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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the Ombudsman for Long Term Care (OMB - LTC) was notified of resident transfers or discharges for 3 of 5 residents (R73, R139, R141) reviewed for transfers or discharges from the facility. Findings include: R73's comprehensive Minimum Data Set (MDS), dated [DATE], indicated R73 was cognitively intact, and diagnoses included chronic kidney disease, and neuralgia and neuritis (general nerve pain or inflammation). R73's progress note, dated 2/16/26 at 5:43 p.m., indicated R73 was sent to the hospital for blood emesis and loss of consciousness. A subsequent progress note, dated 2/25/26 at 4:05 p.m., indicated R73 was readmitted to the facility on [DATE] at 2:00 p.m. The facility's Monthly Notice to OMB-LTC of Emergency Acute Care Transfers and Discharges, dated February 2026, lacked notice of R73's hospital transfer on 2/16/26. R139's comprehensive MDS, dated [DATE], indicated R139 had moderate cognitive impairment and diagnoses included congestive heart failure (CHF) and rheumatoid arthritis. R139's progress note, dated 2/9/26 at 12:40 a.m., indicated R139 was sent to the hospital for an acute behavioral status change. A subsequent progress note, dated 2/9/26 at 10:19 a.m., indicated R139 was admitted to the hospital for encephalopathy, and the family did not wish to hold the bed. The facility's Monthly Notice to OMB-LTC of Emergency Acute Care Transfers and Discharges, dated February 2026, lacked notice of R139's hospital transfer on 2/9/26. On 3/19/26 at 2:52 p.m., director of nursing (DON) verified the OBM-LTC was not notified of R73's hospital transfer on 2/16/26, and R139's hospital transfer on 2/9/26. DON stated when a resident was transferred to the hospital, a notification was expected to be sent to the ombudsman. Findings Include - R141's Face Sheet (undated) documented the diagnoses of Sepsis due to methicillin susceptible Staphylococcus aureus (a germ found on people's skin), pneumonia, acute and subacute infective endocarditis (inflammation of the heart's inner lining). (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R141's Minimum Data Set (MDS), with a registered nurse signing date of 2/07/26, documented R141 was moderately cognitively impaired and require set up to moderate assistance with all activities of daily living. R141's nurse progress notes on 2/08/26, documentation indicated R141 had eloped from the facility being later found wondering at Target. Family arrived and returned R141 to the facility (this was later investigated by the Minnesota Department of Health - Rapid Response Team). Upon returning to the facility, R141's daughter insisted on taking resident home. R141's provider was contacted, and discharge orders were received. During interview on 3/18/26 at 8:36 a.m., the director of nursing (DON) stated she had received a phone call from the facility on 2/8/26, the family was going to take R141 home AMA (against medical advice). Family was upset about the resident's elopement and concerns over staff monitoring resident's whereabouts. DON stated she and the facility staff were trying to prevent a AMA discharge, due to R141 receiving IV antibiotics and level of care. DON stated the daughter informed the facility she was going to take R141 home and place resident on hospice the following morning. R141 was discharge with family on 2/08/26. In a review of the documented listing, provided by the facility by the months submitted to OMB-LTC, the Month of February 2026 lacked R141's name. During interview on 3/19/26 at 2:19 p.m., the DON stated R141's family requested R141's discharge or they would be taking resident AMA (against medical advice). DON stated she involved the primary physician, who at first was against the discharge. However, after family informed facility / primary of the intentions of enrolling R141 into hospice services the following day, the primary physician gave the orders for discharge. DON stated she didn't want the family taking R141 AMA, and due to the emergent situation, wished to make R141 as safe as possible. DON was unable to explain why R141's name was not listed on the February 2026 listing provided to the LTC-OMB. In review of the facility's policy entitled: Transfer and Discharge from the Facility Policy (updated 4/5/25) documented in the procedure section, the following was documented: 9. Fax notice of transfer discharge form to the ombudsman.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and document review, the facility failed to ensure resident records upon discharge were complete and accurate for 1 of 1 resident (R141) reviewed for discharge.Findings Include - R141's Face Sheet (undated) documented the diagnoses of sepsis due to methicillin susceptible staphylococcus aureus (a germ found on people's skin), pneumonia, acute and subacute infective endocarditis (inflammation of the heart's inner lining).R141's Minimum Data Set (MDS), with a registered nurse signing date of 2/07/26, documented R141 was moderately cognitively impaired and require set up to moderate assistance with all activities of daily living.R141's nurse progress notes on 2/08/26, indicated R141 had eloped from the facility and was later found wondering at Target. Family arrived and returned R141 to the facility (this was later investigated by the Minnesota Department of Health - Rapid Response Team). Upon returning to the facility, R141's daughter insisted on taking resident home. R141's provider was contacted, and discharge orders were received.R141's electronic medical record, reviewed on 3/18/26, lacked evidence of a recapitulation of stay (a summarization of cares / services performed), documentation of medications sent with and any care instructions which would have been sent home with r141, by the facility on discharge.During interview on 3/18/26 at 8:36 a.m., the director of nursing (DON stated she would look into it, while that information would have been in R141's paper chart. DON stated she had received a phone call from the facility on 2/8/26, family was going to take R141 AMA (against medical advice) being upset about the resident's elopement and concerns over staff monitoring resident's whereabouts. DON stated she and facility staff were trying to prevent a AMA discharge, due to R141 receiving IV antibiotics and level of care. DON stated the daughter informed the facility she was going to take R141 home and place resident on hospice the following morning. DON stated she knew the documents were there. In a follow-up interview on 3/19/26 at 2:35 p.m., DON stated the facility staff were unable to find the requested documents (recapitulation of stay, documentation of medications sent with and any care instructions), after she and the HUC (health unit coordinator) searched R141's paper record and a pile of documents yet to be scanned. DON stated the evening of R141's daughter's request for discharge and family's demand for discharge or would be taking R141 AMA, the facility staff did their best to meet family's demands and contact and process physician's order to meet this request. DON stated she knew the documentation was completed as the requested documents were reviewed with the Rapid Response investigator who investigated R141's elopement days later. DON stated her concern was, during the investigation of the elopement, she may have failed to make copies and the originals may have been given to the Rapid Response investigator. In review of the facility's policy entitled: Transfer and Discharge from the Facility Policy (updated 4/5/25) documented in the procedure section, the following was documented:1. For resident-initiated discharges, the medical record is expected to contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan, and documented discussions with the resident or, if appropriate, his/her representative, containing details of discharge planning and arrangements for post-discharge care. Additionally, the comprehensive care plan will contain the resident's goals for admission and desired outcomes, which should be in alignment with the discharge if it is resident-initiated.

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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 complete proper disinfection of a blood glucose monitor for 1 of 1 resident (R10) reviewed for glucose monitoring.Findings include: R10's comprehensive Minimum Data Set (MDS), dated [DATE], indicated R10 was cognitively intact, and diagnoses included Parkinson's disease, chronic kidney disease and diabetes. R10's Physician Order Report, dated 2/18/26 - 3/18/26, indicated an order for blood glucose monitoring twice a day for diabetes. During observation and interview on 3/18/26 at 8:26 a.m., registered nurse (RN)-C was observed using an Assure Platinum blood glucose monitor (BGM) to check R10's blood glucose level. After RN-C completed the task and returned to the medication cart with the BGM, RN-C donned gloves, pulled a wipe from a blue-topped canister of PDI Sani-Hands Instant Hand Sanitizing Wipes, wiped the entire BGM with the wipe, and stated she would leave it out to dry. During interview on 3/18/26 at 8:55 a.m., RN-C stated the facility did not use shared blood glucose monitors and each resident had their own. RN-C stated, you can use this one (pointed to the canister of PDI instant hand sanitizing wipes) or you can use the alcohol wipes to sanitize. RN-C stated she was trained to sanitize the BGMs after each use. During interview on 3/18/26 at 2:33 p.m., director of nursing (DON) stated staff were expected to clean and disinfect the BGMs after each use with disinfecting wipes, purple, grey, or orange-topped canisters, and hand wipes were a definite no. DON stated proper disinfection of blood glucose monitors were important for infection control purposes. The Quality Assurance / Quality Control (QA/QC) Reference Manual for the Assure Platinum Blood Glucose Monitoring (BGM) System, provided by the facility on 3/18/26, indicated cleaning and disinfecting the BGM minimized risk of transmitted blood-borne pathogens, and recommended the use of a commercially available EPA-registered disinfectant detergent or germicide wipe. A list of EPA registered disinfectants included Professional disposables International, Inc (PDI)'s Super Sani-Cloth Germicidal Disposable Wipes. The facility's Cleaning of Glucometers policy, updated 8/29/16, indicated to prevent the transmission of blood-borne pathogens glucometers will be cleaned after every use for shared machines and at least weekly if for individual resident and when visibly soiled, with Sani-Cloth wipes (Purple Cap type) and allowed to dry for 2 minutes. Do not use alcohol wipes.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to maintain resident equipment cleanliness of intravenous (IV) poles for 1 of 1 resident (R86) reviewed for tube feeding.R86's quarterly Minimum Data Set (MDS) dated [DATE], indicated R86 had severe cognitive impairment and was dependent on assistance from staff for activities of daily living (ADLs). R86 diagnoses included dysphagia (difficulty swallowing food or liquids) following stroke, hypertension, gastrostomy tube (tube into stomach for feeding), hemiplegia (paralysis on one side) and hemiparesis (muscle weakness) following stroke, and encephalopathy (group of conditions that cause brain dysfunction). On 3/17/26 at 8:40 a.m., observed IV pole in R86's room with tube feeding pump attached. The pole, pole legs, and floor below were observed to have tan colored, dried substance that dripped down the pole, covered all five legs with several dried spots on the floor. Follow up observations on 3/18/26 at 10:08 a.m.; 3/18/26 at 1:55 p.m.; 3/19/26 at 8:15 a.m. and 3/19/26 at 1:07 p.m., the IV pole, pole legs and floor below continued to have dried tan colored substance. When interviewed on 3/19/26 at 1:28 p.m., registered nurse (RN)-A stated the poles should be cleaned of any formula spills as soon as it was seen as well as when starting or stopping the feeding for infection control reasons. When interviewed on 3/19/26 at 1:51 p.m., nurse manager (NM)-B stated the pumps and poles should be cleaned whenever it is observed to have anything on them. NM-B stated evening shift should clean the pump and pole when they started the tube feeding, day shift should clean the pump and pole off in the morning when the feeding was stopped. NM-B observed the pole and floor, stated should have been taken care of for cleanliness and infection control purposes. Facility policy Tube Feedings: Gastrostomy revised 8/2017, indicated the IV standard and pump was to wiped down daily with a cloth dampened with disinfectant.