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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9B1H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00984

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **5/23/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
__ 1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 6/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 6/28/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Minnesota Department of Health

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245439 Y1	A. Building B. Wing Y2	5/23/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0225	Correction	ID Prefix	F0226	Correction	ID Prefix	F0274	Correction
Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. #	483.13(c)	Completed	Reg. #	483.20(b)(2)(ii)	Completed
LSC		05/18/2016	LSC		05/18/2016	LSC		05/18/2016
ID Prefix	F0431	Correction	ID Prefix	F0441	Correction	ID Prefix	F0456	Correction
Reg. #	483.60(b), (d), (e)	Completed	Reg. #	483.65	Completed	Reg. #	483.70(c)(2)	Completed
LSC		05/18/2016	LSC		05/18/2016	LSC		05/18/2016
ID Prefix	F0463	Correction	ID Prefix	F0465	Correction	ID Prefix		Correction
Reg. #	483.70(f)	Completed	Reg. #	483.70(h)	Completed	Reg. #		Completed
LSC		05/18/2016	LSC		05/18/2016	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		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	6/28/2016	18623	5/23/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/8/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245439	A. Building 01 - MAIN BUILDING 01 B. Wing	6/6/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 05/28/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 6/28/2016	SIGNATURE OF SURVEYOR 37009	DATE 6/6/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/6/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9B1H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00984

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/08/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date : Jacob Mabera, HFE NE II 05/03/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 05/27/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

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

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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. 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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. In addition during the recertification survey complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5439027 was completed. The complaint was unsubstantiated.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	F 225		5/18/16

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

Electronically Signed | 04/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that all alleged allegations of mistreatment, bruises of unknown origin and unwitnessed falls with injury were reported to the administrator and the state agency (SA) immediately for 3 of 5 residents (R133, R64, R28) reviewed for abuse. Findings include: Unwitnessed fall with a major injury R133's quarterly Minimum Data Set (MDS) dated 12/7/15, identified R133 had moderate cognitive	F 225	F 225 Facility reporting requirements/expectations for injuries of unknown origin will be reviewed will all staff. Vulnerable reporting and abuse prohibition policies have been reviewed and updated. Weekly IDT meetings will be utilized to monitor and audit that reporting guidelines have been followed. Administrator and DON are responsible for compliance. Results will be brought to the Quality Assurance committee.	

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F 225	Continued From page 2	F 225		

impairment and needed extensive staff assistance with activities of daily living (ADL's).

Review of R133's Resident Progress Notes from 10/15/15 to 1/8/16, revealed a progress note dated 12/12/15, at 4:00 a.m. which indicated R133 had unwitnessed fall in her room. R133 was sent to the emergency room (ER) by ambulance. When the facility contacted the hospital on 12/12/15, at 11:19 a.m. they were informed R133 had been admitted to the hospital with a fractured hip.

Review of the facility's Vulnerable Adult Initial Report dated 12/14/15, revealed R133 was found on the floor on 12/12/15, at 4:00 a.m. Review of the facility's vulnerable adult investigative report dated 12/18/15, revealed R133 was found on the floor on 12/12/15, at 4:00 a.m. and R133 complained of "right leg pain and her right leg was laterally rotated and shorter in length than the left leg". The investigative report further indicated that R133 was sent to ER for evaluation and had sustained a right hip fracture from the fall.

On 3/8/16, at 11:35 a.m. the facility's director of nursing (DON) stated the usual practice for the facility was to immediately report the incident to the administrator and SA. The DON verified R133 had fallen on 12/12/15, however the report to the SA was not completed until 12/14/15, two days following the incident. The DON acknowledged the initial report to the SA was not submitted timely.

Bruises of unknown origin.

R64's quarterly Minimum Data Set (MDS) dated

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F 225	Continued From page 3 2/7/16, identified R64 had moderate cognitive impairment and needed extensive staff assistance with ADL'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. Review of the facility's Vulnerable Adult Initial Report dated 3/15/16, revealed R64 had pale greenish bruises on either side of her neck. The report indicated R64 stated another resident "tried to strangle her". Review of the facility's vulnerable adult investigative report dated 3/22/16, revealed a facility staff working on 3/11/16, saw bruises on resident's neck on 3/11/16, but did not report them. 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 stated on 3/14/15 the unit manager discovered the bruises and initiated an investigation. The DON verified the bruises were of unknown origin and should have been reported to the administrator and SA immediately. R64's bruises of unknown origin were not reported to the administrator until three days later and the SA four days after the bruising was fist identified. Verbal Abuse R28's quarterly Minimum Data Set (MDS) dated 12/22/15, identified R28 had moderate cognitive impairment and needed extensive staff assistance with ADL's.	F 225		

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F 225	Continued From page 4 Review of the facility's Resident Incident Report indicated that R28 was verbally abused by a facility staff, when a facility staff told R28 "shut up and mind your own business" on 12/27/15, during dinner time. Review of the facility's Vulnerable Adult Initial Report dated 12/29/15, revealed a facility staff 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, which indicated 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 eating dinner on 12/27/15. During interview on 4/8/16, at 11:35 a.m. the DON acknowledged that the two facility staff who witnessed the incident did not report the incident until the next day. The DON verified that 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. A facility policy titled Abuse and Neglect Prevention and Investigation revised on 2/22/16, indicated the facility will be proactive in its prevention of abuse/neglect of vulnerable adults. The policy directed facility staff to immediately report to the administrator and state agency any actual/suspected incidents of abuse or neglect. The policy defined verbal abuse by a staff member toward a resident as any shouting or swearing at a resident. The policy directed that it needed to be reported to the administrator and SA immediately.	F 225		

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse policy to ensure immediate reporting of alleged allegations of mistreatment, bruises of unknown origin and unwitnessed fall with major injury to the State Agency (SA) and the administrator for 3 of 5 residents (R133, R64, R28) reviewed for abuse. In addition failed to check professional references for 2 of 5 newly hired employees (E3, E4). Findings include: A facility policy titled Abuse and Neglect Prevention and Investigation revised on 2/22/16, indicated the facility will be proactive in its prevention of abuse/neglect of vulnerable adults. The policy directed facility staff to immediately report to the administrator and state agency any actual/suspected incidents of abuse or neglect. The policy defined verbal abuse by a staff member toward a resident as any shouting or swearing at a resident and the policy directed that it needed to be reported to the administrator and SA immediately. The policy further directed screening of all employees and references were to be checked prior to the offer of employment. Unwitnessed fall with a major injury	F 226	F 226 Facility reporting requirements/expectations for injuries of unknown origin will be reviewed will all staff. Vulnerable reporting and abuse prohibition policies have been reviewed and updated. Weekly IDT meetings will be utilized to monitor and audit that reporting guidelines have been followed. Administrator and DON are responsible for compliance. Results will be brought to the Quality Assurance committee. Reference check requirements will be reviewed with all staff who hire. Reference check form has been revised. Hiring managers are responsible for completing reference checks. HR will conduct random audits and report at Quality Assurance meeting.	5/18/16

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F 226	Continued From page 6	F 226		

Review of the facility's Vulnerable Adult Initial Report dated 12/14/15, revealed R133 was found on the floor on 12/12/15, at 4:00 a.m. Review of the facility's vulnerable adult investigative report dated 12/18/15, revealed R133 was found on the floor on 12/12/15, at 4:00 a.m. and R133 complained of "right leg pain and her right leg was laterally rotated and shorter in length than the left leg". The investigative report further indicated that R133 was sent to the emergency room (ER) for evaluation. She sustained a right hip fracture from the fall.

On 3/8/16, at 11:35 a.m. the facility's director of nursing (DON) stated the usual practice for the facility was to immediately report the incident to the administrator and SA. The DON verified R133 had fallen on 12/12/15, however the report to the SA was not completed until 12/14/15, two days following the incident. The DON acknowledged the initial report to the SA was not submitted timely.

Bruises of unknown origin.

Review of the facility's Vulnerable Adult Initial Report dated 3/15/16, revealed R64 had pale greenish bruises on either side of her neck. The report indicated R64 had stated another resident "tried to strangle her". Review of the facility's vulnerable adult investigative report dated 3/22/16, revealed that a facility staff working on 3/11/16, saw bruises on R64's neck on 3/11/15, but did not report them.

On 4/8/16, at 11:35 a.m. the DON verified the bruises were first identified on 3/11/15, but facility staff member who initially observed the bruising

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did not report them. The DON further stated on 3/14/15, the unit manager discovered the bruises and initiated an investigation. The DON verified the bruises were of unknown origin and should have been reported to the administrator and SA immediately. R64's bruises of unknown origin were not reported to the administrator until three days and the SA four days after a facility staff member initially identified the bruising.

Verbal Abuse

Review of the facility's Vulnerable Adult Initial 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.

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F 226	Continued From page 8 On 4/8/16, at 10:27 a.m. the facility's 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 completed prior to an offer of employment. The DON further stated for rehired employees the expectation was to discuss with their potential rehire with their previous supervisor at the facility. If the employee was in good standing that was the reference.	F 226		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 274		5/18/16

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F 274	Continued From page 9 Based on interview and document review, the facility failed to complete a comprehensive assessment within 14 days after the facility determines, or should have determined there was a significant change in the residents physical or mental condition for 1 of 1 resident (R107) in the sample reviewed for hospice. Findings include: R107's Physician Order Report dated 3/11/16-4/11/16, indicated R107 was on hospice. A progress note dated 9/16/15, indicated R107 was admitted to hospice with a terminal diagnosis of Alzheimer's disease. R107's quarterly Minimum Data Set's (MDS's) dated 11/16/15, and 2/16/16, indicated R107 was on hospice. During interview on 4/7/16, at 1:41 p.m. registered nurse (RN)-A verified R107 was on hospice since 9/16/15. During interview on 4/7/16, at 2:30 p.m. RN-B MDS coordinator stated, "We do a significant change MDS when they start on hospice and if they change hospices or come off hospice." RN-B verified R107 was on hospice. RN-B stated "We did not do a sig [significant] change MDS after she went on hospice. We should have done one, I do not know why we did not do it." During interview on 4/08/16, at 12:47 p.m. the director of nurses said she expected the MDS coordinator to set up a MDS when a resident goes on and off hospice. Catholic Eldercare Policy and Procedure: Resident Assessment Process indicated, "The RAI [resident assessment instrument] process is	F 274	F 274 It is the practice of Catholic Eldercare to comprehensively assess all residents using the RAI process. Significant change MDS for resident 107 is in process. Significant change requirements reviewed with MDS department in regards to Hospice. Weekly IDT meetings are used to identify residents with Hospice orders who would require a significant change assessment. DON and MDS coordinator are responsible for compliance. Random MDS audits will be completed by members of the nursing management team and reports will be made to Quality Assurance meeting.	

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F 274	Continued From page 10 completed in accordance with state and federal laws following the RAI guidelines established in the RAI manual and other sites mandated by CMS [Centers for Medicare and Medicaid Services]." CMS's RAI version 3.0 manual dated 10/14, indicated a significant change of status assessment was appropriate when a resident was admitted on a hospice benefit.	F 274		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		5/18/16

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F 431	Continued From page 11 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review facility failed to ensure that expired medications were removed from 4 medication carts on 3 of 3 units and 1 medication room. Findings Include: During medication storage observation on 4/8/16, at 7:53 a.m. a bottle of aspirin 81 milligram (mg) was found in a second floor medication cart with an expiration date of 3/16. There was no resident name on the bottle and the bottle was not labeled as stock. Licensed practical nurse (LPN)-A verified the bottle of aspirin was expired and stated, "No one uses that because it comes (aspirin) through the dispenser." During medication storage observation on 4/8/16, at 8:39 a.m. a bottle of aspirin 81 mg was found in a first floor medication cart with an expiration date of 1/16. There was no resident name on the bottle and the bottle was not labeled as stock. The trained medication aide (TMA)-A verified that the aspirin expired in 1/16. TMA-A said "I think it [aspirin] comes from the machine. These are back up medications." During medication storage observation on 4/8/16,	F 431	F 431 Expired medications have been removed from medication carts and medication rooms. Education on expectations regarding expired meds will be done at routine TMA/Nurse meetings and with memos. DON and nurse managers will be responsible for compliance. Members of the nursing management team will conduct random audits of the medication rooms and medication carts. Reports will be made at the Quality Assurance meeting.	

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at 8:52 a.m. an open bottle of Geri-Lanta (antacid) with an expiration date of 2/16, was found in the third floor medication room on the shelf behind an unopened bottle. Registered nurse (RN)-A verified the bottle of medication was expired. RN-A stated it was the responsibility of all staff that come into the medication room to check expiration dates on medications. RN-A said "As a nurse I would check expiration dates before I gave it."

During medication storage observation on 4/8/16, at 8:58 a.m. a bottle of Benadryl 25 mg for R141 was found in a third floor medication cart with an expiration date of 8/14/15. TMA-B verified the expiration date and stated R141 was not using the Benadryl. A review of R141's undated current orders indicated R141 had on order for Benadryl Allergy 25 mg twice a day PRN (as needed for tremors and leaning backwards). R141's undated face sheet indicated R141 had diagnoses of allergic rhinitis and Alzheimer's disease.

In addition, a bottle of Tylenol 325 mg for R164 was found in a third floor medication cart with an expiration date that was unreadable. TMA-B verified being unable to read when the medication would or had expired and stated R164 was using Tylenol 500 mg not 325 mg. TMA-B said , "Maybe they are using it for a PRN." A review of R164's undated current orders indicated R164 had an order for Tylenol 500 mg give two tablets but did not have on order for Tylenol 325 mg.

During interview on 4/08/16, at 9:26 a.m. the director of nurses (DON) said, "There should not be expired medication in the carts, nor the medication rooms." The DON said there had been a recent change in the process. Omnicare

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 13 used to do quarterly audits of the medication carts and rooms for expired medications but that was discontinued six months ago. The new process was the charge nurses and TMA's were to go through the carts together. Staff was too busy and leaving notes for each other to get it done. The monthly TMA meeting was used to audit med carts and med rooms. The DON stated the facility switched to an Omnicell medication dispensing machine in 10/15. The DON said, "There are still some problems so the pharmacy is having us keep some of the over the counter pills in bottles." The DON stated the bottle of Tylenol should have been pulled from the medication cart. The facility policy Storage and Expiration of Medications, Biologicals Syringes and Needles revised 1/1/13 instructed staff "Facility should ensure that medications and biologicals: 4.1 Have an Expiration Date on the label; 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines;" "6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift incomplete, damaged or missing labels."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		5/18/16

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F 441	Continued From page 14 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to store community reusable resident use ice packs in a sanitary manner in 2 of 3 resident nourishment freezers and 1 of 3 medication room freezers. This had the potential to affect 50 of 50 residents who resided on the first floor and 47 of 47 residents on the second floor .	F 441	F 441 All patient re-usable ice packs have been removed from kitchenette/med room refrigerator freezer. Ice packs meant for use with med cart cooler have been labeled and are stored in a plastic bag. Re-usable ice packs have been eliminated and we are purchasing ice	

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F 441	Continued From page 15 Findings Include: During the initial kitchen tour on 4/5/16 at 12:00 p.m. a tour was conducted of the kitchenette on each floor with the Director of Dietary Services (DDS). The first floor kitchenette continental breakfast area freezer contained one large ice bag with a resident name sticker (R161), 2 medium Jack Frost ice packs and 1 3M Nexcare ice pack. The ice packs were observed in the freezer next to the Sea Salt Gelato ice cream container, 3/4 loaf of bread, and box of ice cream sandwiches. At that time registered nurse (RN)-D confirmed the ice packs were resident use ice packs and they are usually kept in the medication room. RN-D confirmed the ice packs should not be kept in the kitchenette freezer. The second floor kitchenette continental breakfast area freezer was observed to contain 2 large Jack Frost ice packs, 6 medium Jack Frost ice packs, 1 Igloo ice pack and 1 Ice Brix ice pack. The ice packs were in the freezer with 2 boxes of ice cream sandwiches, 8 ice cream and sherbet cups, and an unmarked, undated half bag of frozen vegetables. RN-C confirmed that the 2 large and 6 medium ice packs were resident use ice packs and should not be stored in the kitchenette freezer with resident food. RN-C confirmed the Igloo ice pack and Ice Brix ice packs were used to keep medications cold if needed and were not for resident personal use. RN-C stated the ice pack should be kept in the medication room freezer and cleaned after each use. RN-C stated	F 441	packs that are re-fillable and will be for individual use only. They will be marked with resident name and stored in resident room. Policy on ice pack usage and storage has been written. Training will be done through routine meetings and memos. TMA's will check the refrigerators in the med room daily and the resident assistants will check the kitchenette refrigerators daily. Nursing Management and Dietary Director are responsible for compliance. Dietary Director and Nursing Management will conduct random audits and results will be reported at Quality Assurance meeting.	

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F 441	Continued From page 16	F 441		

someone must have used the ice packs and then placed them in the freezer. RN-C was unaware if the ice packs were cleaned before being placed in the freezer.

The DDS was unaware of resident personal use ice packs being stored in the kitchenette freezers. The DDS stated she would add this to the kitchen staff cleaning schedule.

An interview with the Director of Nursing (DON) on 4/8/16 at 11:20 p.m. revealed she was unaware the ice packs were in the kitchenette freezers. The DON confirmed resident use ice packs should not be kept in the kitchenette freezers or next to resident food. The DON was unaware of a specific policy regarding resident use ice packs.

On 4/8/16 at 11:33 p.m. the Registered Nurse Educator (RN)-E confirmed there was no policy on the storage or use of resident ice packs.

During medication storage observation on 4/8/16, at 7:53 a.m. five reusable Jack Frost ice packs were observed in the second floor medication room refrigerator. Pint cartons of liquid nutritional supplements were on top of the ice packs.

During interview on 4/8/16, at 7:53 a.m. registered nurse (RN)-C stated, "I instructed staff to clean ice packs before putting them in the med room and told them to not put supplements on them. I did the education this week."

During interview on 4/08/16, at 11:20 a.m. the director of nurses (DON) said, ice packs should not be in the freezer with food. The DON further stated the ice packs were a single use item then

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F 441	Continued From page 17 thrown out. The DON said she would expect them to be kept separate from food or supplements in the medication room.	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain equipment in a safe operating condition for those residents who received ice from the ice machines out of the kitchenettes on the first and second floor. This had the potential to affect 45 of 50 residents on the first floor and 40 of 47 residents on the second floor. Findings include: On 4/7/16 at 12:33 p.m. during the second kitchen tour, the Director of Dietary Services (DDS) observed and confirmed the following observations: The ice machine in the first floor kitchenette had lime build up around the basin, the drain was plugged and stagnant water and floating debris was observed in the basin. The ice machine in the second floor kitchenette had lime build up around the basin, the drain was plugged and stagnant water was observed in the basin.	F 456	F456 The ice machine drip tray has been replaced on 1st and 2nd floor Resident Assistants and Housekeepers will be educated on filling out work orders if water is not draining properly out of drip tray A preventative program is in place to pour hot water in tray daily to keep water flowing through drain tube. Also, resident assistants will be cleaning and sanitizing tray once daily as well as housekeeping staff once daily. The ice machine policy is revised to reflect this. All resident assistants and housekeeping staff will be educated on new procedure. Director of Dietary and Director of Laundry/housekeeping are responsible for compliance. Random audits will be done by the Director of Laundry/Housekeeping and results will be reported at Quality Assurance meeting.	5/18/16

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F 456	Continued From page 18 The DDS stated that ice machines were cleaned and maintained by the maintenance department not the dietary department. On 4/8/16 at 9:20 a.m. during the environmental tour with Director of Maintenance (DM) and maintenance employee (M)-A the following observations were confirmed: The ice machine on the first floor was observed to have lime build up around the basin and the grate of the basin. The drain was plugged and stagnant water with floating debris was observed in the basin. The ice machine on the second floor was observed to have lime build up around the basin and the grate of the basin. The drain was plugged and stagnant water was observed in the basin. The DM and M-A stated that they were unaware of the condition of the ice machine. DM and M-A stated that nursing or dietary staff was responsible for cleaning the ice machines and that the ice machines should be wiped out everyday. M-A stated the maintenance department had the ice machine on an every 6 month water filter change. The ice machines were checked at that time. M-A stated that staff should inform maintenance when the ice machine basins "are bad like this one" as he could replace the basin. M-A stated that there should be no water in the drain basin and confirmed the drain was plugged. DM and M-A stated that it was the responsibility of the nursing or dietary staff to inform them of any issues so they could fix them immediately. DM and M-A stated that work orders were available at every nursing station.	F 456		

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F 456	Continued From page 19 Anyone could fill out a work order or call the maintenance department and problems were addressed immediately. Interview with the Director of Nursing (DON) on 4/8/16 at 11:20 a.m. revealed the dietary department was responsible for maintaining the ice machines in the kitchenette areas on each floor. Any facility staff using the equipment were expected to contact maintenance with any environmental issues needing to be addressed. Although requested, there was no facility policy to address the cleaning or maintenance of the kitchenette ice machines.	F 456		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were functioning for 1 of 40 resident (R116) reviewed. Findings include: On 4/5/16, at 2:41 p.m. R116's call light did not function properly. Three attempts were made to activate R116's call light before it was activated in the resident hallway. R116 was interviewed at this time and stated she	F 463	F 463 The call light cord for room 116 R has been replaced. All call lights have been checked by housekeeping staff and are working properly. All call lights are monitored and checked by housekeeping staff twice weekly and documented on a chart listing room numbers and date checked. All housekeeping staff have been educated on procedure for filling out work requests promptly if a call light is	5/18/16

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F 463	Continued From page 20 "thought it worked that way" and she always had to push the button a few times. If she had to wait too long, she went to the hallway herself and told the staff what she needed. Registered nurse (RN)-D was informed R116's call light was not functioning. RN-D observed and confirmed R116's call light had to be pushed seven times before the call light was activated. RN-D stated that should be fixed immediately and would contact maintenance. During the environmental tour on 4/8/16, at 9:28 a.m. maintenance employee (M)-A confirmed he fixed R116's call light on 4/5/16. M-A was unaware that the call light was not functioning prior to that date. The director of maintenance (DM) stated that maintenance did not check call lights and there was not a current system for call light audits in his department. DM stated nursing "lets us know" if call lights were not working, and maintenance slips were available at the nursing desk. The director of nursing (DON) was interviewed on 4/8/16, at 11:20 a.m. and stated there was not a "formal process" in place to determine if a call light was not functioning. However indicated this was a "priority repair" for the maintenance department and nursing should alert maintenance if a call light did not function properly. Although requested, the facility did not have a policy related to call light audits.	F 463	found to be not working properly. Director of Laundry/Housekeeping and Director of Maintenance are responsible for compliance. Random audits will be done by the Director of Laundry/Housekeeping and results will be reported at Quality Assurance meeting.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		5/18/16

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F 465	Continued From page 21 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment cleaning procedures that would minimize the possibility of food borne illness. This had the potential to affect 146 of 146 residents in the facility who were served food out of the kitchen. Findings include: During the kitchen tour on 4/7/16 at 12:33 p.m. the following was observed and confirmed by the Director of Dining Services (DDS): The six burner stove was observed to have greasy buildup on the stove top. The DDS confirmed that the stove top "definitely has build up" and stated that she was not aware of the last time the stove top was cleaned and that they need to have an outside company to come and clean it. The knobs and the area between the knobs of the stove top were observed to have thick brown greasy build up with a thick layer of dust and debris. The DDS confirmed the area of the stovetop knobs was "not clean" and that there was a schedule to clean the ovens on the weekends. The dietary staff was responsible to complete. Review of Dining Services Cleaning Sheets included cleaning duties of "Stove-clean burners	F 465	F 465 Range is scheduled for deep cleaning on 5/11/16 and will be put on a regular deep cleaning schedule once per year. Cleaning list revised to include cleaning of range knobs and area between. Dining Staff educated on cleaning lists and signing after specific cleaning is complete. Director of Dietary is responsible for compliance. Dining Supervisor/Manager will conduct random audits and results will be reported at Quality Assurance meeting	

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F 465	Continued From page 22 at end of shift" which included a sign off for both the "am cook" and "pm cook". The cleaning sheets were reviewed for the dates of 1/4/16-4/3/16 and were signed off by the dietary staff as completed. The cleaning sheets did not include cleaning the knobs or area between the knobs of the stove top. The DDS also confirmed that the cleaning sheets were filled out however the areas on the stove observed during the kitchen tour were not clean. On 4/7/16 at 2:12 p.m. the DDS provided information to the surveyor that the last time the stove was deep cleaned by the company was in the fall of 2014. A policy was provided entitled Cleaning of Oven and Range dated July 29, 2008 that included the following procedures: Oven grates may require soaking overnight in a diluted degreaser to allow buildup to be easily removed and all non-removable parts are cleaned with detergent, rinsed and sanitized. The policy also included that daily cleaning is done per the cleaning checklist daily and deep cleaning of ovens and range is done on weekends per the cleaning checklist.	F 465		

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	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/06/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, 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:	K 000	EPOC	

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Catholic Eldercare on Main is a three story building with no basement. The building was constructed at four different times. The original building was constructed in 1977 and was determined to be of Type II(222) construction. In 1983, an addition was constructed to he South side of the building that was determined to be of type II(222) construction. In 1994, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. In 1995, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility as surveyed as one building. The building is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 150 beds and had a census of 146 at	K 000		

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K 000	Continued From page 2 time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by.	K 000		
K 029 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on a facility tour and staff interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 Findings include: On facility tour between 9:00 AM 2:30: PM on April 6, 2016, it was observed that the soiled utility room doors, on the even side, across from rooms 316 and 216; are broken from being rammed with carts. The soiled utility door on the third floor, even side, across from 316; has a broken door latch. This deficient practice was verified by the Director of Maintenance, at the time of discovery.	K 029	0029 The replacement doors and door latch for the soiled utility rooms across from 216 and 316 were ordered on April 19th, 2016. Doors will be installed as soon as received. Director of Maintenance is responsible for compliance. Random audits of facility doors will be conducted by maintenance staff. Results will be reported at Quality Assurance meeting.	5/28/16

MDH
Minnesota
Department
of Health

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 only a suggestion 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00984	A. BUILDING: _____ B. WING _____	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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On April 5-8, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. An investigation of complaint, H5439027 was completed. The complaint was not substantiated.	2 000		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive assessment within 14 days after the facility determines, or should have determined there was a significant change in the residents physical or mental condition for 1 of 1 resident (R107) in the sample reviewed for hospice. Findings include: R107's Physician Order Report dated 3/11/16-4/11/16, indicated R107 was on hospice. A progress note dated 9/16/15, indicated R107 was admitted to hospice with a terminal diagnosis of Alzheimer's disease. R107's quarterly Minimum Data Set's (MDS's) dated 11/16/15, and 2/16/16, indicated R107 was on hospice.	2 545	2545 It is the practice of Catholic Eldercare to comprehensively assess all residents using the RAI process. Significant change MDS for resident 107 is in process. Significant change requirements reviewed with MDS department in regards to Hospice. Weekly IDT meetings are used to identify residents with Hospice orders who would require a significant change assessment. DON and MDS coordinator are responsible for compliance. Random MDS audits will be completed by members of the nursing management team and reports will be made to Quality Assurance meeting.	5/18/16

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2 545	Continued From page 3 During interview on 4/7/16, at 1:41 p.m. registered nurse (RN)-A verified R107 was on hospice since 9/16/15. During interview on 4/7/16, at 2:30 p.m. RN-B MDS coordinator stated, "We do a significant change MDS when they start on hospice and if they change hospices or come off hospice." RN-B verified R107 was on hospice. RN-B stated "We did not do a sig [significant] change MDS after she went on hospice. We should have done one, I do not know why we did not do it." During interview on 4/08/16, at 12:47 p.m. the director of nurses said she expected the MDS coordinator to set up a MDS when a resident goes on and off hospice. Catholic Eldercare Policy and Procedure: Resident Assessment Process indicated, "The RAI [resident assessment instrument] process is completed in accordance with state and federal laws following the RAI guidelines established in the RAI manual and other sites mandated by CMS [Centers for Medicare and Medicaid Services]." CMS's RAI version 3.0 manual dated 10/14, indicated a significant change of status assessment was appropriate when a resident was admitted on a hospice benefit. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure significant change MDS's are completed in a timely manner. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing	2 545		

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2 545	Continued From page 4 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 545		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by:	21390		5/18/16

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21390	Continued From page 5 Based on observation, interview and document review the facility failed to store community reusable resident use ice packs in a sanitary manner in 2 of 3 resident nourishment freezers and 1 of 3 medication room freezers. This had the potential to affect 50 of 50 residents who resided on the first floor and 47 of 47 residents on the second floor . Findings Include: During the initial kitchen tour on 4/5/16 at 12:00 p.m. a tour was conducted of the kitchenette on each floor with the Director of Dietary Services (DDS). The first floor kitchenette continental breakfast area freezer contained one large ice bag with a resident name sticker (R161), 2 medium Jack Frost ice packs and 1 3M Nexcare ice pack. The ice packs were observed in the freezer next to the Sea Salt Gelato ice cream container, 3/4 loaf of bread, and box of ice cream sandwiches. At that time registered nurse (RN)-D confirmed the ice packs were resident use ice packs and they are usually kept in the medication room. RN-D confirmed the ice packs should not be kept in the kitchenette freezer. The second floor kitchenette continental breakfast area freezer was observed to contain 2 large Jack Frost ice packs, 6 medium Jack Frost ice packs, 1 Igloo ice pack and 1 Ice Brix ice pack. The ice packs were in the freezer with 2 boxes of ice cream sandwiches, 8 ice cream and sherbet cups, and an unmarked, undated half bag of frozen vegetables. RN-C confirmed that the 2 large and 6 medium	21390	21390 All patient re-usable ice packs have been removed from kitchenette/med room refrigerator freezer. Ice packs meant for use with med cart cooler have been labeled and are stored in a plastic bag. Re-usable ice packs have been eliminated and we are purchasing ice packs that are re-fillable and will be for individual use only. They will be marked with resident name and stored in resident room. Policy on ice pack usage and storage has been written. Training will be done through routine meetings and memos. TMA's will check the refrigerators in the med room daily and the resident assistants will check the kitchenette refrigerators daily. Nursing Management and Dietary Director are responsible for compliance. Dietary Director and Nursing Management will conduct random audits and results will be reported at Quality Assurance meeting.	

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21390	Continued From page 6	21390		

ice packs were resident use ice packs and should not be stored in the kitchenette freezer with resident food. RN-C confirmed the Igloo ice pack and Ice Brix ice packs were used to keep medications cold if needed and were not for resident personal use. RN-C stated the ice pack should be kept in the medication room freezer and cleaned after each use. RN-C stated someone must have used the ice packs and then placed them in the freezer. RN-C was unaware if the ice packs were cleaned before being placed in the freezer.

The DDS was unaware of resident personal use ice packs being stored in the kitchenette freezers. The DDS stated she would add this to the kitchen staff cleaning schedule.

An interview with the Director of Nursing (DON) on 4/8/16 at 11:20 p.m. revealed she was unaware the ice packs were in the kitchenette freezers. The DON confirmed resident use ice packs should not be kept in the kitchenette freezers or next to resident food. The DON was unaware of a specific policy regarding resident use ice packs.

On 4/8/16 at 11:33 p.m. the Registered Nurse Educator (RN)-E confirmed there was no policy on the storage or use of resident ice packs.

During medication storage observation on 4/8/16, at 7:53 a.m. five reusable Jack Frost ice packs were observed in the second floor medication room refrigerator. Pint cartons of liquid nutritional supplements were on top of the ice packs.

During interview on 4/8/16, at 7:53 a.m. registered nurse (RN)-C stated, "I instructed staff to clean ice packs before putting them in the med

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21390	Continued From page 7 room and told them to not put supplements on them. I did the education this week." During interview on 4/08/16, at 11:20 a.m. the director of nurses (DON) said, ice packs should not be in the freezer with food. The DON further stated the ice packs were a single use item then thrown out. The DON said she would expect them to be kept separate from food or supplements in the medication room. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop sysems to ensure ice packs are stored appropriately and educate nursing staff on the system. The DON or designee could monitor the system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		5/18/16

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21426	Continued From page 8 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the agency failed to ensure 2 of 5 employees (E-1, E-2) had proper evaluation and documentation for Tuberculosis testing and screening. In addition, the facility failed to ensure 1 of 5 residents (R108) had the second step of Tuberculin Skin Test (TST) read as recommended per State guidelines. Findings include: Employees E-1's personnel file review revealed a hire date of 7/14/15. E-1 had the tuberculosis symptoms screening completed on 7/11/15, a step one Tuberculin Skin Test (TST) had been administered on 7/11/15, and read on 7/14/15, with 0 millimeters (mm) and negative interpretation. The file contained a document from the clinic with a 3/1/15 date on the top of the page, and noted "This letter is to inform you of your recent test results" of TB skin test 0 millimeter (mm), negative. However the document lacked evidence of when the "recent" test was completed including date of TST administration and/or reading of the results. E-2's personnel file review revealed a hire date of 10/13/15. E-2 had the tuberculosis symptoms screening completed on 9/22/15, and the first	21426	21426 E1 is no longer an employee of Catholic Eldercare. E2 has been scheduled to go to the clinic for a medical evaluation. R108 had his mantoux administered on 4/6 and was read on 4/8 with a result of zero millimeters. TB policies have been reviewed and revised. Staff education to be done at routine meetings and memos. Infection Control nurse and DON are responsible for compliance. Random audits will be conducted weekly by the Infection Control nurse. Reports will be made to Quality Assurance meeting.	

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21426	Continued From page 9	21426		

step of TST was administered on 9/22/15, read as "5 mm", and negative. The second step TST was administered on 12/23/15 (3 months later), and read as "12 mm"", positive. There was a chest x-ray result dated 1/4/16 in E-2's file, which indicated the chest x-ray was within normal limits, however there was no evidence of a medical evaluation identifying no active infection.

Residents:
R108's electronic medical record indicated an admission date of 11/24/15. The TB symptoms screening was completed on 11/27/15, the first step TST was administered on 11/27/15, and read as 0 mm on 11/29/15. The second TST was administered on 12/11/15, however there was no evidence the result was read.

On 4/6/16, at 2:41 p.m. the registered nurse (RN-E)/infection control nurse was interviewed. RN-E reviewed R108's medical record, and stated staff was expected to read the TST's 48 to 72 hours after administration. RN-E reviewed E-1's file and verified the documentation from the clinic did not indicate date of the TST administration or date of the TST reading. RN-E reviewed E-2's file and stated they relied on the clinic to complete the accurate assessments when an employee tested positive with TST testing, and verified E-2 should also have had a medical evaluation completed to rule out TB.

The facility's Tuberculosis- Resident Screening - Admission/Readmission Surveillance policy and procedure last revised on 3/15/16, indicated residents were screened for TB on admission using a two-step Mantoux test.

The facility's Tuberculosis: Pre-Employment Screening policy and procedure last updated on

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21426	Continued From page 10 11/16/15, indicated "Persons with a positive Mantoux are screened for symptoms and referred to the Infection Control Nurse/Director of Health Services. The Infection Control Nurse/Director of Health Services will refer person to our Occupational Health Clinic for evaluation and chest x-ray." the policy further indicated "A person must be cleared for work or a negative chest x-ray must be obtained before beginning employment/orientation." The policy did not clearly reflect current regulatory guidelines. Regulation for Tuberculosis Control in Minnesota Health Care Settings dated 7/13, Screening Health Care Workers (HCW's) directed: "TST documentation should include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative)" In addition the regulation further indicated: " HCW with a newly-identified positive TST or IGRA [Interferon Gamma Release Assay- blood test used to test TB] Before the HCW has direct patient contact, the following should be documented in their record: 1. Test result, 2. Assessment for current TB symptoms, 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done, and 4. Medical evaluation to rule out a diagnosis of infectious TB disease." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	21426		

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21426	Continued From page 11 review and/or revise the current TB policies and procedures to ensure all residents and staff are screened for physical signs and symptoms of active TB disease on admission. The DON or designee could educate the appropriate staff on the policies/procedures, and could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review facility failed to ensure that expired medications were removed from 4 medication carts on 3 of 3 units and 1 medication room. Findings Include: During medication storage observation on 4/8/16, at 7:53 a.m. a bottle of aspirin 81 milligram (mg) was found in a second floor medication cart with an expiration date of 3/16. There was no resident name on the bottle and the bottle was not labeled as stock. Licensed practical nurse (LPN)-A verified the bottle of aspirin was expired and stated, "No one uses that because it comes (aspirin) through the dispenser."	21610	21610 Expired medications have been removed from medication carts and medication rooms. Education on expectations regarding expired meds will be done at routine TMA/Nurse meetings and with memos. DON and nurse managers will be responsible for compliance. Members of the nursing management team will conduct random audits of the medication rooms and medication carts. Reports will be made at the Quality Assurance meeting.	5/18/16

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21610	Continued From page 12 During medication storage observation on 4/8/16, at 8:39 a.m. a bottle of aspirin 81 mg was found in a first floor medication cart with an expiration date of 1/16. There was no resident name on the bottle and the bottle was not labeled as stock. The trained medication aide (TMA)-A verified that the aspirin expired in 1/16. TMA-A said "I think it [aspirin] comes from the machine. These are back up medications." During medication storage observation on 4/8/16, at 8:52 a.m. an open bottle of Geri-Lanta (antacid) with an expiration date of 2/16, was found in the third floor medication room on the shelf behind an unopened bottle. Registered nurse (RN)-A verified the bottle of medication was expired. RN-A stated it was the responsibility of all staff that come into the medication room to check expiration dates on medications. RN-A said "As a nurse I would check expiration dates before I gave it." During medication storage observation on 4/8/16, at 8:58 a.m. a bottle of Benadryl 25 mg for R141 was found in a third floor medication cart with an expiration date of 8/14/15. TMA-B verified the expiration date and stated R141 was not using the Benadryl. A review of R141's undated current orders indicated R141 had on order for Benadryl Allergy 25 mg twice a day PRN (as needed for tremors and leaning backwards). R141's undated face sheet indicated R141 had diagnoses of allergic rhinitis and Alzheimer's disease. In addition, a bottle of Tylenol 325 mg for R164 was found in a third floor medication cart with an expiration date that was unreadable. TMA-B verified being unable to read when the medication would or had expired and stated R164 was using	21610		

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21610	Continued From page 13 Tylenol 500 mg not 325 mg. TMA-B said , "Maybe they are using it for a PRN." A review of R164's undated current orders indicated R164 had an order for Tylenol 500 mg give two tablets but did not have on order for Tylenol 325 mg. During interview on 4/08/16, at 9:26 a.m. the director of nurses (DON) said, "There should not be expired medication in the carts, nor the medication rooms." The DON said there had been a recent change in the process. Omnicare used to do quarterly audits of the medication carts and rooms for expired medications but that was discontinued six months ago. The new process was the charge nurses and TMA's were to go through the carts together. Staff was too busy and leaving notes for each other to get it done. The monthly TMA meeting was used to audit med carts and med rooms. The DON stated the facility switched to an Omnicell medication dispensing machine in 10/15. The DON said, "There are still some problems so the pharmacy is having us keep some of the over the counter pills in bottles." The DON stated the bottle of Tylenol should have been pulled from the medication cart. The facility policy Storage and Expiration of Medications, Biologicals Syringes and Needles revised 1/1/13 instructed staff "Facility should ensure that medications and biologicals: 4.1 Have an Expiration Date on the label; 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines;" "6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift incomplete, damaged or missing labels." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	21610		

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21610	Continued From page 14 develop systems to ensure monitoring of med carts and rooms for expired and improper/illegible labeling. The DON or designee could educate all licensed staff and TMA's. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment cleaning procedures that would minimize the possibility of food borne illness. This had the potential to affect 146 of 146 residents in the facility who were served food out of the kitchen. Findings include: During the kitchen tour on 4/7/16 at 12:33 p.m. the following was observed and confirmed by the Director of Dining Services (DDS): The six burner stove was observed to have greasy buildup on the stove top. The DDS confirmed that the stove top "definitely has build	21695	21695 Range is scheduled for deep cleaning on 5/11/16 and will be put on a regular deep cleaning schedule once per year. Cleaning list revised to include cleaning of range knobs and area between. Dining Staff educated on cleaning lists and signing after specific cleaning is complete. Director of Dietary is responsible for compliance. Dining Supervisor/Manager will conduct random audits and results will be reported at Quality Assurance meeting	5/18/16

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21695	Continued From page 15 up" and stated that she was not aware of the last time the stove top was cleaned and that they need to have an outside company to come and clean it. The knobs and the area between the knobs of the stove top were observed to have thick brown greasy build up with a thick layer of dust and debris. The DDS confirmed the area of the stovetop knobs was "not clean" and that there was a schedule to clean the ovens on the weekends. The dietary staff was responsible to complete. Review of Dining Services Cleaning Sheets included cleaning duties of "Stove-clean burners at end of shift" which included a sign off for both the "am cook" and "pm cook". The cleaning sheets were reviewed for the dates of 1/4/16-4/3/16 and were signed off by the dietary staff as completed. The cleaning sheets did not include cleaning the knobs or area between the knobs of the stove top. The DDS also confirmed that the cleaning sheets were filled out however the areas on the stove observed during the kitchen tour were not clean. On 4/7/16 at 2:12 p.m. the DDS provided information to the surveyor that the last time the stove was deep cleaned by the company was in the fall of 2014. A policy was provided entitled Cleaning of Oven and Range dated July 29, 2008 that included the following procedures: Oven grates may require soaking overnight in a diluted degreaser to allow buildup to be easily removed and all non-removable parts are cleaned with detergent, rinsed and sanitized. The policy also included that daily cleaning is done per the cleaning	21695		

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21695	Continued From page 16 checklist daily and deep cleaning of ovens and range is done on weekends per the cleaning checklist. SUGGESTED METHOD OF CORRECTION: The director of maintenance (DM) or designee could develop systems to ensure appropriate claening of facility equipment. The DM or designee could educate all appropriate staff. The DM could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced	21990		5/18/16

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21990	Continued From page 17 by: Based on interview and document review, the facility failed to ensure that all alleged allegations of mistreatment, bruises of unknown origin and unwitnessed falls with injury were reported to the administrator and the state agency (SA) immediately for 3 of 5 residents (R133, R64, R28) reviewed for abuse. Findings include: Unwitnessed fall with a major injury R133's quarterly Minimum Data Set (MDS) dated 12/7/15, identified R133 had moderate cognitive impairment and needed extensive staff assistance with activities of daily living (ADL's). Review of R133's Resident Progress Notes from 10/15/15 to 1/8/16, revealed a progress note dated 12/12/15, at 4:00 a.m. which indicated R133 had unwitnessed fall in her room. R133 was sent to the emergency room (ER) by ambulance. When the facility contacted the hospital on 12/12/15, at 11:19 a.m. they were informed R133 had been admitted to the hospital with a fractured hip. Review of the facility's Vulnerable Adult Initial Report dated 12/14/15, revealed R133 was found on the floor on 12/12/15, at 4:00 a.m. Review of the facility's vulnerable adult investigative report dated 12/18/15, revealed R133 was found on the floor on 12/12/15, at 4:00 a.m. and R133 complained of "right leg pain and her right leg was laterally rotated and shorter in length than the left leg". The investigative report further indicated that R133 was sent to ER for evaluation and had sustained a right hip fracture from the fall.	21990	21990 Facility reporting requirements/expectations for injuries of unknown origin will be reviewed will all staff. Vulnerable reporting and abuse prohibition policies have been reviewed and updated. Weekly IDT meetings will be utilized to monitor and audit that reporting guidelines have been followed. Administrator and DON are responsible for compliance. Results will be brought to the Quality Assurance committee.	

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21990	Continued From page 18 On 3/8/16, at 11:35 a.m. the facility's director of nursing (DON) stated the usual practice for the facility was to immediately report the incident to the administrator and SA. The DON verified R133 had fallen on 12/12/15, however the report to the SA was not completed until 12/14/15, two days following the incident. The DON acknowledged the initial report to the SA was not submitted timely. Bruises of unknown origin. R64's quarterly Minimum Data Set (MDS) dated 2/7/16, identified R64 had moderate cognitive impairment and needed extensive staff assistance with ADL'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. Review of the facility's Vulnerable Adult Initial Report dated 3/15/16, revealed R64 had pale greenish bruises on either side of her neck. The report indicated R64 stated another resident "tried to strangle her". Review of the facility's vulnerable adult investigative report dated 3/22/16, revealed a facility staff working on 3/11/16, saw bruises on resident's neck on 3/11/16, but did not report them. 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	21990		

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21990	Continued From page 19 stated on 3/14/15 the unit manager discovered the bruises and initiated an investigation. The DON verified the bruises were of unknown origin and should have been reported to the administrator and SA immediately. R64's bruises of unknown origin were not reported to the administrator until three days later and the SA four days after the bruising was fist identified. Verbal Abuse R28's quarterly Minimum Data Set (MDS) dated 12/22/15, identified R28 had moderate cognitive impairment and needed extensive staff assistance with ADL's. Review of the facility's Resident Incident Report indicated that R28 was verbally abused by a facility staff, when a facility staff told R28 "shut up and mind your own business" on 12/27/15, during dinner time. Review of the facility's Vulnerable Adult Initial Report dated 12/29/15, revealed a facility staff 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, which indicated 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 eating dinner on 12/27/15. During interview on 4/8/16, at 11:35 a.m. the DON acknowledged that the two facility staff who witnessed the incident did not report the incident until the next day. The DON verified that 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.	21990		

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21990	Continued From page 20 A facility policy titled Abuse and Neglect Prevention and Investigation revised on 2/22/16, indicated the facility will be proactive in its prevention of abuse/neglect of vulnerable adults. The policy directed facility staff to immediately report to the administrator and state agency any actual/suspected incidents of abuse or neglect. The policy defined verbal abuse by a staff member toward a resident as any shouting or swearing at a resident. The policy directed that it needed to be reported to the administrator and SA immediately. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop systems to ensure immediate reporting of potential abuse/neglect allegations. The administrator or designee could educate all staff on the systems. The administrator or designee could monitor the systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21990		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.	21995		5/18/16

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21995	Continued From page 21 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse policy to ensure immediate reporting of alleged allegations of mistreatment, bruises of unknown origin and unwitnessed fall with major injury to the State Agency (SA) and the administrator for 3 of 5 residents (R133, R64, R28) reviewed for abuse. In addition failed to check professional references for 2 of 5 newly hired employees (E3, E4). Findings include: A facility policy titled Abuse and Neglect Prevention and Investigation revised on 2/22/16, indicated the facility will be proactive in its prevention of abuse/neglect of vulnerable adults. The policy directed facility staff to immediately report to the administrator and state agency any actual/suspected incidents of abuse or neglect. The policy defined verbal abuse by a staff member toward a resident as any shouting or swearing at a resident and the policy directed that it needed to be reported to the administrator and SA immediately. The policy further directed screening of all employees and references were to be checked prior to the offer of employment. Unwitnessed fall with a major injury Review of the facility's Vulnerable Adult Initial Report dated 12/14/15, revealed R133 was found on the floor on 12/12/15, at 4:00 a.m. Review of the facility's vulnerable adult investigative report dated 12/18/15, revealed R133 was found on the floor on 12/12/15, at 4:00 a.m. and R133 complained of "right leg pain and her right leg was laterally rotated and shorter in length than the left leg". The investigative report further	21995	21995 Facility reporting requirements/expectations for injuries of unknown origin will be reviewed will all staff. Vulnerable reporting and abuse prohibition policies have been reviewed and updated. Weekly IDT meetings will be utilized to monitor and audit that reporting guidelines have been followed. Administrator and DON are responsible for compliance. Results will be brought to the Quality Assurance committee. Reference check requirements will be reviewed with all staff who hire. Reference check form has been revised. Hiring managers are responsible for completing reference checks. HR will conduct random audits and report at Quality Assurance meeting	

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21995	Continued From page 22 indicated that R133 was sent to the emergency room (ER) for evaluation. She sustained a right hip fracture from the fall. On 3/8/16, at 11:35 a.m. the facility's director of nursing (DON) stated the usual practice for the facility was to immediately report the incident to the administrator and SA. The DON verified R133 had fallen on 12/12/15, however the report to the SA was not completed until 12/14/15, two days following the incident. The DON acknowledged the initial report to the SA was not submitted timely. Bruises of unknown origin. Review of the facility's Vulnerable Adult Initial Report dated 3/15/16, revealed R64 had pale greenish bruises on either side of her neck. The report indicated R64 had stated another resident "tried to strangle her". Review of the facility's vulnerable adult investigative report dated 3/22/16, revealed that a facility staff working on 3/11/16, saw bruises on R64's neck on 3/11/15, but did not report them. On 4/8/16, at 11:35 a.m. the DON verified the bruises were first identified on 3/11/15, but facility staff member who initially observed the bruising did not report them. The DON further stated on 3/14/15, the unit manager discovered the bruises and initiated an investigation. The DON verified the bruises were of unknown origin and should have been reported to the administrator and SA immediately. R64's bruises of unknown origin were not reported to the administrator until three days and the SA four days after a facility staff member initially identified the bruising. Verbal Abuse Review of the facility's Vulnerable Adult Initial	21995		

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	00984	A. BUILDING: _____ B. WING _____	04/08/2016

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21995	Continued From page 23 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 facility's 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 completed prior to an offer of employment. The	21995		

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21995	Continued From page 24 DON further stated for rehired employees the expectation was to discuss with their potential rehire with their previous supervisor at the facility. If the employee was in good standing that was the reference. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop systems to ensure the consistent implementation of the facility abuse/neglect policy. The administrator or designee could educate all staff on the consistent implementation of the facility policy. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident	23010		5/18/16

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23010	Continued From page 25 bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were functioning for 1 of 40 resident (R116) reviewed. Findings include: On 4/5/16, at 2:41 p.m. R116's call light did not function properly. Three attempts were made to activate R116's call light before it was activated in the resident hallway. R116 was interviewed at this time and stated she "thought it worked that way" and she always had to push the button a few times. If she had to wait too long, she went to the hallway herself and told the staff what she needed. Registered nurse (RN)-D was informed R116's call light was not functioning. RN-D observed and confirmed R116's call light had to be pushed seven times before the call light was activated. RN-D stated that should be fixed immediately and would contact maintenance. During the environmental tour on 4/8/16, at 9:28 a.m. maintenance employee (M)-A confirmed he fixed R116's call light on 4/5/16. M-A was unaware that the call light was not functioning prior to that date. The director of maintenance (DM) stated that maintenance did not check call lights and there was not a current system for call	23010	23010 The call light cord for room 116 R has been replaced. All call lights have been checked by housekeeping staff and are working properly. All call lights are monitored and checked by housekeeping staff twice weekly and documented on a chart listing room numbers and date checked. All housekeeping staff have been educated on procedure for filling out work requests promptly if a call light is found to be not working properly. Director of Laundry/Housekeeping and Director of Maintenance are responsible for compliance. Random audits will be done by the Director of Laundry/Housekeeping and results will be reported at Quality Assurance meeting.	

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23010	Continued From page 26 light audits in his department. DM stated nursing "lets us know" if call lights were not working, and maintenance slips were available at the nursing desk. The director of nursing (DON) was interviewed on 4/8/16, at 11:20 a.m. and stated there was not a "formal process" in place to determine if a call light was not functioning. However indicated this was a "priority repair" for the maintenance department and nursing should alert maintenance if a call light did not function properly. Although requested, the facility did not have a policy related to call light audits. SUGGESTED METHOD FOR CORRECTION: The director or maintenance (DM) or designee could develop systems of ensuring consistent call light use which included the routine random testing of call light function. The DM or designee could educate all appropriate staff. The DM could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	23010		