DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
October 25, 2024

Administrator
Catholic Eldercare On Main
817 Main Street Northeast
Minneapolis, MN 55413

RE: CCN: 245439
Cycle Start Date: October 18, 2024

Dear Administrator:

On October 18, 2024, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 18, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 9, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 9, 2024, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 9, 2024 (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy

must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 18, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Catholic Eldercare On Main is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 18, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 April 18, 2025 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be

emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

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:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 25, 2024

Administrator
Catholic Eldercare On Main
817 Main Street Northeast
Minneapolis, MN 55413

Re: State Nursing Home Licensing Orders
Event ID: BU0C11

Dear Administrator:

The above facility was surveyed on October 14, 2024 through October 18, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	C 10/18/2024

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
E 000	Initial Comments On 10/14/24 to 10/18/14, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, was conducted during a standard recertification survey. Catholic Eldercare on Main was found not in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	E 007		11/7/24

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

Electronically Signed | 11/01/2024

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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(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
E 007	Continued From page 1 *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the comprehensive Emergency Preparedness Plan (EPP) included policies and/or procedures demonstrating the resident population, including those deemed at high risk for adverse outcome, had been assessed for both services which could be provided in a potential emergency situation (i.e., loss of power, natural disaster) and continuity of facility-based operations that could be provided to those residents determined to be most at risk. This had the potential to affect all 161 residents in the facility. Findings include: The provided Catholic Eldercare Facility Assessment, dated 7/2024, identified the nursing home was licensed for 174 beds with a posted average census of 157.7 residents. The assessment identified a listing of common	E 007	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. E007 Emergency Preparedness Plan(EPP) policies shelter in place plan and evacuation plan have been reviewed and revised to include residents assessed/prioritized for high risk in	

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E 007	Continued From page 2 diseases and conditions which were able to be cared-for at the nursing home including diabetes, renal failure, heart failure, Alzheimer's Disease, seizure disorders, and traumatic brain injury (TBI); along with services the home provided to these conditions including ADL (activities of daily living) support, end-of-life care, medication administration, and nutrition support. During the recertification survey, from 10/14/24 to 10/18/24, the EPP was requested. A red-colored binder was provided labeled, "Emergency Procedures," and which contained various information and policies about the EPP. The information identified the EPP was last reviewed 09/2024, and included a policy labeled, "Disaster Preparedness Plan: Evacuation Plan," which outlined procedures to evacuate the campus if needed. This included a section labeled, "11. Priority for Evacuations," which outlined an order as follows: "a. Escort any resident/guest in imminent danger to safe areas or to 1st floor whichever is determined by the person in charge," "b. Ambulatory residents and any resident that family will be bringing their loved one home," "c. Light wheelchair residents," "d. Heavy wheelchair residents," "e. Bed-bound residents," and, "f. Evacuation chair will be used at the direction of emergency personnel, administrator, director or nursing or their designee."	E 007	emergency situations. Emergency planning team and nursing supervisors will be educated on the revised policies. Emergency planning team will review and revise the EPP at least annually	

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E 007	Continued From page 3 However, both this policy and the entire EPP lacked a policy or evidence the resident population had been comprehensively assessed for which residents were considered needing extra assistance in an emergency situation, those determined to be 'most at risk,' or what, if any, services the identified residents would need or the care center was able to provide if shelter-in-place was needed (i.e., dialysis needs, hospice needs). On 10/17/24 at 11:32 a.m., the EPP was reviewed with the administrator, and she reiterated the evacuation policy which outlined an order of evacuation. However, she acknowledged being unable to locate more information within the EPP to demonstrate an evaluation of the population including what services could be provided onsite. The administrator stated they would update it to include that information adding, "I can add that."	E 007		
F 000	INITIAL COMMENTS On 10/14/24 to 10/18/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiencies issued: H54399395C (MN98871) H54399396C (MN99084) H54399397C (MN100103 H54399398C (MN101554) H54393026C (MN102194)	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 4 H54393026C (MN102349) H54399399C (MN102563) H54399400C (MN104832) The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F689 began on 9/14/24 when the facility failed to comprehensively reassess and, if needed, develop interventions with unsupervised eating to reduce the risk of accidental choking or asphyxiation for R67 who ate unsupervised in their room and had two documented episodes of choking. The administrator and director of nursing (DON) were notified of the IJ on 10/17/24 at 4:09 p.m. The IJ was removed on 10/18/24 at 1:14 p.m. The above findings constituted substandard quality of care, and an extended survey was conducted from 10/17/24 to 10/18/24. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		11/7/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 584	Continued From page 5 comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 584		

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F 584	Continued From page 6 Based on observation and interview, the facility failed to promote a dignified home-like environment during dining services in 4 of 6 dining rooms reviewed. Finding include: R48's significant change Minimum Data Set (MDS) assessment, dated 8/24/24, indicated R48 had intact cognition with no hallucinations or delusions with an admission date of 4/21/23. During observation on 10/14/24 at 5:08 p.m., on 2nd floor main dining room residents were seated and had been served their meals. It was observed each resident had a hard plastic tray in front of them which contained a plate of food that was sitting on a plate warmer. The drinks (which ranged from juice to coffee to milk) were also placed on the hard plastic tray along with the silverware. In the middle of the table were hard plastic dome shaped lids (which would have been used to cover the food plates). At 5:12 p.m., a staff member walked up to a resident who was sitting with her head down and prompted her to eat. During observation on 10/14/24 at 5:14 p.m., on 2nd floors smaller dining room, it was observed all residents had been served their meals. One unidentified staff member was seated assisting a resident to eat. It was observed that each resident had a hard plastic tray in front of them which contained a plate of food that was sitting on a plate warmer. The drinks (which ranged from juice to coffee to milk) were also placed on the hard plastic tray along with the silverware. In the middle of the table were hard plastic dome shaped lids, upside down, with disposable plastic	F 584	F584 To promote a dignified home-like environment,staff will remove the food and utensils from the plastic tray and place the items in front of the resident. This process will be completed for residents eating in a communal dining space. Nursing and dining staff will be trained on removing the food and utensils from the plastic tray at the time of delivery of each meal. Dining and Nursing will complete random audits each meal daily for a week, weekly for a month and quarterly thereafter as needed and results will be forwarded to the quality committee for further recommendations or follow-up.	

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F 584	Continued From page 7 lids that had been used to cover the soup bowls and drinks. On 10/15/24 at 11:50 a.m., it was observed that staff were starting to serve resident meals. The staff would take the meals from a lunch cart which was an enclosed cart on wheels with slots, that held hard plastic trays that contained resident meals. The hard plastic trays each contained a paper slip that identified who the meal was intended for, a plate of food that was sitting on a plate warmer and was covered with a hard plastic dome shaped lid. The drinks were covered with a plastic lid and the silverware on the tray was rolled in a napkin. At 11:53 a.m., all residents in the dining room had been served their meal. Each resident had a hard plastic tray in front them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. On 10/15/24 at 12:10 p.m., the dining cart was delivered to the 2nd floor small dining room by dietary aid. The dining cart was an enclosed cart on wheels with slots, that held hard plastic trays that contained resident meals. The cart had a few trays sitting on the top of the cart. The hard plastic trays (both inside and on the top of the cart) contained a paper slip that identified who the meal was intended for, a plate of food that was sitting on a plate warmer and was covered with a hard plastic dome shaped lid. The drinks were covered with a plastic lid and the silverware on the tray was rolled in a napkin. At 12:13 p.m., the first tray was served to a resident. At 12:17 p.m., a dietary aid delivered another dining cart to the	F 584		

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F 584	Continued From page 8 floor that contained 5 more trays. At 12:19 p.m., all residents in the dining room have been served. Each resident had a hard plastic tray in front them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. On 10/16/2024 at 11:46 a.m., the dining cart was delivered to the 2nd floor main dining room. The dining cart observed appeared the same as previous observations. Staff, including administrator, served meals to residents. At 11:51 a.m., all residents in the dining room were served their meal. As previous meals observed, each resident had a hard plastic tray in front them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. On 10/16/2024 12:03 p.m., staff were serving trays to residents in the 2nd floor smaller dining room. Residents had a hard plastic tray in front of them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. During observation on 10/17/24 at 12:15 p.m., on 1st floor dining room, residents were observed to be eating lunch. Each resident had a hard plastic tray in front them of which contained a plate that	F 584		

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F 584	Continued From page 9 sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. During interview on 10/16/24 at 10:39 a.m., R48 stated she has "thought of ways to make it feel more like home here, but they don't listen," and further stated, "we are in a nursing home." R48 stated she eats her meals in the dining room. R48 indicated she feels that it is probably easier for staff to serve the meals on the trays and indicated this is not her preference. On 10/16/2024 at 1:07 p.m., registered nurse (RN)-D indicated they don't know why the meals in the dining rooms are served on the plastic trays. RN-D indicated there is not really a reason. On 10/16/2024 at 12:48 p.m., when asked about serving resident meals in the dining rooms on the hard plastic trays, administrator indicated no rational for this. Administrator verified this is how all meals are served except on 3rd floor. On 10/17/24 at 12:57 p.m., director of nursing (DON) stated, "that will be a dietary question," when asked about serving resident meals on hard plastic trays and declined to further comment. A facility policy, Serving Meals and Feeding the Resident, revision date 7/21/16, was provided. The policy lacked indication on how the facility would promote a dignified home-like environment during dining services.	F 584		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		11/7/24

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F 684	Continued From page 10 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate wheelchair foot supports were provided or, if needed, therapy consulted to promote adequate wheelchair positioning to avoid complication (i.e., pain, edema) for 1 of 1 resident (R51); failed to ensure proactive skin interventions were consistently implemented to reduce the risk of skin tears or bruising for 1 of 1 resident (R110); and failed to assess and revise an insulin administration schedule to promote acceptable diabetes management and improve blood glucose levels for 1 of 1 resident (R161) reviewed for dialysis and who missed multiple doses of insulin related to scheduled dialysis treatments. Findings include: WHEELCHAIR POSITIONING: R51's quarterly Minimum Data Set (MDS), dated 8/7/24, identified R51 had severe cognitive impairment and demonstrated no rejection of care behaviors during the review period. Further, the MDS outlined R51 had no range of motion limitations in her upper or lower extremities, used a wheelchair for a mobility device, and was	F 684	F684: Ensure appropriate wheelchair foot supports are provided R51s wheelchair foot supports were assessed by the therapy team. Appropriate footrests were provided, and adjustments were made to ensure correct positioning. R51 was re-evaluated for pain or edema related to positioning. All residents with wheelchairs will be audited for proper foot pedals and positioning. Resident Policy will be reviewed and revised as needed. Charge Nurses and NARs will receive training on the importance of proper wheelchair positioning and correct foot support usage for residents, with a special emphasis on residents with cognitive impairments or mobility limitations. Nurse managers or designee will conduct random audits of wheelchair positioning for residents using wheelchair foot support daily for a week, weekly for a month, and quarterly thereafter. Corrective action will be	

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F 684	Continued From page 11 dependent on staff for nearly all mobility-related activities (i.e., transfers, bed mobility). On 10/14/24 at 12:37 p.m., R51 was observed seated in a high-back, tilted wheelchair in the hallway on her unit. R51 extended her hand to shake the surveyor' hand and did not verbally respond aloud when asked her name. R51's body was seated upright in the wheelchair, however, there were no attached pedals or platform on the wheelchair and, as a result, her feet dangled downward without touching the floor. Later, on 10/14/24 at 4:47 p.m., R51 was again observed in the same wheelchair while in the dining room waiting for the supper meal. R51 continued to not have any pedals or platform attached to the wheelchair and, again, her feet dangled downward without being able to reach the floor. R51's care plan, dated 6/2023, identified R51 had impaired mobility due to left hip pain, weakness and variable understanding of directions and behaviors. The care plan identified R51 was non-ambulatory and used a Broda wheelchair adding, "WHEELCHAIR: total assist of one around obstacles and to get to all destinations." The care plan lacked rationale or instruction on R51's lack of wheelchair pedals or platform. The following day, on 10/15/24 at 8:56 a.m., R51 was again observed seated in the tilted wheelchair while at a small table in the breakfast area. R51 continued to not have any pedals or platforms in place on the chair causing her feet to be unsupported and dangle downward. Later on 10/15/24 at 11:40 a.m., R51 was seated in her same wheelchair in the dining room but now had bilateral foot pedals attached and in place. However, R51's legs were crossed and her feet	F 684	taken immediately for any issues identified. The results of the audits will be reviewed in the QAPI meetings for further evaluation and recommendation. F684: Ensure proactive skin interventions are consistently implemented to reduce the risk of skin tears or bruising. R110 geri-sleeves were applied as prescribed to provide skin protection and reduce risk of bruising or skin tears. An audit of all residents with orders for protective devices, such as geri-sleeves, will be conducted. Residents with similar risks will have their care plans and orders reviewed to confirm accurate and consistent use of skin protection measures. Skin Injury Prevention policy and procedure will be reviewed and revised as needed. Charge Nurses and NARs will receive education on skin injury risk and protection strategies. Nurse Managers or designee will conduct random audit of skin protective devices daily for one week, weekly for one month, and quarterly thereafter. Result of the audits will be reviewed in the QAPI meetings for further evaluation and recommendation.	

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F 684	Continued From page 12 were positioning behind the affixed pedals dangling downward again. R51 was assisted with eating the noon meal by nursing assistant (NA)-B with no attempts to place R51's feet back onto the pedals observed. When interviewed on 10/15/24 at 12:32 p.m., NA-B stated R51 needed help with eating and most cares. NA-B stated they did not help R51 with morning cares that day and directed the surveyor to NA-C as they were assigned her care. NA-B stated they were unsure if R51 typically used foot pedals or a platform on their wheelchair adding, "I wouldn't be able to go into detail like that." NA-B stated they were unsure if there was a reason or rationale why R51 couldn't use pedals and reiterated aloud, "I'm not too sure." When interviewed on 10/15/24 at 12:43 p.m., NA-C stated they often worked with R51 and described her as needing "whole help" with cares. NA-C stated R51 had used the "tilting one" wheelchair for awhile and expressed she is supposed to use pedals at all times. NA-C stated they did not place the pedals on the wheelchair when they got R51 up and added, "Must be my nurse [who did]." NA-C stated placing the pedals must have "skipped from the memory" adding further, "She's supposed to have them on." However, NA-C stated R51 seemed to be just letting her feet dangle behind the pedals and not actually use them more in the past months. NA-C stated R51 used to be on hospice care but was removed from it "a few months ago" now adding therapy had, at one time, worked with R51 on her wheelchair positioning but it had been "a long time ago." NA-C stated they had never reported R51's dangling feet but felt the nurses were aware of R51 dangling her feet more and not using the pedals adding, "I think they see it."	F 684	F684: Revise insulin administration schedule to promote acceptable diabetes management and improve blood glucose levels for resident receiving dialysis. R161 insulin administration schedule has been revised to accommodate dialysis schedule. Policy and procedure of dialysis care will be reviewed and revised as needed. All residents receiving insulin and undergoing dialysis were reviewed to identify any other insulin administration scheduling conflicts. Adjustments were made where necessary. Charge Nurses will be educated on coordination of care for dialysis residents regarding medication and treatment time adjustments to accommodate dialysis schedule. Random audit of insulin administration records for dialysis patients, ensuring that no doses are missed will be conducted by the nurse managers or designee daily for a week, weekly for a month, and quarterly thereafter. Result of the audits will be reviewed in the QAPI meetings for further evaluation and recommendation.	

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F 684	Continued From page 13 R51's most recent therapy note, dated 1/22/24, identified R51 was seen by occupational therapy (OT) with dictation, "Per RN, resident to be d/cing [discharged] from hospice. Therapy provided 16" tilt-in-space [wheelchair] with standard foam cushion. Therapy to remain available for further needs." The note was authored by certified occupational therapy assistant (COTA)-A. However, R51's medical record was reviewed and lacked evidence therapy had been consulted or R51 had been assessed for wheelchair positioning despite direct care staff seeing R51 not use the provided foot pedals causing her legs to dangle unsupported. On 10/15/24 at 12:55 p.m., COTA-A was interviewed, and verified they are available to see patients in the long-term care units. COTA-A explained therapy places a note into the EMR when patient's are seen, including for wheelchair positioning, and reviewed R51's medical record. COTA-A verified they gave R51 the tilt-in-space wheelchair back in January 2024 and expressed pedals would have been provided at the same time adding, "It comes with cushion and foot rest." COTA-A stated if R51's legs were now dangling and not being supported on the pedals, then perhaps a "calf pad" or rest could be used adding, "I can go approach them [nursing] and see if that will work." COTA-A stated they could not recall anyone from nursing reaching out to them about R51's wheelchair positioning and verified if concerns were seen, such as unsupported feet or legs, then someone should consult therapy adding legs left dangling or unsupported could be a safety issue. When interviewed on 10/15/24 at 2:30 p.m.,	F 684		

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F 684	Continued From page 14	F 684		

registered nurse unit manager (RN)-A verified they had reviewed R51's medical record. RN-A explained R51 had been on hospice care prior and they were aware R51 often crossed their legs while seated in the wheelchair, however, they had just then contacted therapy about possibly getting a smaller wheelchair so R51's feet could a "a little closer to the ground" and better supported. RN-A stated they were unsure why staff had not been using the supplied pedals for R51's chair, as observed on 10/14 and 10/15, and verified the pedals should have been attached so "in case [R51] gets tired and want to put your feet down to rest." RN-A stated none of the nursing staff had reported concerns to them about R51's feet often being behind the pedals, when attached, and unsupported and expressed, "They [staff] should say something." RN-A verified R51's feet should not be left dangling and unsupported while seated in the wheelchair adding, "We agree on that."

A facility' policy on wheelchair positioning was requested, however, none was received.

SKIN PROTECTION:

R110's quarterly Minimum Data Set (MDS), dated 9/6/24, identified R110 had severe cognitive impairment and demonstrated no rejection of care behaviors.

R110's Physician Order Report, dated 9/16/24 to 10/16/24, identified R110's medical conditions along with both her current physician and nursing orders for care. This identified R110 had a history of vitamin deficiency and cellulitis (soft tissue swelling) to the left hand. R110's orders, including both physician orders and nursing orders, were

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F 684	Continued From page 15 listed with their respective start and, if applicable, stop dates. This included, "RISK FOR SKIN INJURY: Bilateral protectors on at all times ... Every Shift; Nights, Days, Evenings." The order had a start date listed, "05/13/2021 - Open Ended." On 10/14/24 at 12:34 p.m., R110 was observed seated in wide-back wheelchair by the doorway on the unit with a stuffed animal in her hands. R110 was asked her name and responded aloud, "I don't know." R110 hands along with the lower part of her arms and wrists were visible, and her right hand had light brown-colored discoloration present on top of the hand. R110 did not have any visible cloth or other protectors on her arms or hands at this time. On 10/14/24 at 1:15 p.m., R110's family member (FM)-D was interviewed. FM-D stated R110 had poor cognition and often would get bruises on her hands. FM-D stated R110, at times, would have cloth-type protectors on her arms and hands but others times not adding, "Sometimes [they] have them on." FM-D stated they believed maybe they were only used when bruises were noticed but was not sure. FM-D stated R110 seemed to bruise "pretty easy" though. Later on 10/14/24, at 4:52 p.m., R110 was again observed seated in her wheelchair. R110 was placed next to the dining room table and, again, had no visible protectors (i.e., geri-sleeves) on her hands or arms at this time. When observed on 10/15/24 at 11:39 a.m., R110 was again seated at the dining room table in her wheelchair. R110 did not have any visible protectors on her hands or lower arms at this time.	F 684		

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F 684	Continued From page 16 R110's skin care plan, dated 3/15/24, identified R110 was at risk for skin breakdown due to limited mobility, moisture exposure and cognitive impairment. The plan listed several interventions for R110 including use of a ROHO cushion in her wheelchair, daily skin checks by the nursing assistant (NA) staff, and elevating her heels off the bed surface. However, the care plan lacked direction or guidance on the ordered protectors. R110's Treatment Administration History (TAR), dated 10/2024, identified R110's physician and nursing orders along with spaces for staff to record their administration or refusal via initial. The TAR outlined an order which read, "RISK FOR SKIN INJURY: Bilateral protectors on at all times," along with a frequency listed, "Every Shift." The order was signed off every day within the month period so far as being completed (despite R110 being observed without them on for multiple days). On 10/16/24 at 9:14 a.m., R110 was again observed seated in her wheelchair while at the table. R110's hair was wetted and combed and she was dressed in a long sleeved shirt, however, her hands were visible and both had a tan-colored, cloth protector in place covering the hand' skin. When interviewed on 10/16/24 at 9:21 a.m., NA-D stated they were assigned to R110 and helped her with morning cares. NA-D stated R110 wore "geri-sleeves" on her hands and arms which were used to protect her skin adding R110 had a couple pairs of them in her room for staff to use. NA-D verified they placed the sleeves on R110 that morning and expressed aloud, "She's	F 684		

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F 684	Continued From page 17 supposed to have them [on] all the time." NA-D stated application of them was "on her care card" and the NA staff should be doing it. Further, NA-D reiterated R110 should be using the geri-sleeves at all times as R110 did, at times, get bruises on her hands adding, "Yea, sometimes she does." R110's medical record was reviewed and lacked evidence why R110's ordered skin protectors (i.e., geri-sleeves) had not been used as observed on 10/14/24 and 10/15/24. On 10/16/24 at 10:40 a.m., registered nurse unit manager (RN)-A was interviewed. RN-A stated the skin protectors for R110 were there as "just like an extra layer of skin" and verified the cloth-type protectors seen on R110 that day (10/16/24) are what the provider order referenced adding they were "an extra layer of protection." RN-A stated R110 used to be more mobile and would obtain cuts and bruises on her hands which is why they were added. RN-A stated they expected them to be on R110 as ordered or care planned adding, "The care plan should be followed." A facility' policy on non-pressure skin management was requested, however, none was received. DIABETES MANAGEMENT: R161's significant change Minimum Data Set (MDS), dated 9/7/24, indicated R161 was admitted to the care facility on 8/14/24, was cognitively intact and required supervision for activities of daily living (ADLs).	F 684		

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F 684	Continued From page 18 R161's Facesheet, printed 10/17/24, indicated R161 was admitted to the care facility with multiple diagnoses including end stage renal disease and type 2 diabetes mellitus with ketoacidosis (a serious complication of diabetes.) R161's Order History, dated 10/15/24, indicated R161 had an order for Novolog U-100 insulin aspart solution; 100 units per milliliter (ml), administered per sliding scale (amount administered based on current blood glucose reading) three times a day before meals at 8:00 a.m., 12:00 p.m., and 4:00 p.m. R161's care plan, dated 8/29/24, indicated R161 went to dialysis on Mondays, Wednesdays and Fridays with a start time of 11:30 a.m. The care plan further directed staff to "monitor/record/report blood glucose per facility schedule and policy and MD [doctor] order." R161's admission provider note, dated 9/5/24, indicated R161 was hospitalized 8/7/24 - 8/14/24 for diabetic ketoacidosis (a life-threatening complication of diabetes that occurs when the body doesn't have enough insulin to allow blood sugar into cells for energy.) The provider note further indicated R161 was hospitalized a second time on 8/23/24 - 8/31/24 for dialysis initiated due to renal failure. R161's medication administration record (MAR), dated 10/1/24 - 10/15/24, indicated R161 did not receive her noon dose of Novolog insulin on 10 out of 15 days in October, including Mondays, Wednesdays, and Fridays when out at dialysis. The MAR further indicated that R161's blood glucose level was over 200 19 times from 10/1/24	F 684		

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F 684	Continued From page 19 - 10/15/24. During an interview on 10/14/24 at 1:02 p.m., R161 stated she had concerns about the management of her diabetes and blood glucose levels. R161 stated she left the facility around 10:20 a.m., on Mondays, Wednesdays and Fridays for dialysis and took a bag lunch with her but no medications, voicing a concern for missing her noon administration of insulin. During a follow up interview on 10/16/24 at 9:38 a.m., R161 again voiced concerns about her elevated blood glucose levels, stating she needed to keep her blood glucose levels below 200 because she needed surgery for a dialysis fistula, but would be unable to until for hemoglobin A1C (a blood test that measures a person's average blood sugar levels over the past two to three months) dropped from 10% to 8.5%. During an interview on 10/16/24 t 9:16 a.m., registered nurse (RN)-H stated R161 went to dialysis three times a week on Mondays, Wednesdays, and Fridays, and while she was out a dialysis she would not get her 12:00 p.m. blood glucose check and insulin administration if needed. RN-H stated he had not updated R161's provider about her missing the 12:00 p.m. blood glucose check and insulin administration because they could check her blood glucose when she returned (at approximately 4:00 p.m.) and R161 was able to voice her preferences. RN-H stated he did not have any concerns with R161's blood glucose lately, noting the provider would be notified if her blood glucose was above 400 per R161's insulin order. During a follow up interview on 10/16/24 at 11:20	F 684		

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F 684	Continued From page 20 a.m., RN-H stated he had spoke with R161's provider that morning and her insulin administration schedule had been adjusted to accommodate her scheduled dialysis. New blood glucose checks and sliding scale insulin administration times were changed to 6:00 a.m., 10:00 a.m., and 5:00 p.m. During an interview on 10/16/24 t 1:25 p.m., R161's dialysis nurse (DN) stated R161 had voiced concerns to her about her unmanaged blood glucose levels. The DN stated R161 had had "really high fluid gains" and unmanaged blood glucose levels could have a "tremendous" affect on her fluid gains and the effects of her dialysis. During an interview on 10/17/24 at 9:58 a.m., R161 stated she had not been told about the change in her insulin administration schedule, stating, "Oh, good, that will help so much!" During an interview on 10/18/24 at 11:35 a.m., the director of nursing (DON) stated it would be expected that staff are notifying the provider if a medication is missed, stating if insulin is missed "just once", the provider should have been notified. In the case of R161, the DON stated the provider should have been notified to make a plan for ensuring R161 was receiving her insulin on scheduled dialysis days. A policy on medication administration and notifying a provider of missed scheduled medications was requested and not received.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		11/7/24

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F 689	Continued From page 21 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and, if needed, develop interventions with unsupervised eating to reduce the risk of accidental choking or asphyxiation for 1 of 1 resident (R67) who ate unsupervised in their room and had two documented episodes of choking. This constituted an immediate jeopardy (IJ) situation for R67. The IJ began on 9/14/24 when R67 choked for a second time on oral food, and the facility failed to comprehensively reassess R67's risk of choking, implement any interventions for increased supervision while eating or safe swallowing (i.e., speech therapy), or reeducate R67 and her responsible party on the risks of choking if R67 remained eating unsupervised as she had been despite choking. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 10/17/24 at 4:09 p.m. The IJ was removed on 10/18/24, but noncompliance remained at an isolated scope with potential for more than minimal harm that is not immediate jeopardy (Level D). In addition, based on observation, interview and document review, the facility failed to comprehensively assess for fall risk upon	F 689	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. F689: R67 was comprehensively assessed to determine interventions with unsupervised eating. Risk and benefit of resident□s meal preferences discussed with family on 10-17-24. Charge Nurses, CNAs, and dietary staff received education on safe eating protocols, supervision requirements, and the specific needs of R 67.	

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F 689	Continued From page 22 admission and with subsequent, repeated falls to determine what, if any, interventions were needed to ensure safety and reduce the risk of injury for 1 of 3 residents (R107) reviewed for accidents. R107 sustained actual harm when they fell multiple times after admission obtaining a head laceration and fracture hip. However, the facility had implemented corrective measures prior to the onsite survey, so these findings (falls) are being issued as past noncompliance. Findings include: CHOKING: R67's quarterly Minimum Data Set, dated 8/24/24, indicated R67 was admitted to the care facility on 12/9/22, had severe cognitive impairment, no swallowing problems and required partial to moderate assistance with eating and oral care. The MDS further indicated R67 was receiving hospice care. R67's facesheet, printed 10/17/24, indicated R67 had several medical diagnoses including dementia with behavioral disturbances, hemiplegia and hemiparesis following cerebral infarction (stroke), and dysphagia (difficulty swallowing) following cerebral infarction. R67's Orders, printed 10/17/24, indicated R67's diet order was mechanical soft, dated 3/23/24. R67's Progress notes, dated 3/4/24 through 10/17/24, indicated R67 had two choking episodes requiring staff intervention on 3/12/24 and 9/14/24. On 3/12/24 it was documented R67 was found in	F 689	A review of other residents was conducted to determine the potential to be affected by the same deficient practice, no other residents were found. The facility□s policies on choking and dietary management will be reviewed and revised. Charge nurses and dietary staff will be trained on dietary safety, supervision, and identifying and managing choking risks. Random audits daily for a week, weekly for a month, and quarterly thereafter will be conducted on residents who eat unsupervised. The results of the audits will be reviewed in QAPI for further recommendation and follow up.	

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F 689	Continued From page 23 her room "in a semi-fowlers position, mouth wide open, not talking, trying to cough but couldn't." R67 required the Heimlich maneuver when "finally a[n] object jumped out which was a piece of toast." The documented response was "diet changed to mechanical soft with choking precautions for residents safety." On 3/12/24 it was documented the licensed dietician (LD) met with R67 who did not want to stop eating toast, however it was "discussed cutting toast and other foods into small pieces, and alternating food and fluids. Also discussed cutting the crust off the bread." On 9/14/24 it was documented R67 was out in the small dining area when she was noted to be "holding her neck and struggling to breathe" when staff "managed to get the food out that was stuck in resident throat." Approximately 20-30 minutes later, R67 became unresponsive for 5-10 minutes. On 9/16/24 it was documented R67 was visited by speech therapy, however a "bedside ST [speech therapy] eval[evaluation] not completed d/t [due to] resident's active hospice status. OK for nursing staff to downgrade solids and liquids as needed for safety." R67's Associated Clinic of Psychology note, dated 3/13/24, indicated it was discussed with R67 that she could continue to eat preferred foods such as toast with a staff member present in her room, however lacked any discussion of the risks of choking or asphyxiation with R67 and her responsible party if R67 continued to eat unsupervised.	F 689		

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F 689	Continued From page 24 R67's Care Plan, dated 3/13/24, indicated R67 was "at risk for choking resident has no upper teeth, root tips on lower and had Dx [diagnosis)] = dementia, psychosis Res [resident] declines to get up for meals - eat in bed, declines staff sitting in room during meals ok'd [okayed] supervision. Risks and benefits discussed." A dcoument labeled, Approaches, also dated 3/13/24, indicated for staff to check R67's vital signs and lung sounds for 48 hours after a choking episode, to notify family, hospice and R67's nurse practitioner with significant changes, to check on R67 "frequently" throughout mealtime to ensure R67 is safe and free from choking, and to position R67 in a "90 degree position" for each meal. The Care Plan lacked any clarity on what "frequently" meant or how often it would be expected for staff to check on R67. The Care Plan further lacked any updates after R67 second choking episode on 9/14/24. R67's electronic medical record (EMR) lacked documented evidence a discussion of the risks and benefits of R67 continuing to eat toast and a mechanical soft diet, unsupervised, after a second choking episode was discussed with R67 and her responsible party. R67's EMR further lacked a comprehensive reassessment and if warranted care plan updates were completed after R67's second choking episode. During observation on 10/14/24 at 5:34 p.m., R67 was sitting up in bed, unsupervised, with an over the bed table across her lap with her dinner set up. On her plate was two slider sized buns with sliced meat and multiple tator tots, not cut into small pieces. R67 was alone in her room with staff present in the main dining room area assisting other residents with dinner.	F 689		

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F 689	Continued From page 25 During observation and interview on 10/16/24 at 10:16 a.m., nursing assistant (NA)-C brought R67 peanut butter and jelly toast, stating because it was R67's "favorite." R67 was sat up in bed and NA-C left the room. During an interview on 10/16/24 at 11:41 a.m., NA-C stated he was aware of R67's choking episode but had been off that day, stating she had choked on a piece of toast. NA-C stated that despite R67 choking on toast, it "didn't happen very often" so R67 was still given toast to eat unsupervised in her room. During an interview on 10/16/24 at 12:05 p.m., speech therapist (ST)-A confirmed she was aware of R67's choking episodes but did not do an evaluation of R67's swallowing on 9/16/24 because she was on hospice, stating if she was not on hospice her choking episode would have warranted a "full evaluation." ST-A stated R67 remained on a mechanical soft diet after her choking episode, and it was recommended for the nursing staff to "downgrade [R67's] diet [to puree] as needed." During an interview on 10/17/24 at 7:55 a.m., social worker (SW)-A stated she recalled R67's choking episodes back in March but did not "remember anything" about R67 choking last month. SW-A stated she remembered having a conversation with nurse manager and registered nurse (RN)-A after R67's choking episode back in March and being told they should be offering R67 "whatever brings her joy". SW-A confirmed R67 was not evaluated by speech therapy back in March after her first choking episode or last month after her second choking episode, nor by	F 689		

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F 689	Continued From page 26 the dietician after her most recent choking episode and was unable to find any documented evidence of a risk versus benefit being competed with R67 for her responsible party regarding offering food choices to R67 that would bring her joy versus safety or what those safer food options would be. During an interview on 10/17/24 at 8:04 a.m., registered nurse (RN)-I stated it was a standing order for all residents that nursing staff could downgrade their diet if needed, meaning if a resident was coughing a lot while eating or drinking, they could downgrade their diet to mechanical soft or puree. RN-I stated they would change the diet and follow up with the doctor. During an interview on 10/17/24 at 2:06 p.m., RN-I stated when R67 was eating in her room, staff would try to check on her every 15-20 minutes. During an interview on 10/17/24 at 2:30 p.m., NA-E stated R67 was independent with eating after she was set up and stated staff would check back every 20-30 minutes to see how well she was eating. NA-E stated R67 "loved" eating toast for breakfast and was unaware of any choking episodes or problems R67 had with chewing or swallowing, again stating she was independent with eating. NA-E stated each resident had a care sheet hanging in their closet to explain what type of diet they were on and how they transfer and other cares however R67's was missing. During an interview on 10/17/24 at 8:44 a.m., RN-A stated there was a standing order for all residents that nursing staff can downgrade a diet if a resident was coughing, having difficult	F 689		

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F 689	Continued From page 27 chewing, or choking on their food, stating nursing staff could change the diet and they would have speech therapy follow up and evaluate. RN-A stated R67 had "coughing" episodes, stating, "I would not really call them choking episodes" however agreed that requiring the Heimlich Maneuver and struggling to breathe would be considered a choking incident. RN-A stated after R67 required the Heimlich Maneuver back in March they attempted to change R67's diet to puree but she refused to eat stating they settled on a mechanical soft diet. RN-A stated her goal would be to have R67 out of bed for every meal, but she often refuses to get up and will often refuse to eat if a staff member is in the room with her, stating R67 will "eat when she is ready." RN-A stated staff had been educated to ensure R67's head of bed was elevated when she was eating, "as much as she [R67] will let us." RN-A stated she had talked with R67's responsible party at her last care conference on 9/11/24 (three days before her second choking episode). RN-A confirmed there was no documented risk versus benefits, no comprehensive reassessment of R67 after her second choking episode, and no changes to her care plan despite current interventions not preventing a second choking episode. During an interview on 10/17/24 at 8:11 a.m., R67's hospice nurse (HN) stated she was on call when R67 choked last month stating she received a call that R67 choked on a piece of bread and stated R67 didn't require the Heimlich Maneuver but at one point couldn't breathe and went into a "state of unresponsiveness." HN stated the day after the choking incident R67 did not eat or take any of her medications, stating "I think she was afraid" to choke again. The HN stated because it	F 689		

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F 689	Continued From page 28 was an "isolated event" and R67 was on hospice, a speech evaluation was not done and further stated at a care conference back in March they had discussed R67's diet and the risks associated with it but had not discussed it since her most recent choking episode. During an interview on 10/17/24 at 11:53 a.m., the director of nursing (DON) stated he could not recall R67's choking incident which happened last month and stated he would have expected the dietician to be involved, hospice to be notified and a speech therapy evaluation to be completed, even with R67 on hospice, confirming the dietician did not evaluation R67 nor was a speech therapy evaluation done after the choking episode in September. The DON further stated he would have expected a comprehensive assessment of what R67 would be willing to do/eat and what she wouldn't, along with the risk associated, and stated this should all have been documented in the EMR. The DON further stated he would have expected for a new plan to be developed since the current interventions in place did not prevent a second choking episode. During an interview on 10/17/24 at 12:08 p.m., R67's responsible party and family member (FM)-A stated she was not aware that R67 was still eating toast for breakfast and thought R67 was on a pureed diet. FM-A stated, "I guess she can't have toast anymore" and they would have to determine what else R67 would be willing to eat for breakfast. FM-A stated she did not believe that R67 would "logically" be able to make the decision on her own regarding the risks versus benefits of continuing to eat toast and other non-pureed foods. FM-A further confirmed the risks of potentially choking to death were not	F 689		

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F 689	Continued From page 29 discussed with her and while she acknowledged R67 was on hospice she did not want her to "die in a horrific manner" from choking. During a follow-up interview on 10/17/24 at 2:35 p.m., nurse manager and RN-A stated they had tried cutting up R67's toast and cutting the crust off per the dietician's March note but R67 would not eat it that way. RN-A stated there was not a time frame for how often to check on R67 when she was eating, and stated she tires easily when she eats so staff were not sure when she would be eating or sleeping. RN-A further stated they had not documented the attempts to cut R67's crust off her toast and she had not discussed the choking episodes with R67's provider but believed the floor nurses had updated the provider. During an interview on 10/18/24 at 10:55 a.m., the medical director (MD) stated he was not made aware of R67's choking episodes until today. The medical director stated he would have advised to change her diet to puree and recommended that she eat in a supervised environment, even with a pureed diet, stating it was an issue with personal preference but also safety. The MD Further stated there was no reason R67 could not have a speech therapy evaluation. The immediate jeopardy that began on 9/14/24, was removed on 10/18/24, when the facility comprehensively reassessed R67, changed her diet to puree, documented discussing the risks of eating unsupervised with R67's responsible party, and educated staff on the care plan changes for R67, but the noncompliance remained at the lower scope and severity because of the	F 689		

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F 689	Continued From page 30 continued risk for potential harm with R67 continuing to eat unsupervised. FALLS (past noncompliance): R107's admission Minimum Data Set (MDS), dated 7/26/24, identified R107 admitted to the care center from the acute hospital. The MDS outlined R107 had severe cognitive impairment, demonstrated no physical or verbal behaviors, and had no rejection of care episodes. The MDS continued and listed a section labeled, "Section J - Health Conditions," which identified R107 did not have a terminal prognosis along with several questions related to R107's fall history (i.e., falls in the month(s) prior to admission), however, these were all answered with, "9. Unable to determine." However, after admission to the care center, the MDS recorded R107 had sustained one fall without injury. The MDS corresponding CAA (Care Area Assessment) Summary Report, completed 8/1/24, identified the various triggered CAAs for R107 which included one labeled, "CAA 11. Falls." This identified R107 was at risk for falls related to impaired cognition, pain, and impaired mobility. The CAA recorded, "One fall during look back without injuries with a matt [sic] placed on the floor next to his bed when he is in bed for safety/injuries. Receives supervision assist with bed mobility, toileting, and transfers currently in	F 689		

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F 689	Continued From page 31 therapy, plan is for short term care per wife ... Staff to place call light within his reach at all times when in his room and encourage him to use. Fall risk assessments per facility protocol." The CAA directed care planning would be completed adding, "Proceed to care planning for fall and injury prevention." On 10/14/24 at 1:50 p.m., R107 was observed seated in a standard wheelchair in the commons area of the locked unit (i.e., memory care) with good posture and no leaning or slouching. R107 had a tan-colored bandage on his right hand and stated he had "scratched it" but was unsure how. R107 was unable to recall how long he had been at the care center and abruptly replied, "I don't live here." R107 stated he was unsure what, if any, lunch meal they had that day, either. R107's current care plan, dated 8/26/24, identified R107's assessed problems, respective goals, and subsequent interventions to meet those goals. A total of three sections were labeled, "Category: FALLS," and each outlined R107's various rationale for fall risk including but not limited to a history of falling, gait/balance problems, self-transfer attempts. All these sections were recorded as still in effect (i.e., not resolved) and these problem statements and interventions in chronological order outlined: "Problem Start Date: 07/20/2024," outlined R107 as being at risk for falls and was last edited on 10/1/24, and a goal was listed which read, "Will remain free from falls and fall-related injuries," with a goal date recorded, "11/21/2025." The section included multiple interventions to help R107 meet the goal including staff to do hourly well-checks to ensure safety, offer toileting or	F 689		

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F 689	Continued From page 32	F 689		

food if persistently self-transferring, and a low bed for safety. However, all the interventions listed within this section listed a start date of 8/21/24 or later. The problem statement and interventions were all initiated by registered nurse unit manager (RN)-A.

"Problem Start Date: 07/22/2024," outlined R107 as being at risk for falls and was last edited on 7/22/24, and a goal was listed which read, "Will remain free from falls and fall-related injuries," with a goal date recorded, "10/22/2025." The section included multiple interventions to help R107 meet the goal including pharmacy consults per protocol, promoting scheduled rest periods, reinforcement to request assistance, not leaving unattended while in the bathroom, safety checks on shoes, monitoring for foot pain, ensuring proper lighting, providing non-skid material in the wheelchair and, "When falls occur investigate root cause through IDT [interdisciplinary team] meeting protocol," and, "When falls occur nursing to monitor using CEOM [Catholic Eldercare on Main] fall protocol." All the interventions listed had a start date recorded, "07/22/2024."

R107's progress note, dated 7/19/24, identified R107 admitted to the care center locked unit on 7/19/24 for long term care placement. R107 was recorded as having a history of alcohol-induced dementia, chronic obstructive pulmonary disease (COPD), and prior stroke. The note outlined, "Resident alert, memory is impaired with poor insight and judgement ... has Foley Catheter ... He is totally dependent on staff for ADL including dressing, grooming, bathing, and transferring." A subsequent note, dated 7/21/24, identified R107 was alert with impaired memory and poor insight. The note added, "He attempt to self transfer with

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F 689	Continued From page 33 out adequate or calling for help [sic]. He is easy to redirect ..." Later, on 7/21/24, another note identified a bed rail was added to his bed to promote increased independence with mobility adding, "Bed rail necessary for use as mobility device," and "Nurse manager updated." On 7/22/24, the notes outlined R107's Foley catheter was removed, and routine bladder scans were started. On 7/23/24, R107 was found with bloody urine adding, "When this writer arrived patient was standing in the middle of his room, urinating and his urine and mixed [sic] with large amount of blood. VS WNL [vital signs stable] ..." Further, another progress note, dated 7/24/24, was recorded with R107 now being COVID-19 positive with symptoms of nasal drainage and emesis. R107's 'SBAR [situation, background, assessment, response]' progress note, dated 7/26/24 at 5:36 p.m., identified R107 sustained a fall without injury. The note outlined, "[nursing assistant] approached this staff at [3:00 p.m.] to say pt [patient] was on the floor in his room. This staff found pt laying on the floor near his bed. Pt denied pain. This staff noted that pt didn't have one of his gripper socks on ... stated that he was self-transferring. Neuro's intact X1, ROM [range of motion] X4 ... R [response]: This staff informed the Evening Supervisor, the Nurse Triage line, the POA [power of attorney]. This staff placed a floor mat in pt's room next to pt's bed. This staff updated pt's care plan to the fall." R107's corresponding Event Report, dated 7/26/24 but closed 8/21/24, identified R107 had sustained a fall without injury in his room adding, "Pt found on the floor near his bed by the NAR." R107 was recorded as lying in bed just prior to the fall and the fall itself was unwitnessed. R107	F 689		

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F 689	Continued From page 34 demonstrated no pain from the fall and the section provided to record what, if any, injury was obtained answered, "N/A." A section labeled, "Possible Contributing Factors," identified R107's impaired cognition and infection (COVID-19) with a checkmark placed next to each, respectively. R107 was recorded as being on an antibiotic and a subsequent section was labeled, "Interventions - Immediate measures taken," which had a checkmark placed next to, "Rest," and "Other - Floor mat to floor next to bed." The report included multiple follow-up progress notes which outlined R107 was at baseline. However, R107's medical record lacked recorded evidence the IDT had reviewed this incident or what, if any, interventions aside from a mat on the floor were considered or implemented. Further, the record lacked any completed comprehensive fall evaluations or assessments upon admission to the care center (on 7/19/24), including with all potential risk factors and what, if any, immediate interventions were assessed as needed despite R107 being recorded in the progress notes as having cognitive impairment with poor insight, needing total assistance with ADLs, and being found standing up in the middle of the room after his Foley catheter was removed (i.e., self-transfer). R107's SBAR progress note, dated 8/19/24 at 6:54 p.m., identified R107 sustained an unwitnessed fall with injury. The note outlined, " ... was found in room on the floor with his wheel chair upside down. He had a cut over his left eye and blood on the floor. Resident was assessed and transferred to chair, pressure applied to site and bleeding stopped ... ROM is intact, he was able to move all extremities, a neuro assessment	F 689		

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F 689	Continued From page 35 and vitals started. Resident spouse was notified and along with [medical provider]." There was no corresponding Event Report for this incident identified in the medical record. A series of subsequent progress notes, dated 8/20/24 through 8/23/24, reiterated the fall had occurred along with nearly all of them having outlined R107 had returned to baseline, and with a dressing in place over his left eye now adding a purple discoloration was present, too. However, a note dated 8/21/24 at 4:44 p.m., had R107 recorded as having some delusional thinking. The note outlined, " ... pt wanted this staff to close the garage door and get his wife." However, again, R107's medical record lacked documented evidence the IDT had reviewed this incident for any root-cause analysis review nor what, if any, other interventions were considered or implemented by the IDT. Further, the medical record continued to lack any completed comprehensive fall evaluations or assessments despite R107 having sustained two falls and demonstrating delusional thinking during similar evening hours (i.e., 4:00 to 7:00 p.m.). There was no evidence documented to provide rationale for what, if any, comprehensive causative factors were considered or evaluated to ensure effective, proactive interventions to reduce his fall risk despite the care plan being updated on 8/21/24 with interventions (i.e., low bed) which were not documented as being a factor in the progress note about the fall with injury. R107's SBAR progress note, dated 8/26/24 at 5:30 a.m., identified R107 sustained a fall due to self-transferring. The note outlined, "Resident was found on the floor when aide notified nurse around 0523 when he was being check on [sic].	F 689		

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F 689	Continued From page 36 Resident was found in the supine position at the foot of his bed ... incontinent of bowel; and bladder when he was found ... bed was in lowest position when he was found on the floor with w/c [wheelchair] in the middle of the room ... showed no signs of having pain at the time ... was resistive to care at the time he was being assisted ... Will report to AM staff to notify [medical provider], family, and continue to monitor." However, a subsequent note dated 8/26/24 at 7:10 a.m. (little over 90 minutes later), identified R107 was found sitting up in bed at 0640 and complaining of right hip pain. The note outlined, " ... [R107] had grimacing on his face and notified staff his right hip/side is in excruciating pain ... complained of pain to touch and with ROM on his right hip ... cognition is impaired with primary DX [diagnosis] of dementia and history of fall." The note identified the medical provider was updated, and an order for pain medication and an x-ray obtained. A subsequent note, dated 8/26/24 at 2:38 p.m., identified R107 was being transferred to the hospital with " ... Right femoral intertrochanteric fracture possibly post fall." A subsequent note, also dated 8/26/24, identified R107 had dementia adding, "Pt has a dx of Dementia and fell today this am, fracturing his right femur ... Pt's [family] talked with MD at the hospital and plans on pt having surgery to fix his right femur." R107 was re-admitted to the care center from the hospital on 8/30/24. R107's corresponding North Memorial Health Admission History and Physical, dated 8/26/24, identified R107 who presented to the hospital " ... after an unwitnessed fall with right hip pain, found to have a hip fracture. He has bruising scattered throughout his body but only c/o [complains] pain in his right leg. Denies other concerns, though he	F 689		

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F 689	Continued From page 37	F 689		

is not oriented." A series of imaging was obtained, including an x-ray of the femur, which identified, "Acute fracture of the proximal femur." R107 was recorded as preparing for surgery intervention to preserve quality of life and needed to be hospitalized for surgical management.

R107's John Hopkins Fall Risk Assessment Tool, dated 8/31/24, was completed after R107 returned from the hospital and included multiple questions answered to help determine a risk-based score for falls such as previous number of falls and changes in condition. This assessment tool scored R107 as 23.0 which outlined, "High Fall Risk." This evaluation was the first one completed as identified within the medical record.

When interviewed on 10/16/24 at 1:21 p.m., NA-D stated they had worked with R107 multiple times at the care center and described him as needing "total" assist with cares. NA-D stated staff often have to use encouragement to get him to allow cares and verified R107 was no longer ambulatory since he fractured his femur adding, "He used to [walk[but not anymore." NA-D stated staff tried to "just keep checking on him" often since he returned from the hospital, and explained R107 used to try to self-transfer more often which caused his falls. NA-D stated R107 had used a low bed since he admitted to the care center and obtained the bedside mat after one of his falls adding, "Not everybody get floor mat." NA-D stated if a fall happens, they report to the nurse who then must evaluate them before staff can get them up adding any new interventions or care following a fall would be communicated to the NA staff using shift-to-shift verbal report and "the care card." NA-D stated these were kept

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both in the room and on the computer for the NA to reference on how to care for each resident adding it was "our responsibility" to view them each shift. NA-D stated R107 currently used a low bed, mat on floor and was being routinely checked on adding he was less mobile than prior.

On 10/16/24 at 1:36 p.m., licensed practical nurse (LPN)-A was interviewed, and explained when a resident admits they are assessed for their fall risk using a "John Hopkins" tool which then helps develop the care plan. LPN-A verified the floor nurses are responsible to do the tool. LPN-A stated if a fall happens after admission, the nurses will check the resident' vital signs, assist them up, and initiate neurological checks if the fall was unwitnessed. LPN-A stated any immediate interventions to help prevent further falls would be dependent on "what the situation is" adding "every fall is kind of different." LPN-A explained the nurse should be updating the medical provider along with doing three items post-fall which included starting a "short-term fall care plan," stating "an event," and completing the paper-based data collection tool. LPN-A explained the paper-based tool was used to record initial data adding it was "kind of brief" with "not too many lines" to do before it gets routed to the nurse manager who, from there, takes the data and meets with IDT where "they talk about it." LPN-A explained the event and short-term care plan were "like a template" which could help guide the nurses on actions or possible interventions. LPN-A recalled R107 having sustained a fall and explained he now used a low bed along with a bedside mat to prevent injury adding they "can't remember off hand" when each intervention was added. LPN-A stated staff always try to "keep an eye on him" and ensure

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F 689	Continued From page 39 the call light was in reach, too, as R107 still, at times, could be "a busy man" and try to move around. LPN-A stated R107's mobility since the femur fracture had "decreased a little bit" and he was no longer ambulatory. Further, LPN-A stated any root-cause analysis of the falls, including potential proactive intervention development, would be "the nurse managers" to do with IDT as they "do their analysis and determine the cause." On 10/17/24 at 10:06 a.m., registered nurse unit manager (RN)-A and the director of nursing (DON) were interviewed, and R107's medical record was reviewed. DON explained, upon admission, the nurse was responsible to complete the "fall risk assessment" on each resident which DON verified was the "John Hopkins" tool. The completed tool is then reviewed by the MDS nurse or unit manager, and the evaluation is then repeated quarterly thereafter with the "fall risk care plan" being developed from it. DON verified the care plan and fall risk assessment were the only two items used within the medical record to demonstrate the facility' comprehensive fall risk evaluation process. DON verified the fall risk assessment was not completed upon admission and should have been, however, attributed the development of a care plan (dated 7/20/24, 7/22/24) as belief someone had done an evaluation. RN-A stated they likely initiated the care plan for R107 on 7/20/24 but added, "I don't remember." RN-A explained they initiated the 7/22/24 falls care plan for R107 but expressed they didn't recall if they reviewed any completed fall risk evaluations or not with it. RN-A stated the "main reason" they initiated it was R107 had a history of falls adding the interventions placed on both the initial care plans, dated 7/20/24 and 7/22/24, were placed	F 689		

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F 689	Continued From page 40 "while we [got] to know him" as the team "didn't know him right away." RN-A and DON both verified the first completed John Hopkins fall risk evaluation was completed upon R107's return from the hospital after he sustained a broken femur and DON added, "I think there was a miss there." DON stated they felt a possible Internet "global failure" around the same time may have contributed to it being missed for so long but were unsure. RN-A explained R107 had used a low bed "from day one" as R107's family was insistent of it. The interview continued with DON and RN-A who reviewed R107's falls. On 7/26/24, R107 sustained a fall without injury and the "incident information" was provided. R107's Catholic Eldercare Resident Incident Report, dated 7/26/24, identified R107 was found on the floor near his bed by the NA. R107's vital signs were stable, and he denied pain with no injury apparent. The form identified a temporary care plan and event were initiated per protocol; and the use of a blue mat at bedside was added to the care plan immediately after the fall. DON acknowledged the form and explained the temporary care plans were used then typically resolved after 72 hours. DON stated they attempted to locate the temporary care plan for R107's fall on 7/26/24 but, so far, had been unable to find it. When questioned on the IDT review process, DON stated the IDT review could be completed solely by the nurse manager but added the IDT met every day during the business week and each fall was typically reviewed aloud to see what, if any, "additional interventions" could be needed. RN-A stated they felt they had discussed this fall with the IDTbut acknowledged the lack of documentation in the medical record to support such adding, "I don't physically find it in	F 689		

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F 689	Continued From page 41 here." RN-A stated the IDT review was typically something which should be documented in the medical record, and verified the care planned interventions were more-so a standard listing of interventions due to R107 being "pretty new" to the campus. DON stated the John Hopkins' tool was not routinely repeated after each fall, either, but more on an "as needed" basis. On 8/19/24, R107 sustained a second fall and obtained an injury. DON verified the progress note with the fall and stated aloud, "This is the first time I've seen this." DON verified the medical record lacked any 'event' for the fall and stated one should have been started as that would be the process which "would trigger" the IDT review process. RN-A stated they didn't recall if they had reviewed this fall or not adding R107 had "quite a few falls" and, "I can't say I do or don't [recall]." DON stated they would check to see if there was additional documentation (i.e., paper-based tool, temporary care plan) to provide for this fall and what, if any, follow up actions had been completed. DON stated they couldn't recall any investigation into this fall as, "I just saw this now." On 8/26/24, R107 sustained a third fall and was found on the floor in his room. R107's Catholic Eldercare Resident Incident Report, dated 8/26/24, identified R107 had sustained a fall with injury and had pain in his right hip. The section to outline a description of the fall was responded with, "See attached," however, nothing else was attached. The interventions in place were listed and included a low bed, blue mat on floor, and frequent checks. The form concluded with dictation that a fracture was noted and R107 was sent to the hospital. DON acknowledged the form and verified R107 sustained a fracture with the	F 689		

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F 689	Continued From page 42 incident. However, since R107 had returned he had now been comprehensively assessed for fall risk, care plan adjusted, and the facility had revised their incident reporting process to ensure the assessments after a fall were not missed. DON verified the root-cause analysis process was now happening within IDT and being recorded in the progress notes. Further, the DON verified verbal education had been completed with the involved staff members who assisted with R107's falls. Later on 10/17/24 at 12:27 p.m., DON provided the additional documentation they could locate about R107's multiple falls. R107's Care Plan History, dated 8/19/24 to 8/24/24, identified a care plan was developed on 8/19/24 and listed, "Category: FALLS," and dictation reading, "Fall r/t [related to] cut over left eye." A single goal was listed multiple times which read, "Short Term Goal Target Date: 09/01/2024 - DC ON: 08/23/2024 - Resolved [space] Mobility will be at resident's highest level." The plan then listed several interventions which included cleansing the left eye and application of a dressing until healed, vital signs and neuros, family and provider notification, applying ice to the affected area as needed, initiate the short-term skin injury care plan, initiate the short-term injury care plan, monitor for 72 hours for bruising or other injury, orthostatic blood pressures, and review pain medication or interventions. However, the temporary care plan lacked any proactive interventions to prevent additional falls nor evidence the IDT had reviewed these interventions or the fall on 8/19/24. DON acknowledged the lack of these items and stated they still were unable to locate the 'event' for the 8/19/24 fall adding, "We're still looking for that."	F 689		

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F 689	Continued From page 43 DON acknowledged the medical record lacked evidence to show their fall review process had been consistently followed or implemented prior to R107 falling and sustaining a hip fracture. No further information was provided or received about R107's past, respective falls. The past noncompliance which began on 7/19/24 was verified, but also found to be corrected prior to the onsite survey exited 10/18/24. The facility' corrective actions were confirmed through a sample of other residents with recent sustained falls, including R107, and verbal interviews with staff and management to affirm education was completed. R107's medical record was reviewed and verified R107 had been comprehensively assessed for fall risk, and the IDT review process was being completed since R107 returned from the hospital. There were no other concerns identified regarding falls during the onsite survey. A Fall Risk Assessment policy, dated 5/2024, identified nursing would complete a Fall Risk Assessment on new admission and re-admissions adding the MDS coordinator or nurse manager would then complete/review it quarterly, annually and with significant changes. The policy continued and identified the MDS coordinator would complete CAA(s) to address fall risk and if the completed evaluation identified a score of 10 or higher; the nurse manager would develop and implement a fall prevention plan which would be communicated to the staff and family. The policy added, "Staff and IDT will review all actual falls and update care plan as necessary." A Interdisciplinary Team Resident Event Review	F 689		

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F 689	Continued From page 44 policy, dated 3/2024, identified all resident' events, including falls, would be reviewed by members of the IDT. The policy outlined the nurse manager would review all events on the unit and follow-up as needed adding, "Documentation of the event in the EHR [record] will be verified and preventative interventions will be evaluated." The policy directed IDT would review events Monday through Friday and as demand needed with members. The policy listed these members as including, but not limited to, the social services, therapeutic recreation, nurse managers, quality assurance (QA) nurse, MDS nurse, and the DON and administrator. The policy added, "Documentation of reviews will be done in the individual resident's EHR."	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to consistently assess a resident's pain level prior administration of an as-need narcotic pain medication, in addition, the facility failed to assess for and implement if requested non-pharmacological pain interventions for 1 of 2 residents (R106) reviewed for pain management. Findings include: R106's quarterly Minimum Data Set (MDS), dated	F 697	F697 R106's pain level assessment and documentation prior to administering as-needed narcotic pain medication has been added to MAR. R106□s care plan has been updated to include non-pharmacological intervention options. All residents receiving as needed analgesic narcotic medications will be audited for pain assessment and	11/7/24

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F 697	Continued From page 45 8/28/24, indicated R106 had intact cognition with no hallucinations or delusions. R106's diagnoses included polyneuropathy (damage or disease affecting nerves in roughly the same areas on both sides of the body), muscle weakness, radiculopathy (the pinching of the nerves at the root), other symptoms and signs involving the musculoskeletal system-wheelchair dependent and alcohol dependence with withdrawal. and required, at least, substantial/maximal assistance with dressing, sitting up or transferring. Further, under "Section J - Health Conditions," the MDS identified R106 consumed no scheduled pain medication but received as-needed (i.e., PRN) pain medication along with non-medication intervention for pain; furthermore, R106 reported pain on a frequent basis which occasionally effected sleep, rarely or not at all interfered with day-to-day activities with a verbal descriptor scale of moderate pain. R106's face sheet, printed 10/17/24, indicated R106's diagnoses included: chronic pain, history of neuralgia (nerve damage or irritation that causes sharp, shock-like pain) and neuritis (inflammation of nerves that can cause pain), insomnia (inability to sleep), other osteoporosis without current pathologic fracture left foot (condition which causes bones to become weak and brittle), urinary incontinence (loss of bladder control), and adult failure to thrive (a syndrome that describes a general decline in health in older adults). R106's care plan, printed 10/17/24, included the following interventions: "-[R106] has complaints of chronic pain R/T [related to] polyneuropathy of lower extremities	F 697	documentation of at least one non-pharmalogic intervention prior to administering PRN. Pain Management Policy will be reviewed and revised as needed. Charge Nurses will be educated on the facility□s pain management policy, with a specific focus on assessing pain levels and offering at least one non-pharmacological intervention before administering as-needed narcotics. Nurse managers or designee will conduct random audit daily for a week, weekly for a month, and quarterly thereafter of residents□ MARs to verify that pain assessments are documented prior to each administration of as-needed narcotic medications and that at least one non-pharmacological intervention is documented prior to administration Result of audits will be reviewed in the QAPI meetings for further evaluation and recommendation.	

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F 697	Continued From page 46 with the following approaches: acknowledge to the resident that her pain is unique and believable; assess effects of pain on the resident (disturbances in sleep, activity, self-care, appetites, psychosocial, etc.); assess past effective and ineffective pain relief measure; caution resident against using unproven cures such as alcohol consumption; handle gently and try to eliminate any environmental stimuli; monitor and record any complaints of pain: location, frequency, effect on function, intensity, alleviating factors, aggravating factors; monitor and record any non-verbal signs of pain: (e.g., crying, guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc.). -Pain with alteration in comfort r/t site: broken toe on left foot r/t to fall; neuropathic pain to bilateral lower extremities (from the knees down); chronic pain; pancreatitis r/t alcohol abuse with the following approaches: review pain interventions-implement or adjust interventions as needed, pharmacological-scheduled and PRN analgesics [medications that treat pain], non-pharmacological; rate pain before and after receiving PRN. Document any refusal of pain medications (PRN or scheduled) -Will offer activities that resident will find intriguing and of interest and make sure to invite her to those. Offer M technique hand massage, aromatherapy, and/or healing touch for physical psychosocial comfort. " During interview on 10/15/24 at 8:47 a.m., R106 was observed lying in bed. She stated she doesn't sleep well due to the constant pain she is in. R106 indicated she has pain from her toes to the middle of her back and in her hands. R106 indicated she gets "half a tab of oxy," and it doesn't treat my pain but "keeps me going.".	F 697		

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F 697	Continued From page 47	F 697		

R106 indicated the facility "don't do anything for my pain .....nobody does anything about it." R106 indicated she did physical therapy previously but "that doesn't help with nerve pain." R106 stated she might be interested in therapy again, so she doesn't lose any more strength as she feels she has "lost a lot." R106 became upset during interview and talking about pain and continued to state, "they don't do anything .... they want me like this."

R106's October Medication Administration Record (MAR/TAR), printed 10/16/24, included the following orders and administrations:
- "acetaminophen [Tylenol] (pain reliever) tablet 325 milligrams (mg) tablet administer 650 mg oral [by mouth] every 6 hours PRN. DX [diagnosis]: other chronic pain. Started 7/2/24."
-No administration or refusals documented in the month of October
- "tizanidine (muscle relaxer) 2 mg capsule administer 2 mg oral three times a day PRN. DX: neuralgia and neuritis. Started 7/16/24."
-No administration or refusals documented in the month of October
- "Offer lavender aromatherapy patch (found in the aromatherapy drawer at the nursing station). Apply one patch on the clothing or clean dry skin daily twice a day PRN. Started 9/24/24."
-No administration or refusal documented in the month of October
- "oxycodone (narcotic pain medication) 5 mg tablet administer 1/2 oral every 12 hours PRN. DX: other chronic pain. Started 7/10/24."
-Administered two times a day for the month of October except for 3 days when it was given one time a day. Of those administrations, 5/26 had a pain scale and 2/26 had a location of pain listed. The remaining administrations, 21/26

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F 697	Continued From page 48 administrations, did not have a pain scale listed and 24/26 administrations did not have a location of pain listed. - "Monitor and record any complaints of pain: location, frequency, effect on function, intensity, alleviating factors, aggravating factors every shift. Started on 10/23/24." -all marked as completed, -A review of the full medical record lacked any additional information related to the of the pain, such as, location, frequency, effect on function, intensity, alleviating factors, aggravating factors despite being marked completed on every shift in October. A review of R106's Pain Assessment Observation Details completed from 10/1/24-10/15/24 revealed the following; No Pain Assessment Observation Detail completed for R106 on 10/15/24. R106's Pain Assessment Observation Detail, dated, 10/14/24 at 8:37 p.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: no The rest of the assessment was left blank. R106's Pain Assessment Observation Detail, dated, 10/13/24 at 9:43 a.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes Pain frequency: almost constantly Pain effect on sleep: occasionally Pain interference with therapy activities: does not apply Pain location: left blank	F 697		

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F 697	Continued From page 49 Pain interference with day-to-day activities: occasionally Verbal scale rating: moderate No Pain Assessment Observation Detail completed for R106 on 10/11/24 and 10/12/24. R106's Pain Assessment Observation Detail, dated, 10/10/24 at 10:10 a.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes Pain frequency: almost constantly Pain effect on sleep: occasionally Pain interference with therapy activities: does not apply. Pain location: bilateral lower extremities Pain interference with day-to-day activities: occasionally Verbal scale rating: moderate No Pain Assessment Observation Detail completed for R106 on 10/8/24 and 10/9/24. R106's Pain Assessment Observation Detail, dated, 10/7/24 at 11:29 a.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes Pain frequency: almost constantly Pain effect on sleep: occasionally Pain interference with therapy activities: does not apply. Pain location: n/a [not applicable] Pain interference with day-to-day activities: almost always Verbal scale rating: moderate No Pain Assessment Observation Detail	F 697		

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F 697	Continued From page 50 completed for R106 on 10/6/24. R106's Pain Assessment Observation Detail, dated, 10/5/24 at 9:39 p.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes Pain frequency: almost constantly Pain effect on sleep: frequently Pain interference with therapy activities: almost constantly Pain location: generalized pain Pain interference with day-to-day activities: almost always Verbal scale rating: moderate R106's Pain Assessment Observation Detail, dated, 10/4/24 at 11:10 a.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes Pain frequency: almost constantly Pain effect on sleep: occasionally Pain interference with therapy activities: almost constantly Pain location: BLA Pain interference with day-to-day activities: almost always Verbal scale rating: moderate No Pain Assessment Observation Detail completed for R106 on 10/3/24. R106's Pain Assessment Observation Detail, dated, 10/2/24 at 8:26 p.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes Pain frequency: occasionally	F 697		

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F 697	Continued From page 51 Pain effect on sleep: occasionally Pain interference with therapy activities: does not apply. Pain location: bilateral toes Pain interference with day-to-day activities: left blank Verbal scale rating: left blank A review of the Pain Assessment Observation Details completed for October lacked indication of non-pharmacological interventions offered or discussed. The documents further lacked coordination of the timing of administration of PRN oxycodone and other medications being offered prior to administration of narcotic medication. R106's Permission Form for the use of Healing Touch, dated 10/24/23, was signed by R106. R106'2 Consent for the use of Aromatherapy, dated 5/21/24, was signed by R106. Progress notes reviewed from 9/1/24 to 10/17/24 identified the following: -10/1/24: note indicated resident rated her pain at 8/10. The note lacked indication of any intervention offered. -9/23/24: "resident had 2.5 mg oxycodone at 11:00pm". The note lacked indication of reason for medication, pain level or location, or non-pharmacological interventions offered. -9/20/24: "administer PRN oxycodone". The note lacked indication of reason for medication, pain level or location, or non-pharmacological interventions offered. -9/17/24: " .... Returned to res's room at 1250 to administer PRN oxycodone ....." The note lacked indication of reason for medication, pain level or	F 697		

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F 697	Continued From page 52 location, or non-pharmacological interventions offered. -9/9/24: resident reported she is unable to complete shower due to pain in lower legs. PRN Oxycodone administered. The note lacked indicated of pain level or non-pharmacological interventions offered. The progress notes, dated 9/1/24 to 10/17/24, lacked documentation of Healing Touch, aromatherapy or other non-pharmacological interventions being offered or declined during the period reviewed. Furthermore, the notes lacked evidence of a discussion with R106 of preferences of non-pharmacological interventions being offered. R106'2 Quarterly care conference note, dated 9/12/24, reviewed care for the last quarter. The note lacked evidence of discussion of R106's pain. Furthermore, it lacked evidence of discussion of pain interventions of non-pharmacological interventions. During an interview on 10/16/2024 at 11:14 a.m., registered nurse (RN)-E stated that residents pain level is measured on a pain scale. RN-E stated the pain level should be documented in the comment section on the medication administration record when a pain medication is administered. RN-E stated the pain level can also be documented in a progress note along with any non-pharmacological interventions offered. During an interview on 10/16/2024 at 12:33 p.m., RN-F indicated they are familiar with R106. RN-F verified that a pain level should be assessed prior to giving as needed pain medication. RN-F verified other interventions should be attempted	F 697		

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

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F 697	Continued From page 53 prior to giving as needed pain medications. RN-F verified that non-pharmacological intervention would be documented on the medication/treatment administration record (MAR/TAR) and the pain level would be documented in the comment section in the MAR when giving the medication. On 10/16/2024 at 12:54 p.m., RN-D stated the expectation was that prior to administration of pain medication that an assessment should be completed. The assessment includes the type of pain, location of pain, pain scale, non-pharmacological interventions offered, effectiveness of the non-pharmacological interventions and then offer a PRN (as needed) pain medication. RN-D stated it is also important to follow-up to see if the PRN medication was effective. RN-D stated it is expected the pain scale to be documented in the comment section when administering R106's PRN oxycodone medication. RN-D did not answer regarding non-pharmacological intervention documentation when asked. RN-D reviewed administration of last 14 days (10/2/24 to 10/16/24) and verified a pain scale was entered 5 times out of 26 times PRN oxycodone was administered. During interview on 10/17/24 at 9:54 a.m., nurse practitioner (NP)-A stated that a pain assessment and non-pharmacological interventions should be offered prior to administration of pain medications. NP-A stated a pain scale should be completed, documented, and then to attempt and document non-pharmacological interventions prior to administration of pain medications. NP-A stated residents can refuse non-pharmacological interventions, but it is important we are asking and documenting. NP-A indicated it is important	F 697		

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F 697	Continued From page 54 we are assessing and re-assessing pain to see what is working and not working and should be documenting all of it. NP-A indicated that pharmacists can be a good resource also for suggestions. During interview on 10/17/24 at 10:37 a.m., pharmacist consultant (PC)-A indicated that it is important for non-pharmacological to be offered and documented on prior to giving as needed pain medication. PC-A stated it is important that pain levels are monitored prior to administration of a pain medication along with after administration of the pain medication. During a follow-up interview on 10/17/24 at 11:28 a.m., RN-D verified there was no PRN use or documented refusal of lavender aromatherapy in October. RN-D verified tizanidine PRN was not administered in October. During interview on 10/17/24 at 12:52 p.m., director of nursing (DON) verified the expectation is that non-pharmacological interventions are offered prior to administration of PRN pain medication along with assessing the residents' pain which includes a pain scale. DON verified this had not been done for R106. DON verified the order was not entered correctly as the order should prompt to enter a pain scale when it is clicked on for administration. DON stated he was going to follow up on this. DON stated the care plan may indicate any non-pharmacological interventions and they might be documented in progress notes. DON stated they were going to follow up and provide further information if available. No further information was provided. A facility policy Pain Management, dated	F 697		

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F 697	Continued From page 55 11/20/20, indicated "non-pharmacological interventions for pain management will include distracting activities such as preferred music, watching a chosen show, 1:1 for calming, heat or cold as indicated, orders for PT or OT, healing touch and other non med modalities as resident indicates interest." Furthermore, "the daily IDT meeting will be used to discuss residents who have pain that is not easily managed. Documentation will be entered into the EHR when these reviews take place."	F 697		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		11/7/24

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F 758	Continued From page 56 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor for resident specific target behaviors related to antipsychotic medications use for 1 of 5 residents (R105) reviewed for unnecessary medications. Findings include: R105's quarterly Minimum Data Set (MDS), dated 8/23/24, indicated R105 had moderately impaired cognition with no hallucinations or delusions and no behavioral symptoms including physical or verbal behavioral symptoms directed at others or behavioral symptoms not directed toward others. Further, it indicated R105 had received an	F 758	F758 R105 care plan has been updated to include specific monitoring parameters for target behaviors associated with antipsychotic medication use. Psychotropic Medication Policy will be reviewed and revised as needed. A complete audit of all residents receiving antipsychotic medications will be conducted to ensure monitoring and documentation of target behaviors. Any residents identified will have their care plans reviewed and updated to specify target behavior monitoring related to antipsychotic use.	

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F 758	Continued From page 57 antipsychotic medication during the seven-day look back period. R105's Physician Order Report, dated 10/16/24, included the following orders: -quetiapine (antipsychotic medication used to treat mental/mood disorders) tablet 25 milligrams (mg) take 12.5 mg one time a day at 8:00 a.m. for delusional disorder with a start date of 2/28/24 -quetiapine tablet 25 mg take one tablet by mouth once in the evening at 8:00 p.m. for delusional disorder with a start date of 2/28/24 The Physician Order Report lacked documentation of an direction to monitor target behaviors or identification of target behaviors. R105's care plan, printed 10/15/24, identified R105's orthostatic blood pressure to be monitored monthly while on anti-psychotic medications and side effect monitoring for antipsychotic medication. The document lacked mention of target behaviors for antipsychotic use or identification of what, if any, target behaviors R105 exhibited. R105's Medications Administration Record (MAR/TAR), printed 10/17/24, for October was reviewed. The document verified R105 received quetiapine. The document indicated an entry for "Target Behavior Monitoring: increased anxiety fears; unrealistic fears/concerns; delusions; hallucinations" with a start date of 10/17/24. The document lacked evidence of target behavior monitoring prior to 10/17/24. On 10/14/24 at 2:24 p.m., R105 was observed sitting in her room. R105 was calm, pleasant and "pinning" her clothes getting them ready to sew. R105 stated how much she enjoys sewing.	F 758	Nurses will undergo training on proper documentation of antipsychotic use and monitoring target behaviors. This training will emphasize the importance of individualized behavior monitoring as part of antipsychotic medication administration. Nurse managers or designee will conduct random audits of residents on antipsychotic medications daily for a week, weekly for a month, and quarterly thereafter. Result of audits will be reviewed in the QAPI meetings for further evaluation and recommendation.	

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F 758	Continued From page 58 On 10/15/24 at 12:21 p.m., R105 was observed sitting in her room in her rocking chair eating lunch. R105 reports she was enjoying her lunch and really liked her desert. At 2:32 p.m., R105 was sitting in her rocking chair and "sewing/pinning" an item of clothing. On 10/16/24 at 10:30 a.m., R105 was observed sleeping in her rocking chair in her room with her sewing items in her lap. No behaviors such as agitation, aggression or paranoia observed. At 2:15 p.m., R105 was observed sitting in her chair in her room sewing. R105 stated she was having a good day and denied any concerns. On 10/17/24 at 9:24 a.m., R105 was observed in her room. R105 would take an item of clothing out of her closet, lay it on her bed and then hang it back up. R105 was observed smiling throughout this time. R105 stated she was having a good day and getting ready to "pin some things." On 10/17/24 at 9:52 a.m., nurse practitioner (NP)-A verified that target behaviors should be monitored if a resident is prescribed an antipsychotic medication. NP-A stated this is important in determining many things such as: if the medication is effective, if the medication is needed, should it be scheduled, do they need a PRN (as needed medication). On 10/17/24 at 10:37 a.m., pharmacist consultant (PC)-A verified that if a resident is prescribed antipsychotic medications, target behaviors (along with other things) should be monitored. PC-A stated target behaviors should be monitored because "we want to monitor the	F 758		

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F 758	Continued From page 59 effectiveness of the medication to why she is receiving it." PC-A verified the monitoring of target behaviors was added to the MAR/TAR on 10/17/24. On 10/17/24 at 11:36 a.m., registered nurse (RN)-D indicated it was important for antipsychotic medications to be monitored. RN-D verified this included monitoring of target behaviors. RN-D stated this is helpful because "then you know the reason for the medications, if they are having side effects and if it is effective." On 10/17/24 at 12:36 p.m., director of nursing (DON) verified antipsychotic medications "absolutely need to be monitored." DON verified that it is important target behaviors are monitored with antipsychotic medications as this helps determine the effectiveness of the medication. DON verified monitoring target behaviors also helps with gradual dose reductions. DON verified there was no target behavior monitoring for R105's quetiapine before today and the behavior monitoring was added today. DON stated it was previously on the TAR but must have "fallen off" at some point. A facility policy titled Psychotropic Medication, dated 1/1/24, The document has a procedure for the facility to follow when a resident has an order for psychotropic medication. Number 4 identified "Add problem to care plan listing behavior to be treated. List measurable goal in the care plan." The document further indicated "Initiate a psychotropic drug monitoring graph. List the specific behavior(s). Each shift is to document frequently of behavior. This information is used to monitor effectiveness of drug."	F 758		

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F 791	Continued From page 60	F 791		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility	F 791		11/7/24

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F 791	Continued From page 61 policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental needs were coordinated with a dental provider for further care to reduce the risk of complication (i.e., cavities, oral pain) for 1 of 1 residents (R88) reviewed for dental care and services. Findings include: R88's quarterly Minimum Data Set (MDS), dated 8/9/24, indicated R88 had intact cognition with no hallucinations or delusions with an admission date of 4/11/23. Further, R88's face sheet, printed 10/17/24, identified R88's primary payer as, "Medicaid." R88's care plan, printed 11/5/23, identified R88 has natural teeth and "may require assistance with oral care r/t [related to] Parkinson disease [a disease that affects the central nervous system that affects both motor and non-motor systems of the body], impaired mobility with a goal of adequate oral hygiene will be maintained. The care plan listed several interventions to help R88 meet this goal which included, "assess condition of oral cavity, teeth, tongue, lips and set-up/supervision and cueing for mouth care and hygiene." The care plan lacked identification of coordination with dental appointments, or identification of missing teeth.	F 791	F791: R88 has been scheduled for a dental consultation to assess and address any current dental concerns. Family members have been updated with the plan. A facility wide audit will be conducted on residents who have had dental visits within the previous 3 months to identify any other residents who may have pending or unmet dental needs. All identified residents will be scheduled for necessary dental assessments. Long-Term Care Ancillary Services policy will be reviewed and revised as needed. All nurses will undergo training on dental visit follow-up. Nurse managers or designee will conduct random audit daily for a week, weekly for a month, and quarterly thereafter to ensure dental care coordination is documented and followed through. Result of audits will be reviewed in the QAPI meetings for further evaluation and recommendation	

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F 791	Continued From page 62 During interview on 10/14/24 at 2:12 p.m., R88 indicated that she sees the dentist that provides in-house services at the facility. R88 stated she has not seen them in 5 or 6 months and was supposed to have a follow up visit with them as she is missing 2 or 3 teeth on the right side of her mouth. R88 stated she is waiting for either "implants or a partial [denture] on that side." R88 indicated that she does not have pain and is able to chew on the opposite side of her mouth, but the facility hasn't updated her on when her appointment is or if was arranged. R88 indicated she was sure she was supposed to have the appointment by now and stated she asked a staff about it but unsure when that was or who it was. R88's Chart Progress Note from her dental appointment, dated 4/19/24, indicated R88 had an appointment on 4/19/24 for a dental appointment. The note indicated on a previous visit R88 had a tooth extracted (removed). During 4/19/24, R88 had a cavity filled along with routine teeth cleaning. The note recommended that R88 to be seen in 3 months by the dentist for follow up. R88's Progress notes, dated 3/17/24 to 10/17/24, were reviewed and revealed the following: -4/22/24: "Dentist: S: Seen by Dentist with no new orders." Progress notes, dated 3/17/24 to 10/17/24, lacked indication of any coordination on follow up on dental appointment. During interview on 10/16/24 at 11:00 a.m., nursing assistant (NA)-A indicated that if they notice any dental concerns with a resident, they notify the nurse for further assessment.	F 791		

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F 791	Continued From page 63 On 10/16/24 at 11:14 a.m., registered nurse (RN)-E indicated that dental appointments could vary depending on a residents insurance. RN-E indicated that they are not sure about this as the HUC (Health Unit Coordinator) manages the appointments. RN-E stated that if a dental concern gets reported to a nurse, the nurse assesses the concern and if an appointment needs to be made then the HUC sets up the appointment. RN-E stated she is not aware of any dental pain with R88. RN-E verified that R88's last dental appointment was 4/19/24 and the recommendation was a follow-up in 3 months. On 10/17/24 at 9:30 a.m., health unit coordinator (HUC)-A verified that they are responsible for setting up dental appointments. HUC-A stated when a resident moves in, consents are signed, and that information gets faxed to the dental provider that comes to the facility (in-house dental provider). The dental provider adds the resident to the calendar and updates the facility on when they are coming. HUC-A stated after a dental visit, the after-visit summary (AVS) is reviewed by nursing to see if there are any new orders and then they upload the document into the electronic medical record (EMR). HUC-A stated the nurse will initial the AVS after reviewing it. HUC-A stated that once a resident is seen by the in-house dental provider, the dental provider manages the resident's dental schedule. HUC-A verified she does not track routine or follow up dental appointment for residents seen by the in-house dental provider and she only gets them initially set up and if they need to be seen for an urgent reason. HUC-A stated she was not sure why R88 was not seen as the dental provider manages that schedule.	F 791		

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F 791	Continued From page 64 During follow-up interview with HUC-A on 10/17/24 at 10:24 a.m., HUC-A stated she called the in-house dental provider and verified the last visit with R88 was 4/19/24. HUC-A verified she was over-due for the appointment. HUC-A stated the dental provider added her to the schedule and will hopefully be seen the next time they are at the facility or in December. During interview on 10/17/24 at 11:37 a.m., RN-D verified that she oversees the schedule for dental appointments along with the HUC. RN-D stated the dental provider sends a list of residents that will be seen to review prior to arrival. RN-D stated that all after visit summaries from dental appointments are reviewed by nursing to help ensure if it is recommended that they are seen in 3 months for follow up then the resident is. RN-D stated she does not have a tracking system to track when residents should be seen for routine or follow up appointments by the dental provider. RN-D stated she does not know why R88 has not been seen since 4/19/24 if the recommendation was to be seen in 3 months. RN-D stated "I don't have access to the system." During interview on 10/17/24 at 12:38 p.m., director of nursing (DON) indicated that a resident family can always take the resident to an outside dental appointment and should be documented in progress notes or care conferences. DON indicated that the after-visit summaries are reviewed by nursing and then go to the HUC to be uploaded. DON verified that if it is recommended to be seen in 3 months for a follow up dental appointment, then a resident should be seen in 3 months. DON stated she was going to look for documentation on another dental	F 791		

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F 791	Continued From page 65 appointment. No additional documentation was received. A policy on dental appointments was requested and not received.	F 791		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		11/7/24

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	245439	A. BUILDING _____ B. WING _____	C 10/18/2024

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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F 880	Continued From page 66 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents clothing was covered during storage and delivery to the residents. The uncovered linen had the	F 880	F880- Linen Delivery Director of Environmental Services ordered a cover for the laundry personals delivery cart. The linen cart cover has	

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F 880	Continued From page 67 potential to affect all residents. Findings include: During observation and interview on 10/14/24 at 1:13 p.m. laundry aide (H)-C was observed pushing a large metal uncovered laundry cart down a resident hallway on the first floor containing various cleaned resident clothing items. H-C stated she had worked at the facility as a laundry aide for a long time and they had never covered the personal laundry carts. During observation and interview on 10/15/24 at 1:28 p.m. H-A verified she was delivering cleaned personal linen on the second floor in an uncovered cart. H-A stated the carts used to deliver personal clothing were never covered. During interview on 10/15/24 at 1:34 p.m. the director of environmental services-housekeeping and laundry, (H)-B, stated he had been in his position since 2016, and they had never covered the carts used to deliver personal clothing. H-B added, we only cover the cart use the bed linen and towels. "It's the process we have." During interview on 10/17/24 at 1:27 a.m., the director of nursing (DON) stated the personal clothing carts should be covered to minimize possible cross contamination. Facility policy titled Laundering Linen and Resident Clothing, revised on 9/2/16, indicated all linen and resident clothing was cleaned and handled in such manner that prevents contamination and decreased the risk of spreading infection. The policy also indicated, clean linen and clothing will be sorted and folded	F 880	been installed. Reviewed facility policy Laundering Linen and Resident Clothing and revised as necessary. Laundry staff have been educated on updated policy, Laundering Linen and Resident Clothing Director of Environmental Services will perform random visual audits of clean personal laundry delivery to ensure compliance and report findings to Quality Assurance Performance Improvement committee for further recommendations or follow-up.	

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F 880	Continued From page 68 in laundry and placed on covered shelves or racks for transport to nursing stations.	F 880		

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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: On 10/14/24 through 10/18/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued. H54399395C (MN98871) H54399396C (MN99084) H54399397C (MN100103 H54399398C (MN101554) H54393026C (MN102194) H54393026C (MN102349) H54399399C (MN102563) H54399400C (MN104832) 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to	2 000		

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2 000	Continued From page 2 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. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 830	corrected	11/7/24

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2 830	Continued From page 3 review, the facility failed to ensure appropriate wheelchair foot supports were provided or, if needed, therapy consulted to promote adequate wheelchair positioning to avoid complication (i.e., pain, edema) for 1 of 1 resident (R51); failed to ensure proactive skin interventions were consistently implemented to reduce the risk of skin tears or bruising for 1 of 1 resident (R110); and failed to assess and revise an insulin administration schedule to promote acceptable diabetes management and improve blood glucose levels for 1 of 1 resident (R161) reviewed for dialysis and who missed multiple doses of insulin related to scheduled dialysis treatments. Findings include: WHEELCHAIR POSITIONING: R51's quarterly Minimum Data Set (MDS), dated 8/7/24, identified R51 had severe cognitive impairment and demonstrated no rejection of care behaviors during the review period. Further, the MDS outlined R51 had no range of motion limitations in her upper or lower extremities, used a wheelchair for a mobility device, and was dependent on staff for nearly all mobility-related activities (i.e., transfers, bed mobility). On 10/14/24 at 12:37 p.m., R51 was observed seated in a high-back, tilted wheelchair in the hallway on her unit. R51 extended her hand to shake the surveyor' hand and did not verbally respond aloud when asked her name. R51's body was seated upright in the wheelchair, however, there were no attached pedals or platform on the wheelchair and, as a result, her feet dangled downward without touching the floor. Later, on 10/14/24 at 4:47 p.m., R51 was again observed in the same wheelchair while in the dining room	2 830		

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2 830	Continued From page 4 waiting for the supper meal. R51 continued to not have any pedals or platform attached to the wheelchair and, again, her feet dangled downward without being able to reach the floor. R51's care plan, dated 6/2023, identified R51 had impaired mobility due to left hip pain, weakness and variable understanding of directions and behaviors. The care plan identified R51 was non-ambulatory and used a Broda wheelchair adding, "WHEELCHAIR: total assist of one around obstacles and to get to all destinations." The care plan lacked rationale or instruction on R51's lack of wheelchair pedals or platform. The following day, on 10/15/24 at 8:56 a.m., R51 was again observed seated in the tilted wheelchair while at a small table in the breakfast area. R51 continued to not have any pedals or platforms in place on the chair causing her feet to be unsupported and dangle downward. Later on 10/15/24 at 11:40 a.m., R51 was seated in her same wheelchair in the dining room but now had bilateral foot pedals attached and in place. However, R51's legs were crossed and her feet were positioning behind the affixed pedals dangling downward again. R51 was assisted with eating the noon meal by nursing assistant (NA)-B with no attempts to place R51's feet back onto the pedals observed. When interviewed on 10/15/24 at 12:32 p.m., NA-B stated R51 needed help with eating and most cares. NA-B stated they did not help R51 with morning cares that day and directed the surveyor to NA-C as they were assigned her care. NA-B stated they were unsure if R51 typically used foot pedals or a platform on their wheelchair adding, "I wouldn't be able to go into detail like that." NA-B stated they were unsure if there was a reason or rationale why R51 couldn't use pedals and reiterated aloud, "I'm not	2 830		

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2 830	Continued From page 5 too sure." When interviewed on 10/15/24 at 12:43 p.m., NA-C stated they often worked with R51 and described her as needing "whole help" with cares. NA-C stated R51 had used the "tilting one" wheelchair for awhile and expressed she is supposed to use pedals at all times. NA-C stated they did not place the pedals on the wheelchair when they got R51 up and added, "Must be my nurse [who did]." NA-C stated placing the pedals must have "skipped from the memory" adding further, "She's supposed to have them on." However, NA-C stated R51 seemed to be just letting her feet dangle behind the pedals and not actually use them more in the past months. NA-C stated R51 used to be on hospice care but was removed from it "a few months ago" now adding therapy had, at one time, worked with R51 on her wheelchair positioning but it had been "a long time ago." NA-C stated they had never reported R51's dangling feet but felt the nurses were aware of R51 dangling her feet more and not using the pedals adding, "I think they see it." R51's most recent therapy note, dated 1/22/24, identified R51 was seen by occupational therapy (OT) with dictation, "Per RN, resident to be d/cing [discharged] from hospice. Therapy provided 16" tilt-in-space [wheelchair] with standard foam cushion. Therapy to remain available for further needs." The note was authored by certified occupational therapy assistant (COTA)-A. However, R51's medical record was reviewed and lacked evidence therapy had been consulted or R51 had been assessed for wheelchair positioning despite direct care staff seeing R51 not use the provided foot pedals causing her legs to dangle unsupported.	2 830		

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2 830	Continued From page 6 On 10/15/24 at 12:55 p.m., COTA-A was interviewed, and verified they are available to see patients in the long-term care units. COTA-A explained therapy places a note into the EMR when patient's are seen, including for wheelchair positioning, and reviewed R51's medical record. COTA-A verified they gave R51 the tilt-in-space wheelchair back in January 2024 and expressed pedals would have been provided at the same time adding, "It comes with cushion and foot rest." COTA-A stated if R51's legs were now dangling and not being supported on the pedals, then perhaps a "calf pad" or rest could be used adding, "I can go approach them [nursing] and see if that will work." COTA-A stated they could not recall anyone from nursing reaching out to them about R51's wheelchair positioning and verified if concerns were seen, such as unsupported feet or legs, then someone should consult therapy adding legs left dangling or unsupported could be a safety issue. When interviewed on 10/15/24 at 2:30 p.m., registered nurse unit manager (RN)-A verified they had reviewed R51's medical record. RN-A explained R51 had been on hospice care prior and they were aware R51 often crossed their legs while seated in the wheelchair, however, they had just then contacted therapy about possibly getting a smaller wheelchair so R51's feet could a "a little closer to the ground" and better supported. RN-A stated they were unsure why staff had not been using the supplied pedals for R51's chair, as observed on 10/14 and 10/15, and verified the pedals should have been attached so "in case [R51] gets tired and want to put your feet down to rest." RN-A stated none of the nursing staff had reported concerns to them about R51's feet often being behind the pedals, when attached, and unsupported and expressed, "They [staff] should	2 830		

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2 830	Continued From page 7 say something." RN-A verified R51's feet should not be left dangling and unsupported while seated in the wheelchair adding, "We agree on that." A facility' policy on wheelchair positioning was requested, however, none was received. SKIN PROTECTION: R110's quarterly Minimum Data Set (MDS), dated 9/6/24, identified R110 had severe cognitive impairment and demonstrated no rejection of care behaviors. R110's Physician Order Report, dated 9/16/24 to 10/16/24, identified R110's medical conditions along with both her current physician and nursing orders for care. This identified R110 had a history of vitamin deficiency and cellulitis (soft tissue swelling) to the left hand. R110's orders, including both physician orders and nursing orders, were listed with their respective start and, if applicable, stop dates. This included, "RISK FOR SKIN INJURY: Bilateral protectors on at all times ... Every Shift; Nights, Days, Evenings." The order had a start date listed, "05/13/2021 - Open Ended." On 10/14/24 at 12:34 p.m., R110 was observed seated in wide-back wheelchair by the doorway on the unit with a stuffed animal in her hands. R110 was asked her name and responded aloud, "I don't know." R110 hands along with the lower part of her arms and wrists were visible, and her right hand had light brown-colored discoloration present on top of the hand. R110 did not have any visible cloth or other protectors on her arms or hands at this time.	2 830		

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2 830	Continued From page 8 On 10/14/24 at 1:15 p.m., R110's family member (FM)-D was interviewed. FM-D stated R110 had poor cognition and often would get bruises on her hands. FM-D stated R110, at times, would have cloth-type protectors on her arms and hands but others times not adding, "Sometimes [they] have them on." FM-D stated they believed maybe they were only used when bruises were noticed but was not sure. FM-D stated R110 seemed to bruise "pretty easy" though. Later on 10/14/24, at 4:52 p.m., R110 was again observed seated in her wheelchair. R110 was placed next to the dining room table and, again, had no visible protectors (i.e., geri-sleeves) on her hands or arms at this time. When observed on 10/15/24 at 11:39 a.m., R110 was again seated at the dining room table in her wheelchair. R110 did not have any visible protectors on her hands or lower arms at this time. R110's skin care plan, dated 3/15/24, identified R110 was at risk for skin breakdown due to limited mobility, moisture exposure and cognitive impairment. The plan listed several interventions for R110 including use of a ROHO cushion in her wheelchair, daily skin checks by the nursing assistant (NA) staff, and elevating her heels off the bed surface. However, the care plan lacked direction or guidance on the ordered protectors. R110's Treatment Administration History (TAR), dated 10/2024, identified R110's physician and nursing orders along with spaces for staff to record their administration or refusal via initial. The TAR outlined an order which read, "RISK FOR SKIN INJURY: Bilateral protectors on at all times," along with a frequency listed, "Every Shift." The order was signed off every day within	2 830		

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2 830	Continued From page 9 the month period so far as being completed (despite R110 being observed without them on for multiple days). On 10/16/24 at 9:14 a.m., R110 was again observed seated in her wheelchair while at the table. R110's hair was wetted and combed and she was dressed in a long sleeved shirt, however, her hands were visible and both had a tan-colored, cloth protector in place covering the hand' skin. When interviewed on 10/16/24 at 9:21 a.m., NA-D stated they were assigned to R110 and helped her with morning cares. NA-D stated R110 wore "geri-sleeves" on her hands and arms which were used to protect her skin adding R110 had a couple pairs of them in her room for staff to use. NA-D verified they placed the sleeves on R110 that morning and expressed aloud, "She's supposed to have them [on] all the time." NA-D stated application of them was "on her care card" and the NA staff should be doing it. Further, NA-D reiterated R110 should be using the geri-sleeves at all times as R110 did, at times, get bruises on her hands adding, "Yea, sometimes she does." R110's medical record was reviewed and lacked evidence why R110's ordered skin protectors (i.e., geri-sleeves) had not been used as observed on 10/14/24 and 10/15/24. On 10/16/24 at 10:40 a.m., registered nurse unit manager (RN)-A was interviewed. RN-A stated the skin protectors for R110 were there as "just like an extra layer of skin" and verified the cloth-type protectors seen on R110 that day (10/16/24) are what the provider order referenced adding they were "an extra layer of protection." RN-A stated R110 used to be more mobile and	2 830		

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	00984	A. BUILDING: _____ B. WING _____	C 10/18/2024

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2 830	Continued From page 10 would obtain cuts and bruises on her hands which is why they were added. RN-A stated they expected them to be on R110 as ordered or care planned adding, "The care plan should be followed." A facility' policy on non-pressure skin management was requested, however, none was received. DIABETES MANAGEMENT: R161's significant change Minimum Data Set (MDS), dated 9/7/24, indicated R161 was admitted to the care facility on 8/14/24, was cognitively intact and required supervision for activities of daily living (ADLs). R161's Facesheet, printed 10/17/24, indicated R161 was admitted to the care facility with multiple diagnoses including end stage renal disease and type 2 diabetes mellitus with ketoacidosis (a serious complication of diabetes.) R161's Order History, dated 10/15/24, indicated R161 had an order for Novolog U-100 insulin aspart solution; 100 units per milliliter (ml), administered per sliding scale (amount administered based on current blood glucose reading) three times a day before meals at 8:00 a.m., 12:00 p.m., and 4:00 p.m. R161's care plan, dated 8/29/24, indicated R161 went to dialysis on Mondays, Wednesdays and Fridays with a start time of 11:30 a.m. The care plan further directed staff to "monitor/record/report blood glucose per facility schedule and policy and MD [doctor] order."	2 830		

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2 830	Continued From page 11 R161's admission provider note, dated 9/5/24, indicated R161 was hospitalized 8/7/24 - 8/14/24 for diabetic ketoacidosis (a life-threatening complication of diabetes that occurs when the body doesn't have enough insulin to allow blood sugar into cells for energy.) The provider note further indicated R161 was hospitalized a second time on 8/23/24 - 8/31/24 for dialysis initiated due to renal failure. R161's medication administration record (MAR), dated 10/1/24 - 10/15/24, indicated R161 did not receive her noon dose of Novolog insulin on 10 out of 15 days in October, including Mondays, Wednesdays, and Fridays when out at dialysis. The MAR further indicated that R161's blood glucose level was over 200 19 times from 10/1/24 - 10/15/24. During an interview on 10/14/24 at 1:02 p.m., R161 stated she had concerns about the management of her diabetes and blood glucose levels. R161 stated she left the facility around 10:20 a.m., on Mondays, Wednesdays and Fridays for dialysis and took a bag lunch with her but no medications, voicing a concern for missing her noon administration of insulin. During a follow up interview on 10/16/24 at 9:38 a.m., R161 again voiced concerns about her elevated blood glucose levels, stating she needed to keep her blood glucose levels below 200 because she needed surgery for a dialysis fistula, but would be unable to until for hemoglobin A1C (a blood test that measures a person's average blood sugar levels over the past two to three months) dropped from 10% to 8.5%. During an interview on 10/16/24 t 9:16 a.m., registered nurse (RN)-H stated R161 went to	2 830		

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2 830	Continued From page 12 dialysis three times a week on Mondays, Wednesdays, and Fridays, and while she was out a dialysis she would not get her 12:00 p.m. blood glucose check and insulin administration if needed. RN-H stated he had not updated R161's provider about her missing the 12:00 p.m. blood glucose check and insulin administration because they could check her blood glucose when she returned (at approximately 4:00 p.m.) and R161 was able to voice her preferences. RN-H stated he did not have any concerns with R161's blood glucose lately, noting the provider would be notified if her blood glucose was above 400 per R161's insulin order. During a follow up interview on 10/16/24 at 11:20 a.m., RN-H stated he had spoke with R161's provider that morning and her insulin administration schedule had been adjusted to accommodate her scheduled dialysis. New blood glucose checks and sliding scale insulin administration times were changed to 6:00 a.m., 10:00 a.m., and 5:00 p.m. During an interview on 10/16/24 t 1:25 p.m., R161's dialysis nurse (DN) stated R161 had voiced concerns to her about her unmanaged blood glucose levels. The DN stated R161 had had "really high fluid gains" and unmanaged blood glucose levels could have a "tremendous" affect on her fluid gains and the effects of her dialysis. During an interview on 10/17/24 at 9:58 a.m., R161 stated she had not been told about the change in her insulin administration schedule, stating, "Oh, good, that will help so much!" During an interview on 10/18/24 at 11:35 a.m., the director of nursing (DON) stated it would be	2 830		

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2 830	Continued From page 13 expected that staff are notifying the provider if a medication is missed, stating if insulin is missed "just once", the provider should have been notified. In the case of R161, the DON stated the provider should have been notified to make a plan for ensuring R161 was receiving her insulin on scheduled dialysis days. A policy on medication administration and notifying a provider of missed scheduled medications was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, or designee could ensure residents receive proper supervision and diet textures when eating. The facility could revise policies and procedures, educate staff on the changes. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure and monitor for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services	21325		11/7/24

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21325	Continued From page 14 that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental needs were coordinated with a dental provider for further care to reduce the risk of complication (i.e., cavities, oral pain) for 1 of 1 residents (R88) reviewed for dental care and services. Findings include: R88's quarterly Minimum Data Set (MDS), dated 8/9/24, indicated R88 had intact cognition with no hallucinations or delusions with an admission date of 4/11/23. Further, R88's face sheet, printed 10/17/24, identified R88's primary payer as, "Medicaid." R88's care plan, printed 11/5/23, identified R88 has natural teeth and "may require assistance with oral care r/t [related to] Parkinson disease [a disease that affects the central nervous system that affects both motor and non-motor systems of the body], impaired mobility with a goal of adequate oral hygiene will be maintained. The care plan listed several interventions to help R88 meet this goal which included, "assess condition of oral cavity, teeth, tongue, lips and set-up/supervision and cueing for mouth care and hygiene." The care plan lacked identification of coordination with dental appointments, or identification of missing teeth. During interview on 10/14/24 at 2:12 p.m., R88 indicated that she sees the dentist that provides in-house services at the facility. R88 stated she	21325	corrected	

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21325	Continued From page 15 has not seen them in 5 or 6 months and was supposed to have a follow up visit with them as she is missing 2 or 3 teeth on the right side of her mouth. R88 stated she is waiting for either "implants or a partial [denture] on that side." R88 indicated that she does not have pain and is able to chew on the opposite side of her mouth, but the facility hasn't updated her on when her appointment is or if was arranged. R88 indicated she was sure she was supposed to have the appointment by now and stated she asked a staff about it but unsure when that was or who it was. R88's Chart Progress Note from her dental appointment, dated 4/19/24, indicated R88 had an appointment on 4/19/24 for a dental appointment. The note indicated on a previous visit R88 had a tooth extracted (removed). During 4/19/24, R88 had a cavity filled along with routine teeth cleaning. The note recommended that R88 to be seen in 3 months by the dentist for follow up. R88's Progress notes, dated 3/17/24 to 10/17/24, were reviewed and revealed the following: -4/22/24: "Dentist: S: Seen by Dentist with no new orders." Progress notes, dated 3/17/24 to 10/17/24, lacked indication of any coordination on follow up on dental appointment. During interview on 10/16/24 at 11:00 a.m., nursing assistant (NA)-A indicated that if they notice any dental concerns with a resident, they notify the nurse for further assessment. On 10/16/24 at 11:14 a.m., registered nurse (RN)-E indicated that dental appointments could vary depending on a residents insurance. RN-E	21325		

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21325	Continued From page 16 indicated that they are not sure about this as the HUC (Health Unit Coordinator) manages the appointments. RN-E stated that if a dental concern gets reported to a nurse, the nurse assesses the concern and if an appointment needs to be made then the HUC sets up the appointment. RN-E stated she is not aware of any dental pain with R88. RN-E verified that R88's last dental appointment was 4/19/24 and the recommendation was a follow-up in 3 months. On 10/17/24 at 9:30 a.m., health unit coordinator (HUC)-A verified that they are responsible for setting up dental appointments. HUC-A stated when a resident moves in, consents are signed, and that information gets faxed to the dental provider that comes to the facility (in-house dental provider). The dental provider adds the resident to the calendar and updates the facility on when they are coming. HUC-A stated after a dental visit, the after-visit summary (AVS) is reviewed by nursing to see if there are any new orders and then they upload the document into the electronic medical record (EMR). HUC-A stated the nurse will initial the AVS after reviewing it. HUC-A stated that once a resident is seen by the in-house dental provider, the dental provider manages the resident's dental schedule. HUC-A verified she does not track routine or follow up dental appointment for residents seen by the in-house dental provider and she only gets them initially set up and if they need to be seen for an urgent reason. HUC-A stated she was not sure why R88 was not seen as the dental provider manages that schedule. During follow-up interview with HUC-A on 10/17/24 at 10:24 a.m., HUC-A stated she called the in-house dental provider and verified the last visit with R88 was 4/19/24. HUC-A verified she	21325		

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21325	Continued From page 17 was over-due for the appointment. HUC-A stated the dental provider added her to the schedule and will hopefully be seen the next time they are at the facility or in December. During interview on 10/17/24 at 11:37 a.m., RN-D verified that she oversees the schedule for dental appointments along with the HUC. RN-D stated the dental provider sends a list of residents that will be seen to review prior to arrival. RN-D stated that all after visit summaries from dental appointments are reviewed by nursing to help ensure if it is recommended that they are seen in 3 months for follow up then the resident is. RN-D stated she does not have a tracking system to track when residents should be seen for routine or follow up appointments by the dental provider. RN-D stated she does not know why R88 has not been seen since 4/19/24 if the recommendation was to be seen in 3 months. RN-D stated "I don't have access to the system." During interview on 10/17/24 at 12:38 p.m., director of nursing (DON) indicated that a resident family can always take the resident to an outside dental appointment and should be documented in progress notes or care conferences. DON indicated that the after-visit summaries are reviewed by nursing and then go to the HUC to be uploaded. DON verified that if it is recommended to be seen in 3 months for a follow up dental appointment, then a resident should be seen in 3 months. DON stated she was going to look for documentation on another dental appointment. No additional documentation was received. A policy on dental appointments was requested and not received.	21325		

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21325	Continued From page 18 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental agreements and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21325		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents clothing was covered during storage and delivery to the residents. The uncovered linen had the potential to affect all residents. Findings include: During observation and interview on 10/14/24 at 1:13 p.m. laundry aide (H)-C was observed pushing a large metal uncovered laundry cart	21675	corrected	11/7/24

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21675	Continued From page 19 down a resident hallway on the first floor containing various cleaned resident clothing items. H-C stated she had worked at the facility as a laundry aide for a long time and they had never covered the personal laundry carts. During observation and interview on 10/15/24 at 1:28 p.m. H-A verified she was delivering cleaned personal linen on the second floor in an uncovered cart. H-A stated the carts used to deliver personal clothing were never covered. During interview on 10/15/24 at 1:34 p.m. the director of environmental services-housekeeping and laundry, (H)-B, stated he had been in his position since 2016, and they had never covered the carts used to deliver personal clothing. H-B added, we only cover the cart use the bed linen and towels. "It's the process we have." During interview on 10/17/24 at 1:27 a.m., the director of nursing (DON) stated the personal clothing carts should be covered to minimize possible cross contamination. Facility policy titled Laundering Linen and Resident Clothing, revised on 9/2/16, indicated all linen and resident clothing was cleaned and handled in such manner that prevents contamination and decreased the risk of spreading infection. The policy also indicated, clean linen and clothing will be sorted and folded in laundry and placed on covered shelves or racks for transport to nursing stations. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures for proper infection control measures for linen handling and educate staff on those policies. The quality	21675		

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21675	Continued From page 20 assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21675		
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 and interview, the facility failed to promote a dignified home-like environment during dining services in 4 of 6 dining rooms reviewed. Finding include: R48's significant change Minimum Data Set (MDS) assessment, dated 8/24/24, indicated R48 had intact cognition with no hallucinations or delusions with an admission date of 4/21/23. During observation on 10/14/24 at 5:08 p.m., on 2nd floor main dining room residents were seated and had been served their meals. It was observed each resident had a hard plastic tray in front of them which contained a plate of food that was sitting on a plate warmer. The drinks (which ranged from juice to coffee to milk) were also placed on the hard plastic tray along with the	21695	corrected	11/7/24

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21695	Continued From page 21 silverware. In the middle of the table were hard plastic dome shaped lids (which would have been used to cover the food plates). At 5:12 p.m., a staff member walked up to a resident who was sitting with her head down and prompted her to eat. During observation on 10/14/24 at 5:14 p.m., on 2nd floors smaller dining room, it was observed all residents had been served their meals. One unidentified staff member was seated assisting a resident to eat. It was observed that each resident had a hard plastic tray in front of them which contained a plate of food that was sitting on a plate warmer. The drinks (which ranged from juice to coffee to milk) were also placed on the hard plastic tray along with the silverware. In the middle of the table were hard plastic dome shaped lids, upside down, with disposable plastic lids that had been used to cover the soup bowls and drinks. On 10/15/24 at 11:50 a.m., it was observed that staff were starting to serve resident meals. The staff would take the meals from a lunch cart which was an enclosed cart on wheels with slots, that held hard plastic trays that contained resident meals. The hard plastic trays each contained a paper slip that identified who the meal was intended for, a plate of food that was sitting on a plate warmer and was covered with a hard plastic dome shaped lid. The drinks were covered with a plastic lid and the silverware on the tray was rolled in a napkin. At 11:53 a.m., all residents in the dining room had been served their meal. Each resident had a hard plastic tray in front them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and	21695		

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(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) COMPLETE DATE
21695	Continued From page 22 contained the disposable plastic lids that once covered the drinks. On 10/15/24 at 12:10 p.m., the dining cart was delivered to the 2nd floor small dining room by dietary aid. The dining cart was an enclosed cart on wheels with slots, that held hard plastic trays that contained resident meals. The cart had a few trays sitting on the top of the cart. The hard plastic trays (both inside and on the top of the cart) contained a paper slip that identified who the meal was intended for, a plate of food that was sitting on a plate warmer and was covered with a hard plastic dome shaped lid. The drinks were covered with a plastic lid and the silverware on the tray was rolled in a napkin. At 12:13 p.m., the first tray was served to a resident. At 12:17 p.m., a dietary aid delivered another dining cart to the floor that contained 5 more trays. At 12:19 p.m., all residents in the dining room have been served. Each resident had a hard plastic tray in front them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. On 10/16/2024 at 11:46 a.m., the dining cart was delivered to the 2nd floor main dining room. The dining cart observed appeared the same as previous observations. Staff, including administrator, served meals to residents. At 11:51 a.m., all residents in the dining room were served their meal. As previous meals observed, each resident had a hard plastic tray in front them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and	21695		

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 _____	C 10/18/2024

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) COMPLETE DATE
21695	Continued From page 23 contained the disposable plastic lids that once covered the drinks. On 10/16/2024 12:03 p.m., staff were serving trays to residents in the 2nd floor smaller dining room. Residents had a hard plastic tray in front of them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. During observation on 10/17/24 at 12:15 p.m., on 1st floor dining room, residents were observed to be eating lunch. Each resident had a hard plastic tray in front them of which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. During interview on 10/16/24 at 10:39 a.m., R48 stated she has "thought of ways to make it feel more like home here, but they don't listen," and further stated, "we are in a nursing home." R48 stated she eats her meals in the dining room. R48 indicated she feels that it is probably easier for staff to serve the meals on the trays and indicated this is not her preference. On 10/16/2024 at 1:07 p.m., registered nurse (RN)-D indicated they don't know why the meals in the dining rooms are served on the plastic trays. RN-D indicated there is not really a reason. On 10/16/2024 at 12:48 p.m., when asked about serving resident meals in the dining rooms on the hard plastic trays, administrator indicated no	21695		

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	00984	A. BUILDING: _____ B. WING _____	C 10/18/2024

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) COMPLETE DATE
21695	Continued From page 24 rational for this. Administrator verified this is how all meals are served except on 3rd floor. On 10/17/24 at 12:57 p.m., director of nursing (DON) stated, "that will be a dietary question," when asked about serving resident meals on hard plastic trays and declined to further comment. A facility policy, Serving Meals and Feeding the Resident, revision date 7/21/16, was provided. The policy lacked indication on how the facility would promote a dignified home-like environment during dining services. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, or designee could ensure a safe, clean, functional and dignified homelike environment was developed to accurately reflect a dignified homelike dining experience in the facility is provided. The facility could create policies and procedures, educate staff on the changese regarding the importance of a safe, clean, functional and homelike environment and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/15/2024**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/15/2024. At the time of this survey, Catholic Eldercare On Main was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/01/2024

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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	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/15/2024**

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Catholic Eldercare on Main is a three story building with no basement. The building was constructed at five 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	K 000		

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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**

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K 000	Continued From page 2 constructed to the West side of the building that was determined to be of Type II(222) construction. In 2015, an addition was constructed to the South side of the building and was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully protected throughout by an automatic fire sprinkler system and 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 174 beds and had a census of 162 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 226 SS=D	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 226	K226	11/7/24

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K 226	Continued From page 3 facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5, 7.2.4.3.1, and 8.3.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/15/2024 at 11:14 AM, it was revealed by observation that a large section of electrical conduit above the ceiling in the physical therapy office and data room was going through the firewall that was not sealed. An interview with the Director of Operations, Director of Maintenance, and the Environmental Director verified this deficient finding at the time of discovery.	K 226	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. Assessed the electrical conduit above the ceiling in the physical therapy room and data room and sealed using fire caulking in and around the electrical conduit. Assess the fire barrier wall after work is being performed by contractors or maintenance staff and make necessary repairs/seals. Maintenance will check above fire walls annually. Maintenance director is responsible for monitoring and compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		11/7/24

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K 345	Continued From page 4 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code sections 10.19 and 14.2.1.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/15/2024 at 11:22 AM, it was revealed by observation that the building's main fire panel located in the data room was showing 18 trouble signals at the time of the survey. An interview with the Director of Operations, Director of Maintenance, and the Environmental Director verified this deficient finding at the time of discovery.	K 345	K345 Our life safety company will be reprograming the fire panel to repair the trouble signals. When the fire panel has a trouble signal notify our life safety company to be repaired immediately. It is expected that the maintenance director/department act on any fire panel issues. Maintenance director is responsible for monitoring and compliance.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible	K 363		11/7/24

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K 363	Continued From page 5 materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/15/2024 at 11:47 AM, it was revealed by observation that the door to resident room 313	K 363	K363 Assessed resident room door latch 313 and replaced the latch with new latch. Staff are expected to complete a work order if door is not operating or closing properly Maintenance will check resident room doors annually. Maintenance director is responsible	

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K 363	Continued From page 6 would not positively latch. An interview with the Director of Operations, Director of Maintenance, and the Environmental Director verified this deficient finding at the time of discovery.	K 363	for monitoring and compliance.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, and 8.5.2.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/15/2024 at 11:02 AM, it was revealed by observation that a metal support was going through the smoke barrier above the ceiling near room 332 causing the smoke barrier to not be	K 372	K372 Assess smoke barrier wall above the ceiling where metal supports are going through the smoke barrier wall and seal. Assess the fire barrier wall after work is being performed by contractors or the maintenance staff immediately. Maintenance will check smoke barrier walls annually for proper seals. Maintenance director is responsible for monitoring and compliance.	11/7/24

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K 372	Continued From page 7 fully sealed. An interview with the Director of Operations, Director of Maintenance, and the Environmental Director verified this deficient finding at the time of discovery.	K 372		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical	K 920	K920 Refridgerator in office 329, 229 and	11/7/24

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K 920	Continued From page 8 adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 10/15/2024 at 11:37 AM, it was revealed by observation that there was a small refrigerator plugged into a power strip in office 329. 2. On 10/15/2024 at 11:57 AM, it was revealed by observation that there was a small refrigerator plugged into a power strip in office 229. 3. On 10/15/2024 at 12:14 PM, it was revealed by observation that there was a small refrigerator plugged into a power strip in room 131. An interview with the Director of Operations, Director of Maintenance, and the Environmental Director verified these deficient findings at the time of discovery.	K 920	room 131 were immediately removed from the power strip and plugged into the electrical outlet, power strips removed. Verify that all small refrigerators are plugged into the receptacle directly and not in a power strip. Educate housekeeping and maintenance staff on the use of power strips. Maintenance will complete an annual audit of power strips and extension cords. Maintenance director is responsible for monitoring and compliance.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 26, 2024

Administrator
Catholic Eldercare On Main
817 Main Street Northeast
Minneapolis, MN 55413

RE: CCN: 245439
Cycle Start Date: October 18, 2024

Dear Administrator:

On October 25, 2024, we notified you a remedy was imposed. On November 20, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 7, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 9, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 25, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 18, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 26, 2024

Administrator
Catholic Eldercare On Main
817 Main Street Northeast
Minneapolis, MN 55413

Re: Reinspection Results
Event ID: BU0C12

Dear Administrator:

On November 20, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 18, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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