DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1G6T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00984

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245439**
2.STATE VENDOR OR MEDICAID NO.
(L2) **375542800**

3. NAME AND ADDRESS OF FACILITY
(L3) **CATHOLIC ELDERCARE ON MAIN**
(L4) **817 MAIN STREET NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55413**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/24/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **150** (L18)

13.Total Certified Beds **150** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	150			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Gloria Derfus, Unit Supervisor — 01/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — MPM 04/09/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/11/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/30/2014
(L33)

DETERMINATION APPROVAL

CCN-24-5439

Based on review of the facility's Plan of Correction (POC) the facility is back in compliance with the Federal requirements identified as deficient at the time of the recertification survey completed on December 13, 2014. Refer to the CMS 2567b forms for both health and life safety code.

Effective January 22, 2014 the facility is certified for 150 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5439

April 9, 2014

Ms. Kimberly King, Administrator
Catholic Eldercare On Main
817 Main Street Northeast
Minneapolis, Minnesota 55413

Dear Ms. King:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 22, 2014 the above facility is certified for:

150 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 150 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245439	A. Building B. Wing	1/24/2014

Name of Facility	Street Address, City, State, Zip Code
CATHOLIC ELDERCARE ON MAIN	817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program , to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0257** Reg. # **483.15(h)(6)** LSC	Correction Completed **01/22/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **01/22/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/22/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** MM/GD	**Date:** 01/27/2014	**Signature of Surveyor:** 18623	**Date:** 01/24/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/13/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245439	01 - MAIN BUILDING 01	1/23/2014

Name of Facility	Street Address, City, State, Zip Code
CATHOLIC ELDERCARE ON MAIN	817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix ___ Reg. # NFPA 101 LSC K0072	Correction Completed 01/22/2014	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed
ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed
ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed
ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed
ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed	ID Prefix ___ Reg. # ___ LSC ___	Correction Completed

Reviewed By ___ State Agency	Reviewed By 16022	Date: 1/27/14	Signature of Surveyor: 28120	Date: 1/23/14
Reviewed By ___ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/23/2013	___	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 27, 2014

Ms. Kimberly King, Administrator
Catholic Eldercare On Main
817 Main Street Northeast
Minneapolis, MN 55413

RE: Project Number S5439023

Dear Ms. King:

On January 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 13, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 23, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 23, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 13, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 22, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 13, 2013, effective January 22, 2014 and therefore remedies outlined in our letter to you dated January 3, 2014, will not be imposed.

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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Telephone: 651-201-3792 Fax: 651-201-3790

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1G6T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00984

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245439**

2.STATE VENDOR OR MEDICAID NO.
(L2) **375542800**

3. NAME AND ADDRESS OF FACILITY
(L3) **CATHOLIC ELDERCARE ON MAIN**
(L4) **817 MAIN STREET NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55413**

4. TYPE OF ACTION: **2** (L8)
1. Initial — **2. Recertification**
3. Termination — 4. CHOW
5. Validation — 6. Complaint
7. On-Site Visit — 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/13/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited — 1 TJC
2 AOA — 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **150** (L18)

13.Total Certified Beds **150** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	150			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Sandra Nelson, HFE NE II — 01/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/28/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1G6T

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(L5) **MINNEAPOLIS, MN** (L6) **55413**

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* Code: **A*** (L12)

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18 SNF	18/19 SNF	19 SNF	ICF	IID
	150			
(L37)	(L38)	(L39)	(L42)	(L43)

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16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Gloria Derfus, Unit Supervisor — 01/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — MPM 04/09/2014 (L20)

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(L44)
B. Rescind Suspension Date:
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07-Provider Status Change
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(L28)

29. INTERMEDIARY/CARRIER NO.
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(L31)

30. REMARKS
Posted 04/11/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/30/2014
(L33)

DETERMINATION APPROVAL

CCN-24-5439

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Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5439

April 9, 2014

Ms. Kimberly King, Administrator
Catholic Eldercare On Main
817 Main Street Northeast
Minneapolis, Minnesota 55413

Dear Ms. King:

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If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245439	A. Building B. Wing	1/24/2014

Name of Facility	Street Address, City, State, Zip Code
CATHOLIC ELDERCARE ON MAIN	817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0257** Reg. # **483.15(h)(6)** LSC	Correction Completed **01/22/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **01/22/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **01/22/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/22/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** MM/GD	**Date:** 01/27/2014	**Signature of Surveyor:** 18623	**Date:** 01/24/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/13/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245439	A. Building B. Wing 01 - MAIN BUILDING 01	1/23/2014

Name of Facility	Street Address, City, State, Zip Code
CATHOLIC ELDERCARE ON MAIN	817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0072	Correction Completed 01/22/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By 16022	Date: 1/27/14	Signature of Surveyor: 28120	Date: 1/23/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/23/2013	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 27, 2014

Ms. Kimberly King, Administrator
Catholic Eldercare On Main
817 Main Street Northeast
Minneapolis, MN 55413

RE: Project Number S5439023

Dear Ms. King:

On January 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 13, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 23, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 23, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 13, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 22, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 13, 2013, effective January 22, 2014 and therefore remedies outlined in our letter to you dated January 3, 2014, will not be imposed.

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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Telephone: 651-201-3792 Fax: 651-201-3790

Enclosure
cc: Licensing and Certification File

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-245439

At the time of the standard survey completed December 13, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to bewidespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7338

January 3, 2014

Ms. Kimberly King, Administrator
Catholic Eldercare on Main
817 Main Street Northeast
Minneapolis, Minnesota 55413

RE: Project Number S5439023

Dear Ms. King:

On December 23, 2013, a standard 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 22, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 22, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 March 13, 2014 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 13, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING _____ B. WING _____	12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC ELDERCARE ON MAIN	817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	RECEIVED JAN 14 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent survey results conducted on 2/11/13, were posted for residents and the public. This had the potential to affect families, staff, visitors and all 147 residents residing at the facility.	F 167	**F 167** Survey results were replaced in the 3 ring binder prior to exit. Receptionist will be checking the binder daily to ensure the most current survey have not been removed and will replace as needed. Random audits will be conducted by Lead Receptionist and results reported to Quality Assurance Committee.	**01/22/14**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly King — TITLE: Administrator — (X6) DATE: 1-9-14

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 167	Continued From page 1 Findings include: On 12/9/13, at 12:26 p.m. survey results from the survey conducted on 12/7/11, were observed to be stored in a three ring binder located at the back of the reception desk. No recent survey results were posted from the survey conducted 2/11/13. On 12/9/13, at 9:00 a.m. the survey results remained the same as observed on 12/9/13, and the following consecutive days on 12/11/13, and 12/12/13. On 12/12/13, at 3:30 p.m. the administrator stated she had handed the responsibility to post the results to the receptionist supervisor and verified the survey results were from 12/7/11, and not the most current results.	F 167		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the call lights for 3 of 6 residents (R88, R131, R159) were within reach.	F 246	**F 246** During survey the call lights of residents R88, R131, R159 were moved so residents had access to them. Nursing staff re-educated on expectation that call lights are within reach. Charge nurses are to monitor call light placement during their shifts. Random audits will be completed by Nursing Management and Nursing Supervisors and results will be reported to Quality Assurance Committee.	**01/22/14**

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F 246	Continued From page 2 Findings include: On 12/9/13, at 3:58 p.m. the call light for R88 was observed to be on top of the over bed light. During the environmental tour on 12/12/13, at 2:56 p.m. R88's call light was again observed on top of the over bed light. R88's impaired mobility care plan dated 5/24/11, directed to place call light within reach. On 12/9/13, at 3:50 p.m. R131's call light was observed to be hanging on the over bed light. During the environmental tour on 12/12/13, at 2:56 p.m. R131's call light was observed hanging over the back of the head board on the floor. R131's fall care plan dated 6/15/10, identified "[R131] does use the call light appropriately" and directed to reinforce R131 requesting for assist. On 12/9/13, at 5:00 p.m. and on 12/10/13, at 1:34 p.m. R159's call light was observed to be stored inside the drawer of the bedside stand. During the environmental tour on 12/12/13, at 2:56 p.m. the call light was again observed to be inside the drawer of the bedside stand. The Significant Change in Status (SCSA) Minimum Data Set (MDS) dated 8/26/13, indicated R159 had severely impaired cognitive status for daily decision making. During the environmental tour, the director of housekeeping and laundry and maintenance verified the call lights were out of reach for R88, R131 and R159. When interviewed on 12/13/13, at 8:09 a.m. the director of nursing stated call lights are not supposed to be out of reach of the residents.	F 246		

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F 246	Continued From page 3 The facility Call Light policy revised on 3/25/10, directed all residents will have access to a working call light while in their room and receive a timely response.	F 246		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain comfortable bathroom temperatures for 7 of 8 residents (R25, R40, R68, R136, R90, R61, R98) in the sample with complaints of cold bathrooms. Findings include: During an interview on 12/10/13, at 9:11 a.m. R25 reported "it's too cold" and stated she had been "freezing" the whole week. During interview on 12/10/13, at 9:55 a.m. R40 reported as soon as the sun goes down the room gets cold. On 12/10/13, at 10:38 a.m. R68 approached surveyor and stated the room got cold after the sun went down and the bathrooms were cold. R68 explained the room temperature felt comfortable and the bathroom felt cold. At the time of the interview, cold air was felt blowing	F 257	**F 257** The timer for the bathroom Infrared Ceiling Tile heaters will be changed to a constant run for the winter months for resident rooms 213, 207, 113, 125, 123. Timers will also be changed in all resident rooms identified with concerns through random audits. Log developed for random auditing of resident bathroom temperatures. Random audits of resident bathroom temperatures will be conducted and recorded by Maintenance staff. Results will be reported to the Quality Assurance Committee.	**01/22/14**

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F 257	Continued From page 4 down over the toilet by the surveyor. During the environmental tour on 12/12/13, at 2:56 p.m. maintenance (M)-A checked the temperature in the shared bathroom for R136 and R90 and found it to be 63 degrees Fahrenheit (°F). M-A stated the bathrooms did not have heat, so the doors had to be kept open to draw in heat from the room. The temperature in the shared bathroom of R61 and R68 was observed to be 66.5 °F. During observation of R98 on 12/12/13, at 3:02 p.m. R98 told the surveyor she wanted to use the bathroom. When the bathroom door was opened a draft of cold air came out of the bathroom. R98 was observed wringing her fingers and wrist and stated "am so cold!" M-A accompanied the surveyor to R98's room on 12/13/13, at 8:10 a.m. and noted the bathroom temperature was 69 °F. The Maintenance Work Requests dated 11/26/13, 12/11/13 and 12/12/13, noted residents had reported cold rooms to maintenance. The Eldercenter-HVAC Control Record Boiler for November and December 2013, were reviewed and indicated the facility was monitoring the facility temperatures. The log did not include bathroom temperatures. On 12/12/13, at 2:56 p.m. the administrator reported the maintenance staff were visually checking the facility temperatures daily and were recording them every other day.	F 257		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=E	Continued From page 5 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview, the facility failed to ensure care plan interventions for fall prevention were followed for 1 of 3 residents (R46); failed to ensure grooming assistance was provided as directed by the care plan for 2 of 3 residents (R131, R48). In addition, the facility failed to ensure care plan interventions for repositioning were followed for 1 of 3 residents (R170) who required assistance with positioning. Findings Include: FALLS: R46's care plan was not followed for prevention of falls interventions. A behavior care plan dated 9/20/11, noted R46 made self-transfer attempts daily. The impaired physical mobility care plan dated 1/6/11, directed to place a mat on the floor next to the bed and the wheelchair should not be left at R46's bedside. The fall care plan dated 1/6/11, directed to provide adaptive reachers in the room and bathroom "at all times" to assist with reaching items. The care plan directed R46 to have a mobility alarm on at all times, and directed "do not leave resident unattended in bathroom." During observation on 12/11/13, at 6:58 a.m. R46	F 282	**F 282** Refer to POC for F 323, F 312, F 314. The care plans of the residents listed in this deficiency have been reviewed with primary care staff. Care plans have been updated as necessary. Nurse Managers and MDS nurses routinely review all resident care plans for appropriateness of interventions. Charge nurses monitor NAR compliance with care plans and report any concerns to nurse managers. Random audits will be completed by Nursing Management and Nursing Supervisors and results will be reported to Quality Assurance Committee.	**01/22/14**

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F 282	Continued From page 6 was observed in bed with a personal alarm under the pillow, a mat was observed on the floor at the bed side with a wheelchair on top of the mat. On 12/11/13, at 8:17 a.m. R46 was observed on the toilet with the door slightly ajar. The nursing assistant (NA)-D was in R46's room making the bed. - At 8:20 a.m. NA-D entered the bathroom, then left and went to the hallway to get wash clothes. NA-D was observed to go in and out of R46's bathroom while the resident was on the toilet and assisted with grooming. R46 was left unattended on the toilet while NA-D was in and out of the bathroom. NA-D assisted R46 to transfer into a wheelchair and left the bathroom to get coffee for R46. - At 8:29 a.m. R46 was observed unattended in the bathroom and did not have a reacher with him. NA-D returned to the room with coffee and at 8:33 a.m. stated "see you later" and left R46 in the bathroom. R46 was observed to bend forward in his wheelchair to pick something up off the floor and then wheeled back to the room. On 12/12/13, at 1:04 p.m. the registered nurse (RN)-E verified R46's care plan was not followed. GROOMING: R131 was not provided grooming assistance as directed by the care plan. The care plan dated 6/14/13, identified R131 with an alteration in activity of daily living (ADLs) and R131 required extensive assistance in dressing, bathing, personal hygiene, dementia, congestive heart failure and activity intolerance. The care plan goal indicated R131, "Will wash her face daily with cares." The undated bath schedule indicated R131 had a bath on Tuesday morning	F 282		

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	245439	A. BUILDING _____ B. WING _____	12/13/2013

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CATHOLIC ELDERCARE ON MAIN	817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413

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F 282	Continued From page 7 (AM) shift. R131 was observed to have multiple white facial hairs the evening of 12/9/13, and during subsequent days of the survey on 12/10/13, and 12/11/13. R48 was not provided grooming assistance as directed by the care plan. The care plan dated 11/13/10, identified R48 had a self-care deficit, required extensive assist with grooming and was cooperative with cares. R48's goal was, "Will participate with dressing and grooming ..." The undated morning Bath Schedule indicated R48 received a bath on Tuesday morning. R48 was observed to have multiple white facial hairs the evening of 12/9/13, and during subsequent days of the survey on 12/10/13, and 12/11/13. On 12/11/13, at 9:07 a.m. RN-A stated her expectation was for facial hairs to be checked with daily cares by the NA's. RN-A stated if there was a concern, the NA was supposed to report to the charge nurse. On 12/13/13, at 9:40 a.m. the director of nursing (DON) stated if nursing identified R131 and R48 had facial hair with cares, then staff was supposed to find a means to remove the hair for the residents. DON confirmed grooming needs should be addressed in the resident care plan. REPOSITIONING:	F 282		

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F 282	Continued From page 8 REPOSITIONING: R170 was not provided with every two hour repositioning assistance as directed by the care plan. On 12/11/13, R170 was observed to not be repositioned from 7:10 a.m. until 9:27 a.m. (two hours and 17 minutes). R170's skin integrity care plan dated as edited on 10/18/13, identified R170 had "potential for skin breakdown r/t [related to] impaired cognition, incontinence, end stage dementia and bunion/cellulitis on left great toe." The care plan goal indicated, "Resident will be free of skin breakdown." The care plan approach dated 10/18/13, directed, "Offloading/repositioning: turn and reposition in bed about every 2 hours." R170's ADL care plan dated 9/4/13, identified R170 had "Impaired physical mobility r/t: total assist with all mobility" and identified R170 required one to two staff assistance with bed mobility and transferring. During continuous observations on 12/11/13, from 7:10 a.m. until 9:27 a.m. R170 was not offered assistance with repositioning. On 12/11/13, at 2:50 p.m. RN-D verified R170 should have been repositioned every two hours according to the care plan.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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.	F 312		

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F 312	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview, the facility failed to provide personal hygiene care for 2 of 3 residents (R131, R48) who were dependent upon staff for personal cares reviewed for activities of daily living (ADL's). Findings Include: R131 was observed to have multiple white facial hairs the evening of 12/9/13, and during subsequent days of the survey on 12/10/13, and 12/11/13. On 12/09/13, at 7:08 p.m. R131 was observed to have multiple white facial hairs approximately a quarter (1/4) inch long to her lower chin and upper lip areas. On 12/10/13, at 9:36 a.m. R131 was observed to still have the facial hairs while sitting in her wheelchair at the television lounge. During continuous observations on 12/11/13, the following was observed: -At 7:07 to 7:39 a.m. the door to R131's room was observed to be shut. No staff activity occurred in the room at that time. -At 7:40 a.m. registered nurse (RN)-D opened the door quietly, then peeked inside the room, came out briefly and shut the door. The light in the room was on. -At 8:05 a.m. a nursing assistant (NA)-A entered R131's room and shut the door. - From 8:05 a.m. through 8:22 a.m. NA-A was	F 312	**F 312** Resident 131 facial hairs were cut. Primary care staff made aware of concern and expectation of removal of facial hair during routine cares. Resident 48 family wishes to continue to manage removal of her facial hair. Care plan has been updated to reflect this. Nurse Manager and charge nurses to check female residents needing assistance with facial hair removal and ensure care plans are current. Facility policy reviewed and updated. Nursing staff educated. Charge nurses will be responsible for monitoring. Random audits will be completed by Nursing Management and Nursing Supervisors and results will be reported to Quality Assurance Committee.	**01/22/14**

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F 312	Continued From page 10 observed to assist R131 with transferring, personal hygiene, toileting, dressing and grooming. -At 8:24 a.m. NA-A obtained a comb cued R131 to lift her head, combed R131 hair and looked directly at R131's face. NA-A did not acknowledge or offer to remove the facial hair. - From 8:24 a.m. until 8:40 a.m. NA-A assisted R131 with pericare, readjusted R131's incontinence pad and clothing, transferred R131 to the wheelchair, provided denture care and oral cavity care. -At 8:40 a.m. NA-A cued R131 to open her mouth and assisted her to apply her dentures. NA-A did not offer to remove the facial hairs. NA-A applied lip stick, cologne for R131 and stated she was done with R131's cares. -At 8:47 a.m. outside R131's door NA-A stated she would go back later to toilet and ambulate R131, but she was done providing morning cares. On 12/11/13, at 1:30 p.m. during a random observation, R131 was observed in the dining room area with the multiple facial hairs remaining. On 12/11/13, at 2:22 p.m. during another random observation, R131 was observed sitting in her wheelchair, the multiple white facial hairs remained on her chin and upper lip. The annual Minimum Data Set (MDS) dated 11/15/13, indicated R131's diagnoses included dementia, hypertension, heart failure, depression, and chronic obstruction pulmonary disease (COPD). The MDS indicated R131 required extensive physical assist of one staff for personal hygiene needs/cares. The ADL Functional/Rehab Potential CAA dated 11/28/13, indicated R131 required extensive physical assistance of one	F 312		

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F 312	Continued From page 11	F 312		

staff with grooming, dressing, bathing and toileting needs. In addition R131's Brief Interview for Mental Status (BIMS-tool used to measure cognitive status) was six out of the possible 15 (severe cognitive impairment).

The care plan dated 6/14/13, identified R131 with an alteration in ADL's and R131 required extensive assistance in dressing, bathing, personal hygiene, dementia, congestive heart failure and activity intolerance. The care plan goal indicated R131 "Will wash her face daily with cares." The undated bath schedule indicated R131 had a bath on Tuesday morning (AM) shift.

On 12/11/13, at 2:42 p.m. the registered nurse (RN)-D stated she had assisted R131 with several medications including eye drops and nasal sprays. RN-D stated she was not vigilant of the facial hair, "I just never realized the hair." RN-D stated therapeutic recreation (TR) staff had a little shaver they used for each resident. RN-D stated TR staff also clipped the nails and the nursing staff was "not used to doing it." RN-D further stated residents had nails and facial hair removed on bath day and she would not have removed R131's facial hair as she did not have the tools (shaver) to do so. RN-D verified R131 had multiple long facial hairs.

On 12/11/13, at 2:43 p.m. NA-A stated she was not sure what she would do with R131's facial hair and stated facial hair was usually removed with weekly baths. NA-A added TR removed it during a grooming activity.

On 12/11/13, at 9:07 a.m. RN-A stated her expectation was for facial hairs to be checked with daily cares by the NA's. RN-A stated if there

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F 312	Continued From page 12 was a concern, the NA was supposed to report to the charge nurse. RN-A stated the charge nurse would look for the shaver or call down to TR to request a personal shaver. R131's Body Audit and Foot Exam dated 9/3/13, through 12/10/13, indicated a body and foot exam was completed by nursing weekly and included resident shaving. The forms indicated R131 shaving was not completed. R131's Quarterly Activity Goal sheets for September through December 2013, indicated R131 had last received "GR (grooming)" from TR staff on 9/22/13, 10/20/13, 11/17/13, and on 12/1/13. R48 was observed to have multiple white facial hairs the evening of 12/9/13, and during subsequent days of the survey on 12/10/13, and 12/11/13. The annual MDS dated 9/10/13, indicated R48's diagnoses included Alzheimer's disease, diabetes mellitus, general muscle weakness, osteoporosis, and macular degeneration. The MDS indicated R48 required extensive physical assist of one staff with personal hygiene needs. The BIMS for R48 was seven out of the possible 15 (severe cognitive impairment). The ADL Functional/Rehab Potential CAA dated 9/23/13, identified R48 required extensive assist of one for grooming, bathing, dressing and toileting. The care plan dated 11/13/10, identified R48 had a self-care deficit, required extensive assist with grooming and was cooperative with cares. R48's goal was, "Will participate with dressing and grooming ..." The undated morning Bath Schedule indicated R48 received a bath on	F 312		

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F 312	Continued From page 13 Tuesday morning. On 12/09/13, at 3:31 p.m. R48 was observed sitting on the edge of her bed. R48 had multiple white facial hairs on her upper lip and chin area approximately one half (1/2) inch long. On 12/9/13, at 3:32 p.m. R48's family (F)-A stated, "I try to catch them [facial hairs] before the sun goes down." F-A stated either she or another family member usually would help R48 remove the facial hairs, but stated she did not know if facility staff would do it. On 12/10/13, at 2:30 p.m. during a random observation, R48 was observed at the common television area sitting in a chair visiting with another resident. R48 was observed to still have the facial hairs. During continuous observations on 12/11/13, the following was observed: -At 7:13 a.m. R48 was observed to be dressed and lying on top of a made bed. R48's roommate stated R48 was still sleeping, stated R48 had been dressed by staff and had gone back to bed. R48 was observed to still have multiple facial hairs on her chin and upper lip. - From 7:13 a.m. through 7:57 a.m. remained in bed without staff interaction in the room. -At 7:57 a.m. the house keeping aide was observed to enter the room, mop the bathroom floor, and then leave the room. -From 7:57 a.m. through 9:26 a.m. R48 was observed to remain in bed. - 9:26 a.m. R48 was transported to the dining room. -At 10:30 a.m. R48 was observed in the main dining room eating breakfast independently.	F 312		

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F 312	Continued From page 14 Several staff were observed to assist R48 with setting up the meal. -At 1:15 p.m. R48 was observed to be in her room, R48 was observed to still have the facial hairs. On 12/11/13, at 1:23 p.m. NA-C assigned to R48 stated she was done providing R48 with morning cares, but would go back to R48's room later to toilet her. NA-C stated that morning when she went to R48's room, R48 had requested to use the toilet and after toileting R48 had requested to be assisted with dressing. NA-C stated R48 returned to bed afterwards. NA-C added R48 had not come to the continental breakfast and had slept until brunch time at 10:30 a.m. NA-C verified R48 had multiple facial hairs and stated she had offered to remove the facial hair with morning cares, but R48 had refused. NA-C stated she had "gotten busy" the whole day and had not reported he refusal to the nurse. On 12/11/13, at 1:25 p.m. RN-C stated he expected facial hair to be removed daily with cares per facility standards. RN-C verified R48 had multiple facial hairs and requested NA-C to assist R48 to remove the facial hairs. RN-C further directed NA-C to ask R48's visiting daughter for assistance if the resident was refusing. On 12/11/13, at 1:41 p.m. RN-B stated her expectation was to have facial hair removed daily with cares and as needed. On 12/11/13, at 1:55 p.m. RN-B approached the surveyor and stated she had talked to one of R48's visiting daughters and stated R48's family would like to continue to remove the facial hair for	F 312		

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F 312	Continued From page 15 R48. RN-B stated they would update the care plan to indicate R48's family was responsible for R48's facial hair removal. R48's weekly Body Audit and Foot Exam forms dated 9/3/13, through 12/10/13, included resident shaving. The forms indicated R48's shaving had not been completed. The Resident Progress Notes dated 9/1/13, through 12/13/13, indicated R48 was co-operative with cares. On 12/13/13, at 9:40 a.m. DON stated if nursing identified R131 and R48 had facial hair with cares, then staff was supposed to find a means to remove the hair for the residents. DON confirmed grooming needs should be addressed in the resident care plan and that failure to remove resident facial hair was a dignity issue. The facility Shaving the Resident policy dated 4/1/2000, directed, "Female residents with excess facial hair may be shaven as needed as per the resident request." The Personal Cares: AM Cares policy dated 9/12/13, directed, "Each resident will receive A.M. care every morning, A.M. care includes a partial bath, (face, hands, back, axillae, and perineal) dressing, oral care and grooming." Although both policies directed to provide assistance with removal of facial hair for female residents, both policies lacked direction as to which facility staff was responsible to complete resident facial hair removal. Both policies lacked direction as which facility staff were responsible for oversight and documentation of resident grooming.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 16 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R170) assessed to be at risk for skin breakdown, was provided repositioning assistance according to their assessed and care planned individual needs. Findings include: R170 was at risk for skin breakdown and was not repositioned every two hours on 12/11/13, from 7:10 a.m. until 9:27 a.m. (two hours and 17 minutes). During continuous observation on 12/11/13, from 7:10 a.m. until 9:27 a.m. the following was observed: - At 7:10 a.m. R170 was observed to be in the bed, lying on her back with foam boots on both feet. R170 was wearing a hospital gown and had a pillow in between her knees. - Between 7:10 a.m. and 7:45 a.m. a nursing student (NS) was observed monitoring R170's vital signs, including lung and bowel sounds. At no time during the observation did NS offer or	F 314	**F 314** Resident 170 – care plan has been reviewed and updated. Skin remains intact. Pressure ulcer assessment and treatment policy and procedure reviewed and updated. Monitoring of re-positioning plans for residents is the responsibility of the charge nurse. Random audits will be assigned by nursing management. Reports will be made to the Quality Assurance Committee.	**01/22/14**

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F 314	Continued From page 17 attempt to reposition R170. - At approximately 7:45 a.m. NS walked out of 170's room. - From 7:45 a.m. until 9:10 a.m. no staff entered R170's room and R170 did no change position. - At 9:10 a.m. NS came by 170's room and looked at the resident and stated, "I guess it is a sleeping morning today." R170 was not repositioned. - At 9:21 a.m. a nursing assistant (NA)-A confirmed R170 was last repositioned "sometime around 6:50 a.m." and stated, "I checked on her at 6:50 a.m. and she was dry. Now I came to get her ready and get her up." - At 9:27 a.m. NA-A entered R170's room and started to perform morning cares including check and change of R170's incontinence brief. Upon removal of the brief, R170's buttocks and thighs had numerous deep red craters and crevices from the wrinkling of the brief. The areas were blanchable at the time and the skin was intact. The admission Minimum Data Set (MDS) dated 9/8/13, indicated R170 was always incontinent of bladder and bowel, required total assistance of two staff for bed mobility, transfers and toileting, and R170 was at risk for of developing pressure ulcers. R170's Brief Interview for Mental Status (BIMS- a tool used to determine potential cognition) score indicated R170 had severely impaired cognitive skills and was rarely/never able to make decisions. The MDS indicated R170's diagnoses included Alzheimer's disease and Parkinson's disease. R170's Care Area Assessment (CAA) was requested and not provided. R170's skin integrity care plan dated as edited on 10/18/13, identified R170 had "potential for skin	F 314		

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F 314	Continued From page 18 breakdown r/t [related to] impaired cognition, incontinence, end stage dementia and bunion/cellulitis on left great toe." The care plan goal indicated, "Resident will be free of skin breakdown." The care plan approach dated 10/18/13, directed, "Offloading/repositioning: turn and reposition in bed about every 2 hours." R170's activities of daily living (ADL) care plan dated 9/4/13, identified R170 had "Impaired physical mobility r/t: total assist with all mobility" and identified R170 required one to two staff assistance with bed mobility and transferring. On 12/11/13, at 2:00 p.m. NA-A verified she had not repositioned R170 and stated, "I had to prioritize what had to be done and it depends on what is going on." On 12/11/13, at 2:50 p.m. the registered nurse (RN)-D stated, "I realized that [R170] was up late today I don't know why she got up late, but I know that is not her normal routine, because she is one of the first resident that should be up first, but I don't know what happened today." RN-D verified R170 should have been repositioned. The facility's Ulcer: pressure - assessment and treatment Care Plan Policy and Procedure dated as reviewed on 4/18/12, directed, "Appropriate assessment and treatment will be provided to residents who have pressure ulcers according to industry standards of care." The policy further identified, "Intervention/management of pressure ulcers is to include: 3) Charge nurse monitor every shift that pressure relief measures are in place as per plan of care as indicated, MD orders related to pressure sore are fully implemented and residents are repositioned per plan of care."	F 314		

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	245439	A. BUILDING _____ B. WING _____	12/13/2013

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F 323 F 323 SS=D	Continued From page 19 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the manufacturer's instructions on applying a personal alarm (device-used to alert staff of resident movement), failed to ensure an adaptive reacher was in place and failed to ensure intervention implemented was appropriate for 2 of 3 residents (R131, R46) reviewed for falls. Findings include: During observation on 12/11/13, at 6:58 a.m. R46 was observed in bed with a personal alarm under the pillow, a mat was observed on the floor at the bed side with a wheelchair on top of the mat. Review of R46's Resident Incident Reports indicated the following: - On 7/5/13, R46 was found on the floor next to the bed and noted R46 had been "digging for something." R46's items were encouraged to be placed at a higher level (to prevent reaching). - On 10/10/13, R46 fell while attempting a self-transfer. R46 was noted to have been in bed and got up to reach for the wheelchair. The report	F 323 F 323	**F 323** Resident 46 primary care staff reviewed care plan. Care plan was updated as needed. Personal alarm was placed appropriately. Resident 131 – mobility alarm was changed to a motion sensor due to self-removal. Nurse Managers will review all personal alarm orders for appropriateness of use and proper placement. Care plans will be updated as needed. Charge nurses will be responsible for monitoring that alarms are used as ordered and placed appropriately. Facility policy on mobility alarms reviewed and updated. Random audits will be completed by Nursing Management and Nursing Supervisors and results will be reported to Quality Assurance Committee.	**01/22/14**

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F 323	Continued From page 20 noted R46 was able to independently unclip the mobility alarm. - On 11/11/13, R46 was found sitting on the floor by the bed after a self-transfer attempt. - On 12/2/13, R46 was found on the floor with a bump and laceration to the head after a self-transfer attempt. - On 12/5/13, R46 was found sitting on the bathroom floor and had reached to pick something up that he dropped. On 12/11/13, at 8:17 a.m. R46 was observed on the toilet with the door slightly ajar. The nursing assistant (NA)-D was in R46's room making the bed. - At 8:20 a.m. NA-D entered the bathroom, then left and went to the hallway to get wash clothes. NA-D was observed to go in and out of R46's bathroom while the resident was on the toilet and assisted with grooming. R46 was left unattended on the toilet while NA-D was in and out of the bathroom. NA-D assisted R46 to transfer into a wheelchair and left the bathroom to get coffee for R46. - At 8:29 a.m. R46 was observed unattended in the bathroom and did not have a reacher with him. NA-D returned to the room with coffee and at 8:33 a.m. stated "see you later" and left R46 in the bathroom. R46 was observed to bend forward in his wheelchair to pick something up off the floor and then wheeled back to the room. R46's quarterly Minimum Data Set (MDS) dated 9/1/13, included diagnoses of dementia and depression. The MDS indicated R46's a Brief Interview of Mental Status (BIMS) score was four (which indicated severe cognitive impairment). The MDS indicated R46 had a history of falls and required extensive assist of one for bed mobility,	F 323		

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F 323	Continued From page 21 transfers and toileting. A nurse practitioner progress noted dated 11/12/13, included a diagnosis of severe degenerative joint disease. The falls Care Area Assessment (CAA) dated 6/21/13, noted R46 had a history of multiple falls related to self-transfers and leaning from chair to pick something up. The CAA indicated his had occurred in his room and several of the falls had resulted in major injuries. A Fall Risk Assessment dated 9/16/13, noted R46 was at high risk for falls. A behavior care plan dated 9/20/11, noted R46 made self-transfer attempts daily. The impaired physical mobility care plan dated 1/6/11, directed to place a mat on the floor next to the bed and the wheelchair should not be left at R46's bedside. The fall care plan dated 1/6/11, directed to provide adaptive reachers in the room and bathroom "at all times" to assist with reaching items. The care plan directed R46 to have a mobility alarm on at all times, and directed "do not leave resident unattended in bathroom." The Resident Profile (used by the NA to provide care) printed on 12/12/13, included direction not to leave the wheelchair at the bed side, to apply a mobility alarm on at all times, directed to not leave R46 unattended in the bathroom and to have the adaptive reacher within reach in R46's room and bathroom at all times "to assist in reaching items." On 12/11/13, at 7:32 a.m. NA-D stated the personal alarm was not supposed to be under the pillow and stated it had a clip on it. NA-D removed the personal alarm from under the pillow and clipped it onto the grab bar next to R46's right	F 323		

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F 323	Continued From page 22 shoulder. At 1:29 p.m. NA-D verified the directives from the Resident Profile in the computer, and confirmed it was the form the NA staff used referred to for resident cares. On 12/12/13, at 11:42 a.m. NA-D reported she knew R46 had a history of falls and R46 should not have been left unattended in the bathroom. On 12/12/13, at 1:04 p.m. the registered nurse (RN)-E stated placing a personal alarm under a pillow would not be okay and the personal alarm should have been attached to the head board or on the clip. RN-E stated the head board on R46's bed had been removed because R46 needed an extra-long bed. RN-E also verified R46 should not have a wheelchair at bedside. RN-E further stated R46 could be left unattended at the sink in the bathroom, but not on the toilet. R131's personal alarm was not applied appropriately on 12/12/13. R131's annual MDS dated 11/15/13, included diagnoses of dementia, hypertension, heart failure, depression, and chronic obstruction pulmonary disease (COPD). The MDS indicated R131 required extensive physical assistance of one with transfers and R131's BIMS was six (severe cognitive impairment). The Cognitive Loss/Dementia CAA dated 11/28/13, indicated R131 had impaired decision making with poor safety awareness and judgment. The care plan dated 6/15/10, identified R131 was at risk for falls; had a history of falls, gait/balance problems, visual impairments, speech/communication deficit, perceptual disturbances, hearing impairment, self-transfer attempts, and impaired cognitive status. The care	F 323		

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F 323	Continued From page 23 plan goal indicated, "[R131] Will remain free from injuries related to falls." The care plan directed to use an alarm in bed at all times On 12/11/13, at 8:06 a.m. R131 was observed sitting at the edge of the bed. NA-A went over to the bathroom washed hands, came back, applied gloves, the transfer belt and R131's shoes. NA-A then cued R131 to assist during the transfer. The personal alarm was observed sitting on top of the bedside dresser. NA-A stated she had just taken the tabs alarm off. On 12/12/13, at 8:25 a.m. R131's door was observed to be wide open with curtain pulled all the way. The lights were out in the room. R131 was observed to be lying in bed, facing the wall, with the bed covers partially covering the resident. R131's personal alarm was observed to not be clipped to R131 clothing and was sitting on top of the bedside dresser. The alarm was partially covered with a picture frame and the call-light was observed to be hanging over the head board and not accessible to R131. On 12/12/13, at 8:43 a.m. NA-B stated she had been to R131's room at the beginning of the shift around 7:00 a.m. NA-B stated R131 was lying in bed with personal alarm clipped to her gown and stated the alarm was tucked under the pillow. NA-B further stated R131 was capable of getting up independently, removing the personal alarm, and setting the alarm on top of the bed side dresser. R131's Fall Risk Assessment dated 11/20/13, indicated she was at high risk for falls. Further review indicated R131 had two falls on 11/5/13, and 11/21/13; R131 was found lying on the floor	F 323		

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F 323	Continued From page 24 between the bed and bedside table with no injuries. A Progress Note dated 11/26/13, indicated, "Resident had two falls from bed in November. Resident has a history of delusions and attempts to self- transfer at night. No injuries on either falls. Initially refused bed alarm use after fall of 11/5/13, when asked. Now she says she will try it. Nights will check on her on last rounds to ensure she is safe and help if needed. Morning shift will check on her first rounds to do the same." The note indicated the nurse practitioner had been updated, "Order for the bed alarm obtained and transcribed." On 12/12/13, at 9:07 a.m. RN-A stated she was aware R131 was capable of removing the personal alarm, but R131's alarm had been instituted on 11/26/13. RN-A stated R131 was still in the assessment period to see if the tabs alarm was appropriate. RN-A stated the personal alarm should have been mounted to the Velcro on the head board or to a stationary object when in use. RN-A verified the alarm should not have been secured under the pillow. RN-A further stated it was "probably a good time" to look into the effectiveness of the intervention. On 12/12/13, at 3:47 p.m. RN-A stated R131 was cognitively intact in the past, had refused to use the alarm, and would actually throw it away. RN-A stated despite knowing R131 was capable of removing the alarm in the past, R131's cognition had declined and that was why the personal alarm as re-instituted. On 12/13/13, at 9:40 a.m. DON stated she expected the personal alarm to be attached to the Velcro on a stationary object such as a bed or wheelchair, and not tacked under the pillow.	F 323		

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F 323	Continued From page 25 When asked regarding apply a personal alarm the resident was known to be able to remove, DON stated all interventions had to be tried before actually deciding if they were not effective. DON stated the personal alarm had been implemented at the end of last month and the interdisciplinary team (IDT) was to meet and discuss the findings that week. The Personal Alarm #8202L Instructions manual directed, "The personal Alarm features two mounting options. It may be applied to a wheelchair, geri-chair or bed frame with its saddle mount; or it may be applied directly to a surface such as a nightstand, headboard, or toilet with the adhesive hook and loop attachment... and Note: Always check the mounting before each use, making sure the alarm is securely positioned." The Fall Prevention: Motion Sensor Detector, Mobility alarms policy dated 10/30/12, directed, "7. Mobility alarms - see manufacturer ' s direction sheet (attached) for use."	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356	**F 356** Form for posting Nurse staffing information was updated prior to exit. Receptionist on duty will complete and post document daily. Random audits will be conducted by Lead Receptionist and results reported to Quality Assurance Committee.	**01/22/14**

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F 356	Continued From page 26 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nursing staff posting reflected the actual hours worked by nursing staff for both licensed and non-licensed staff. This had the potential to affect family members, staff, visitors and all 147 residents residing at the facility. Findings include: On 12/9/13, at 12:26 p.m. posted nursing hours were observed behind the receptionist desk. The facility Report For Nursing Staff Directly Responsible For Resident Care dated 12/9/13, indicated the census, number of registered nurses (RNs), licensed practical nurses (LPNs), unlicensed staff trained medical aides (TMAs) and nursing assistants (NAs), actual hours for each of the titles but lacked the specific hours the staff were working.	F 356		

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F 356	Continued From page 27 On 12/9/13, at 12:32 p.m. the receptionist was interviewed stated the actual hours were filled out on each shift and showed surveyors a previous day completed posting. On 12/12/13, at 12:35 p.m. interviewed the staffing coordinator who stated she usually called the receptionist at the start of each shift to fill the number and actual hours for staff working as indicated on the daily nursing posting. On 12/12/13, at 3:30 p.m. the administrator verified the specific hours staff worked for each shift was not documented on staff posting. Document review revealed the facility Report For Nursing Staff Directly Responsible For Resident Care dated 11//13 through 12/12/13, lacked the specific hours the staff were working.	F 356		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	**F 431** The 3 health unit coordinators turned in their keys to the medication room prior to exit. Facility policy reviewed with licensed nursing staff. HUC job description will be updated. Random audits will be completed by Nursing Management and Nursing Supervisors and results will be reported to Quality Assurance Committee.	**01/22/14**

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F 431	Continued From page 28 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the medications stored in 3 of 3 medication rooms were only accessible to authorized personnel. This had to potential to affect all 147 of 147 residents residing in the facility. Findings include: First floor - On 12/13/13, at 9:32 a.m. when access to the first floor locked medication storage room was requested by the surveyor, the health unit coordinator (HUC)-A offered to unlock and open the medication storage room. HUC-A produced a ring of keys, selected the key to the medication storage room and allowed access to the surveyor. The medication storage room was observed to	F 431		

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F 431	Continued From page 29 have approximately six cupboards on the back wall and a refrigerator. The cupboards were observed to have locks on doors but were all observed to be unlocked. HUC-A stated her responsibility was to "stock supplies" in the room and that was why HUC staff was allowed access. The cupboards were observed to have multiple stock medications, such as over the counter Tylenol, aspirin, fleets enema, and Milk of Magnesia. The center upper cupboard was observed to have multiple medications waiting to be destroyed. The refrigerator was unlocked and contained various vials of resident insulin and multiple boxes of suppositories. HUC-A verified she was neither licensed, nor authorized to dispense medications. - At 9:35 a.m. the registered nurse charge nurse (RN)-G verified HUC-A had her own key to the first floor medication room and verified five of the cupboard doors had locks. RN-G stated the cupboards and refrigerator were "never locked" and HUC-A was not authorized to dispense or handle medications. - At 9:41 a.m. the nurse manager (RN)-H verified HUC-A "always has had access" to the medications stored in the first floor medication room. Third Floor - - At 9:50 a.m. the third floor had no HUC present at the time of the observation. The medication room door was observed to be locked. The inside of the medication room was observed to have the same unlocked cupboards and refrigerator. Resident prescription insulin was observed in the refrigerator and multiple stock medications were observed to be stored in the unlocked cupboards. Second Floor -	F 431		

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F 431	Continued From page 30 - At 10:02 a.m. HUC-B (the HUC for the second floor) stated she had a key to the medication storage room and verified she also put supplies away unattended in the medication room. HUC-B produced her own key to the medication storage room, opened the door, and allowed access to the surveyor; HUC-B verified the locks on the cupboards in the medication storage room were "never" locked. Medications observed in the second floor medication room were as follows: - 41 cards of resident prescription medications such as Pristiq (antidepressant), Tramadol (narcotic like pain reliever), Torsemide (a loop diuretic), Calcium Acetate (Antihyperphosphatemic), Potassium (a supplement), Lansoprazole (proton pump inhibitor), Hydralazine HCL (anti-hypertensive), Gabapentin (anticonvulsant), Diltiazem XR (calcium channel blocker), Diovan (anti-hypertensive), Carvedilol (beta blocker), Abilify (antipsychotic), Metoprolol (beta blocker) were observed to be stored in a plastic tub in the unlocked cupboard. The cards were observed to all be full or partially full; - Multiple bottles of resident prescriptions such as Risperdone (antipsychotic), Acyclovir (antiviral), Metoprolol, Nitrostat (vaso-dilator), and Unisom (an antihistamine used to promote sleep); - Multiple vials of opened and unopened insulin, suppositories stored in all three refrigerators. There were also multiple resident boxes of nebulizer medication. HUC-B confirmed a HUC was usually scheduled on the third floor; the HUC had the same responsibilities as HUC-B (such as stocking medication supplies). HUC-B verified the HUC on	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING _____ B. WING _____	12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC ELDERCARE ON MAIN	817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 31 the third floor had the same duties and was provided access to a key to the room. Stock medications such as full bottles of Tylenol, Aspirin, Geritussin, multi-vitamins, and fleets enemas were observed to be stored in all three facility medication rooms during the above observations. On 12/13/13, at 10:05 a.m. the second floor clinical manager (RN)-I verified HUC-B had access to the medication room and put away supplies unattended. RN-I verified the medications stored in the room were also resident prescription medications waiting to be destroyed. RN-I was unclear on the facility policy for which facility staff was allowed to have access to medications. The Catholic Eldercare, Inc. HUC Job Description (undated) listed an expected HUC job duty of, "5. Maintain stock of nursing supplies, including forms & stationary, according to established guidelines." The description directed to "Stock medication room, nursing station." The Omnicare 5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles dated 12/1/07, indicated, "1. Facility should ensure that only authorized Facility [sic] staff, as defined by Facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable Law." On 12/13/13, at 10:39 a.m. the director of nursing	F 431		

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F 431	Continued From page 32 (DON) and administrator both verified the job description and the policy were contradictory. They both verified the HUC should not be handling stock medications and should not have access to resident medications and medication room. Both verified HUC staff had access to the keys for all three medication storage rooms in the facility.	F 431		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5439027

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/23/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHOLIC ELDERCARE ON MAIN	**817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Catholic Eldercare On Main was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok RB 1-14-14 RECEIVED JAN 13 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 1-22-14

EXIT: 12-13-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly A King

TITLE: Administrator

(X6) DATE: 1-9-14

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 IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/23/2013**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Catholic Eldercare on Main is a 3-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1977 and was determined to be of Type II(222) construction. In 1983, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction. In 1994, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. In 1995, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 150 beds and had a	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 census of 146 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of patients in an emergency situation. Findings include: On facility tour between 10:00 AM and 11:45 AM on 12/23/2013, observation revealed that the Meals on Wheels is storing food and storage racks in the egress corridor near the main kitchen which is obstructing the exit. This deficient practice was verified by the Maintenance Director at the time of the inspection.	K 072	**K 072** The distribution of the Meals on Wheels program has been relocated to a room to ensure that the egress corridor near the main kitchen is not obstructed. Random audits will be conducted by the dietary manager to ensure egress corridor is not obstructed. Results will be reported to the Quality Assurance Committee.	**01/22/14**