### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	9BIH	
Eng	11tr ID: 00084	

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MEDICARE/MEDICAID PROVIE     NO.(L1) 245439	DER	3. NAME AND AI (L3) <b>CATHOLIC</b>			N	4. TYPE OF ACTI	<u> </u>	
2. STATE VENDOR OR MEDICAID	) NO	(L4) 817 MAIN S	TREET NOR	THEAST		1. Initial 3. Termination	2. Recertification 4. CHOW	
(L2) 375542800	. 110.	(L5) MINNEAPO	DLIS, MN		(L6) <b>55413</b>	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY	<u>02</u> (L7)			
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After	er Compiaint	
6. DATE OF SURVEY 5/23	3/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR END	ING DATE: (L35)	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		ING DATE. (E33)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILIT	Y IS CERTIFIEI	O AS:				
From (a):		X A. In Compli	ance With		And/Or Approved Waivers Of	The Following Requires	nents:	
To (b):		_	Requirements		2. Technical Personnel	6. Scope of S	Services Limit	
		Compliano	ce Based On:		3. 24 Hour RN	7. Medical D	pirector	
12.Total Facility Beds	<b>150</b> (L18)	1. A	Acceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Ro	om Size	
13.Total Certified Beds	150 (L17)	B Not in Com	pliance with Prog	uram	5. Life Safety Code	9. Beds/Roor	n	
13.Total Collinea Beas			s and/or Applied		* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN	I.			15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
150								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Gloria Derfus, Unit S	Supervisor		5/28/2016	(L19)	K <u>amala Fiske-Downing, Hea</u>	alth Program Repres	entative 6/28/2016 (L20)	
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF ELIGIBI			IPLIANCE WIT	H CIVIL	<ul><li>21. 1. Statement of Fina</li><li>2. Ownership/Control</li></ul>	ncial Solvency (HCFA-25 ol Interest Disclosure Stm		
1. Facility is Eligible to	•	inempher.			3. Both of the Above :			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLU</u>	NTARY	
03/01/1987					01-Merger, Closure	05-Fail to	Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to	Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		der Status Change	
			(L44)			00-Activ	e	
(L27)	B. Rescind St	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAI	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245439

June 28, 2016

Ms. Kimberly King, Administrator Catholic Eldercare On Main 817 Main Street Northeast Minneapolis, MN 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 May 18, 2016 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,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 28, 2016

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

RE: Project Number S5439026

Dear Ms. King:

On April 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 8, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 23, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 6, 2016 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 April 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 18, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 8, 2016, effective May 18, 2016 and therefore remedies outlined in our letter to you dated April 22, 2016, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

### POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION  A. Building		DATE OF RE	VISIT
	B. Wing	Y2	5/23/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOLIC ELDERCARE ON N	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).

ITE Y4			<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5	ITEM Y4			DATE Y5
ID Prefix	483.13(c)(1)(ii)-(	iii) (c)(2)	Correction	ID Prefix Reg. #	F0226 483.13		Correction	ID Prefix	F0274 483.20(b)(2)(ii)		Correction
Reg. # LSC	- (4)		5/18/2016	LSC			O5/18/2016	Reg. # LSC			O5/18/2016
ID Prefix	F0431	C	Correction	ID Prefix	F0441		Correction	ID Prefix	F0456		Correction
Reg. # LSC	483.60(b), (d), (e		Completed 5/18/2016	Reg. # LSC	483.65		Completed 05/18/2016	Reg. # LSC	483.70(c)(2)		Completed 05/18/2016
ID Prefix	F0462		Correction	ID Prefix	F0465		Correction	ID Prefix			Correction
Reg. #	483.70(f)		Completed		483.70		Completed	Reg. #			Completed
LSC		0:	5/18/2016	LSC			05/18/2016	LSC			
ID Prefix		C	Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. # LSC		C	Completed	Reg. # LSC			Completed	Reg. # LSC			Completed
ID Prefix		C	Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. # LSC		C	Completed	Reg. # LSC			Completed	Reg. # LSC			Completed
REVIEWI STATE A		REVIEWED (INITIALS) GD		<b>DATE</b> 6/28/20	16	SIGNATURE OF	SURVEYOR 18623			<b>DATE</b> 5/23	/2016
REVIEWI CMS RO	ED BY	REVIEWED (INITIALS)		DATE	. •	TITLE	.0020			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 4/8/2016			ED ON			R ANY UNCORRECTED DEFICIENCI					s 🗆 no

		POST-0	CERTIFICATIO	N REVISIT F	REPORT	
	DER / SUPPLIER / CLIA /	MULTIPLE CON				DATE OF REVISIT
1DENTIF 245439	FICATION NUMBER )	D Mina	- MAIN BUILDING 01			6/6/2016 <sub>v3</sub>
	OF FACILITY			etheet annhees (	YZ CITY, STATE, ZIP CODE	2 0/0/2010 Y3
	DLIC ELDERCARE ON	MAIN		817 MAIN STREET NO	•	
0,				MINNEAPOLIS, MN 5	5413	
prograr correcte provision	n, to show those deficiently and the date such co	encies previouslorrective action	urveyor for the Medicare, y reported on the CMS-25 was accomplished. Each code previously shown on	67, Statement of Defic deficiency should be for	iencies and Plan of Corre ully identified using either	ction, that have been the regulation or LSC
ITI	EM	DATE	ITEM	DATE	ITEM	DATE
Y	4	Y5	Y4	Y5	Y4	Y5
ID Prefix	<	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC	K0029	05/28/2016	LSC		LSC	
ID Prefix	<	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC		_	LSC		LSC	
ID Prefix	<	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC		_	LSC		LSC	
ID Prefix	·	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC		_	LSC		LSC	
ID Prefix	· ·	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed

Form CMS - 2567B (09/92) EF (11/06)

FOLLOWUP TO SURVEY COMPLETED ON

**REVIEWED BY** 

**REVIEWED BY** 

(INITIALS)

(INITIALS)

LSC

REVIEWED BY

STATE AGENCY

**REVIEWED BY CMS RO** 

4/6/2016

Page 1 of 1

TITLE

SIGNATURE OF SURVEYOR

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

LSC

DATE

DATE

6/28/2016

EVENT ID:

LSC

37009

9B1H22

DATE

DATE

6/6/2016

☐ YES ☐ NO

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 9B1H

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY A	AGENCY		Fac	ility ID: 00984
1. MEDICARE/MEDICAID PROVI NO.(L1) 245439	DER	3. NAME AND ALL (L3) <b>CATHOLIC</b>			IN		4. TYPE O	FACTION:	2 (L8) 2. Recertification
2. STATE VENDOR OR MEDICAL (L2) <b>375542800</b>	D NO.	(L4) 817 MAIN S (L5) MINNEAPO		THEAST	(L6)	55413	3. Termina 5. Validati 7. On-Site	ion	4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO	GORY 09 ESRD	<u>02</u> (L7) <b>13 PTIP</b>	22 CLIA		rvey After Co	
6. DATE OF SURVEY <b>04/</b> 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>08/2016</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEA		DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds  14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SNF 150 (L37) (L38)	150 (L18) 150 (L17) OWN 19 SNF (L39)	Compliance1. A: X B. Not in Con Requirements  ICF  (L42)	ance With equirements e Based On: cceptable POC mpliance with Progrand/or Applied V  IID  (L43)	gram Waivers:	2. Tech3. 24 H4. 7-Da5. Life:	y RN (Rural SN Safety Code B MEETS	6. Scc 7. Me F) 8. Pat 9. Bea (L12)	ope of Servicedical Direct	ces Limit tor
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY	APPROVAL		Date:
Jacob Mabera, HFE	NE II	0	05/03/2016	(L19)	Kamala Fiske-D	Downing, Heal	th Program R	Representa	ative 05/27/2016 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	COFFICE OR	SINGLE ST	TATE AGEN	ICY	
DETERMINATION OF ELIGIBLE	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	2. O	tatement of Finan ownership/Contro oth of the Above	l Interest Disclos		CFA-1513)
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	ΓΙΟΝ ACTION:		(L3	0)
OF PARTICIPATION <b>03/01/1987</b>	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Close		0:	NVOLUNTA	
(L24)	(L41)		(L25)		02-Dissatisfactio		-	6-Fail to Mee	et Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involu 04-Other Reason	=	<u>U</u>	THER	T. C.
(L27)	-	n of Admissions:	(L44)		or other reason	ioi walatawai		/-Provider S 0-Active	Status Change
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
	(L28)	03001		(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	L DATE					

(L33)

DETERMINATION APPROVAL

(L32)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 22, 2016

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

RE: Project Number S5439026

Dear Ms. King:

On April 8, 2016, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the April 8, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5439027 that was found to be unsubstantiated.

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:

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

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

<u>Remedies</u> - 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:

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

### <u>Informal Dispute Resolution</u> - 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 gloria.derfus@state.mn.us Telephone: (651) 201-3792 Fax: (651) 215-9697

#### **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 May 18, 2016, 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

Catholic Eldercare On Main April 22, 2016 Page 2

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 July 8, 2016 (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 October 8, 2016 (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:

Catholic Eldercare On Main April 22, 2016 Page 2

> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program
Health Regulation Division

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 05/03/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` /	E SURVEY IPLETED
		245439	B. WING		<del></del>	04/	08/2016
	PROVIDER OR SUPPLIER	лаin		8	TREET ADDRESS, CITY, STATE, ZIP CODE 17 MAIN STREET NORTHEAST IINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000		of correction (POC) will serve of compliance upon the	F0	000			
	Department's accepenrolled in ePOC, yat the bottom of the	otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will					
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with					
		ne recertification survey tion was also completed at the d survey.					
F 225 SS=D	completed. The cor 483.13(c)(1)(ii)-(iii),	PORT	F 2	225			5/18/16
	been found guilty or mistreating residen had a finding entered registry concerning of residents or misa and report any known court of law against indicate unfitness for	of employ individuals who have if abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a transpropriation and employee, which would for service as a nurse aide or to the State nurse aide registry ties.					
	·	sure that all alleged violations					
LABORATOR'	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

04/29/2016

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245439	B. WING	·····	04	/08/2016
	PROVIDER OR SUPPLIER	MAIN		STREET ADDRESS, CITY, STATE, ZIP COE 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	involving mistreatm including injuries of misappropriation of immediately to the to other officials in a through established State survey and control of the facility must have a violations are thorough established of the facility must have a violations are thorough event further pote investigation is in pure to the administrator representative and with State law (includent, and if the state of the state o	ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law I procedures (including to the ertification agency).  Eve evidence that all alleged ughly investigated, and must ential abuse while the rogress.  Evestigations must be reported	F2	25		
	by: Based on interview facility failed to ens of mistreatment, brunwitnessed falls wadministrator and thimmediately for 3 o R28) reviewed for a Findings include: Unwitnessed fall wirth R133's quarterly Mi			F 225  Facility reporting requirements/expectations for unknown origin will be reviewed staff. Vulnerable reporting an prohibition policies have been and updated. Weekly IDT mediated to monitor and aud reporting guidelines have been Administrator and DON are refor compliance.  Results will be brought to the Assurance committee.	ed will all d abuse reviewed eetings will it that n followed. esponsible	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	_		E SURVEY PLETED
		245439	B. WING			04/0	08/2016
	PROVIDER OR SUPPLIER	MAIN		STREET ADDRESS, CITY, ST 817 MAIN STREET NORTH MINNEAPOLIS, MN 554	HEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPF ICIENCY)	BE	(X5) COMPLETION DATE
F 225	assistance with act Review of R133's F 10/15/15 to 1/8/16, dated 12/12/15, at R133 had unwitnes sent to the emerge When the facility co 12/12/15, at 11:19 a had been admitted hip.  Review of the facilit Report dated 12/14 on the floor on 12/14 the facility's vulnera dated 12/18/15, rev floor on 12/12/15, a complained of "rigl was laterally rotated the left leg". The ini indicated that R133 and had sustained fall.  On 3/8/16, at 11:35 nursing (DON) stat facility was to imme the administrator ac had fallen on 12/12 SA was not comple following the incide	deded extensive staff ivities of daily living (ADL's).  Resident Progress Notes from revealed a progress note 4:00 a.m. which indicated sed fall in her room. R133 was ncy room (ER) by ambulance. Ontacted the hospital on a.m. they were informed R133 to the hospital with a fractured ty's Vulnerable Adult Initial v15, revealed R133 was found 2/15, at 4:00 a.m. Review of able adult investigative report realed R133 was found on the at 4:00 a.m. and R133 and leg pain and her right leg d and shorter in length than restigative report further a was sent to ER for evaluation a right hip fracture from the a.m. the facility's director of ed the usual practice for the rediately report the incident to a.m. The DON verified R133 v15, however the report to the reduction at the ted until 12/14/15, two days of the SA was not submitted	F 2	25			
		imum Data Set (MDS) dated					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245439	B. WING		<del> </del>	04/	08/2016
	PROVIDER OR SUPPLIER	<i>I</i> IAIN		817	EET ADDRESS, CITY, STATE, ZIP CODE MAIN STREET NORTHEAST NEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	2/7/16, identified Reimpairment and new assistance with ADI Review of R64's Re 1/13/16 to 4/8/16, redated 3/15/16, at 12 noted with pale ligh of her neck on 3/14 indicated the bruise origin.  Review of the facility Report dated 3/15/16 greenish bruises or report indicated R6 to strangle her". Readult investigative rafacility staff working resident's neck on 3 them.	64 had moderate cognitive eded extensive staff L's.  esident Progress Notes from evealed a progress note 2:34 p.m., indicating R64 was t green bruising on back sides /16. The progress note es on R64 were of unknown  by's Vulnerable Adult Initial left, revealed R64 had pale in either side of her neck. The 4 stated another resident "tried view of the facility's vulnerable eport dated 3/22/16, revealed ing on 3/11/16, saw bruises on 3/11/16, but did not report	F 2	25			
	bruises were first ich facility staff member bruising did not reputated on 3/14/15 the bruises and inition DON verified the bruises and should have be administrator and Sof unknown origin vadministrator until the four days after the Inverbal Abuse R28's quarterly Min 12/22/15, identified	A immediately. R64's bruises were not reported to the hree days later and the SA bruising was fist identified.  imum Data Set (MDS) dated R28 had moderate cognitive eded extensive staff					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245439	B. WING		04/	/08/2016
	PROVIDER OR SUPPLIER	<b>MAIN</b>		STREET ADDRESS, CITY, STATE, ZIP C 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 225	indicated that R28 of facility staff, when a and mind your own dinner time. Review of the facilitic Report dated 12/29 reported to the unit that they overheard say to R28 "shut up business" on 12/27 the facility's vulnerarevealed a note dat two facility staff over "shut up and mind you two different occasidining room eating During interview on acknowledged that witnessed the incident witnessed the incident in the SA two days aft stated the incident of the administrator and A facility policy titled Prevention and Investment of abused The policy directed report to the administrator are swearing at a reside member toward a resident swearing at a resident stated the residual of the policy defined of the policy defined of the policy defined of the swearing at a residual of the policy defined of the policy de	cy's Resident Incident Report was verbally abused by a facility staff told R28 "shut up business" on 12/27/15, during cy's Vulnerable Adult Initial /15, revealed a facility staff nurse manager on 12/28/15, another facility staff member of and mind your own damn /15, during dinner. Review of able adult investigative file ed 12/29/15, which indicated erhead a staff member tell R28 your own damn business" on sons while R28 was in the dinner on 12/27/15.  4/8/16, at 11:35 a.m. the DON the two facility staff who ent did not report the incident of the DON verified that the not informed until one day and er the incident. The DON needed to be reported to both	F 2	25		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY IPLETED
		245439	B. WING		04/	08/2016
	PROVIDER OR SUPPLIER	<b>MAIN</b>	8	STREET ADDRESS, CITY, STATE, ZIP CODE 117 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE
F 226 SS=D	policies and proced mistreatment, negle and misappropriation.  This REQUIREMENT by: Based on interview facility failed to impensure immediate rof mistreatment, brunwitnessed fall with Agency (SA) and thresidents (R133, Reference) In addition failed to for 2 of 5 newly hire Findings include:  A facility policy titled Prevention and Investment of abused The policy directed report to the admining the second process.	ETC POLICIES  Evelop and implement written	F 226	,	I all use ewed es will t owed. sible ty be vised.	5/18/16
	member toward a r swearing at a resid- it needed to be repo SA immediately. Th screening of all em	verbal abuse by a staff esident as any shouting or ent and the policy directed that orted to the administrator and he policy further directed ployees and references were to the offer of employment.  th a major injury		conduct random audits and report and Quality Assurance meeting.	ai	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245439	B. WING _		04/	/08/2016
	ROVIDER OR SUPPLIER	MAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Report dated 12/14, on the floor on 12/1 the facility's vulnera dated 12/18/15, rev floor on 12/12/15, a complained of "righwas laterally rotated the left leg". The invindicated that R133 room (ER) for evaluating fracture from the On 3/8/16, at 11:35 nursing (DON) state facility was to immethe administrator ar had fallen on 12/12/SA was not completed following the incident initial report to the facilit Report dated 3/15/13 greenish bruises on report indicated R6/12/16, revealed the vulnerable adult inv 3/22/16, revealed the 3/11/16, saw bruise but did not report the On 4/8/16, at 11:35 bruises were first id	y's Vulnerable Adult Initial /15, revealed R133 was found 2/15, at 4:00 a.m. Review of ble adult investigative report ealed R133 was found on the t 4:00 a.m. and R133 It leg pain and her right leg d and shorter in length than vestigative report further was sent to the emergency lation. She sustained a right e fall.  a.m. the facility's director of ed the usual practice for the ediately report the incident to and SA. The DON verified R133 /15, however the report to the ted until 12/14/15, two days and the DON acknowledged the SA was not submitted  a origin.  y's Vulnerable Adult Initial lef, revealed R64 had pale a either side of her neck. The 4 had stated another resident r". Review of the facility's estigative report dated and a facility staff working on s on R64's neck on 3/11/15,	F 2:	26		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245439	B. WING _		04	/08/2016	
	PROVIDER OR SUPPLIER	1AIN		STREET ADDRESS, CITY, STATE, ZIP COD 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 226	did not report them. 3/14/15, the unit may and initiated an investive been reported immediately. R64's were not reported to days and the SA for member initially ide Verbal Abuse Review of the facilit Report dated 12/29 member reported to 12/28/15, that they member say to R28 damn business" on Review of the facilit investigative file revindicating two facilit member tell R28 "s damn business" on R28 was in the dinit On 4/8/16, at 11:35 the two facility staff did not report the in DON verified the acuntil one day and the incident. The DON be reported to both immediately. Reference Checks Review of employed (E) 3 was hired on 11/25/15. Review of evidence of profess completed prior to the Review of E4's persof professional reference of the service of professional reference of professional re	The DON further stated on an ager discovered the bruises estigation. The DON verified unknown origin and should to the administrator and SA bruises of unknown origin the administrator until three ar days after a facility staff entified the bruising.  The property of the unit nurse manager on overheard another facility staff of the unit nurse manager on overheard another facility staff of the unit nurse district of the unit nurse manager on overheard another facility staff of the unit nurse manager on overheard another facility staff of the unit nurse manager on the unit nurse district of the unit nurse manager on overheard another facility staff of the unit nurse manager on the unit of the uni	F 22	26			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245439	B. WING		04	1/08/2016	
	PROVIDER OR SUPPLIER	лаin		STREET ADDRESS, CITY, STATE, ZIP COD 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE	
F 274 SS=D	coordinator (SC) st for E3 were done b documentation to d stated E4 used to v rehired. SC further reference checks where the checks where the completed prior to a DON further stated expectation was to rehire with their present the employee was the reference.  483.20(b)(2)(ii) CO AFTER SIGNIFICA A facility must condust assessment of a refacility determines, that there has been resident's physical purpose of this second means a major decresident's status the itself without further implementing standinterventions, that hone area of the resequires interdiscip care plan, or both.)	a.m. the facility's staffing ated professional references ut could not provide any emonstrate it was done. SC work at the facility and was stated no professional were done for E4.  a.m. the DON stated the rofessional references to be an offer of employment. The for rehired employees the discuss with their potential vious supervisor at the facility. It is in good standing that was	F2			5/18/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245439	B. WING		04/0	08/2016	
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CATUOL	IO EL DEDOADE ON I			817 MAIN STREET NORTHEAST			
CATHOL	IC ELDERCARE ON	MAIN		MINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 274	Based on intervie facility failed to con assessment within determines, or sho a significant chang mental condition for sample reviewed for Findings include:  R107's Physician C3/11/16-4/11/16, incomplete A 11/16 and A progress note dawas admitted to ho of Alzheimer's dise Data Set's (MDS's) indicated R107 was During interview or registered nurse (Fhospice since 9/16)  During interview or MDS coordinator schange MDS when they change hospic verified R107 was did not do a sig [sig she went on hospic I do not know why During interview or director of nurses scoordinator to set u goes on and off ho Catholic Eldercare Resident Assessm	w and document review, the implete a comprehensive 14 days after the facility and have determined there was e in the residents physical or or 1 of 1 resident (R107) in the or hospice.  Order Report dated dicated R107 was on hospice. Atted 9/16/15, indicated R107 is pice with a terminal diagnosis is ase. R107's quarterly Minimum of dated 11/16/15, and 2/16/16, is on hospice.  A 4/7/16, at 1:41 p.m. RN)-A verified R107 was on 1/15.  A 4/7/16, at 2:30 p.m. RN-B tated, "We do a significant in they start on hospice and if they start on hospice and if they start on hospice." RN-B on hospice. RN-B stated "We gnificant] change MDS after the said she expected the MDS up a MDS when a resident	F 2	It is the practice of Catholic comprehensively assess al using the RAI process. Sig change MDS for resident 1 process. Significant changreviewed with MDS departrosed to identify residents worders who would require a change assessment. DON coordinator are responsible compliance.  Random MDS audits will be members of the nursing mateam and reports will be measurance meeting.	Il residents gnificant 07 is in the requirements ment in regards eetings are vith Hospice a significant I and MDS e for the completed by anagement		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245439	B. WING		04/08/2016	
	PROVIDER OR SUPPLIER	<b>JAIN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 274	laws following the F the RAI manual and CMS [Centers for N Services]."	dance with state and federal RAI guidelines established in d other sites mandated by Medicare and Medicaid	F 2	74		
F 431 SS=E	indicated a significate assessment was as admitted on a 483.60(b), (d), (e) [	-	F 4	31		5/18/16
	a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in orde	nploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable antion; and determines that drug r and that an account of all maintained and periodically				
	labeled in accordar professional princip appropriate access	als used in the facility must be ace with currently accepted bles, and include the ory and cautionary e expiration date when				
	facility must store a locked compartmen	State and Federal laws, the III drugs and biologicals in Ints under proper temperature to only authorized personnel to keys.				
	permanently affixed	ovide separately locked, I compartments for storage of ted in Schedule II of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245439	B. WING _		04/	04/08/2016	
	PROVIDER OR SUPPLIER	//AIN		STREET ADDRESS, CITY, STATE, ZIP CC 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 431	Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected.	ug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can	F 4:	31			
	by: Based on observat review facility failed medications were re carts on 3 of 3 units  Findings Include:  During medication s at 7:53 a.m. a bottle was found in a secon an expiration date of name on the bottle as stock. Licensed verified the bottle of stated, "No one use (aspirin) through the  During medication s at 8:39 a.m. a bottle in a first floor medic date of 1/16. There bottle and the bottle The trained medica the aspirin expired	ion, interview, and record to ensure that expired emoved from 4 medication and 1 medication room.  Storage observation on 4/8/16, of aspirin 81 milligram (mg) and floor medication cart with a 3/16. There was no resident and the bottle was not labeled practical nurse (LPN)-A f aspirin was expired and es that because it comes a dispenser."  Storage observation on 4/8/16, of aspirin 81 mg was found eation cart with an expiration was no resident name on the e was not labeled as stock. It in a 1/16. TMA-A said "I think it in the machine. These are		Expired medications have be from medication carts and m rooms. Education on expect regarding expired meds will be routine TMA/Nurse meetings memos. DON and nurse may be responsible for compliance Members of the nursing man team will conduct random au medication rooms and medication rooms and medication rooms are at the CAssurance meeting.	edication ations be done at and with anagers will be agement dits of the eation carts.		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	MAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORRESTIVE ACTION OF CORRECT CORRESTIVE ACTION OF CORRECT	ULD BE	(X5) COMPLETION DATE
F 431	(antacid) with an exported in the third flow shelf behind an under nurse (RN)-A verification at the state of the expired. RN-A state all staff that come is check expiration date. The state of the expiration date of the state o	en bottle of Geri-Lanta (piration date of 2/16, was por medication room on the opened bottle. Registered ed the bottle of medication was ed it was the responsibility of into the medication room to ates on medications. RN-A said I check expiration dates before storage observation on 4/8/16, e of Benadryl 25 mg for R141 if floor medication cart with an /14/15. TMA-B verified the stated R141 was not using liew of R141's undated current eat aday PRN (as needed for g backwards). R141's undated d R141 had diagnoses of Alzheimer's disease.  of Tylenol 325 mg for R164 if floor medication cart with an ewas unreadable. TMA-B le to read when the medication ed and stated R164 was using 325 mg. TMA-B said, "Maybe a PRN." A review of R164's ders indicated R164 had an 100 mg give two tablets but did	F4	31		

AND DUAN OF CODDECTION INDENTIFICATION NUMBER			IPLE CONSTRUCTION  IG	` '	(X3) DATE SURVEY COMPLETED	
		245439	B. WING _	B. WING		/08/2016
	PROVIDER OR SUPPLIER	MAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 431	carts and rooms for was discontinued s process was the character to go through the cabusy and leaving not done. The monthly audit med carts and the facility switched dispensing machine "There are still som is having us keep spills in bottles." The	ige 13 by audits of the medication of expired medications but that ix months ago. The new harge nurses and TMA's were harts together. Staff was too oftes for each other to get it TMA meeting was used to did med rooms. The DON stated to an Omnicell medication the in 10/15. The DON said, the problems so the pharmacy ome of the over the counter to DON stated the bottle of the been pulled from the	F 4:	31		
F 441 SS=E	Medications, Biolog revised 1/1/13 instrensure that medica an Expiration Date been retained longer manufacturer or sushould destroy and biologicals with soil incomplete, damag 483.65 INFECTION SPREAD, LINENS  The facility must estinfection Control Prasafe, sanitary and control to help prevent the of disease and infe	l Program tablish an Infection Control	F 44	11		5/18/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245439	B. WING		04/08/2016	
	PROVIDER OR SUPPLIER	<b>MAIN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	in the facility; (2) Decides what poshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spreading (1) When the Infect determines that a reprevent the spreadisolate the resident (2) The facility mus communicable disefrom direct contact direct contact will tr (3) The facility mus hands after each din hand washing is incorposessional practice (c) Linens Personnel must har	ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective afections.  Read of Infection ion Control Program esident needs isolation to of infection, the facility must asse or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 44			
	by: Based on observative review the facility fareusable resident umanner in 2 of 3 reand 1 of 3 medicative potential to affe	NT is not met as evidenced tion, interview and document ailed to store community se ice packs in a sanitary sident nourishment freezers on room freezers. This had ct 50 of 50 residents who floor and 47 of 47 residents on		F 441  All patient re-usable ice packs have removed from kitchenette/med rook refrigerator freezer. Ice packs measuse with med cart cooler have been labeled and are stored in a plastic Re-usable ice packs have been eliminated and we are purchasing	om ant for n bag.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		245439	B. WING		04/	08/2016	
	PROVIDER OR SUPPLIER	MAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 441	p.m. a tour was coreach floor with the (DDS).  The first floor kitchearea freezer contairesident name stick Frost ice packs were obsequenced bread, and box of ice packs were obsequenced bread, and box of ice packs were they are usually key RN-D confirmed thein the kitchenette from the kitchenette from the kitchenette from the second floor kitcheakfast area free large Jack Frost ice packs, 1 Igloo ice packs, 1 Igloo ice packs, 1 Igloo ice packs, 1 Igloo ice packs of ice cream sherbet cups, and a bag of frozen veget RN-C confirmed theice packs were resinot be stored in the resident food. RN-C and Ice Brix ice packs medications cold if resident personal ushould be kept in the stored in the should be kept in the stored in the resident personal ushould be kept in the stored in the should be kept in the stored in the should be kept in the stored in t	chen tour on 4/5/16 at 12:00 inducted of the kitchenette on Director of Dietary Services enette continental breakfast med one large ice bag with a ker (R161), 2 medium Jack d 1 3M Nexcare ice pack. The served in the freezer next to the error container, 3/4 loaf of ce cream container, 3/4 loaf of ce cream sandwiches.  The medication room.  The ice packs should not be kept error was observed to contain 2 error wa	F 441	packs that are re-fillable and wi individual use only. They will be with resident name and stored i room.  Policy on ice pack usage and stored through routine meetings and mand through routine meetings and mand room daily and the resider assistants will check the kitcher refrigerators daily. Nursing Mand Dietary Director are response compliance.  Dietary Director and Nursing Mand Will conduct random audits and be reported at Quality Assurance.	e marked in resident torage has one nemos. irs in the at nette nagement sible for anagement results will		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		X3) DATE SURVEY COMPLETED	
		245439	B. WING _		04	/08/2016	
	PROVIDER OR SUPPLIER	MAIN		STREET ADDRESS, CITY, STATE, ZIP CO 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413			
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F 441	placed them in the the ice packs were in the freezer.  The DDS was unavice packs being sto The DDS stated sh staff cleaning schedard for the transfer of the packs should not be freezers. The DON packs should not be freezers or next to unaware of a speciuse ice packs.  On 4/8/16 at 11:33 Educator (RN)-E coon the storage or unaware of the storage of the	vare of resident personal use ored in the kitchenette freezers.	F 44	.1			
	registered nurse (F to clean ice packs I	14/8/16, at 7:53 a.m. IN)-C stated, "I instructed staff pefore putting them in the med in to not put supplements on cation this week."					
	director of nurses ( not be in the freeze	4/08/16, at 11:20 a.m. the DON) said, ice packs should or with food. The DON further s were a single use item then					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	G	(X3) DATE SURVEY COMPLETED		
		245439	B. WING		04/0	08/2016
	PROVIDER OR SUPPLIER	<b>I</b> AIN		STREET ADDRESS, CITY, STATE, ZIP CODE 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 F 456	to be kept separate the medication roor	N said she would expect them from food or supplements in	F 44			5/18/16
SS=E	OPERATING CONIT The facility must ma mechanical, electric equipment in safe of the control of th	caintain all essential cal, and patient care operating condition.  NT is not met as evidenced ion, interview, and document ailed to maintain equipment in notition for those residents who he ice machines out of the first and second floor. This affect 45 of 50 residents on 0 of 47 residents on the rector of Dietary Services d confirmed the following the first floor kitchenette had d the basin, the drain was ant water and floating debris		The ice machine drip tray has been replaced on 1st and 2nd floor Resident Assistants and Housekeep will be educated on filling out work of water is not draining properly out tray  A preventative program is in place to hot water in tray daily to keep water flowing through drain tube. Also, resussistants will be cleaning and sanit tray once daily as well as housekee staff once daily. The ice machine porevised to reflect this. All resident assistants and housekeeping staff veducated on new procedure. Direct Dietary and Director of Laundry/housekeeping are respons compliance.  Random audits will be done by the Director of Laundry/Housekeeping are results will be reported at Quality Assurance meeting.	pers orders of drip o pour sident tizing ping olicy is will be tor of	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		245439	B. WING		04/	08/2016
NAME OF PROVIDER OR SUPPLIER  CATHOLIC ELDERCARE ON MAIN				STREET ADDRESS, CITY, STATE, ZIP CODE 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413	COMPLETED  04/08/2016  T ADDRESS, CITY, STATE, ZIP CODE  NIN STREET NORTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
F 456	Continued From particles and maintained by the and maintained by the not the dietary depart on 4/8/16 at 9:20 at tour with Director of maintenance employ observations were discontinuous to have lime build upgrate of the basin. The ice machine or observed to have lime the basin. The ice machine or observed to have lime and the grate of the and stagnant water. The DM and M-A stof the condition of the stated that nursing responsible for clear that the ice machine and the properties of the condition of the stated that nursing responsible for clear that the ice machine and maintained the properties of the condition of the stated that nursing responsible for clear that the ice machine and maintained the properties of the propert	ge 18  It ice machines were cleaned the maintenance department artment.  I.m. during the environmental Maintenance (DM) and oyee (M)-A the following confirmed:  In the first floor was observed p around the basin and the The drain was plugged and floating debris was observed in the second floor was me build up around the basin. The drain was plugged was observed in the basin.  In the second floor was me build up around the basin basin. The drain was plugged was observed in the basin.  In the second floor was me build up around the basin basin. The drain was plugged was observed in the basin.  In the second floor was me build up around the basin.  In the second floor was me build up around the basin.  In the second floor was plugged was observed in the basin.	F 4.	,		
	department had the month water filter of were checked at the should inform main basins "are bad like the basin. M-A state water in the drain bowas plugged. DM a responsibility of the inform them of any immediately. DM a	tice machine on an every 6 hange. The ice machines at time. M-A stated that staff tenance when the ice machine this one" as he could replace at that there should be no asin and confirmed the drain and M-A stated that it was the nursing or dietary staff to issues so they could fix them and M-A stated that work alle at every nursing station.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245439	B. WING		04/0	08/2016
	PROVIDER OR SUPPLIER	//AIN	8	STREET ADDRESS, CITY, STATE, ZIP CODE B17 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 456 F 463 SS=D	maintenance depart addressed immedia addressed immedia addressed immedia addressed immedia addressed immedia and at 11:20 a.m department was resice machines in the floor. Any facility state expected to contact environmental issue address the cleaning kitchenette ice mach 483.70(f) RESIDEN ROOMS/TOILET/B	at a work order or call the tment and problems were ately.  Director of Nursing (DON) on revealed the dietary sponsible for maintaining the kitchenette areas on each aff using the equipment were maintenance with any less needing to be addressed.  If, there was no facility policy to ag or maintenance of the thines.  IT CALL SYSTEM -	F 456			5/18/16
	by: Based on observatoreview, the facility functioning for 1 of Findings include: On 4/5/16, at 2:41 pfunction properly. Tactivate R116's call the resident hallway	ion, interview and document ailed to ensure call lights were 40 resident (R116) reviewed.  o.m. R116's call light did not hree attempts were made to light before it was activated in //.		F 463  The call light cord for room 116 R h been replaced. All call lights have leaded by housekeeping staff and working properly. All call lights are monitored and checked by houseke staff twice weekly and documented chart listing room numbers and dat checked. All housekeeping staff has been educated on procedure for fill work requests promptly if a call light	been d are eeping on a e ave ing out	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		245439	B. WING _	····	04/	08/2016
	THOLIC ELDERCARE ON MAIN  STREET ADDRESS, CITY, STATE, ZIP CODE  817 MAIN STREET NORTHEAST  MINNEAPOLIS, MN 55413					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	"thought it worked to push the button a too long, she went to the staff what she in Registered nurse (Ficall light was not fur confirmed R116's conseven times before RN-D stated that should contact main During the environma.m. maintenance of fixed R116's call light unaware that the caprior to that date. The (DM) stated that malights and there was light audits in his definition and the shown if call maintenance slips where the director of nurse 4/8/16, at 11:20 a.m. "formal process" in light was not function was a "priority repart department and nur if a call light did not Although requested policy related to call 483.70(h)	hat way" and she always had a few times. If she had to wait to the hallway herself and told needed.  RN)-D was informed R116's nctioning. RN-D observed and all light had to be pushed the call light was activated. In the call light was activated. In the call light was activated. In the call light was activated and tenance.  In ental tour on 4/8/16, at 9:28 employee (M)-A confirmed he had ton 4/5/16. M-A was all light was not functioning the director of maintenance aintenance did not check call as not a current system for call expartment. DM stated nursing I lights were not working, and were available at the nursing were available at the nursing sing (DON) was interviewed on a light and stated there was not a place to determine if a call pring. However indicated this ir" for the maintenance function properly.  If the facility did not have a	F 46	found to be not working properly of Laundry/Housekeeping and D Maintenance are responsible for compliance. Random audits will be done by t Director of Laundry/Housekeeping results will be reported at Quality Assurance meeting.	irector of ne ng and	5/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245439	B. WING			04/0	08/2016	
	PROVIDER OR SUPPLIER	<i>I</i> IAIN		817 MAI	ADDRESS, CITY, STATE, ZIP CODE N STREET NORTHEAST APOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 465	Continued From partial The facility must present and comformation of the facility and comformation of the facility and the following was on the facility who were set to facility who were set to facility who were set on the following was on the following was on the facility who were set on the following was on the following was on the following was on the facility who were set on the following was on the following was on the following was on the following was on the facility who were set on the following was	ge 21 ovide a safe, functional, ortable environment for the public.  NT is not met as evidenced tion, interview and document ailed to follow equipment s that would minimize the orne illness. This had the 46 of 146 residents in the erved food out of the kitchen.	F 4	F 4 Ran 5/11 clea Clea rang Staf sign Dire com Dinii rand	DEFICIENCY)	ning on ar deep aning of ining nd omplete. or		
	stove top were obs greasy build up with debris. The DDS c stovetop knobs was was a schedule to d	erved to have thick brown n a thick layer of dust and onfirmed the area of the s "not clean" and that there clean the ovens on the tary staff was responsible to						
		ervices Cleaning Sheets uties of "Stove-clean burners						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245439	B. WING _			04/0	8/2016
	PROVIDER OR SUPPLIER	<b>MAIN</b>		STREET ADDRESS, CITY, STATE, ZIP COE 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413	)E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		COMPLETION
F 465	the "am cook" and 'sheets were review 1/4/16-4/3/16 and w staff as completed. include cleaning the knobs of the stove that the cleaning shifthe areas on the stokitchen tour were not consider the fall of 2014.  A policy was provide and Range dated Jufollowing procedure soaking overnight in buildup to be easily non-removable part rinsed and sanitized that daily cleaning is checklist daily and consider the service of the serv	ch included a sign off for both 'pm cook". The cleaning ed for the dates of vere signed off by the dietary. The cleaning sheets did not e knobs or area between the top. The DDS also confirmed leets were filled out however ove observed during the ot clean.  I.m. the DDS provided urveyor that the last time the land by the company was in leed entitled Cleaning of Oven less: Oven grates may require in a diluted degreaser to allow	F 40	65			

PRINTED: 05/03/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245439 04/06/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **817 MAIN STREET NORTHEAST** CATHOLIC ELDERCARE ON MAIN MINNEAPOLIS, MN 55413 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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, State Fire Marshal Division on April 6, 2016. 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 TO:** Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITI F

Electronically Signed

04/29/2016

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.

Facility ID: 00984

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, ,	TIPLE CONSTRUCTION NG <b>01 - Main Building 01</b>		E SURVEY MPLETED	
		B. WING		04	04/06/2016		
NAME OF PROVIDER OR SUPPLIER  CATHOLIC ELDERCARE ON MAIN			STREET ADDRESS, CITY, STATE, ZIP CODE  817 MAIN STREET NORTHEAST  MINNEAPOLIS, MN 55413				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUS FOLLOWING INFO  1. A description of to correct the defice  2. The actual, or properties of the correct the defice  3. The name and/oresponsible for corprevent a reoccurr.  Catholic Eldercare building with no bac constructed at four building was constructed at four building was constructed to be 1983, an addition viside of the building type II(222) constructed to the was determined to construction. In 19 constructed to the was determined to construction. Becathe additions meet for existing building one building.  The building is full The facility has a find detection in the cocorridors that is midepartment notifice.	state.mn.us and n@state.mn.us  PRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:  what has been, or will be, done	KO				

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

PRINTED: 05/03/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G 01 - Main Building 01		SURVEY PLETED	
		245439	B, WING _	<del></del>	04/0	6/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETIO DATE	
K 000	Continued From p time of the survey The requirement a NOT MET as evid	at 42 CFR, Subpart 483.70(a) is	K 00				
K 029 SS=B	One hour fire rate fire-rated doors) of extinguishing systiand/or 19.3.5.4 properties and/or 19.3.5 properties are singled protes and	d construction (with o hour or an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. When omatic fire extinguishing system exareas are separated from moke resisting partitions and self-closing and non-rated or ctive plates that do not exceed the bottom of the door are		The replacement doors and door the soiled utility rooms across fro and 316 were ordered on April 19 Doors will be installed as soon as received. Director of Maintenance responsible for compliance.  Random audits of facility doors we conducted by maintenance staff. will be reported at Quality Assura meeting.	m 216 ith, 2016. ie is ill be Results	5/28/16	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00984



Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted April 22, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5439026

Dear Ms. King:

The above facility was surveyed on April 5, 2016 through April 8, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5439027 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES

Catholic Eldercare On Main April 22, 2016 Page 2

ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 05/03/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00984	B. WING		04/0	8/2016
	PROVIDER OR SUPPLIER	ΛΔIN 817 MAIN	DRESS, CITY, S STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000 Initial Comments		2 000				
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all a rule provided at the tag alle number indicated below. In the several items, failure to the items will be considered be a becompliance upon any item of multi-part rule will ment of a fine even if the item aring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these tawritten request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 04/29/16

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00984	B. WING		04/0	8/2016
	PROVIDER OR SUPPLIER	ΛΔΙΝ 817 MAIN	DRESS, CITY, S STREET NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department be State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be state Licensing federal software. To assigned to Minnesota Department be state Licensing federal software. To state Licensing federal software. To state and replaces the "To column entitled "ID statute/rule out of c "Summary Statement and replaces the "To correction order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Corpus PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLAAPPLIES TO FEDE	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  surveyors of this visited the above provider and tion orders are issued. our electronic plan of have reviewed these orders, e when they will be completed. The ent of Health is documenting and numbers have been total state statutes/rules for the prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the	2 000			

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ATE SURVEY OMPLETED	
			A. BOILDING.			
		00984	B. WING		4/08/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	ΛΔΙΝ	STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
		complaint, H5439027 was mplaint was not substantiated.				
2 545	MN Rule 4658.0400 Resident Assessme	O Subp. 3 A-C Comprehensive ent; Frequency	2 545		5/18/16	
	assessments must A. within 14 day B. within 14 day the resident's physi	by. Comprehensive resident be conducted: s after the date of admission; a after a significant change in cal or mental condition; and every 12 months.				
	by: Based on interview facility failed to com assessment within determines, or shou a significant changemental condition for sample reviewed for Findings include: R107's Physician C 3/11/16-4/11/16, inc A progress note day was admitted to how of Alzheimer's disease	order Report dated dicated R107 was on hospice. ted 9/16/15, indicated R107 spice with a terminal diagnosis ase. R107's quarterly Minimum dated 11/16/15, and 2/16/16,		It is the practice of Catholic Eldercare to comprehensively assess all residents using the RAI process. Significant chan MDS for resident 107 is in process. Significant change requirements review with MDS department in regards to Hospice. Weekly IDT meetings are use to identify residents with Hospice orders who would require a significant change assessment. DON and MDS coordinat are responsible for compliance. Random MDS audits will be completed members of the nursing management team and reports will be made to Qualit Assurance meeting.	ed ed ed or by	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00984	B. WING		04/0	8/2016
	PROVIDER OR SUPPLIER	ΛΔΙΝ 817 MAIN	DRESS, CITY, S STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 545	During interview on registered nurse (R hospice since 9/16/ During interview on MDS coordinator st change MDS when they change hospic verified R107 was odid not do a sig [sig she went on hospic I do not know why was a sessment was ap was admitted on a long survey of the RAI manual and CMS [Centers for M Services]."	4/7/16, at 1:41 p.m. N)-A verified R107 was on 15.  4/7/16, at 2:30 p.m. RN-B ated, "We do a significant they start on hospice and if es or come off hospice." RN-B on hospice. RN-B stated "We nificant] change MDS after e. We should have done one, we did not do it."  1 4/08/16, at 12:47 p.m. the aid she expected the MDS p a MDS when a resident spice.  Policy and Procedure: ent Process indicated, "The esment instrument] process is dance with state and federal RAI guidelines established in dother sites mandated by Medicare and Medicaid  3.0 manual dated 10/14, ant change of status opropriate when a resident hospice benefit.	2 545	DEFICIENCY)		
	develop systems to MDS's are complete DON or designee c	DON) or designee could ensure significant change ed in a timely manner. The ould educate all appropriate lesignee could develop to ensure ongoing				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00984	B. WING	<del></del>	04/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	IAIN	STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 545	Continued From pa	ge 4	2 545			
	compliance.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			5/18/16
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and com E. a resident he immunization progradefined in part 465 procedures of resid the prevention and F. the development of the procedures of resid the prevention and F. the development of the procedures which affed disinfectants, antised incontinence products. In methods for the procedures which affed disinfectants, antised incontinence products.	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; nent and implementation of dicies and infection control a tuberculosis program as 8.0815; reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and				
	This MN Requirements	ent is not met as evidenced				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	
		00984	B. WING		04/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
CATHOL	IC ELDERCARE ON I	MAIN	STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21390	Based on observative review the facility fareusable resident unanner in 2 of 3 reand 1 of 3 medicative potential to afferesided on the first the second floor.  Findings Include:  During the initial kitp.m. a tour was coreach floor with the (DDS).  The first floor kitchearea freezer containesident name stick Frost ice packs and ice packs were obseed Sea Salt Gelato ice bread, and box of ice.  At that time register the ice packs were they are usually key RN-D confirmed the in the kitchenette from the second floor kitbreakfast area free.	ion, interview and document ailed to store community is ice packs in a sanitary sident nourishment freezers on room freezers. This had ict 50 of 50 residents who floor and 47 of 47 residents on the community of the community sident nourishment freezers on room freezers. This had ict 50 of 50 residents who floor and 47 of 47 residents on the community of the kitchenette on the community of the kitchenette on the community of the kitchenette on the community of t	21390	All patient re-usable ice packs have removed from kitchenette/med rown refrigerator freezer. Ice packs me use with med cart cooler have been abeled and are stored in a plastic Re-usable ice packs have been el and we are purchasing ice packs re-fillable and will be for individual only. They will be marked with resoname and stored in resident room Policy on ice pack usage and store been written. Training will be done through routine meetings and mer TMA's will check the refrigerators med room daily and the resident assistants will check the kitchenet refrigerators daily. Nursing Managand Dietary Director are responsible compliance.  Dietary Director and Nursing Managand Conduct random audits and resident assistants at Quality Assurance in the provided state of the provided state of the packs of the pac	om ant for en bag. iminated that are use sident . age has e nos. in the te gement ole for agement sults will	
	ice packs, 1 Igloo ic pack. The ice pack boxes of ice cream sherbet cups, and a bag of frozen veget	e packs, 6 medium Jack Frost ce pack and 1 Ice Brix ice ks were in the freezer with 2 sandwiches, 8 ice cream and an unmarked, undated half tables. at the 2 large and 6 medium				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00984	B. WING		04/0	8/2016	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CATHOLIC ELDERCARE ON	MAIN	STREET NO OLIS, MN 55				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
not be stored in the resident food. RN-and Ice Brix ice pare medications cold it resident personal is should be kept in the and cleaned after someone must has placed them in the the ice packs were in the freezer.  The DDS was unaice packs being stored the being	sident use ice packs and should be kitchenette freezer with C confirmed the Igloo ice pack cks were used to keep if needed and were not for use. RN-C stated the ice pack the medication room freezer each use. RN-C stated we used the ice packs and then freezer. RN-C was unaware if the cleaned before being placed ware of resident personal use pred in the kitchenette freezers.	21390				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00984	B. WING		04/0	8/2016	
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
CATHOL	IC ELDERCARE ON N	ΛΑΙΝ	STREET NO OLIS, MN 5				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21390	Continued From pa	ge 7	21390				
	room and told them them. I did the educ	to not put supplements on cation this week."					
	director of nurses ( not be in the freeze stated the ice packs thrown out. The DC	4/08/16, at 11:20 a.m. the DON) said, ice packs should r with food. The DON further s were a single use item then DN said she would expect them from food or supplements in m.					
	director of nursing ( develop sysems to appropriately and e	THOD OF CORRECTION: The (DON) or designee could ensure ice packs are stored ducate nursing staff on the or designee could monitor the ngoing compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21426	MN St. Statute 144 Prevention And Cor	A.04 Subd. 3 Tuberculosis	21426			5/18/16	
	maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volume Health shall provide	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease attion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of etechnical assistance intation of the guidelines.					

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Minnesc	<u>ita Department of He</u>	alth				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00984	B. WING		04/08/2016	
NAME OF		CTDEET AD	DDECC OITY	CTATE ZID CODE	•	
NAIVIE OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I	ΛΔΙΝ	STREET NO	_		
	Г		OLIS, MN 5			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
21426	Continued From pa	ne 8	21426			
21120	•		21120			
		ance with this subdivision must				
	be maintained by th	ne nursing home.				
	This MN Requireme	ent is not met as evidenced				
	by:					
	Based on interview	and document review, the		21426		
		sure 2 of 5 employees (E-1,				
		aluation and documentation for		E1 is no longer an employee of Ca		
		g and screening. In addition,		Eldercare. E2 has been schedule		
		ensure 1 of 5 residents (R108)		to the clinic for a medical evaluation		
		p of Tuberculin Skin Test		R108 had his mantoux administer		
		mmended per State		4/6 and was read on 4/8 with a res		
	guidelines.			zero millimeters. TB policies have		
	Findings include:			reviewed and revised. Staff educate be done at routine meetings and r		
	i indings include.			Infection Control nurse and DON a		
	Employees			responsible for compliance.	ai C	
		review revealed a hire date of		Random audits will be conducted	weekly	
		e tuberculosis symptoms		by the Infection Control nurse.		
		ed on 7/11/15, a step one		will be made to Quality Assurance	•	
	Tuberculin Skin Tes			meeting.		
	administered on 7/1	11/15, and read on 7/14/15,		_		
	with 0 millimeters (r					
		file contained a document				
		a 3/1/15 date on the top of the				
		his letter is to inform you of				
		ults" of TB skin test 0				
		egative. However the				
		vidence of when the "recent" I including date of TST				
		or reading of the results.				
	aummonanum anu/	or reading or the results.				
	E-2's personnel file	review revealed a hire date of				
		he tuberculosis symptoms				
		ed on 9/22/15, and the first				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00984	B. WING		04/0	08/2016
	PROVIDER OR SUPPLIER	ΛΔΙΝ 817 MAIN	DRESS, CITY, S' STREET NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	step of TST was ad as "5 mm", and neg was administered of and read as "12 mm chest x-ray result didicated the chest however there was evaluation identifying.  Residents: R108's electronic madmission date of screening was comstep TST was admired as 0 mm on 1 administered on 12 evidence the result.  On 4/6/16, at 2:41 pc (RN-E)/infection constant Residents and Resident Re	Iministered on 9/22/15, read gative. The second step TST in 12/23/15 (3 months later), in "", positive. There was a lated 1/4/16 in E-2's file, which x-ray was within normal limits, no evidence of a medical ing no active infection.  Interest of the TST symptoms pleted on 11/27/15, the first inistered on 11/27/15, and 1/29/15. The second TST was 1/11/15, however there was no was read.  Interest of the TST symptoms pleted on the TST's 48 to inistration. RN-E reviewed and the documentation from the second the TST reading. RN-E and stated they relied on the ne accurate assessments tested positive with TST are of the TST assessments tested positive with TST accompleted to rule out TB.  Culosis- Resident Screening - sision Surveillance policy and sed on 3/15/16, indicated bened for TB on admission	21426			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00984	B. WING		04/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	<b>ΛΑΙΝ</b>	STREET NO			
	T	MINNEAP	OLIS, MN 5		_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 10	21426			
21426	11/16/15, indicated Mantoux are screen to the Infection Corn Services. The Infection Health Services will Occupational Health Chest x-ray." the pomust be cleared for x-ray must be obtain employment/orients clearly reflect curre.  Regulation for Tube Health Care Setting Health Care Worke "TST documentation the test (i.e., month millimeters of indured document "0" mm) positive or negative. In addition the regulation the regulation that the set used to test TB Before the HCW has following should be 1. Test result, 2. Assessment for calcal test used to test TB Before the HCW has following should be 1. Test result, 2. Assessment for calcal test used to test TB Before the HCW has following should be 1. Test result, 2. Assessment for calcal test used to test TB Before the HCW has following should be 1. Test result, 2. Assessment for calcal test used to test TB Before the Chest X-ray should be 1. Test result, 2. Assessment for calcal test used to test TB done within the three TST/IGRA is acceptable not been expossince the chest X-ray 4. Medical evaluation infectious TB disease.	"Persons with a positive ned for symptoms and referred atrol Nurse/Director of Health tion Control Nurse/Director of refer person to our holicy further indicated "A person work or a negative chest ned before beginning ation." The policy did not not regulatory guidelines.  Perculosis Control in Minnesota as dated 7/13, Screening rs (HCW's) directed: In should include the date of ation (if no induration, and interpretation (i.e., and interpretation (i.e., and interpretation (i.e., and interpretation to the documented in their record:  Perculosis Control in Minnesota as dated 7/13, Screening rs (HCW's) directed: In should include the date of ation (if no induration, and interpretation (i.e., and interpretation (i.e., and interpretation (i.e., and interpretation (i.e., and interpretation to the documented in their record:  Perculosis Control in Minnesota as dated 7/13, Screening rs (HCW's) directed: In should include the date of ation (if no induration, and interpretation (i.e., and interpretati	21426			
		HOD OF CORRECTION: sing (DON) or designee could				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00984	B. WING	<del></del>	04/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	ΛΔΙΝ	STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE COMPLE	
21426 21610	review and/or revision procedures to ensure screened for physic active TB disease of The DON or design appropriate staff or could develop a moongoing compliance.  TIME PERIOD FOR (21) days.	e the current TB policies and are all residents and staff are cal signs and symptoms of con admission. The could educate the at the policies/procedures, and conitoring system to ensure es.  CORRECTION: Twenty one	21426			5/18/16
	must store all drugs under proper tempor only authorized nur access to the keys.  This MN Requirements: Based on observation review facility failed medications were rearts on 3 of 3 units.  Findings Include:  During medication at 7:53 a.m. a bottle was found in a second an expiration date on ame on the bottle as stock. Licensed verified the bottle of the second authorized the second authorized the second temporary and temporary and temporary and temporary and temporary and temporary and temp	e of drugs. A nursing home in locked compartments are ture controls, and permit sing personnel to have  ent is not met as evidenced on, interview, and record to ensure that expired emoved from 4 medication and 1 medication room.  Storage observation on 4/8/16, of aspirin 81 milligram (mg) and floor medication cart with of 3/16. There was no resident and the bottle was not labeled practical nurse (LPN)-A faspirin was expired and as that because it comes to dispenser."		Expired medications have been refrom medication carts and medications. Education on expectations regarding expired meds will be do routine TMA/Nurse meetings and memos. DON and nurse manage be responsible for compliance. Members of the nursing managent team will conduct random audits of medication rooms and medication Reports will be made at the Qualit Assurance meeting.	tion s ne at with ers will nent f the carts.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00984	B. WING		04/0	8/2016
	PROVIDER OR SUPPLIER	MAIN 817 MAIN	ORESS, CITY, S STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	During medication of at 8:39 a.m. a bottle in a first floor medic date of 1/16. There bottle and the bottle The trained medicat the aspirin expired [aspirin] comes from back up medication at 8:52 a.m. an oper (antacid) with an exfound in the third flow shelf behind an unconurse (RN)-A verification expired. RN-A state all staff that come in check expiration dat "As a nurse I would I gave it."  During medication of at 8:58 a.m. a bottle was found in a third expiration date and the Benadryl. A reviorders indicated R1 Allergy 25 mg twice tremors and leaning face sheet indicated allergic rhinitis and In addition, a bottle was found in a third expiration date that verified being unab	storage observation on 4/8/16, e of aspirin 81 mg was found eation cart with an expiration was no resident name on the e was not labeled as stock. tion aide (TMA)-A verified that in 1/16. TMA-A said "I think it in the machine. These are	21610			

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AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00984	B. WING		04/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	<b>1ΔΙΝ</b>	STREET NO			
0(0.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	OLIS, MN 5			(X5)
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	ILD BE COMPLETE	
21610	0 Continued From page 13		21610			
	they are using it for undated current ordorder for Tylenol 50 not have on order for During interview on director of nurses (I be expired medication rooms." been a recent chan used to do quarterly carts and rooms for was discontinued si process was the ch to go through the cabusy and leaving not done. The monthly audit med carts and the facility switched dispensing machine "There are still som is having us keep spills in bottles." The	325 mg. TMA-B said, "Maybe a PRN." A review of R164's ders indicated R164 had an 0 mg give two tablets but did or Tylenol 325 mg.  4/08/16, at 9:26 a.m. the DON) said, "There should not ion in the carts, nor the The DON said there had ge in the process. Omnicare a audits of the medication expired medications but that its months ago. The new arge nurses and TMA's were arts together. Staff was too oftes for each other to get it TMA meeting was used to a med rooms. The DON stated to an Omnicell medication in 10/15. The DON said, e problems so the pharmacy ome of the over the counter DON stated the bottle of e been pulled from the				
	Medications, Biolog revised 1/1/13 instruensure that medicate an Expiration Date of been retained longer manufacturer or supshould destroy and biologicals with soil incomplete, damage	torage and Expiration of icals Syringes and Needles ucted staff "Facility should tions and biologicals: 4.1 Have on the label; 4.2 Have not er than recommended by opplier guidelines;" "6. Facility reorder medications and ed, illegible, worn, makeshift ed or missing labels."				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	ATE SURVEY OMPLETED		
		00984	B. WING	o	4/08/2016
	PROVIDER OR SUPPLIER	MAIN 817 MAIN	ORESS, CITY, S STREET NO OLIS, MN 5	<del>-</del>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	carts and rooms for labeling. The DON licensed staff and T could develop moni ongoing compliance	ensure monitoring of med expired and improper/illegible or designee could educate all MA's. The DON or designee toring systems to ensure	21610		
21695	Subp. 4. Houseke provide housekeep necessary to maintacomfortable interior	Subp. 4 Plant eration, & Maintenance eping. A nursing home must ng and maintenance services ain a clean, orderly, and , including walls, floors, ixtures, equipment, lighting,	21695		5/18/16
	by: Based on observati review, the facility for cleaning procedure possibility of food b potential to affect 1- facility who were set  Findings include:  During the kitchen to the following was of Director of Dining Set	ent is not met as evidenced on, interview and document ailed to follow equipment is that would minimize the orne illness. This had the 46 of 146 residents in the rved food out of the kitchen.  our on 4/7/16 at 12:33 p.m. oserved and confirmed by the ervices (DDS): e was observed to have the stove top. The DDS stove top "definitely has build		21695 Range is scheduled for deep cleaning o 5/11/16 and will be put on a regular deep cleaning schedule once per year. Cleaning list revised to include cleaning range knobs and area between. Dining Staff educated on cleaning lists and signing after specific cleaning is comple Director of Dietary is responsible for compliance. Dining Supervisor/Manager will conduct random audits and results will be reported at Quality Assurance meeting	of re.

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00984	B. WING		04/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	ΛΑΙΝ	STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	time the stove top verification in the stove top were observed by build up with debris. The DDS constovetop knobs was a schedule to weekends. The diecomplete.  Review of Dining Sincluded cleaning dat end of shift" which the "am cook" and outlier to be something to the "am cook" and outlier to be stoved by the "am cook" and outlier to be stoved by the "am cook" and outlier to be stoved by the stove top weekends.	she was not aware of the last was cleaned and that they tside company to come and area between the knobs of the erved to have thick brown a thick layer of dust and onfirmed the area of the s'not clean" and that there clean the ovens on the tary staff was responsible to ervices Cleaning Sheets uties of "Stove-clean burners the included a sign off for both "pm cook". The cleaning				
	staff as completed. include cleaning the knobs of the stove that the cleaning shifther areas on the stokitchen tour were not consider the fall of 2014.  A policy was provided and Range dated J following procedure soaking overnight in buildup to be easily	vere signed off by the dietary The cleaning sheets did not e knobs or area between the top. The DDS also confirmed neets were filled out however ove observed during the ot clean.  I.m. the DDS provided urveyor that the last time the aned by the company was in ed entitled Cleaning of Oven uly 29, 2008 that included the es: Oven grates may require on a diluted degreaser to allow or removed and all				
	rinsed and sanitized	ts are cleaned with detergent, d. The policy also included s done per the cleaning				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONTILOTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII	LLILD
		00984	B. WING		04/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	ΛΔΙΝ	STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21695	checklist daily and range is done on w checklist.  SUGGESTED MET director of maintenadevelop systems to of facility equipment	deep cleaning of ovens and eekends per the cleaning  THOD OF CORRECTION: The ance (DM) or designee could ensure appropriate claening t. The DM or designee could	21695			
	develop monitoring compliance.  TIME PERIOD FOR (21) days.	iate staff. The DM could systems to ensure ongoing  R CORRECTION: Twenty-one				
21990	Subd. 4. Reporting immediately make a entry point. Use of for the deaf or othe considered an oral point may not requirent possible, the content to identify the caregiver, the nature maltreatment, any of maltreatment, the reporter, the time, of incident, and any of reporter believes method the suspected malt reporter may disclosin section 13.02, and section 144.335, to comply with this suite.	ig. A mandated reporter shall an oral report to the common a telecommunications device r similar device shall be report. The common entry re written reports. To the report must be of sufficient he vulnerable adult, the re and extent of the suspected evidence of previous name and address of the date, and location of the ther information that the light be helpful in investigating reatment. A mandated se not public data, as defined ad medical records under the extent necessary to	21990			5/18/16

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00984	B. WING		04/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	<b>ΛΑΙΝ</b>	STREET NO			
(VA) ID	SHIMMA DV STA	TEMENT OF DEFICIENCIES	OLIS, MN 5		)N	(VE)
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	OULD BE COMPLETE	
21990	Continued From pa	ge 17	21990			
	by: Based on interview facility failed to ens of mistreatment, brunwitnessed falls wadministrator and the immediately for 3 or R28) reviewed for a Findings include: Unwitnessed fall with R133's quarterly Mith 12/7/15, identified Fimpairment and new assistance with active Review of R133's F10/15/15 to 1/8/16, dated 12/12/15, at R133 had unwitnessent to the emerger When the facility control of the second se	and document review, the ure that all alleged allegations uises of unknown origin and ith injury were reported to the ne state agency (SA) f 5 residents (R133, R64, abuse.  th a major injury  nimum Data Set (MDS) dated R133 had moderate cognitive eded extensive staff vities of daily living (ADL's).  Resident Progress Notes from revealed a progress note 4:00 a.m. which indicated sed fall in her room. R133 was ncy room (ER) by ambulance. Intacted the hospital on		Facility reporting requirements/expectations for injuunknown origin will be reviewed w staff. Vulnerable reporting and ab prohibition policies have been reviand updated. Weekly IDT meeting be utilized to monitor and audit that reporting guidelines have been fol Administrator and DON are responder compliance.  Results will be brought to the Qual Assurance committee.	ill all use ewed gs will at lowed. nsible	
		a.m. they were informed R133 to the hospital with a fractured				
	Report dated 12/14 on the floor on 12/1 the facility's vulneradated 12/18/15, revision on 12/12/15, a complained of "right was laterally rotated the left leg". The invindicated that R133	y's Vulnerable Adult Initial /15, revealed R133 was found 2/15, at 4:00 a.m. Review of able adult investigative report realed R133 was found on the at 4:00 a.m. and R133 at leg pain and her right leg d and shorter in length than restigative report further awas sent to ER for evaluation a right hip fracture from the				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00984	B. WING		04/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I	MAIN	STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	Continued From page 18		21990			
	nursing (DON) state facility was to imme the administrator at had fallen on 12/12 SA was not comple following the incide the initial report to t timely.	a.m. the facility's director of ed the usual practice for the ediately report the incident to and SA. The DON verified R133/15, however the report to the ted until 12/14/15, two days ant. The DON acknowledged he SA was not submitted				
	Bruises of unknowr	n origin.				
	2/7/16, identified Re	imum Data Set (MDS) dated 64 had moderate cognitive eded extensive staff L's.				
	Review of R64's Resident Progress Notes from 1/13/16 to 4/8/16, revealed a progress note dated 3/15/16, at 12:34 p.m., indicating R64 was noted with pale light green bruising on back sides of her neck on 3/14/16. The progress note indicated the bruises on R64 were of unknown origin.					
	Report dated 3/15/greenish bruises or report indicated R6 to strangle her". Readult investigative rafacility staff worki	ty's Vulnerable Adult Initial 16, revealed R64 had pale in either side of her neck. The 4 stated another resident "tried eview of the facility's vulnerable report dated 3/22/16, revealed ing on 3/11/16, saw bruises on 3/11/16, but did not report				
	On 4/8/16, at 11:35 a.m. the DON verified the bruises were first identified on 3/11/15 but the facility staff member who initially observed the bruising did not report them. The DON further					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00984	B. WING		04/0	8/2016	
	PROVIDER OR SUPPLIER	AAIN 817 MAIN	ORESS, CITY, S STREET NO OLIS, MN 5				
(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 SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE COMPLETE		
21990	stated on 3/14/15 the bruises and initit DON verified the brand should have be administrator and Sof unknown origin vadministrator until the four days after the IVerbal Abuse R28's quarterly Min 12/22/15, identified impairment and new assistance with ADI Review of the facility indicated that R28 value facility staff, when a and mind your own dinner time. Review of the facility Report dated 12/29 reported to the unit that they overheard say to R28 "shut up business" on 12/27 the facility's vulnerare revealed a note dat two facility staff over "shut up and mind your own different occasion dining room eating During interview on acknowledged that witnessed the inciduntil the next day. Tadministrator was after SA two days after the SA two days	ne unit manager discovered ated an investigation. The uises were of unknown origin pen reported to the standard investigation. The standard investigation. The uises were not reported to the standard investigation and the SA pruising was fist identified.  Immum Data Set (MDS) dated R28 had moderate cognitive edded extensive staff L's.  Ty's Resident Incident Report was verbally abused by a facility staff told R28 "shut up business" on 12/27/15, during ty's Vulnerable Adult Initial vy's Vulnerable Adult Initial v	21990				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00984	B. WING		04/0	8/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	ΛΑΙΝ	STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLET	
21990	A facility policy titled Prevention and Invindicated the facility prevention of abuse The policy directed report to the admin actual/suspected in The policy defined member toward a result swearing at a residueded to be report SA immediately.  SUGGESTED MET administrator or deator ensure immediate abuse/neglect allegates designee could edu. The administrator or systems to ensure	d Abuse and Neglect estigation revised on 2/22/16, will be proactive in its e/neglect of vulnerable adults. facility staff to immediately istrator and state agency any icidents of abuse or neglect. werbal abuse by a staff esident as any shouting or ent. The policy directed that it ted to the administrator and THOD OF CORRECTION: The signee could develop systems be reporting of potential pations. The administrator or icate all staff on the systems. For designee could monitor the ongoing compliance.	21990			
21995	Maltreatment of Vu Subd. 4a. Interna (a) Each facility sh ongoing written pro applicable licensing of suspected maltre facility has an intern mandated reporter requirements of this internally. Howeve	I reporting of maltreatment. all establish and enforce an ocedure in compliance with grules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting r, the facility remains applying with the immediate	21995			5/18/16

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AND PLAN OF CORRECTION IDENTIF	ICATION NUMBER:		E CONSTRUCTION	(X3) DATE :	
00984	1	B. WING		04/0	8/2016
NAME OF PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 04/0	0/2010
		STREET NO			
CATHOLIC ELDERCARE ON MAIN		OLIS, MN 5			
(X4) ID SUMMARY STATEMENT OF D PREFIX (EACH DEFICIENCY MUST BE PRI TAG REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995 Continued From page 21		21995			
This MN Requirement is not not by: Based on interview and docum facility failed to implement their ensure immediate reporting of of mistreatment, bruises of und unwitnessed fall with major injut Agency (SA) and the administration residents (R133, R64, R28) really addition failed to check professor of 5 newly hired employed.  A facility policy titled Abuse and Prevention and Investigation resindicated the facility will be proprevention of abuse/neglect of The policy directed facility staff report to the administrator and actual/suspected incidents of a The policy defined verbal abus member toward a resident and the it needed to be reported to the SA immediately. The policy fur screening of all employees and to be checked prior to the offer Unwitnessed fall with a major in Review of the facility's Vulnera Report dated 12/14/15, revealed on the floor on 12/12/15, at 4:00 a.m. complained of "right leg pain a was laterally rotated and shorted."	nent review, the rabuse policy to alleged allegations known origin and cury to the State rator for 3 of 5 viewed for abuse. essional references es (E3, E4).  d Neglect evised on 2/22/16, active in its vulnerable adults. It to immediately state agency any abuse or neglect. It is eby a staff any shouting or policy directed that administrator and ther directed direferences were rof employment.  Injury  ble Adult Initial ed R133 was found to a.m. Review of vestigative report and R133 and her right leg	21995	Facility reporting requirements/expectations for injuunknown origin will be reviewed w staff. Vulnerable reporting and abprohibition policies have been reviand updated. Weekly IDT meetin be utilized to monitor and audit that reporting guidelines have been fol Administrator and DON are respotor compliance.  Results will be brought to the Quatassurance committee.  Reference check requirements with reviewed with all staff who hire.  Reference check form has been resulting managers are responsible to completing reference checks. He conduct random audits and report Quality Assurance meeting	rill all puse gewed gs will at lowed. Ity libe evised. for the will be great with the great will be great will be great with the great will be great with the great win	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
		00984	B. WING		04/	08/2016
	PROVIDER OR SUPPLIER	AAIN 817 MAIN	DRESS, CITY, S STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21995	indicated that R133 room (ER) for evaluating fracture from the On 3/8/16, at 11:35 nursing (DON) state facility was to immet the administrator are had fallen on 12/12 SA was not comple following the incided the initial report to the timely.  Bruises of unknown Review of the facility Report dated 3/15/13 greenish bruises or report indicated R6. "tried to strangle he vulnerable adult inv 3/22/16, revealed the 3/11/16, saw bruises but did not report the On 4/8/16, at 11:35 bruises were first indicated an inverse who in the bruises were of have been reported to the days and the SA for member initially ide Verbal Abuse	was sent to the emergency vation. She sustained a right e fall.  a.m. the facility's director of ed the usual practice for the ediately report the incident to and SA. The DON verified R133/15, however the report to the ted until 12/14/15, two days and the SA was not submitted  n origin.  by's Vulnerable Adult Initial 16, revealed R64 had pale an either side of her neck. The 4 had stated another resident or." Review of the facility's restigative report dated and a facility staff working on s on R64's neck on 3/11/15, tem.  a.m. the DON verified the lentified on 3/11/15, but facility nitially observed the bruising anager discovered the bruises restigation. The DON verified unknown origin and should to the administrator and SA bruises of unknown origin the administrator until three are days after a facility staff	21995			

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AND FLAN OF CORRECTION IDENTIFICATION NOWIBER.  A. BUILDING:		
00984 B. WING 04/08/2	04/08/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOLIC ELDERCARE ON MAIN  817 MAIN STREET NORTHEAST  MINNEAPOLIS, MN 55413		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)    CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)   CACH DEFICIENCY   PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Report dated 12/29/15, revealed a facility staff member reported to the unit nurse manager on 12/28/15, that they overheard another facility staff member say to R28 "shut up and mind your own damn business" on 12/27/15, during dinner. Review of the facility's vulnerable adult investigative file revealed a note dated 12/29/15, indicating two facility staff overhead a staff member tell R28 "shut up and mind your own damn business" on two different occasions while R28 was in the dining room on 12/27/15. On 4/8/16, at 11:35 a.m. the DON acknowledged the two facility staff who witnessed the incident did not report the incident until the next day. The DON verified the administrator was not informed until one day and the SA two days after the incident. The DON stated the incident needed to be reported to both the administrator and SA immediately. Reference Checks Review of employee roster revealed employee (E) 3 was hired on 1/18/16, and E4 was hired on 11/25/15. Review of E3's personnel record lacked evidence of professional reference checks being completed prior to the offer of employment. Review of E4's personnel record lacked evidence of professional reference checks being completed prior to the offer of employment.  On 4/8/16, at 10:27 a.m. the facilitys staffing coordinator (SC) stated professional references for E3 were done but could not provide any documentation to demonstrate it was done. SC stated E4 used to work at the facility and was rehired. SC further stated no professional reference checks were done for E4.  On 4/8/16, at 11:29 a.m. the DON stated the expectation is for professional references to be		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		DATE SURVEY COMPLETED	
7.1.12 . 27.11	o. cozo		A. BUILDING:				
		00984	B. WING		04/0	8/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CATHOLIC ELDERCARE ON MAIN  817 MAIN STREET M MINNEAPOLIS, MN							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21995	5 Continued From page 24						
	DON further stated expectation was to rehire with their pre	for rehired employees the discuss with their potential vious supervisor at the facility. s in good standing that was					
	administrator or de- to ensure the consi facility abuse/negle designee could edu implementation of t	HOD OF CORRECTION: The signee could develop systems stent implementation of the ct policy. The administrator or locate all staff on the consistent he facility policy. The signee could develop to ensure ongoing					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
23010	MN Rule 4658.4638 Construction	5 A Nurse Call System; New	23010			5/18/16	
	communication sys from the resident a required by this par system, if electrical connected to the er Nurse calls and em of being inactivated central annunciator	must be equipped with a tem designed to receive calls and nursing service areas t. The communication be powered, must be mergency power supply. The regency calls must be capable a lonly at the points of origin. A must be provided where the rom the nurses' station.					
	resident's bed. Cal communication dev they are within read from a resident mu	must be provided for each I cords, buttons, or other vices must be placed where ch of each resident. A call st register at the nurses' ght outside the resident					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00984	B. WING		04/0	8/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 04/0	0/2010	
		817 MAIN	STREET NO				
CATHOL	IC ELDERCARE ON I	MINNEAP	OLIS, MN 5	5413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
23010	Continued From page 25 23010						
	bedroom, and activ medication room, n room, soiled utility r multi-corridor nursi	ate a duty signal in the ourishment area, clean utility room, and sterilizing room. In any units, visible signal lights t corridor intersections.					
	by: Based on observati review, the facility f functioning for 1 of Findings include: On 4/5/16, at 2:41 p function properly. T activate R116's call the resident hallway R116 was interview "thought it worked t to push the button a too long, she went the staff what she r  Registered nurse (I call light was not fu confirmed R116's o seven times before RN-D stated that sh would contact main  During the environr a.m. maintenance of fixed R116's call lig unaware that the call	red at this time and stated she hat way" and she always had a few times. If she had to wait to the hallway herself and told needed.  RN)-D was informed R116's nctioning. RN-D observed and all light had to be pushed the call light was activated. nould be fixed immediately and		The call light cord for room 116 R been replaced. All call lights have checked by housekeeping staff ar working properly. All call lights are monitored and checked by housestaff twice weekly and documente chart listing room numbers and dachecked. All housekeeping staff heen educated on procedure for fi work requests promptly if a call lig found to be not working properly. of Laundry/Housekeeping and Dir Maintenance are responsible for compliance.  Random audits will be done by the Director of Laundry/Housekeeping results will be reported at Quality Assurance meeting.	been id are exceping d on a ite nave lling out ht is Director ector of		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00984	B. WING		04/0	3/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 04/00	5/2010
		817 MAIN	STREET NO	•		
CATHOL	IC ELDERCARE ON N	MINNEAP	OLIS, MN 5	5413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
23010	O Continued From page 26					
	"lets us know" if cal	epartment. DM stated nursing I lights were not working, and were available at the nursing				
	4/8/16, at 11:20 a.m "formal process" in light was not function was a "priority repa	sing (DON) was interviewed on an and stated there was not a place to determine if a call oning. However indicated this ir" for the maintenance rsing should alert maintenance function properly.				
	Although requested policy related to cal	I, the facility did not have a I light audits.				
	The director or mai could develop syste light use which inclu testing of call light f could educate all ap	THOD FOR CORRECTION: ntenance (DM) or designee ems of ensuring consistent call uded the routine random unction. The DM or designee opropriate staff. The DM could systems to ensure ongoing				
	TIME PERIOD FOR Twenty-One (21) da					

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