall since admission. NA-B stated staff frequently check on R90, ensure call light is in reach, and keep the door open. R90's family recently hired a patient care assistant (PCA) to sit with him. NA-B stated appropriate footwear included grippy socks on when in bed and shoes or grippy socks on when walking. NA-B verified R90 was not wearing grippy socks and stated he should be and went to obtain grip socks from the nurse. An interview on 7/21/26 at 3:26 p.m., licensed practical nurse (LPN)-B stated R90 was a fall risk and most of the time had family or PCA in with him. LPN-B verified one intervention for R90 was to have appropriate footwear on and R90 should have grip socks in place. LPN-B was not aware of any refusals of grip socks. An interview on 7/23/26 at 9:21 p.m., RN-B stated after a resident falls, the interdisciplinary team (IDT) meets to review the fall and collaborate on interventions. RN-B identified appropriate footwear to be gripped socks when in bed and grip socks or shoes in place when up walking. RN-B expected staff to be following the care planned interventions for falls and stated grip socks should have been in place for R90. An interview on 7/23/26 at 12:09 p.m., the Director of Nursing (DON) expected fall interventions to be in place and stated R90 should have had the grip socks in place. DON further stated this was important to help prevent falls. A facility policy titled Fall Prevention and Management revised 6/21/21, directed staff to implement interventions according to resident specific risk factors and care plans would indicate the resident specific interventions to prevent falls.		

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NAME OF PROVIDER OR SUPPLIER Shirley Chapman Sholom Home East		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure documentation of clinical indications for the continued use of a foley catheter was in place and failed to ensure interventions were in place to prevent urinary tract infections for 1 of 1 residents (R90) reviewed with a catheter. Findings include: R90's face sheet printed 7/22/26, indicated R90 was recently admitted and had diagnoses of stroke with aphagia (trouble finding words to speak), dementia with mood disturbance, urine retention and had a urinary device. R90's Comprehensive Nursing assessment dated [DATE], indicated R90 had short and long-term memory problems, had severely impaired cognitive skills for daily decision making, and was admitted with a foley catheter. R90's hospital Discharge summary dated [DATE], indicated R90 had hematuria (blood in the urine) with urinary retention and required a urology consultation. A foley catheter was placed with a plan to discharge with the catheter and have a trial of void in clinic in 2 weeks as well as a trial of void at the skilled nursing facility next Monday (7/20/26).R90's hospital discharge orders dated 7/16/26, indicated R90 required catheter removal on 7/20/26 with a monitor of post void residual at least twice daily for 24 hours or facility protocol. R90's provider orders dated 7/16/26, indicated the following:-remove foley and perform a trial void on 7/20/26.-R90's catheter required gravity drainage and instructed staff to not loop or kink the tubing so urine can drain, and to keep the drainage bag below the waist. R90's care plan date 7/16/26, indicated R90 had a foley catheter related to neurogenic bladder and was at risk for urinary tract infection (UTI). Interventions included to change foley when needed, keep tubing/bag below the bladder, and ensure tubing was free of kinks.R90's nursing progress note dated 7/20/26 at 9:56 a.m., indicated provider was notified via portal and requested foley removal to be delayed due to resident impulsiveness and self-transferring. R90's nursing progress note dated 7/20/26 at 4:06 p.m., indicated nurse practitioner (NP)-A provided orders to delay trial void until 7/27/26.R90's provider note dated 7/20/26, indicated R90 will need trial void and to continue with foley cares. R90's provider note lacked clinical indication of why catheter removal was delayed. R90's medical record lacked indication R90's family had been involved in decision to delay discontinuation of foley, wanting to keep catheter in place or were educated on risks or benefits. An observation on 7/20/26 at 11:06 a.m., R90 was lying in bed sleeping. There was not a catheter bag hanging from his bed or below his waist to facilitate drainage. An observation on 7/21/26 at 9:08 a.m., R90 was sleeping in bed. R90's catheter tubing was looped and had urine in the tubing. R90's catheter bag was not hanging to gravity and was not below his waist to facilitate drainage. An observation on 7/21/26 at 11:52 a.m., R90 was lying in bed sleeping. R90's catheter bag was attached to his leg. The tubing was looped twice and had urine sitting in the tubing. R90's catheter bag was not hanging below his waist to facilitate drainage.An interview on 7/20/26 at 3:17 p.m., FM-B stated R90 had recently been admitted to the facility and was so confused. R90 was admitted with a catheter. FM-B further stated the catheter was supposed to come out today and was not sure why it was still in. An interview on 7/21/26 at 3:04 p.m., nursing assistant (NA)-B wasn't sure why R90 had a catheter in place. NA-B stated catheter bags should be hanging below the waist and to gravity, so they drain properly. NA-B verified R90's catheter was not hanging below waist and the catheter tubing had loops with urine sitting in the tube. NA-B stated normally catheters were hung from the bed and the tubing should not have loops or kinks however, R90 would play or pull on the tubing, and they wanted to keep it out of sight. An interview on 7/21/26 at 3:26 p.m., registered nurse (RN)-A stated R90 was admitted with the catheter for urine (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	retention. RN-A stated R90's catheter should be below the waist or to gravity and verified R90's orders. RN-A wasn't sure of why the trial void and catheter discontinuation was delayed and would need to speak to the nurse manager. An interview on 7/21/26 at 3:21 p.m., RN-B stated R90 had an incident where R90 had been fidgeting with the catheter that caused some bleeding and required the catheter to be replaced. RN-B stated NP-A had made the decision to keep it for an additional week. An interview on 7/22/26 at 9:24 a.m., NP-A stated R90 was very mobile and that was not a good reason to delay the catheter removal and trial void. However, trying to prevent falls having the catheter may reduce some impulsiveness with getting out of bed to void. NP-A was aware of the incident that required a catheter change for R90 and stated there were no further complications. NP-A stated she instructed nursing R90's trial void had to happen sooner than next week if he was discharging from the facility. A follow up interview on 7/23/26 at 9:21 a.m., RN-B expected staff to ensure interventions were put in place for catheters were implemented, including catheter bags that were hung below the waist to facility gravity drainage. RN-B further stated family of R90 had also requested the catheter to stay in longer, however verified there was no documentation of this or education of risks and benefits of keeping the catheter in. An interview on 7/23/26 at 12:09 p.m., the Director of Nursing (DON) expected staff to ensure interventions were in place to prevent UTI when residents have a catheter. Family requesting to keep the foley in isn't the best reason, however if family wanted to keep the catheter in place, education of risks and benefits should be documented and in place. A facility policy titled Urinary Catheter Care no date, directed staff to check frequently to ensure the catheter tubing is free of kinks and ensure the drainage bag is always positioned lower than the bladder to prevent urine in the tubing/bag to flow back into the bladder. The policy did not address clinical indications or justification needed for catheter use.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure staff followed proper infection prevention and control practices by using the required personal protective equipment (PPE) during Enhanced Barrier Precautions (EBP) for 1 of 1 resident (R11) reviewed for infection control. Findings include: R11's comprehensive Minimum Data Set (MDS) assessment dated [DATE], indicated R11 had severe cognitive impairment and was dependent on staff for total body care, bed mobility, and transfers. Diagnoses included chronic heart failure, chronic kidney disease, and nontraumatic intracranial hemorrhage (brain bleed). R11's care plan dated 7/21/26, indicated EBP had been initiated on 6/17/26, due to a pressure wound on the right heel. The care plan instructed staff to wear a gown and gloves during high-contact resident care activities, including dressing, providing hygiene care, and changing briefs. During observation on 7/21/26 at 8:45 a.m., nursing assistant (NA)-A provided personal care to R11 without wearing the required gown. NA-A wore a mask and gloves but failed to don the required gown while providing high-contact care. NA-A repositioned R11 from side to side, performed perineal care, changed the brief and clothing, and completed additional personal care without the required PPE. During an interview on 7/21/26 at 9:23 a.m., NA-A stated she believed R11 was not on EBP, although she knew R11 had an open sore on the heel. NA-A stated resident-specific care information was obtained from the care plan and care sheets. NA-A stated there was no sign on the resident's door, so she believed EBP was not required while providing close-contact care. NA-A further stated there would normally be an EBP sign posted on the door and a PPE supply bin located outside the room. After reviewing the information posted above the foam sanitizer dispenser, NA-A acknowledged there was a sign indicating R11 was on EBP and that a gown and gloves should have been worn while providing personal care, including perineal care, changing the brief, changing clothing, and completing hygiene care. During an interview on 7/22/26 at 8:53 a.m., licensed practical nurse (LPN)-A stated it was important for staff to follow each resident's care plan to provide care within the resident's individualized needs and to reduce the risk of infections and injuries. LPN-A stated the expectation was that staff would universally and consistently don and doff all required PPE for residents on EBP, as ordered, to protect residents and reduce the risk of infection transmission. During an interview on 7/23/26 at 9:37 a.m., the Director of Nursing (DON) stated the expectation was for staff to universally and consistently don and doff PPE in accordance with EBP requirements. The DON stated following EBP was important to protect residents, staff, and the community by reducing potential portals of entry for infection and decreasing the risk of transmission. The DON further stated it was important for staff to follow each resident's care plan. The facility policy titled Isolation - Categories of Transmission-Based Precautions updated 5/29/26, directed staff to implement EBP as an infection prevention and control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) within the facility. The policy indicated EBP required the use of a gown and gloves during high-contact resident care activities. High-contact care activities included dressing, bathing, providing hygiene care, transferring residents, changing linens, changing briefs, and providing device care.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and document review, the facility failed to ensure the plan of correction (POC) for the most recent survey of the facility was readily accessible and that the POC for the three preceding years was available upon request. This had the potential to affect all 82 residents residing in the facility as well as family, visitors, and staff. During observation and record review on 7/22/26 at 8:10 a.m., a review of the survey results binder located near the elevators on the first floor of the facility was completed. Although the binder included the survey results from the past three years, the 2024 and 2025 survey results did not include the facility's plan of correction (POC) or indicate that these could be requested from facility staff. During an interview on 7/22/26 at 2:44 p.m., the administrator stated that she was responsible for maintaining the survey results binder. She stated that the POC for the previous three years should be included with the survey results. The administrator confirmed she had reviewed the binder and stated that the POCs for all surveys occurring from 2024 to current were missing from the binder. A request was made for the facility policy regarding the posting of survey results, but this was not provided.		