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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4RK8

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 **04/21/2015** (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

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 04/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/11/2015 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/13/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245439

Electronically Delivered: April 29, 2015

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 April 14, 2015 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 about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 29, 2015

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

RE: Project Number S5439025

Dear Ms. King:

On March 19, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 5, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 14, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 5, 2015, effective April 14, 2015 and therefore remedies outlined in our letter to you dated March 19, 2015, 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.Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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	4/21/2015

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 **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **04/14/2015**
ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/14/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **04/14/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **04/14/2015**
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	Date:	Signature of Surveyor:	Date:
	GD/AK	04/29/2015	18623	04/21/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/5/2015

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**

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(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 **03/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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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

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To (b) :

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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):

17. SURVEYOR SIGNATURE Date :
Cynthia Wentkiewicz, HFE NE II 03/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/09/2015 (L20)

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

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____ 2. Facility is not Eligible
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3. Both of the Above :
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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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 19, 2015

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

RE: Project Number S5439025

Dear Ms. King:

On March 5, 2015, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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;

Electronic 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

Email: gloria.derfus@state.mn.us
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 April 14, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 June 5, 2015 (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 September 5, 2015 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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 _____	03/05/2015

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's 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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal	F 159		4/14/15

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

Electronically Signed | 03/26/2015

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 _____ B. WING _____	03/05/2015

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 159	Continued From page 1 funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure resident's personal funds were deposited in an interest-bearing account for and to have the accounts accessible at all times for 2 of 2 residents (R131, R8) reviewed for personal funds. Findings include: R131 was interviewed on 3/3/15, at 11:27 a.m. When asked if facility gave updates regarding how much money was left in R131's personal funds account without having to go and ask, R131 replied she had to go to the business office and ask about balances in her personal funds	F 159	All resident's personal funds in excess of $50.00 have been moved to an interest bearing account. Receptionist and nursing supervisor have access to $50.00 cash that is kept in a secure location after office hours so that residents can obtain personal funds. Residents are being provided with statements that provide personal fund account balances. Policies have been reviewed and updated. Resident satisfaction will be monitored at next 2 monthly resident council meetings or more frequently if issues are identified. Concerns will be reported to facility Administrator and Business Office	

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	245439	A. BUILDING _____ B. WING _____	03/05/2015

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F 159	Continued From page 2 account. The quarterly Minimum Data Set (MDS) dated 11/15/14, indicated R131 was cognitively intact. R8 was interviewed on 3/2/15, at 3:56 p.m. where she answered negatively when asked if facility gives updates regarding how much money was left in personal funds account. R8 added she had to go ask facility staff about personal funds account balances. The quarterly MDS dated 12/7/14, indicated R8 had no cognitive impairment. On 3/5/15, at 9:55 a.m. the Business Office Representative (BOR) confirmed R8 and R131 had personal funds accounts handled by the facility. BOR also displayed notices given to residents or responsible family members to update them about their balances on personal funds accounts. Statements or notices were given on quarterly bases and as needed when the accounts go below $25. A review of R8's and R131's personal funds accounts revealed they had money in excess of $50. When asked if the residents' accounts were deposited in interest bearing accounts, BOR answered "no." On 3/5/15, at 1:00 p.m. BOR stated he will talk to the administrator about the need to deposit residents money in an interest-bearing account and about finding a way on how to have residents' money accessible to them at all times. A review of the facility's undated policy regarding access to personal funds, revealed residents	F 159	Director.	

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F 159	Continued From page 3 were only allowed to get money from their accounts during "business hours" or when the receptionist was at the front desk that was from 7:00 a.m. to 8:00 p.m. BOR also verified when the receptionist's desk was closed, residents had to wait until the next morning to get their money. The policy did not indicate if the facility would deposit the money in an interest bearing account when a resident had an excess of $50.00.	F 159		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272		4/14/15

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F 272	Continued From page 4 Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility did not ensure comprehensive pressure ulcer assessment was completed for 1 of 3 residents (R176) reviewed for pressure ulcer. Findings include: The Resident Admission Record dated 11/13/14, indicated R176 was admitted to facility with diagnoses including altered consciousness; rib fracture; muscle weakness; osteoporosis; history of personal fall; contusion on shoulder region and lower limb; and generalized pain. The nurses' admission notes dated 11/13/14, described R176's feet as dry and scaly. The admission notes did not list any other skin issues on R176's left foot. The nurses' progress notes dated 11/14/14 (night of admission), indicated R176 had a "fluid fill [sic] blister on left side of heel." There was lack of evidence to show thorough assessment was completed to include circumstances related to the blister formation.	F 272	Resident #176 was discharged 17 days after admission on 11/30/14 and had no pressure ulcers at that time. Policies on pressure ulcer risk assessment, identification and prevention will be reviewed with licensed nurses at nurses meeting on 04/01/15. Expectations on assessment within 24 hours of residents' admission will stressed. Records of residents' who have pressure ulcers have been reviewed to ensure comprehensive assessment and documentation. Medical Director and Wound Nurse do routine rounds on all pressure ulcers and document as necessary. Information is reviewed and audited at weekly IDT meetings (including MDS department). Nurse Managers, RN supervisors and DON will be responsible for monitoring compliance by reviewing admission and re-admission skin assessments within 24 hours of completion. Reports will be made to QA.	

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F 272	Continued From page 5 R176's Skin - Body Audit and Foot Exam form dated 11/18/14, identified redness on left foot heel. It was not specified if the reddened area was the same fluid-filled blister that was previously identified on the night of admission. The admission Minimum Data Set (MDS) dated 11/20/14, indicated R176 did not have any risk for pressure ulcer development and that there was no unhealed pressure ulcer, although a fluid-filled blister was identified on R176's left heel on 11/14/14, and a reddened area on the left foot noted during skin audit on 11/18/14. A review of nurses' progress notes dated 11/21/14, indicated left foot lateral heel had "callous/resolving blister" that measured 1 cm L (length) X 1 W (width) cm. The notes further revealed presence of two additional skin issues on the left foot, identified and described as "Left foot lateral malleolus - 1.3 cm diameter affected red area with 0.4 cm diameter dark center" and "Left lateral mid foot has 2 areas (1.7 cm L X 0.7 cm W and 0.3 cm diameter) both with 100% eschar." The Care Area Assessments (CAA) dated 11/26/14, revealed the pressure ulcer section was marked to indicate pressure ulcer triggered but the CAAs lacked a narrative summary to explain details of the pressure ulcer on the foot. The CAAs stated, "Do not proceed with pressure ulcers CP-resident is not at risk and triggered due to physical assistance with toileting." The CAAs lacked evidence of a comprehensive assessment for the blister that was identified on the left foot upon admission and reddened area that was identified on 11/18/14. The CAAs lacked causal	F 272		

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F 272	Continued From page 6	F 272		

and factors, potential decline or worsening condition of the left foot open area and reddened area, interventions for care, and potential need for expert referrals for the open areas on the foot.

On 3/5/15, at 3:15 p.m. registered nurse (RN)-A stated a fluid-filled blister was identified on R176's left heel on the night of admission on 11/14/14. RN-A acknowledged the two additional areas on R176's left foot (left foot lateral malleolus and left lateral mid foot) were only identified on 11/21/14. RN-A denied that two new scabbed areas on R176's left foot were pressure ulcers but RN-A admitted there was lack of documentation to show they were present on admission. RN-A also verified the CAA did not have an analysis on RN-A's risk for pressure ulcer as well as the presence of R176's pressure ulcer on left heel.

On 3/5/15, at 3:56 p.m. the director of nursing stated she expected all the skin issues should have been thoroughly assessed and documented during admission. DON further stated she expected the MDS and CAA to have identified the R176's risks for pressure ulcer and the actual presence of R176's pressure ulcer.

The facility's Pressure Ulcer Risk Assessment and Prevention policy with last review dated 4/18/13, provided "all residents will be assessed for risk of developing pressure ulcers. Information obtained in the risk assessment will be used for developing a preventative plan of care." The policy also directed staff to complete Catholic Eldercare Pressure Ulcer Risk Assessment within 24 hours of resident's admission; determine risk for pressure ulcer based on individual risk factors; and residents with "actual pressure ulcers need to have tissue tolerance testing [test to determine

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F 272	Continued From page 7 ability of skin to withstand unrelieved pressure] done per facility policy." The Catholic Eldercare Policy and Procedure for Resident Assessment Process dated as revised 12/20/14, identified the MDS coordinator was responsible for scheduling, closing and submission of the MDS assessments in accordance with Federal and State regulations.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a significant change was identified for 1 of 1 resident (R86) in the sample who declined in activities of daily living (ADLs). Findings include: The annual Minimum Data Set (MDS) dated	F 274	It is the practice of Catholic Eldercare to comprehensively assess all residents using the RAI process. MDS for resident #86 has been modified. Significant change process has been reviewed with MDS department. Weekly IDT meetings are used to identify residents with significant change.	4/14/15

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F 274	Continued From page 8 10/9/14, identified R86 required extensive assistance with toilet use; limited assistance for bed mobility, transferring, walking in corridor and locomotion off the unit; R86 was independent with locomotion on the unit, dressing, eating and personal hygiene; R86 did not walk in the room. The quarterly MDS dated 1/9/15, identified R86 had declined in two areas of activities of daily living (ADLs) and required extensive assistance with locomotion off the unit and dressing; R86 remained unchanged in the other ADLs. On 3/5/15, at 12:45 p.m. the MDS coordinator/registered nurse (RN)-E reviewed the above MDS data and verified R86 had declined in ADL ability. RN-E stated, "Yeah, we've got a coding problem here, for starters." RN-E verified R86 had a potential significant change on the 1/9/15, MDS. RN-E stated the significant decline should have been brought to the interdisciplinary team (IDT) for review. RN-E stated if the decline was not identified as a significant change, documentation of the rational why the MDS would not be coded as a significant change should be written in the Care Area Assessment (CAA) or in the clinical record. RN-E verified no rational was documented. The Catholic Eldercare Policy and Procedure for Resident Assessment Process dated as revised 12/20/14, identified the MDS coordinator was responsible for scheduling, closing and submission of the MDS assessments in accordance with Federal and State regulations. The policy lacked direction for how to identify significant changes, what constituted a significant change and the facility specific protocol for addressing significant changes MDS.	F 274	DON and MDS Coordinator will be responsible for compliance. Random MDS audits will be completed by members of the nursing management team weekly. Reports will be made to QA.	

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pressure ulcers were identified on the Minimum Data Set (MDS) for 1 of 3 residents (R176) in the sample reviewed for pressure ulcers.	F 278	Resident #176 was discharged 17 days after admission on 11/30/14 and had no pressure ulcers at that time. Policies on pressure ulcer risk assessment, identification and prevention will be reviewed with licensed nurses at nurses	4/14/15

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F 278	Continued From page 10 Findings include: R176's Resident Admission Record indicated R176 was admitted to facility from the hospital on 11/13/14, with diagnoses including history of personal fall; rib fracture; muscle weakness; osteoporosis; contusion on shoulder region and lower limb; and generalized pain. The nurses' admission notes dated 11/13/14, indicated R176's feet were dry and scaly. The nurses' progress notes dated 11/14/14 (night of admission), indicated R176 had a "fluid fill [sic] blister on left side of heel." R176's Skin - Body Audit and Foot Exam form dated 11/18/14, identified redness on left foot heel. The admission Minimum Data Set (MDS) dated 11/20/14, indicated R176 did not have any risk for pressure ulcer development and that there was no unhealed pressure ulcer, although a fluid-filled blister was identified on R176's left heel on 11/14/14, and a reddened area noted during skin audit on 11/18/14. The Care Area Assessment (CAA) dated 11/26/14, revealed the pressure ulcer section was marked to indicate pressure ulcer triggered but the CAA lacked a narrative summary to explain details of the pressure ulcer on the foot. The CAA lacked evidence of a comprehensive assessment for the blister and reddened area that was identified on the left foot upon admission. On 3/5/15, at 3:56 p.m. the director of nursing stated she expected all the skin issues should	F 278	meeting on 04/01/15. Expectations on assessment within 24 hours of residents' admission will stressed. Records of residents' who have pressure ulcers have been reviewed to ensure comprehensive assessment and documentation. Medical Director and Wound Nurse do routine rounds on all pressure ulcers and document as necessary. Information is reviewed at weekly IDT (including MDS department). MDS Coordinator and DON will be responsible for compliance. Members of the nursing management team will conduct weekly audits of MDS accuracy in identification of pressure ulcers. Reports will be made to QA.	

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F 278	Continued From page 11 have been thoroughly assessed and documented during admission. DON further stated she expected the MDS and CAA to have identified R176's risks for pressure ulcer and the actual presence of R176's pressure ulcer. The facility's Pressure Ulcer Risk Assessment and Prevention policy with last review dated 4/18/13, directed staff to use the Resident Assessment Instrument (RAI) process to identify possible risk factors.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		4/14/15

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F 279	Continued From page 12 Based on observation, interview and document review, the facility failed to ensure visual and hearing deficits was identified as a problem on the care plan with resident specific interventions to address the visual and hearing problems for 1 of 1 resident (R86) in the sample. Findings include: Vision: On 3/4/15, at 9:27 a.m. R86 and family member (F)-A were interviewed together in R86's room. R86 stated she made the decision to admit to the facility due to difficulty with hands and daily function, such as getting out of the apartment. R86 stated she had falls at the apartment and explained it was due to vision and hearing problems. During the interview, R86 explained her visual limitations, stated she only saw from the peripheral aspects of her vision; both R86 and F-A stated the resident was technically "blind." R86 gestured around her to show what she could see from peripheral aspects of her vision and could not see in the center areas of her vision. The annual Minimum Data Set (MDS) dated 10/9/14, identified R86 was cognitively intact without behavioral concerns; the MDS identified R86 could see "large print" only. The Care Area Assessments (CAAs) all documented as a late entry in Resident Progress Notes on 10/28/14, identified R86 had diabetic retinopathy, identified R86 "is clearly blind in her left eye" and R86 could read large print with a magnifying glass. The CAAs identified R86 could navigate safely with her environment. The quarterly MDS dated 1/9/15, identified R86 had no change in visual impairment.	F 279	Care plan of resident #86 was updated. Care plans of residents with visual and hearing impairments have been reviewed and updated as necessary. Comprehensive care plan expectations will be reviewed at 04/01/15 nurses meeting. Nurse Managers and DON will monitor care plan development by conducting weekly audits of care plans. Reports will be made to QA.	

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F 279	Continued From page 13 R86's care plan dated as edited last on 10/22/14, identified R86 as "At risk for falls" related to risk factors including "*visual impairments." The Falls care plan interventions included, "Monitor equipment, glasses and/or hearing aid." Although the care plan appropriately identified a visual impairment as a potential contributor to falls, the care plan lacked identification of R86's assessed specific visual impairments, interventions to address the impairments, including but not limited to how vision affected R86's daily activities. On 3/5/15, at 12:45 p.m. the MDS coordinator/registered nurse (RN)-E reviewed the above MDS data and verified a visual care plan was triggered and stated a care plan should have been written for R86's assessed visual needs. Hearing: R86 and family member (F)-A were interviewed together in R86's room on 3/4/15, at 9:27 a.m. During the interview, R86 was observed to wear hearing aids in both ears and stated she stored them in her room. R86 directed the surveyor to adjust the tone during the interview due to her hearing deficits. R86 stated the hearing aids were functional. The care plan dated 10/2/14 through 1/24/15, was reviewed and the care plan lacked any interventions of how the facility was going to maintain the assistive device such as repairs and batteries, when appointments were needed and how the facility was going to monitor for changes in hearing. The medical record indicated R86 had the hearing aids dispensed on 10/10/14, per On-Site	F 279		

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F 279	Continued From page 14 hearing. The plan of care was not developed for the hearing aid use. The quarterly MDS dated 1/9/15, identified R86 had no hearing impairment and did identify R86's hearing aid use. The Catholic Eldercare, Inc. Care Planning, Care Conference and MDS policy and procedure dated as revised on 12/16/14, indicated an "individualized written care plan" should be formulated to "communicate each resident's individual needs, problems, preferences, strengths and goals."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		4/14/15

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	245439	A. BUILDING _____ B. WING _____	03/05/2015

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F 280	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for nutrition for 1 of 3 residents (R15) reviewed for weight loss Findings include: R15's quarterly admission Minimum Data Set (MDS) dated 9/10/14, identified diagnoses of chronic pain, history of fractures, diverticulosis, and hyperlipidemia. The nutritional section stated there was no concern with chewing, swallowing or weight loss. The Care Area Assessment (CAA) dated 7/28/14, triggered the nutritional status related to therapeutic diet. Review of R15's weights was documented as follows: 3/3/15: 106 Pounds (lbs.) 2/3/15: 108 lbs. 1/8/15: 112 lbs. 12/2/14: 117 lbs. 9/8/14: 116 lbs. R15's care plan edited 1/29/15, indicated nutritional problems with a goal resident would maintain stable weight +/- 5%. The interventions included diet as ordered by physician, was able to feed herself, monitor weights monthly and as needed, monitor intakes quarterly and as needed. On 3/4/15, at 10:30 a.m. R15 ate 50% of meal and she denied pain. On 3/5/15, at 10:30 a.m. the resident stated she does not eat much as she was not very hungry, she did not eat the noon meal and she denied pain. The resident was not	F 280	F280 Clinical Dietitian met with resident #15 to discuss her personal goals/desires. Care plan updated to reflect residents wishes for no interventions as she feels better at this weight. Documentation about this desire entered into the resident□s record. Discussed residents□ desires with Nurse Practitioner who supports residents□ goal. All care plans of residents with weight loss are being reviewed and updated to reflect resident goals/wishes for weight. Nutritional policies regarding weight monitoring reviewed and updated. This will be reviewed at IDT and Monthly Nurses Meeting. The Clinical Dietitian will be responsible for monitoring compliance and will do weekly audits of weights with Director of Dining Services/Dietitian. Concerns will be reported to QA.	

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F 280	Continued From page 16 aware of how much weight she has lost. The registered nurse (RN)-A interviewed on 3/5/15, at 12:20 p.m. stated she was unaware of the resident's weight loss. The registered dietician (RD) interviewed on 3/5/15, at 11:30 a.m. stated she was aware the resident was losing weight, however she did not know R15 was down to 106 until today when she reviewed it. She stated the resident wanted to lose weight, however did not provide any documentation the resident wanted to lose weight, nor did she discuss the risks and benefits of weight loss with the resident. The physician was not notified of the weight loss. There were no new nutritional interventions implemented to avoid ongoing weight loss. The RD stated they only do intake once a month and only weigh the resident once a month as well. The RD verified the resident was not on a supplement and there had not been interventions put into place regarding the ongoing weight loss. The Catholic Eldercare, Inc. Care Planning, Care Conference and MDS policy and procedure dated as revised on 12/16/14, indicated an "individualized written care plan" should be formulated to "communicate each resident's individual needs, problems, preferences, strengths and goals." R15 did not have the care plan revised with interventions to maintain and/or prevent weight loss.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		4/14/15

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F 314	Continued From page 17 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 interview and document review, the facility failed to conduct a comprehensive assessment when pressure ulcer(s) were identified, failed to ensure staff monitored and provided care that promoted healing, and failed to develop measures to prevent further deterioration and reduce the risk of new pressure ulcers for 1 of 3 residents (R176) reviewed who were admitted with pressure ulcers. Findings include: The Resident Admission Record indicated R176 was admitted to facility on 11/13/14, with diagnoses including: rib fracture, muscle weakness, osteoporosis, history of falls, contusion on shoulder region and lower limb, and generalized pain. The Resident Progress Notes dated 11/13/14, described R176's feet as dry and scaly. The admission notes did not list any other skin issues on R176's left foot. Resident Progress notes dated 11/14/14, at 12:00 a.m. indicated R176 had a "fluid fill [sic] blister on left side of heel." The medical record lacked evidence of the dimensions of the blister.	F 314	Resident #176 was discharged 17 days after admission on 11/30/14 and had no pressure ulcers at that time. Policies on pressure ulcer risk assessment, identification and prevention will be reviewed with licensed nurses at nurses meeting on 04/01/15. Expectations on assessment within 24 hours of residents' admission will stressed. Records of residents' who have pressure ulcers have been reviewed to ensure comprehensive assessment and documentation. Medical Director and Wound Nurse do routine rounds on all pressure ulcers and document as necessary. Information is reviewed at weekly IDT (including MDS department). Nurse Managers and DON will be responsible for monitoring compliance and will do weekly audits of care plan interventions for residents with pressure sores. Reports will be made to QA.	

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F 314	Continued From page 18 R176's Skin - Body Audit and Foot Exam form dated 11/18/14, at 8:13 a.m. identified redness on left foot heel. It was not specified if the reddened area was the same fluid-filled blister that was previously identified. The form also noted the Primary Care Team was not updated regarding the redness on the left heel and the note section was void of any comments. The admission Minimum Data Set (MDS) for R176 dated 11/20/14, did not identify any risk factors for pressure ulcer development, and did not identify there was an unhealed pressure ulcer, even though a fluid-filled blister had been identified on R176's left heel on 11/14/14, and a reddened area had been noted during a skin audit on 11/18/14. Resident Progress notes dated 11/21/14, at 12:59 p.m. indicated left foot lateral heel had "callous/resolving blister" that measured 1 cm (centimeter) L (length) X 1 cm W (width). The notes further revealed the presence of two additional skin issues on the left foot, identified and described as "Left foot lateral malleolus - 1.3 cm diameter affected red area with 0.4 cm diameter dark center" and "Left lateral mid foot has 2 areas (1.7 cm L X 0.7 cm W and 0.3 cm diameter) both with 100% eschar [an area of dead tissue on the skin]." The Resident Progress Notes were reviewed from admission to 11/21/14, and the medical record lacked evidence of monitoring and assessing the blister and the two additional skin issues that was documented on 11/14/14. After the progress note of 11/21/4, the medical record was void of any documentation for the wound that was identified on the left foot. The resident was discharged to home on 11/30/14.	F 314		

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F 314	Continued From page 19	F 314		

Review of the Physician's Orders dated 11/21/14, for treatment of the ulcers noted "Treatment to left lateral heel, left lateral malleolus and left lateral mid-foot resolving blisters/abrasions: Monitor daily for changes, and for s/s [signs and symptoms] of infection. Keep dry and uncovered. Update MD [physician] if drainage noted."

A Daily Pressure Wound Documentation report dated 11/21/14, at 8:41 p.m. indicated R176's left foot malleolus wound base was characterized as "black/brown eschar" and wound bases on "mid foot two areas" were characterized as "black/brown eschar." The note section was void of any documentation.

A care plan for R176's left foot pressure ulcers was developed and initiated on 11/21/14, (eight days after a fluid-filled blister was identified on R176's left heel on admission and three days after the reddened area on the left heel was observed). The care plan directed staff to do daily skin checks; daily documentation on status of pressure areas on R176's left foot lateral heel, left foot lateral malleolus and two areas on left mid-foot; and to elevate R176's heels off bed "especially left lateral foot." In addition, there was no care plan developed prior to 11/21/14, to address the identified blister and the two new skin areas and no interventions were put into place to minimize and/or prevent further skin breakdown until 11/21/14.

The Care Area Assessments (CAA) dated 11/26/14, revealed the pressure ulcer section was marked to indicate pressure ulcer triggered but the CAAs lacked a narrative summary to explain details of the pressure ulcer on the foot. The CAAs stated, "Do not proceed with pressure

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F 314	Continued From page 20	F 314		

ulcers CP [care plan]-resident is not at risk and triggered due to physical assistance with toileting." The CAAs lacked evidence of a comprehensive assessment for the blister that was identified on the left foot upon admission and reddened area that was identified on 11/18/14. The CAAs lacked causal and factors, potential decline or worsening condition of the left foot open area and reddened area, interventions for care, and potential need for expert referrals for the open areas on the foot.

A Daily Pressure Wound Documentation report dated 11/29/14, at 5:27 p.m. indicated the "character of the wound base was normal for skin." It could not be determined if the wound had healed or if the wound was still present as the Resident Progress Notes and the wound documentation form for that date lacked evidence of any comments or measurements of the left foot ulcer(s).

On 3/5/15, at 3:15 p.m. registered nurse (RN)-A stated a fluid-filled blister was identified on R176's left heel on the night of admission on 11/14/14, and two additional areas on left foot were only identified on 11/21/14. RN-A claimed R176's "calloused" left heel on 11/21/14, was in the "normal" process of healing. However, RN-A also confirmed there was no documentation to show the blister had been monitored. RN-A verified there was no written care plan developed to address the blister when it had first been identified on 11/14/14, and to prevent the development of more pressure areas.
- At 3:56 p.m. the director of nursing (DON) stated she expected all the skin issues to have been thoroughly assessed and documented during admission. The DON added she expected

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F 314	Continued From page 21 a care plan to have been developed when a skin problem was identified and interventions implemented. DON also stated she expected documentation to reflect skin monitoring was in place. - At 4:12 p.m. DON stated the blister on R176's left heel when first identified on 11/14/14, was at a Stage 2 (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). When asked to determine the stages of the pressure areas on R176's left foot based on the nurses' notes on 11/21/14, DON replied that according to the un-named form (a tool used by the facility to determine the stages of pressure ulcer) dated 1/10/11, and attached to Scenarios for Pressure Ulcer Coding dated 5/13, since wound bases could not be observed then wounds were at Stage 4 (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers). The facility's Pressure Ulcer Risk Assessment and Prevention policy with last review dated 4/18/13, provided "all residents will be assessed for risk of developing pressure ulcers. Information obtained in the risk assessment will be used for developing a preventative plan of care." The policy also directed staff to complete Catholic Eldercare Pressure Ulcer Risk Assessment within 24 hours of resident's admission; determine risk for pressure ulcer based on individual risk factors; and residents with "actual pressure ulcers need to have tissue tolerance testing [test to determine ability of skin to withstand unrelieved pressure]	F 314		

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F 314	Continued From page 22 done per facility policy." The facility failed to comprehensively assess R176's risk factors after development of the pressure ulcer at the time of admission and failed to identify individualized interventions necessary for staff to implement to prevent further skin breakdown.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for nutrition for 1 of 3 residents (R15) reviewed for weight loss. Findings include: R15's quarterly admission Minimum Data Set (MDS) dated 9/10/14, identified diagnoses of chronic pain, history of fractures, diverticulosis, and hyperlipidemia. The nutritional section stated there was no concern with chewing, swallowing or weight loss. The Care Area Assessments (CAAs) dated 7/28/14, triggered the nutritional status	F 325	F325 Clinical Dietitian met with resident #15 to discuss her personal goals/desires. Care plan updated to reflect residents wishes for no interventions as she feels better at this weight. Documentation about this desire entered into the resident□s record. Resident□s goal changed regarding her weight. Nurse Practitioner reviewed resident□s weight with Clinical Dietitian. All care plans of residents with weight loss are being reviewed and updated to reflect interventions and goals. Weight Monitoring Policy reviewed and	4/14/15

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F 325	Continued From page 23 related to therapeutic diet. Review of R15's weights was documented as follows: 3/3/15: 106 Pounds (lbs.) 2/3/15: 108 lbs. 1/8/15: 112 lbs. 12/2/14: 117 lbs. 9/8/14: 116 lbs. R15's care plan edited 1/29/15, indicated nutritional problems with a goal resident would maintain stable weight +/- 5%. The interventions included diet as ordered by physician, was able to feed herself, monitor weights monthly and as needed, monitor intakes quarterly and as needed. On 3/4/15, at 10:30 a.m. R15 ate 50% of meal and she denied pain. On 3/5/15, at 10:30 a.m. the resident stated she does not eat much as she was not very hungry, she did not eat the noon meal and she denied pain. The resident was not aware of how much weight she has lost. The registered nurse (RN)-A interviewed on 3/5/15, at 12:20 p.m. stated she was unaware of the resident's weight loss. The registered dietician (RD) interviewed on 3/5/15, at 11:30 a.m. stated she was aware the resident was losing weight, however she did not know R15 was down to 106 until today when she reviewed it. She stated the resident wanted to lose weight, however did not provide any documentation the resident wanted to lose weight, nor did she discuss the risks and benefits of weight loss with the resident. The physician was not notified of the weight loss. There were no new nutritional interventions implemented to	F 325	revised. Reviewed at monthly nurses meeting and IDT The Clinical Dietitian will be responsible for monitoring compliance and doing weekly audits of weights with Director of Dining Services/Dietitian. Concerns will be reported to QA.	

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F 325	Continued From page 24 avoid ongoing weight loss. The RD stated they only do intake once a month and only weigh the resident once a month as well. The RD verified the resident was not on a supplement and there had not been interventions put into place regarding the ongoing weight loss. The policy titled "Nutrition Risk" revised on 9/2/08, indicated the facility would monitor any resident at nutritional risk of weight loss 5% in one month or 10% in six months. The nursing would report to the RD of any nutritional changes. The policy titled "Weight Changes, Significant" revised on 9/2/08, indicated the facility would ensure the implementation of appropriate interventions in the event of a significant weight change in residents. The facility would notify the physician, family, start weekly weight, monitor food/fluid intake, and dietary modifications as needed.	F 325		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the walker for 1 of 1 resident (R132) had cleanable surfaces. Findings include: On 3/3/15, at 12:59 p.m. during the stage one interview in R132's room, the right side of the	F 465	The foam and duct tape were removed from resident #132 walker. There were no other pieces of equipment identified that needed similar adaptations removed. Therapy staff reviewed that adaptations to equipment must be able to be removed and cleaned. Policy about disinfection of wheelchairs, walkers and commodes	4/14/15

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F 465	Continued From page 25 roller walker hand grip was observed to be built up with foam and affixed to the walker frame with duct tape. R132 verified the walker was used by her and stated the hand grip cushion was added to address her "back pain." R132 stated the walker was provided by the facility. When asked how and when the walker was cleaned, R132 was unclear when the walker was cleaned or by whom. When asked how long duct tape had been used to affix the foam to the walker frame, R132 was unclear how long the duct tape was applied to the walker. The OT (occupational therapy) Daily Treatment Note dated 6/19/14, indicated, "Noted pt's [patient's] built up grip on R [right] walker handle was unraveling and slipping preventing pt from maintaining stable grip during amb. [ambulation]." A follow up note on the same form dated 6/20/14, indicated, "Adjusted pt's built up handle on R side of FWW (four wheeled walker) to decrease pressure during use/ambulation." The note further explained, "Per pt the built up handle had helped to take the pressure off her right hand..." The Care Area Assessments (CAAs) all dated 7/2/14, indicated: ADL Functional/Rehab Potential identified R132 required supervision with mobility tasks; the Falls CAA identified potential balance issues. The CAAs did not identify the use of the walker or built up foam grip. R132's quarterly Minimum Data Set (MDS) dated 12/20/14, identified R132 had moderate cognitive impairment, required supervision with walking and used a walker. The care plan dated 1/13/14, identified a potential for impaired mobility and R132 used a four	F 465	reviewed with housekeeping and nursing staff. Director of housekeeping and Infection Control Nurse will be responsible for monitoring compliance. Housekeeping will audit during daily routines, infection control dept. will do weekly audits. Reports will be made to QA.	

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F 465	Continued From page 26 wheeled walker to ambulate to all destinations. The care plan did not identify the modification to the walker and directed, "Ensure 4WW (four wheeled walker) is working properly." R132's Resident Admission Record dated 3/5/15, identified diagnoses to include neuropathy, vertigo and Sciatica. On 3/5/15, at 9:48 a.m. a housekeeper (H)-A stated if she noticed resident equipment required cleaning or was soiled, she would clean it. H-A stated wheelchairs, walkers and resident equipment was routinely cleaned on the night shift. When asked regarding the last time R132's walker was cleaned, H-A stated R132 was new to the unit and she had not checked the walker. On 3/5/15, at 9:51 a.m. the clinical manager/registered nurse (RN)-D stated R132 was new to the unit and she noticed the duct taped foam on the walker "yesterday." RN-D verified the foam and duct tape were not cleanable surfaces and was unclear when or why they were added. The Catholic Eldercare, Inc. Disinfection - Wheelchairs, Gerichairs, Walkers, and Commodes policy and procedure dated as effective 7/28/06, identified "all pads or adaptive equipment should be removed" and washed separately and replaced after cleaning. The policy identified walkers should be wiped down weekly and as needed.	F 465		

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 _____	**03/10/2015**

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 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 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. Catholic Eldercare on Main, Building 1 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. Catholic Eldercare on Main 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 census of 142 at the time of the survey.	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/10/2015**

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K 000	Continued From page 1 The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		