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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L1R1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00984

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/09/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 04/19/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/19/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 5/1/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/29/2013
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5439

At the time of the standard survey completed February 14, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On April 9, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on February 14, 2013, effective March 26, 2013. Therefore, the remedies outlined in our letter dated March 4, 2013, will not be imposed. See the attached CMS-2567B form for the results of the April 9, 2013 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5439 April 19, 2013

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

Dear Ms. King:

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

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

Effective March 26, 2013 the above facility is certified for:

150 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 19, 2013

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

RE: Project Number S5439022

Dear Ms. King:

On March 4, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 14, 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 9, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 14, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 26, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 14, 2013, effective March 26, 2013 and therefore remedies outlined in our letter to you dated March 4, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5439r113.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245439	A. Building B. Wing	4/9/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0254** Reg. # **483.15(h)(3)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0256** Reg. # **483.15(h)(5)** LSC	Correction Completed **03/26/2013**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/26/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/26/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/26/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/sd	04/19/13	18623	04/09/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/14/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L1R1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00984

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(L1) **245439**

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(L2) **375542800**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/14/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jamie Butterfass, HFE NE II 03/14/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/28/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/29/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5439

At the time of the standard survey completed February 14, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.

Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 3804

March 4, 2013

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

RE: Project Number S5439022

Dear Ms. King:

On February 14, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (651) 201-3792

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 26, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 26, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 14, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 14, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

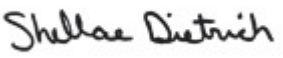
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5439s13.rtf

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 _____	02/14/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED MAR 14 2013 ISOLUTSO	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure there were no signs posted in visible areas which included confidential clinical information, and failed to ensure a resident was called by the name of choice for 1 of 1 resident (R60) reviewed for dignity. Findings include: R60's diagnoses included Alzheimer's disease, depressive disorder and paranoid state. The annual Minimum Data Set (MDS) dated 1/14/13, indicated R60 had both short and long term with severely impaired cognitive status.	F 241	**F 241** All resident rooms were audited to ensure no signs were posted in visible areas which included confidential information. Staff training to be provided regarding dignity and respect as it pertains to the use of nicknames and posting of signs. Staff will be instructed to intervene and report in the event that anything other than name of choice is used when addressing a resident. Residents care plans are being updated with resident's name of choice or preferred way of being addressed. All managers are responsible for auditing at all times. Concerns will be addressed immediately. Reports will be made to the quality assurance committee.	3/26/13

POC accepted LSfanto 3/14/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Kirg — TITLE: Administrator — (X6) DATE: 3-14-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING _____ B. WING _____	02/14/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 During observation on 2/11/13, at 6:18 p.m. a sign was observed on top of R60's dresser which instructed the staff "Please put *Lantiseptic* [a protective ointment] on my peri [perineal] Area Thank you." The sign was visible to anyone who entered the room such as housekeepers, laundry staff and activity staff who did not provide R60 with personal cares. On 2/13/13, at 10:04 a.m. nursing assistant (NA) -B was observed providing morning cares to R60. NA-B applied Laniseptic to R60's perineum. NA-B was heard calling R60 "Grandma" repeatedly while she provided R60's cares. When asked what R60 preferred to be called, NA-B stated [a shortened version of R60's first name]. NA-B further stated the nurses would tell her when to apply creams and the sign in R60's room helped her to remember. R60's care plan dated 8/8/11, indicated R60 had altered thought process and may miss part/intent of message. The care plan did not indicate if R60 had a preferred name. A sign posted on R60's closet door indicated R60 preferred to be called by her full first name or a shortened version of her first name and did not indicate R60 liked to be called "Grandma." When interviewed on 2/14/13, at 9:14 a.m. licensed practical nurse (LPN)-C stated Laniseptic was a physician's order and the nurse's put it on from the treatment sheets. LPN-C stated NAs only use house standing order creams which the nurse would direct them to apply.	F 241		

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F 241	Continued From page 2 The licensed social worker (LSW)-A was interviewed on 2/14/13, at 9:17 a.m. LSW-A stated R60 was more alert when she was admitted and was able to communicate her needs. LSW-A stated she was not aware of any nicknames R60 liked to be called. LSW-A stated private resident information was usually posted inside the closet and that LSW-A does not post private information about residents. When interviewed on 2/14/13, at 12:43 p.m. registered nurse (RN)-C stated the sign in R60's room was not okay and removed it from the room. RN-C verified Lanlseptic was to be applied by nurses and trained medication aides and not by nursing assistants. RN-C indicated she was not aware if R60 liked to be called, "Grandma," currently R60 was not able to state her preference and R60 should be called by her preferred name. Upon interview 2/14/13, at 12:43 p.m. the director of nursing stated the sign in R60's room was not acceptable and they would try to identify who put it in R60's room.	F 241		
F 254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based observation, interview, and document review, the facility failed to provide clean bed linens for 1 of 1 resident (R66) reviewed for personal cares.	F 254	F 254 Housekeeping department has audited all bed linens to ensure they are in good condition. Housekeeping and nursing staff will be retrained in the expectation that bed linens are clean and in good condition and that soiled linens are to be changed at the time they are noted. Charge nurses will be responsible to audit daily. Any concerns to be reported to nurse managers. Reports will be made to the quality assurance committee.	3/26/13

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F 254	Continued From page 3 Findings include: R66 had a diagnosis of Alzheimer's disease. The annual Minimum Data Set dated 10/26/12, identified R66 required extensive assistantance of one staff with bed mobility, toileting and personal hygiene. On 2/13/13, at 8:03 a.m. nursing assistant (NA)-A assisted R66 out of bed into her wheelchair. R66's cream colored draw sheet had a strong urine odor, and was observed wet in two area's. There was a quarter sized hole in the fitted sheet next to R66's pillow at the head of the bed. R66 was brought into the bathroom and sat on the toilet. NA-A stated R66's incontinence product was wet, but not soaked. NA-A proceeded to make R66's bed. NA-A stated R66's linens were changed yesterday when she had a shower and would not need to be changed again today. NA-A was asked to observe the draw sheet after the bed was fully made. NA-A took down the blanket and sheet and stated the bed was not wet. The surveyor pointed out the two wet areas on the draw sheet and NA-A felt the areas with her bare hand, pulled the draw sheet back and felt the fitted sheet then pulled the fitted sheet off and felt mattress protector. NA-A reported the sheets were soaked through three layers of bedding. NA-A stated she had not noticed it before because the draw sheet was cream colored. On 2/13/13, at 2:08 p.m. NA-A stated because R66's brief was not soaked the linens were likely soiled overnight and not changed then. On 2/14/13, at 12:45 p.m. the director of nursing	F 254		

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F 254	Continued From page 4 and registered nurse (RN)-A case manager confirmed soiled bed linens should be changed. The facility's Linen Change/Bedmaking policy revised 3/15/05, Instructed all resident bed linens should be changed weekly or more often as needed.	F 254		
F 256 SS=E	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to repair overhead spot lights that had burnt out in the main dining room. This had the ability to affect 39 of 80 residents who ate in the main dining room, six square tables that seated four and three round tables that seated five. Findings include: On 2/11/13, at 7:30 p.m. the main dining room was being used for bingo, the majority of the residents playing were sitting under the fluorescent lighted area. On 2/11/13, at 4:30 p.m. four of five residents seated at a round table in the main dining room complained that it was not light enough to see well (R146, R94, R1, R28) the fifth resident was being assisted to eat her meal. R146 turned on the pillar lights (low level lighting with an upward facing fixture), and stated "would	F 256	F 256 All 4 burnt out light bulbs were replaced in the main dining prior to survey team exit. All staff instructed on process for completing work orders for lighting concerns. Daily check of dining room lighting added to the maintenance staff daily rounds sheet of mechanical equipment. Dietary supervisor will conduct random auditing. Reports will be made to the quality assurance committee.	3/26/13

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F 256	Continued From page 5 you let the facility know that it is hard to see in the main dining room, the overhead spot lights are burnt out, and they cannot change them by themselves because they are so high up they have to hire someone to change them with a special ladder. They burnt out one at a time but now all four spots are burnt out and it's hard to see each other to talk." R146 stated she had let the kitchen know that it was hard to see. In the main dining room there were two large chandeliers hanging, but they provided low light only; in addition, there were four sets of pillar lights in the dining room that provided indirect lighting. There were fluorescent lights in the hallway leading to the dining room, in an L-shape in front of the kitchen and around the back side of the dining room. Ten of 20 tables were positioned under the fluorescent lights and had very good lighting. The additional 10 tables had only low level lighting and over the course of three days of dining room observations a total of nine residents of the 39 affected stated it was dark in the dining room. On 2/12/13, at 10:30 a.m. the spot lights were not on and the area not covered by fluorescent lighting had only low level lighting. On 2/13/13, at 10:30 a.m. the main dining room was being used for brunch service and the spot lights were not on. On 2/14/13, at 10:30 a.m. the dietary director (DD) was informed of the residents' complaint of difficulty seeing in the dining room, and was not aware that all four spot lights were burnt out.	F 256		

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F 256	Continued From page 6 On 2/14/13, at 4:00 p.m. R146 remarked how much brighter the dining room was since the new bulbs were put in. On 3/1/13, at 8:45 a.m. a voicemail message was left for the director of maintenance at the facility requesting logs or audits of burnt out lights in the dining room, if any exist; or how they are notified of burnt out lights. On 3/1/13, at 9:20 a.m. the administrator returned the call and stated that maintenance tours the building looking for burnt out lights and also receives work orders. The administrator further stated that the light bulbs are special order, they had ordered them when the first bulb burned out and replaced the spot lights when the new bulbs arrived. The administrator stated normally they rent a lift to replace the bulbs that are so high, and she did not know where the staff had gotten the ladder they used on 2/14/13. On 3/1/13, at 3:25 p.m. a representative was contacted from the Industrial and Residential Lighting, Inc. company. The representative indicated the facility first contacted the company on 2/14/13, to purchase the light bulbs, which was the day of exit of the survey.	F 256		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	**F 280** A complete case review was completed on R1's medical record. Care plan was updated to reflect all fall prevention interventions. Medical Director reviewed chart. Resident, family, NP and Doctor were consulted on fall prevention care plan. Care conference held on 3/12/13. All staff trained to report any resident condition/events and suggestions/ideas for improvement of resident safety. All residents' fall prevention care plans will be reviewed by nursing management. Nurse Managers and charge nurses will be responsible for keeping care plan updated. Nursing management team will conduct random audits of fall prevention care plans. Reports will be made to the quality assurance committee.	**3/26/13**

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F 280	Continued From page 7 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to minimize the risk for falls from self transfer, which resulted in a fractured left shoulder 2/20/12, and fractured left phalange 1/20/13, for 1 of 3 (R1) resident reviewed for falls. Findings include: R1 was admitted to the facility on 11/28/11, with diagnoses of fall with a non-union fracture (un-healed) of left humerus (arm), convulsions (seizure), dementia, generalized pain and osteoarthrosis (degenerative joint disease) with profound joint deformities and limited range of motion (ROM). R1 fell in the facility at least 11 times in a twelve month period, which aggravated existing injuries and resulted in actual harm of a newly diagnosed left shoulder fracture and a left fifth phalange (finger) fracture on 1/20/13.	F 280		

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F 280	Continued From page 8 A fall prevention protocol care plan dated 11/29/11, directed the staff to "check on shoes, safety check on equipment, scheduled toileting, scheduled walks, proper lights/night lights, and reinforcement to request assistance." A care plan dated 12/15/11, directed the staff to give R1 verbal reminders not to ambulate/transfer without assistance, keep (the) call light in reach at all times, keep personal items and frequently used items within reach, low bed in place to allow residents feet to touch the floor, provide resident an environment free of clutter, provide toileting assistance about every two hours and as needed. R1 required extensive weight-bearing assist of one with all transfers, assist of one with transfer to toilet and with manipulation of clothing, peri-care, changing pull-ups provided by family which resident chooses to wear, and assist with toileting about every two hours and per request. A memory recall care plan dated 12/15/11, related to short term memory loss, forgetfulness, and pain directed staff to provide verbal cueing and reassurance. An annual Minimum Data Set (MDS) dated 12/14/12, revealed a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. R1 was completely dependent for locomotion off the unit with a wheelchair, required extensive assistance with assist of one for bed mobility, transfers, walking in the corridor, location on the unit, dressing, toilet use, and personal hygiene. R1 was not steady and only able to stabilize with staff assistance when moving from seated to standing position, walking, moving on and off the toilet, and surface to surface transfers.	F 280		

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F 280	Continued From page 9 A Resident Incident Report dated 1/31/12, indicated R1 had an un-witnessed fall at 12:00 p.m. "[R1] was in room, had to go to bathroom, light was on and [R1] tried to ambulate into the bathroom and fell, hitting the left side of the head, causing a six by two bruised area around the left eye and side of face." - An interdisciplinary team (IDT) note dated 2/3/12, indicated a fall on 1/31/12, and was reviewed. A bruise was sustained on the left side of the face after the fall. R1 normally used her call light. R1 had become more confident and may have attempted to do more on her own. The note further implied that staff had been notified that R1 may be self-transferring more. The note identified, "interventions are in place, will continue with the plan of care." R1's care plan dated 11/29/11, directed staff to check for proper footwear. R1 fell without having proper footwear on according to the incident report. The report lacked any evidence of interventions to minimize R1's self-transfer attempts. A Resident Incident Report dated 2/20/12, indicated at 6:20 a.m. R1 fell from bed and "a housekeeper saw R1 sitting on the floor in her room. R1 said she wanted to get up in bed, and used the bedside table for support. The table slide [sic] and she slipped and fell on her bottom, R1 denies hitting her head. An [unmeasured] abrasion on the right elbow was noted. .- An IDT note dated 1/27/12, revealed that the team met and reviewed the fall of 1/25/12, no apparent injury noted from fall. The intervention included to encourage resident to call/wait for assistance, monitor safety as needed, and continue plan of care. - A progress note dated 2/22/12, a chest x-ray	F 280		

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F 280	Continued From page 10 was ordered for increased temperature and revealed a new left humeral (shoulder) fracture. - An IDT note dated on 2/24/12, at 11:00 a.m. indicated fall with injury on 2/20/12, R1 had left leg pain and received an abrasion on the left elbow. X-rays of left arm and leg were negative for fracture on 2/21/12, however, the chest x-ray on 2/22/12. The x-ray revealed a proximal left humerus fracture. The IDT note identified, "R1 does have osteoporosis and some dementia, usually asks for and waits for help. R1 used an unstable surface to reposition self in the bed. Orthopedic appointment today, will talk to her about removing the over bed table. No changes to plan of care at this time." The note lacked any evidence of new interventions to minimize R1's self-transfer attempts. A care plan revision dated 3/20/12, directed staff to ask yes or no questions, anticipate needs, and provide toileting assistance per toileting care. The care plan lacked any evidence of intervention put into place to minimize R1's self-transfer attempts. A Resident Incident Report dated 4/24/12, indicated R1 had an un-witnessed fall while walking. "At 10:30 p.m. resident was found on floor by staff after a self-transfer. R1 denied hitting her head, no injury noted or observed. The report lacked any evidence of new interventions put into place to minimize injury from R1's self-transfers. - A progress note on 4/27/12, at 11:00 a.m. indicated "the fall/injury reduction committee met to review the fall at 10:30 p.m. on 4/24/12. The call light system was checked and documented as "call light out" at the time of the fall. "Will request maintenance to check call light cord as	F 280		

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F 280	Continued From page 11 this happened more than once this past month where the call light cord was out." A Resident Incident Report dated 5/12/12, at 8:35 a.m. R1 had a witnessed fall from the toilet; (while) "I was cleaning up R1 after using the toilet she lost her balance and sat flat on the floor." "R1 hit the left side of her head and back of her shoulder on the wall. No bruise or bump noted at the site. R1 complained of a headache and shoulder pain after the fall. A care plan revision dated 6/13/12, directed staff to provide "weight bearing assist of one to lift legs in and out of bed, and to assist to sitting position from bed daily. Weight bearing assist of one daily with transfer to toilet and staff completes manipulation of clothing and peri-care as needed after voiding or ball movement. No male NA as able [to schedule]. Assist of one to thread arms into sleeves due to limited ROM and pain." A Resident Incident Report dated 7/1/12, indicated at 5:20 p.m. R1 had an unwitnessed fall from the wheelchair. "R1 put the call light on and was found sitting on the floor near the toilet, against the wall in the shower bathroom. R1 stated, "Someone in blue brought me in here. [R1664] had wheeled R1 into the shower room bathroom. R1 denies pain or hitting her head. An IDT note on 7/13/12, at 11:00 a.m. indicated a discussion on the fall of 7/1/12, R1 attempted to self-transfer onto the toilet and was found on the floor. R1 received no injuries and there no changes in care plan. A care plan revision dated 10/2/12, directed staff	F 280		

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F 280	Continued From page 12 to provide low bed in place to allow residents feet to touch the floor. A Resident Incident Report dated 10/13/12, indicated at 9:20 p.m. R1 had a witnessed fall during a transfer. "Staff responded to call light and found resident on floor by the toilet. NA stated she was transferring resident from chair to toilet, R1 lost balance and sat nicely on the floor, holding the toilet bar. No injury noted, PROM [passive range of motion] intact. A care plan revision dated 10/14/12, directed staff to provide a low bed, clutter free environment and call light within reach at all times for fall prevention. The low bed had been in place since the fall of 1/25/12. The care plan lacked any new intervention put into place to minimize injury from R1's self-transfer. A Resident Incident Report dated 10/21/12, indicated at 10:00 p.m. R1 was up walking and had an un-witnessed fall. "R1's roommate notified staff that R1 was on the floor. Noted R1 laying supine on floor in roommate's side of the room. No injury noted, R1 stated she hit her head, no bruises or swelling noted." A Neuro-check was performed and was normal. -An IDT progress note on 10/26/12, at 11:00 a.m. indicated two falls reviewed. On 10/13/12, and on 10/21/12, the plan was to continue with the current plan of care. A Resident Incident Report dated 11/24/12, indicated at 3:00 p.m. R1 had an un-witnessed fall, "NA heard R1 yelling out and found R1 sitting on the floor by the bed with legs out in front of her. R1 stated I was searching for my pop and I	F 280		

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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 280	Continued From page 13 slide out of bed. Denies hitting her head, no injuries noted at this time, denies any pain. A Resident Incident Report dated 1/20/13, indicated at 10:00 p.m. R1 had an un-witnessed fall from bed. "Staff reported seeing R1 on the floor lying on her back by the closet, the wheelchair was pulled away. [R1] stated was getting off bed to look for her remote and fell hitting the back of her head on the floor. Complained of left (small) finger pain, finger was swollen, Neurocheck's within normal limits, prom intact, the left extremity was weak. The call light was hanging on the bed. No new interventions were put into place. A fall reduction committee review note on 1/25/13, at 10:58 a.m. revealed "a new NA on and likely does not completely know likes and dislikes." NA's to be re-educated on leaving her remote control within reach to prevent that from occurring again. "X-rays were done of left wrist, femur, tibia and fibula. Left hand pinky fractured. OT provided immobilizer on pinky and to be left on until MD or NP state it can be removed. Left hand was to be elevated as much as possible for one week, nursing to leave remote within reach, R1 reminded not to self-transfer but likely won't remember." R1's plan of care was not revised to minimize R1's injury from falls due to self-transfer. A Resident Incident Report dated 2/2/13, indicated at 2:30 a.m. R1 had an unwitnessed fall from bed. "At 2:30 a.m. heard R1 calling for help. NA went in and found R1 on the floor. Stated she was trying to get up then slipped and fell out on her bottom, denies hitting her head. The call light	F 280		

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F 280	Continued From page 14 within reach, but was not used. The Neurocheck was normal. Further investigation - on trial mobilization alarm was documented." R1 had eleven falls between 1/25/12 and 2/2/13. Two falls were witnessed, nine falls were due to self-transfer and R1 had hit her head at least four times during the fall incidence. R1 sustained harm for one left shoulder fracture and one left hand fifth finger fracture (both in separate falls) before the facility put mobilization alarms into place. The NA assignment group A. AM. and PM. assignment sheet printed 2/13/13, directed staff to use medium purple pad and assist as needed for the toileting plan, use transfer belt with all transfers, low bed. The NA sheets did not direct staff to place the mobilization alarm for R1. R1's assigned aide (NA-E) was interviewed at 2:00 p.m. and stated that R1 was taken to the bathroom about every two hours and sometimes less. On 2/14/13, At 4:00 p.m. an interview with the administrator, director of nursing (DON), and registered nurse (RN)-A was held to review the incident reports, progress notes and IDT notes regarding the falls and the new interventions put into place to prevent future falls. The group stated that they had considered other things such as room changes, or gripper socks, but the resident would not agree to the changes. RN-A stated that she let the staff know R1 was getting more confident so they would be more aware that she may try to self-transfer and that she had notified the staff that the bedside table with her pop and remote control and tissue box should be within	F 280		

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F 280	Continued From page 15 reach, RN-A stated she looked for these things every time she entered R1's room, but had not actually done an audit to see how often they were in place. The administrator stated the call light failure was specific to R1's room and had not affected other residents. One of the falls was related to an urinary tract infection and a low grade fever and was treated with antibiotics. In February of 2012 R1 was still receiving therapy, and had been working with restorative nursing intermittently for shoulder pain and degenerative joint disease and now for swallowing. Had been referred to therapy for balance and gait training and for sit to stand transition. R1 had constant reminders not to self-transfer and to remember to ask for help. R1 stated "it's an ongoing intervention versus a brand new one." "We want to honor her needs and do not want to distress her." RN-A verified that R1 did have some dementia, some short-term memory loss, and may not remember not to get up by herself. RN-A stated most of the time R1 was very steady and we just stand by. R1 has always been very clear on what she did and did not want, the last few falls seemed more of a pattern at night, I checked with the niece first, "would she let me try a mobility alarm"; we tried it over the weekend and we called on Monday to say it didn't sound, she did not get up, but we are leaving the alarm on since it didn't distress her. The Catholic Eldercare Policy and Procedure, Fall Risk Assessment dated 1/1/2000, indicated "all residents will be assessed for safety on admission, readmission, annually, quarterly, with significant changes and as needed. Individualized care plans will be developed for those residents found to be at high risk for falls."	F 280		

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F 280	Continued From page 16 The Purpose: To maintain safety of residents by preventing injuries from falls. 2) MDS Coordinator/Nurse Managers will complete / review the Fall Risk Assessment Quarterly, annually and with significant changes. 3) If the Fall Risk Assessment shows the resident is at high risk for falls (total score above 10), the interdisciplinary team will develop a fall prevention protocol and initiate the treatment approaches. The team discussion and decision will be documented in the MDS / Assessment notes. Nursing will document the fall prevention plan in the resident's care plan using the Fall Prevention Protocol Form. 4) Nursing will communicate Fall Prevention Plan to staff and family by oral report, updating NAR Care Sheets and/or written notice. The Catholic Eldercare Policy and Procedure, Fall Prevention: Physical Restraint/Mobility Devices policy revised 2/13/13, indicated, "It is the intent of Catholic Eldercare to remain restraint free. However, in rare circumstances, devices may be medically necessary to protect residents from physical injury or for psychological comfort." The policy clarified the requirements to be met when staff applied restraint/mobility devices and gave options to staff for maintaining a least restrictive environment. The policy revealed a multidisciplinary team approach will be used to promote the resident's highest level of physical, psychological and social functioning. "Procedure: Prior to any device or restraint usage, the nurse as part of a multi-disciplinary team, will complete the following steps: 1) interventions to consider when a resident has falls or is at risk for falls, or exhibits behavior that is considered a treat to the resident or others.	F 280		

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F 280	Continued From page 17 (Not all are necessary): a) Observe for gait and balance impairments, transfer abilities - PT referral if indicated b) Medical observation/assessment by nurse, then NP or MD. Assess for possible infection, dehydration, hypoxia, constipation, toxic drug levels, recent trauma, etc. c) Drug review by pharmacy - review recent education changes d) Check for environmental hazards e) Cognitive evaluation f) Observe wheelchair positioning/bed mobility, - OT referral if indicated g) Check for sensory or perceptual impairments h) Check for emotional factors or changes in routine - Psychology referral if indicated i) 1:1 time j) Diversional activities k) Assisted exercise, transfer and/or toileting 2) If falls or threatening behavior persist: a) consult with medical provider for the "medical provider for the "medical symptoms" (e.g. impulsiveness related to dementia, unsteady gait related to Parkinson's Disease, or weakness related to recent hip fracture.) 3) Consider the least restrictive intervention / restraint: a) Personal alarm b) Motion detector c) Sound monitor d) scheduled ambulation e) Perimeter mattress f) Low bed g) Mat on floor next to bed h) Wedge cushion in wheelchair i) Grab bar, 1/2 side rail on bed for mobility	F 280		

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F 280	Continued From page 18 assist 4) Implement the intervention, device or restraint a) Discuss the options, the benefits, risks and possible side effects of the proposed intervention, device or restraint with the family and obtain consent. Complete "Permission for use of Device". b) Obtain a physicians order, including unalterable medical symptom making device necessary, duration and circumstances under which the device is to be used and expected outcome of the use of the device. c) See manufacturer instruction sheets for each type of device. Maintenance and therapy staff to apply devices to beds or wheelchairs. d) Update Care Plan e) Update NA Care Sheet f) Update treatment sheet (every shift to implement and monitor)."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the plan of care for 1 of 1 resident (R33) with an undocumented bruise on the right forearm. Findings include: On 2/12/13, at 8:49 a.m. R33 was asked if she	F 282	**F 282** Weekly skin check audit form was revised. Staff will be reinstructed in the expectation that resident injuries are reported to charge nurse immediately. Charge nurses to be re-trained about injury follow-up, monitoring and reporting expectations. IDT will review all resident injuries. Nurse Managers and charge nurses will be responsible for verifying that all resident injuries have been documented and reported. This process will be monitored by the quality assurance committee.	3/26/13

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F 282	Continued From page 19	F 282		

had any bruises. R33 showed the surveyor a laceration to the left forearm approximately five centimeters (cm) long, with scabbed blood, and a plum sized bruise was observed on the right forearm that was red and purple in color. R33 did not know how the laceration or bruise had gotten there.

R33 was admitted 11/20/12, with diagnoses of senile dementia, transient ischemic attack (a temporary lack of blood flow to the brain that produces stroke like symptoms that resolve), and peripheral vascular disease. The admission Minimum Data Set (MDS) dated 12/9/12, revealed a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. R33 required extensive assistance with assist of one for bed mobility, transfers, dressing, toilet use and personal hygiene and was completely dependent for locomotion on and off the unit. The Care Area Assessment (CAAs) triggered for R33 were Cognitive loss, dementia, urinary incontinence and indwelling Foley catheter, psychosocial well-being, falls, dehydration/fluid maintenance, and psychotropic drug use.

A care plan dated 12/13/12, indicated R33 was at risk for skin breakdown and had interventions of "daily skin check by nursing assistant [NA] with am [sic] and pm [sic] cares. Full body inspection by nurse weekly with bath/shower. Keep skin clean and dry as possible to minimize exposure to moisture. Report any signs of skin breakdown (sore, tender, red, or broken areas)." The plan of care was not followed for the daily skin checks.

A skin care sheet dated 2/1/13, indicated skin

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F 282	Continued From page 20 intact during bath observation. A skin care sheet dated 2/8/13, documented abrasion on left arm 3 cm, applied Coversite (absorbent adhesive wound). A progress note dated 2/8/13, documented a new abrasion observed on skin check, nurse practitioner (NP) and power of attorney (POA) were updated. The skin care sheet lacked evidence that the right forearm had a bruise. On 2/13/13, at 8:30 a.m.(NA)-D noted old bruises on the right arm of R33 but she "is a float to this floor today", and further stated if she had noted a new bruise, she would go right to the nurse (to report it). On 2/13/13, at 8:31 a.m. licensed practical nurse (LPN)-E was not aware of a bruise and would have gotten information on a bruise from the 24 hour report. LPN-E had checked R33's progress notes and the bruise was not noted. LPN-E reviewed the 24 hour report and the bruise was not noted. On 2/13/13, at 8:42 a.m. registered nurse (RN)-A had not been notified of a bruise and would expect that staff caring for R33 would have reported a bruise to the nurse. On 2/14/13, at 1:45 p.m. LPN-E stated she was surprised the bruise was not documented, because when she had called R33's daughter to report the bruise, the daughter already knew and had noted the bruise on Sunday when she had visited. LPN-E verified at least seven shifts of nursing staff failed to report the bruise.	F 282		

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F 282	Continued From page 21 On 2/14/13, at 2:00 p.m. NA-C was interviewed and she would let the nurse know if she saw a new or old bruise. The new employee orientation for NA education included a review of the documentation sheets, report sheets and included the directions "Skin care: NA, every shift, a full skin inspection." A Performance Evaluation Skin and Positioning check off sheet revealed. "General Skin: 1. states frequency of an [sic] skin inspections (done daily by NA's)." A Catholic Eldercare, Inc. policy Bathing-Shower dated 3/1/00, indicated, "Each resident will receive a tub or shower bath at least weekly.... to provide an opportunity for close (skin) observation... 13. Inspect resident's skin and promptly report any changes. 23. Report observations as appropriate."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to note, internally report, assess, treat and document a bruise of unknown	F 309	F 309 Weekly skin check audit form was revised. Staff to be retrained in the expectation that resident injuries will be reported to charge nurse immediately. Charge nurses to be re-trained about injury follow-up, monitoring and reporting expectations. IDT will review all resident injuries. Nurse Managers and charge nurses will be responsible for verifying that all resident injuries have been documented and reported. This process will be monitored by the quality assurance committee.	3/26/13

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F 309	Continued From page 22 origin for 1 of 1 residents (R33) reviewed for non-pressure related skin issues. Findings include: R33 had diagnoses of senile dementia, transient ischemic attack (a temporary lack of blood flow to the brain that produces stroke like symptoms that resolve), peripheral vascular disease, osteoarthrosis, chronic kidney disease stage III, and a history of falls. R33 was observed on 2/12/13, at 8:49 a.m. R33 was asked if she had any bruises. R33 showed the surveyor a laceration to the left forearm approximately five centimeters (cm) long, with scabbed blood on it and a plum sized bruise on the right forearm that was red and purple in color (which indicated the bruise to be two to three days old). R33 did not know how the laceration or bruise had gotten there. The admission Minimum Data Set (MDS) dated 12/9/12, revealed a brief interview for mental status (BIMS) score of three which indicated severe cognitive impairment. R33 required extensive assistance with assist of one for bed mobility, transfers, dressing, toilet use and personal hygiene and was completely dependent for locomotion on unit, off unit and required supervision and cueing for eating. A care plan dated 12/13/12, indicated R33 was at risk for skin breakdown and had interventions of daily skin check by nursing assistant (NA) with a.m. and p.m. cares, full body inspection by nurse weekly with bath/shower. It instructed staff to report any signs of skin breakdown (sore, tender,	F 309		

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F 309	Continued From page 23 red, or broken areas). A care plan dated 12/20/12, indicated R33 had inadequate self-care related to impaired cognition, dementia, unable to sequence tasks; and had intervention of assist of one to dress. The NA assignment sheets (undated document) for both morning and evening indicated R33 required assist of one with activities of daily living. A skin care sheet dated 2/1/13, indicated skin intact during bath observation. A skin care sheet dated 2/8/13, documented abrasion on left arm three cm, applied Coversite. A progress note dated 2/8/13, documented a new abrasion observed on skin check, nurse practitioner (NP) and power of attorney (POA) were updated. An incident report dated 2/8/13, identified a three cm abrasion. The incident report book lacked documentation of the right forearm bruise. -The 24 hours report book lacked documentation of the right forearm bruise. -The 24 hour report sheets for 2/11/13 and 2/12/13, did not indicate a bruise on days, evenings, or nights. The bruise was noted by surveyors at 8:49 a.m. on 2/12/13, and noted to be red and purple, and appeared two to three days old (based on observation of the bruise). On 2/13/13, at 8:30 a.m. NA-D noted old bruises on the right arm of R33, "but she is a float to this floor today," and further stated if she "had noted a new bruise, she would go right to the nurse (to report it)."	F 309		

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F 309	Continued From page 24 On 2/13/13, at 8:31 a.m. on 2/13/13, licensed practical nurse (LPN)-E/charge nurse, was not aware of a bruise and would have gotten information on a bruise from the 24 hour report. LPN-E had checked the progress notes already and there was nothing there, she provided the 24 hour report and it did not identify a bruise. On 2/13/13, at 8:42, Registered nurse (RN)-A had not been notified of a bruise and would expect that staff observing her in dressing and undressing would report a bruise to the nurse. On 2/13/13, at 9:30 a.m. LPN-E stated she had not had time to measure the bruise yet, but will do it soon. On 2/13/13, at 12:10 p.m. LPN-E stated she had not had time to measure the bruise yet, and was just going to do so but the resident was gone from her room. On 2/13/13, at 12:25 p.m. LPN-E stated she measured the bruise as five by five cm right forearm, and described it as dark purple. On 2/14/13, at 1:45 p.m. LPN-E stated she was surprised the bruise was not documented, because when she had called R33's daughter to report the bruise, the daughter already knew and had noted the bruise on Sunday when she had visited. LPN-E verified at least seven shifts of nursing assistants failed to report the bruise. On 2/14/13, at 2:00 p.m. NA-C would let the nurse know if she saw a new or old bruise. A Catholic Eldercare, Inc. policy Bathing-Shower	F 309		

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F 309	Continued From page 25 dated 3/1/00, indicated: each resident will receive a tub or shower bath at least weekly.... to provide an opportunity for close (skin) observation... 13. Inspect residents skin and promptly report any changes. 23. report observations as appropriate. A Catholic Eldercare, Inc. policy for Pressure Ulcer Risk Assessment and Prevention dated 3/8/06, indicated: Procedures... Basic prevention interventions may include: *Daily monitoring of the skin by NA's.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to minimize the risk for falls resulting in a fracture for 1 of 3 (R1) resident reviewed for falls. In addition, the facility failed to provide an environment that was free of accident hazards related to bed rails that did not meet the Federal Drug Administration (FDA) guidelines for safety for 1 of 1 resident (R66) reviewed for accident's related to hazardous devices. The facility did not ensure the environment was free of accident hazards related to ice on the side walk in	F 323	F 323 A complete case review was completed on R1's medical record. Care plan was updated to reflect all fall prevention interventions. Medical Director reviewed chart. Resident, family, NP and Doctor were consulted on fall prevention care plan. Care conference held on 3/12/13. All staff will be retrained to report any resident condition/events and suggestions/ideas for improvement of resident safety. All residents' fall prevention care plans will be reviewed by nursing management. Fall prevention policies and procedures and care plans will be reviewed and revised. Facility incident reports will be revised to include possible interventions for fall prevention. Nurse Managers and charge nurses will be responsible for keeping care plan updated. Nursing management team will conduct random audits of fall prevention care plans.	3/26/13

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	245439	A. BUILDING _____ B. WING _____	02/14/2013

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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 323	Continued From page 26 the Atrium courtyard which had the potential to affect 40 of 80 residents in the sample. Findings include: R1 was admitted to the facility on 11/28/11, with diagnoses of fall with a non-union fracture (un-healed) of left humerus (arm), convulsions (seizure), dementia, generalized pain and osteoarthrosis (degenerative joint disease) with profound joint deformities and limited range of motion (ROM). R1 fell in the facility at least 11 times in a twelve month period, which aggravated existing injuries and resulted in actual harm of a newly diagnosed left shoulder fracture and a left fifth phalange (finger) fracture on 1/20/13. R1 was under continuous observations on 2/14/13, from 7:15 a.m. to 11:29 a.m. R1 left her room at 8:51 a.m. to eat breakfast. After breakfast R1 was moved to the day room on the unit and at 9:54 a.m. was taken from the day room to the beauty shop by a volunteer. At 10:55 a.m. R1 was taken back to the unit by the volunteer and delivered to the nursing desk. At 10:56 a.m. (two hours since resident left her room) she was in the unit dining room having brunch. At 11:17 a.m. licensed practical nurse (LPN)-E offered to take R1 to her room and asked if the bathroom was needed stated, "I will send your aide in." At 11:18 a.m. R1 was interviewed and stated, "Needed to go to the bathroom and they better hurry because I haven't gone all morning." At 11:29 a.m. R1 put her call light on and nursing assistant (NA)-F entered the room. At 11:31 a.m. NA-F left R1's room and stated she took R1 to the bathroom, her pullup was dry, and she left the room and closed the	F 323	**F 323 cont.** Room to room audit conducted to evaluate beds/grab bars. Older beds replaced as necessary with beds that meet requirements. Manufacturer directions are followed. Process of implementation of grab bar/side rail to be further clarified between nursing and therapy. All orders for side rails/grab bars reviewed for appropriateness. Ice on side walk outside Atrium door was salted immediately. Salt is applied to all walkways after snow removal in that area is completed. Salt is re-applied as necessary. Maintenance staff will conduct random audits. Signs remain on Atrium door stating that this is "Not an Exit". Staff trained to report any unsafe conditions to supervisor or receptionist. Reports will be made to the quality assurance committee.	

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F 323	Continued From page 27	F 323		

door, because R1 would call when she was done. An interview was attempted three times and the resident was not ready nor was the resident available.

A fall prevention protocol care plan dated 11/29/11, directed the staff to "check on shoes, safety check on equipment, scheduled toileting, scheduled walks, proper lights/night lights, and reinforcement to request assistance." A care plan dated 12/15/11, directed the staff to give R1 verbal reminders not to ambulate/transfer without assistance, keep (the) call light in reach at all times, keep personal items and frequently used items within reach, low bed in place to allow residents feet to touch the floor, provide resident an environment free of clutter, provide toileting assistance about every two hours and as needed. R1 required extensive weight-bearing assist of one with all transfers, assist of one with transfer to toilet and with manipulation of clothing, peri-care, changing pull-ups provided by family which resident chooses to wear, and assist with toileting about every two hours and per request. A memory recall care plan dated 12/15/11, related to short term memory loss, forgetfulness, and pain directed staff to provide verbal cueing and reassurance.

An annual Minimum Data Set (MDS) dated 12/14/12, revealed a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. R1 was completely dependent for locomotion off the unit with a wheelchair, required extensive assistance with assist of one for bed mobility, transfers, walking in the corridor, location on the unit, dressing, toilet use, and personal hygiene. R1

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F 323	Continued From page 28 was not steady and only able to stabilize with staff assistance when moving from seated to standing position, walking, moving on and off the toilet, and surface to surface transfers. A Resident Incident Report dated 1/31/12, indicated R1 had an un-witnessed fall at 12:00 p.m. "[R1] was in room, had to go to bathroom, light was on and [R1] tried to ambulate into the bathroom and fell, hitting the left side of the head, causing a six by two bruised area around the left eye and side of face." ROM was intact. "Medical treatment to injury was a cold pack. The action taken to prevent further injury to resident - moved to place of safety and monitored." The report further noted a low bed was in place with a left grab bar, R1 was oriented to person and confused; R1 was able to use the call light, and the call light was used. Prior mobility status was assisted with ambulation, transfer, bed mobility and toileting. The investigation determined R1 was last toileted at 11:15 a.m. after brunch. The possible contributing factors identified were "behavior, acute illness [urinary tract infection], improper footwear, unsteady gait, and a self-transfer attempt." R1's progress notes were reviewed for the fall of 1/30/12: - A progress note dated 1/29/12, indicated R1 complained of right shoulder and arm pain. - On 1/30/12, R1 complained of lower back pain and the nurse practitioner (NP) was called. The NP wrote a new order for pain medication related to R1's increased pain threshold. - A progress note dated 1/31/12, indicated fall earlier today, "has bruise and some swelling to left eye and lateral area, denies any discomfort. No fall this shift. Transferring with SBA [stand by	F 323		

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F 323	Continued From page 29 assist]. Continue to monitor." - An interdisciplinary team (IDT) note dated 2/3/12, indicated a fall on 1/31/12, was reviewed. R1 was found in the bathroom and had attempted to self-transfer. A bruise was sustained on the left side of the face after the fall. R1 normally used her call light. R1 had become more confident and may have attempted to do more on her own. The note further implied that staff had been notified that R1 may be self-transferring more. The note identified, "interventions are in place, will continue with the plan of care." R1's care plan dated 11/29/11, directed staff to check for proper footwear. R1 fell without having proper footwear on according to the incident report. The only fall assessment located in the medical record was the initial assessment which was completed on 11/29/11. The report/note lacked any evidence of new interventions to minimize R1's self-transfer attempts, lacked a new comprehensive medication review after the fall and lacked any additional falls assessments. A Resident Incident Report dated 2/20/12, indicated at 6:20 a.m. R1 fell from bed and "a housekeeper saw [R1] sitting on the floor in her room. [R1] said she wanted to get up in bed, and used the bedside table for support. The table slide [sic] and she slipped and fell on her bottom, [R1] denies hitting her head. An [unmeasured] abrasion on the right elbow was noted. [R1] was laughing about the fall, complained of left leg pain." The action taken to prevent further injury to resident included, "moved to place of safety, medical treatment provided was to cleanse/dress abrasion. A low bed was in place, [R1] was oriented to person, place, and time. Prior mobility status was assisted with ambulation, transfer, bed	F 323		

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F 323	Continued From page 30 mobility and toileting. At 5:04 a.m. [R1] had been assisted with toileting and at 6:15 a.m. was given a scheduled medication [medication was not delineated on the form]. Possible contributing factor indicated was self transfer attempt." The low bed was already in place at the 1/25/12 fall. The report lacked any evidence of new interventions to minimize R1's self-transfer attempts. R1's progress notes were reviewed for the fall of 2/20/12: - A progress note dated 2/20/12, indicated R1 fell at 6:20 a.m. trying to get up in bed. An abrasion on the right elbow was noted and R1 complained of left leg pain. "[R1] was alert and oriented, attempted a self-transfer from bed using the bedside table for support, the table slid out and [R1] fell on the floor." - A progress note dated on 2/20/12, at 8:30 p.m. indicated R1 complained of pain in the left hip and elbow and had refused to ambulate to the main dining room (MDR). The report noted R1 was taken by wheelchair to the MDR and then refused to transfer from the wheelchair to a chair. During evening cares and transfers, R1 was moaning and protected the left side. "[R1] had difficulty bearing weight on the left leg and with each step a click, click sound was heard." The report indicated a call was placed to the on-call medical doctor for increasing left hip discomfort and possible fracture. A physicians order dated 2/20/12, ordered x-ray of R1's left hip and left elbow, no fracture was noted on the x-ray report. - A progress note dated 2/22/12, a chest x-ray was ordered for increased temperature and revealed a new left humeral (shoulder) fracture. - A progress note for the day shift on 2/23/12,	F 323		

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F 323	Continued From page 31 indicated R1 was weepy related to increased pain in left arm due to humeral fracture. The NP was notified and a physician's order dated 2/23/12, noted Oxycodone (a narcotic) 10 milligrams (mg) orally three times a day. Staff was to schedule between the Oxycontin (a narcotic) dose and the extra strength Tylenol (a mild analgesic) for shoulder pain, increased pain in left humeral fracture. A physician progress note dated 2/23/12, indicated fever of unknown origin, likely secondary to fracture, orthopedic appointment tomorrow. - An IDT note dated on 2/24/12, at 11:00 a.m. indicated fall with injury on 2/20/12. R1 used the over-bed table to boost herself up in bed, the table moved and she fell to the floor. It identified R1 had left leg pain and received an abrasion on the left elbow. X-rays of left arm and leg were negative for fracture on 2/21/12, however, the chest x-ray on 2/22/12 revealed a proximal left humerus fracture. The IDT note identified, "[R1] does have osteoporosis and some dementia, usually asks for and waits for help. [R1] used an unstable surface to reposition self in the bed. Orthopedic appointment today, will talk to her about removing the over bed table. No changes to plan of care at this time." The only fall assessment located in the medical record was the initial assessment which was completed on 11/29/11. The report/note lacked any evidence of new interventions to minimize R1's self-transfer attempts, lacked a new comprehensive medication review after the fall and lacked any additional falls assessments. A care plan revision dated 3/20/12, directed staff to ask yes or no questions, anticipate needs, and provide toileting assistance per toileting care. The	F 323		

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F 323	Continued From page 32 care plan lacked any evidence of intervention put into place to minimize R1's self-transfer attempts. A Resident Incident Report dated 4/24/12, indicated R1 had an un-witnessed fall while walking. "At 10:30 p.m. resident was found on floor by staff after a self-transfer: [R1] denied hitting her head, no injury noted or observed Medical treatment - none needed. Action taken to prevent further injury to resident - none needed. A low bed was in place; [R1] was oriented to person, place, and time. Prior mobility status was assisted with ambulation, transfer, bed mobility and toileting." The report lacked any evidence of new interventions put into place to minimize injury from R1's self-transfers. R1's progress notes were reviewed for the fall of 4/24/12: - A progress note dated on 4/24/12, at 10:30 p.m. indicated NA called into the room and noted R1 to be on her floor at the bottom of her bed. R1 stated she was falling on her way to the bathroom, stated "the (call) lights do not work. R1 was found in a sitting position on the floor, was able to move within her limits and was alert and oriented to person, place and time, denied hitting her head, without distress at that time." - A progress note dated 4/25/12, at 4:30 a.m. indicated R1 fall at 10:30 p.m., no apparent injuries. R1 had a history of self-transfers, falls, and pain. "Was alert and oriented per usual with forgetfulness. No noted bruises at this time. Fall related to self-transfer and impaired safety awareness. Remind [R1] to ask for help per the fall prevention plan of care." - A progress note on 4/27/12, at 11:00 a.m. indicated "the fall/injury reduction committee met to review the fall at 10:30 p.m. on 4/24/12. The	F 323		

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F 323	Continued From page 33 call light system was checked and documented as "call light out" at the time of the fall. "Will request maintenance to check call light cord as this happened more than once this past month where the call light cord was out." A Resident Incident Report dated 5/12/12, at 8:35 a.m. R1 had a witnessed fall from the toilet; (while) "I was cleaning up R1 after using the toilet she lost her balance and sat flat on the floor." "[R1] hit the left side of her head and back of her shoulder on the wall. No bruise or bump noted at the site. [R1] complained of a headache and shoulder pain after the fall. The wheelchair was behind the resident, unlocked and the gait belt was around the waist. Passive range of motion intact. Medical treatment - none. Action taken to prevent further injury to resident - moved to place of safety, monitored, remove clutter and re-arrange furniture. A low bed was in place with a left grab bar, wheelchair brakes were functioning properly, [R1] was oriented to person, place, and time; able to use the call light, the call light was used, and the call light was within reach. Prior mobility status was assisted with ambulation, transfer, bed mobility and toileting. Possible contributing factor was unsteady gait." A care plan revision dated 6/13/12, directed staff to provide "weight bearing assist of one to lift legs in and out of bed, and to assist to sitting position from bed daily. Weight bearing assist of one daily with transfer to toilet and staff completes manipulation of clothing and peri-care as needed after voiding or bail movement. No male NA as able [to schedule]. Assist of one to thread arms into sleeves due to limited ROM and pain."	F 323		

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F 323	Continued From page 34 A Resident Incident Report dated 7/1/12, indicated at 5:20 p.m. R1 had an unwitnessed fall from the wheelchair. "[R1] put the call light on and was found sitting on the floor near the toilet, against the wall in the shower bathroom. R1 stated, "Someone in blue brought me in here. [R1664] had wheeled [R1] into the shower room bathroom. [R1] denies pain or hitting her head. Medical treatment - none needed. Action taken to prevent further injury to [R1664] encouraged not to help patients. [R1] was oriented to person, place, and forgetful, able to use the call light, the call light was used, and the call light was within reach. Prior mobility status was assisted with ambulation, transfer, bed mobility and toileting. Possible contributing factors indicated were unsteady gait and self-transfer attempt." The incident report did not include any new interventions put into place to minimize R1's self-transfer attempts. An (untimed) progress note dated 7/1/12, indicated R1 put the call light on and was found sitting on the floor against the wall, near the toilet in the shower bathroom. R1 was alert and denied pain or hitting her head, ROM intact. R1 stated, "an elderly woman in blue took her in there." An IDT note on 7/13/12, at 11:00 a.m. indicated a discussion on the fall of 7/1/12, R1 was brought to shower room bathroom by another resident. The note identified R1 attempted to self-transfer onto the toilet and was found on the floor. R1 received no injuries and there no changes in care plan. A care plan revision dated 10/2/12, directed staff to provide low bed in place to allow residents feet to touch the floor.	F 323		

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F 323	Continued From page 35 A Resident Incident Report dated 10/13/12, indicated at 9:20 p.m. R1 had a witnessed fall during a transfer. "Staff responded to call light and found resident on floor by the toilet. NA stated she was transferring resident from chair to toilet, [R1] lost balance and sat nicely on the floor, holding the toilet bar. No injury noted, PROM [passive range of motion] intact. Medical treatment - none needed. Action taken to prevent further injury to resident - moved to place of safety, monitored, remove clutter and re-arrange furniture. A low bed was in place, [R1] was oriented to person, place, and time; able to use the call light. Prior mobility status was assisted with ambulation, transfer, bed mobility and toileting. Possible contributing factor indicated was unsteady gait." A care plan revision dated 10/14/12, directed staff to provide a low bed, clutter free environment and call light within reach at all times for fall prevention. The low bed had been in place since the fall of 1/25/12. The care plan lacked any new intervention put into place to minimize injury from R1's self-transfer. A Resident Incident Report dated 10/21/12, indicated at 10:00 p.m. R1 was up walking and had an un-witnessed fall. "[R1]'s roommate notified staff that [R1] was on the floor. Noted [R1] laying supine on floor in roommate's side of the room. No injury noted, [R1] stated she hit her head, no bruises or swelling noted." A Neuro-check was performed and was normal. "Medical treatment - none needed. Action taken to prevent further injury to resident - none documented. [R1] was oriented to person, place,	F 323		

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F 323	Continued From page 36 and time. Prior mobility status was assisted with toileting. Possible contributing factors indicated were unsteady gait and self-transfer attempt. Last toileted at 8:30 p.m. and refused toileting at 9:45 p.m." A NP progress note dated 10/22/12, revealed, "Apparently her balance issues persist and she has been falling a lot." The NP did not write any new orders for R1 with regards to her persistent falling. An IDT progress note on 10/26/12, at 11:00 a.m. indicated two falls reviewed. On 10/13/12, R1 lost her balance being toileted by staff. At 10:00 p.m. on 10/21/12, R1 was found on the floor in roommate's room. R1 stated she was trying to go to the bathroom and was toileted at 8:30 p.m. and was offered toileting at 9:45 p.m. R1 received assistance for toileting and had a low bed. The plan was to continue with the current plan of care. A Resident Incident Report dated 11/24/12, indicated at 3:00 p.m. R1 had an un-witnessed fall, "NA heard [R1] yelling out and found [R1] sitting on the floor by the bed with legs out in front of her. [R1] stated I was searching for my pop and I slide out of bed. Denies hitting her head, no injuries noted at this time, denies any pain. Medical treatment - none needed. Action taken to prevent further injury to resident - none documented. [R1] was oriented to person, place, and time, was able to use the call light and the call light was within reach. Prior mobility status was assisted with ambulation, transfer, bed mobility; last toileted at 1:45 p.m. possible contributing factors - none documented."	F 323		

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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
F 323	Continued From page 37 A progress note on 11/24/12, at 4:47 p.m. indicated R1 had a history of falls due to unsafe self-transfers. A progress dated 11/27/12, indicated PT requested to assess the resident's mobility status. PT completed the assessment and requested orders for gait and wheelchair placement as resident does not reach back to place arms on wheelchair and would "plop" down on the chair. A progress note dated 12/13/12, indicated inadequate pain control, discontinue scheduled Oxycontin and Oxycodone, start Methadone (a narcotic) 7.5 mg every twelve hours. Change as needed Oxycodone to 10 mg every six hours as needed. A PT discharge summary note dated 12/13/12, indicated therapy from 11/28/12 through 12/13/12, consisting of passive ROM for both shoulders, muscle relaxation elbow and hand, lower extremity ROM and strengthening, sit to stand, transfer training, and gait training. A Resident Incident Report dated 1/20/13, indicated at 10:00 p.m. R1 had an un-witnessed fall from bed. "Staff reported seeing [R1] on the floor lying on her back by the closet, the wheelchair was pulled away. [R1] stated was getting off bed to look for her remote and fell hitting the back of her head on the floor. Complained of left (small) finger pain, finger was swollen, Neurocheck's within normal limits, prom intact, the left extremity was weak. The call light was hanging on the bed. Medical treatment - none needed and cold pack. Action taken to prevent further injury to resident - moved to place of safety, monitored, remove clutter and	F 323		

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	245439	A. BUILDING _____ B. WING _____	02/14/2013

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

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F 323	Continued From page 38 re-arrange furniture. [R1] was oriented to person, place, and forgetful; able to use the call light and the call light was within reach. Prior mobility status was assisted with ambulation, transfer, bed mobility and toileting. Possible contributing factors indicated were behavior and unsteady gait. Further investigation required - new staff was documented." The report implied that the new staff member was working with R1 and may not have known to keep all items within reach. The only fall assessment located in the medical record was the initial assessment which was completed on 11/29/11. The report/note lacked any evidence of new interventions to minimize R1's self-transfer attempts, lacked a new comprehensive medication review after the fall and lacked any additional falls assessments. A progress note dated 1/21/13, revealed R1 had an x-ray of the left hand. The result of the x-ray noted a fracture of the left fifth finger. The MD was notified and wrote new orders for hand elevation, cold therapy and immobilization of the finger. PT was requested and a treatment order dated 1/21/13, directed "immobilizer fifth finger with tongue depressor inside palm and tape 4th and 5th fingers together." A progress note on 1/21/13, at 10:17 p.m. indicated the lateral left hand was swollen and the fifth finger was not in good alignment. Ice was applied for 10 minutes for comfort. R1 was received scheduled pain medication given for discomfort with relief. The left hand was elevated on a pillow. "Fracture of fifth finger of left hand requiring attention, new orders given. Protect from further damage to finger, reduce selling, ice and pain medication for discomfort."	F 323		

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F 323	Continued From page 39 An occupation therapy note dated 1/22/13, indicated orders received recommendations for splinting following resident's fall and subsequent fracture of base of left little finger, large plastic D ring orthotic provided with padding which should be kept on at all times. A fall reduction committee review note on 1/25/13, at 10:58 a.m. revealed R1 was found on the floor lying on her back by her closet. R1 was getting up to find the remote and fell and hit the back of her head on the floor. R1 did have an order for a low bed that was in place. There was a new NA on and likely does not completely know likes and dislikes. NA's to be re-educated on leaving her remote control within reach to prevent that from occurring again. "X-rays were done of left wrist, femur, tibia and fibula. Left hand pinky fractured. OT provided immobilizer on pinky and to be left on until MD or NP state it can be removed. Left hand was to be elevated as much as possible for one week, nursing to leave remote within reach, [R1] reminded not to self-transfer but likely won't remember." R1's plan of care was not revised to minimize R1's injury from falls due to self-transfer. A Resident Incident Report dated 2/2/13, indicated at 2:30 a.m. R1 had an unwitnessed fall from bed. "At 2:30 a.m. heard [R1] calling for help. NA went in and found [R1] on the floor. Stated she was trying to get up then slipped and fell out on her bottom, denies hitting her head. The call light within reach, but was not used. The Neurocheck was normal, Medical treatment - none needed. An as needed medication was given. A low bed was in place with a left grab bar,	F 323		

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F 323	Continued From page 40 [R1] was oriented to person, place, and time; able to use the call light and the call light was within reach. Prior mobility status was assisted with ambulation, transfer, bed mobility and toileting. Possible contributing factors - none documented. Further investigation - on trial mobilization alarm was documented." R1 had eleven falls between 1/25/12 and 2/2/13. Two falls were witnessed, nine falls were due to self-transfer and R1 had hit her head at least four times during the fall incidence. R1 sustained harm for one left shoulder fracture and one left hand fifth finger fracture (both in separate falls) before the facility put bed alarm into place. A treatment order dated 2/8/12, identified a trial of mobility alarm in bed and during the night related to frequent falls. Staff was to document effectiveness and the resident's response in progress notes. Staff was to evaluate the use of the alarm on Monday 2/11/13, and call the NP for order if helpful. A progress note on 2/12/13, at 6:59 a.m. indicated R1 did not use the mobility alarm all weekend. She had put her call light on and waited for a NA to take her to the bathroom. The note revealed, "If call light is answered on time [R1] has no problem." A progress note on 2/12/13, at 3:05 p.m. indicated the resident declined a room change that was offered to have her continue to get out of the left side of the bed, and would be closer to the nursing station. Four of the 11 reports had orthostatic blood pressures taken to assess the blood pressure.	F 323		

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F 323	Continued From page 41 The 11 reports/IDT notes lacked any evidence of new interventions to minimize R1's self-transfer attempts, lacked a new comprehensive medication review after the fall and lacked any additional falls assessments. The NA assignment group A. AM. and PM. assignment sheet printed 2/13/13, directed staff to use medium purple pad and assist as needed for the toileting plan, use transfer belt with all transfers, low bed. The NA sheets did not direct staff to place the bed alarm for R1. R1's assigned aide (NA-E) was interviewed at 2:00 p.m. and stated that R1 was taken to the bathroom about every two hours and sometimes less. On 2/14/13, At 4:00 p.m. an interview with the administrator, director of nursing (DON), and registered nurse (RN)-A was held to review the incident reports, progress notes and IDT notes regarding the falls and the new interventions put into place to prevent future falls. The group stated that they had considered other things such as room changes, or gripper socks, but the resident would not agree to the changes. RN-A stated that she let the staff know R1 was getting more confident so they would be more aware that she may try to self-transfer and that she had notified the staff that the bedside table with her pop and remote control and tissue box should be within reach, RN-A stated she looked for these things every time she entered R1's room, but had not actually done an audit to see how often they were in place. The administrator stated the call light failure was specific to R1's room and had not affected other residents. One of the falls was	F 323		

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F 323	Continued From page 42 related to an urinary tract infection and a low grade fever and was treated with antibiotics. In February of 2012 R1 was still receiving therapy, and had been working with restorative nursing intermittently for shoulder pain and degenerative joint disease and now for swallowing. Had been referred to therapy for balance and gait training and for sit to stand transition. R1 had constant reminders not to self-transfer and to remember to ask for help. "It's an ongoing intervention versus a brand new one." "We want to honor her needs and do not want to distress her." RN-A verified that R1 did have some dementia, some short-term memory loss, and may not remember not to get up by herself. RN-A stated most of the time R1 was very steady and we just stand by. "R1 has always been very clear on what she did and did not want, the last few falls seemed more of a pattern at night, I checked with the niece first, and if she would she let me try a mobility alarm; we tried it over the weekend and we called on Monday to say it didn't sound, she did not get up, but we are leaving the alarm on since it didn't distress her." At the beginning of the interview the facility was questioned if there was any further evidence the facility could provide such as assessments and new interventions put into place for R1 and the facility provided none. The Catholic Eldercare Policy and Procedure, Fall Risk Assessment dated 1/1/2000, indicated, "all residents will be assessed for safety on admission, readmission, annually, quarterly, with significant changes and as needed. Individualized care plans will be developed for those residents found to be at high risk for falls." "The Purpose: To maintain safety of residents by preventing injuries from falls.	F 323		

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F 323	Continued From page 43 2) MDS Coordinator/Nurse Managers will complete / review the Fall Risk Assessment Quarterly, annually and with significant changes. 3) If the Fall Risk Assessment shows the resident is at high risk for falls (total score above 10), the interdisciplinary team will develop a fall prevention protocol and initiate the treatment approaches. The team discussion and decision will be documented in the MDS/Assessment notes. Nursing will document the fall prevention plan in the resident's care plan using the Fall Prevention Protocol Form. 4) Nursing will communicate Fall Prevention Plan to staff and family by oral report, updating NAR Care Sheets and/or written notice." The Catholic Eldercare Policy and Procedure, Fall Prevention: Physical Restraint/Mobility Devices policy revised 2/13/13, indicated "It is the intent of Catholic Eldercare to remain restraint free. However, in rare circumstances, devices may be medically necessary to protect residents from physical injury or for psychological comfort. This policy clarifies the requirements to be met when applying restraint/mobility devices and gives requirements to be met when applying restraint/mobility devices and gives options to staff for maintaining a least restrictive environment. A multidisciplinary team approach will be used to promote the resident's highest level of physical, psychological and social functioning. Procedure: Prior to any device or restraint usage, the nurse as part of a multi-disciplinary team, will complete the following steps: 1) Interventions to consider when a resident has falls or is at risk for falls, or exhibits behavior that is considered a treat to the resident or others.	F 323		

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F 323	Continued From page 44 (Not all are necessary): a) Observe for gait and balance impairments, transfer abilities - PT referral if indicated b) Medical observation/assessment by nurse, then NP or MD. Assess for possible infection, dehydration, hypoxia, constipation, toxic drug levels, recent trauma, etc. c) Drug review by pharmacy - review recent education changes d) Check for environmental hazards e) Cognitive evaluation f) Observe wheelchair positioning/bed mobility, - OT referral if indicated g) Check for sensory or perceptual impairments h) Check for emotional factors or changes in routine - Psychology referral if indicated i) 1:1 time j) Diversional activities k) Assisted exercise, transfer and/or toileting 2) If falls or threatening behavior persist: a) consult with medical provider for the "medical provider for the "medical symptoms" (e.g. impulsiveness related to dementia, unsteady gait related to Parkinson's Disease, or weakness related to recent hip fracture.) 3) Consider the least restrictive intervention / restraint: a) Personal alarm b) Motion detector c) Sound monitor d) scheduled ambulation e) Perimeter mattress f) Low bed G) Mat on floor next to bed Rh) Wedge cushion in wheelchair I) Grab bar, 1/2 side rail on bed for mobility	F 323		

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F 323	Continued From page 45 assist 4) Implement the intervention, device or restraint a) Discuss the options, the benefits, risks and possible side effects of the proposed intervention, device or restraint with the family and obtain consent. Complete "Permission for use of Device". b) Obtain a physicians order, including unalterable medical symptom making device necessary, duration and circumstances under which the device is to be used and expected outcome of the use of the device. c) See manufacturer instruction sheets for each type of device. Maintenance and therapy staff to apply devices to beds or wheelchairs. d) Update Care Plan e) Update NA Care Sheet f) Update treatment sheet (every shift to implement and monitor) R66 had diagnoses that included history of frequent falls, Alzheimer's disease with cognitive impairments, legally blind and osteoporosis. R66 utilized a bed rail device that was not in compliance with the U.S. Food and Drug Administration (FDA) measurement guidelines, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment Document issued on March 10, 2006. In addition, R66 did not receive an accurate comprehensive assessment for/or supervision with the bed rail devices to reduce the risk for entrapment. R66's empty bed was observed on 2/11/13, at 3:28 p.m. with a metal brown quarter bed rail raised on the side away from the wall. The side of the bed against the wall had a bed rail in the	F 323		

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F 323	Continued From page 46 down position that prevented the bed from being flush with the wall. The bed had a distance between the rail and the mattress (FDA zone 3) at approximately six inches. The mattress used was not secured to the bed frame and easily slide to the wall, which created the gap/space. The FDA 2006 recommendation for dimensional limit for zone 3 indicated the gap should be no greater than 4 3/4 inches. In addition, the bed rail was loose. On 2/11/13 at 7:23 p.m. R66 was calling out for her daughter, made several attempts to self-transfer, setting off her wheelchair alarm and was very confused. On 2/13/13, at 7:38 a.m. R66 was observed in bed with the quarter bed rail raised. Prior to starting morning cares, the distance between the mattress and bed rail was approximately five inches. R66 was assisted with morning cares by using the bed rail to turn; that moved the mattress away from the bed rail which created more space between the mattress and the bed rail. On 2/13/13, at 8:12 a.m. nursing assistant (NA)-A provided morning cares. NA-A verified R66 frequently repositioned herself in bed, which caused the mattress to slide to the wall. NA-A confirmed there was an approximate six inch space between the mattress and bed rail, and added it was like that most morning's. The Permission for Use of Device form dated 5/17/12, indicated R66's power of attorney was informed of the possible risks associated with the use of a, "grab bar on bed for mobility." The form did not identify the device as a side rail.	F 323		

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F 323	Continued From page 47 The Care Conference Summary dated 5/17/12, indicated they, "discussed grab bar vs. [versus] side rail," and identified mobility devices as a, "grab bar for bed mobility." R66's current care plan dated 8/31/12, noted a potential for impaired physical mobility related to extensive assistance with bed mobility and transfers. The approaches, included the use of a, "Grab bar on bed for mobility," but did not address the use of a bed rail device or when and why they were safely utilized and monitored. Physician orders initiated 10/1/12, indicate R66 required a low bed due to unsteady gait and attempts of unsafe transfers and instructed R66 should have a, "grab bars on bed for mobility." The annual Minimum Data Set (MDS) dated 10/26/12, identified R66 with severe cognitive loss, a history of falls since admission, required extensive assistants of one staff for bed mobility, tolleting and personal hygiene. The MDS also noted bed rails were not used. On 2/13/13, at 8:25 a.m. the registered nurse (RN)-A case manager stated therapy was responsible for assessing the appropriateness of devices such as bed rails/grab bars. RN-A stated she was not sure if therapy had assessed R66's bed rail. RN-A confirmed the bed rail was in the raised position and there was a large gap between the mattress and the bed rail. RN-A attributed the space to the staff making the bed, which manipulated the mattress on the frame. RN-A confirmed there was nothing in place to prevent the mattress from shifting toward the	F 323		

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F 323	Continued From page 48 wall. RN-A verified this was a quarter bed rail and not a grab bar. Therapy assessment for appropriateness of this device was requested at this time, no assessment was provided. On 2/13/13, at 8:33 a.m. the administrator confirmed R66's bed rail was not a new bed rail which was plastic and cream. Administrator stated the facility's process was to have the therapy department assess for appropriateness of devices, which included bed rails. Administrator reported maintenance was responsible for applying the device which are compatible for the residents bed. Administrator was not aware the older model of beds did not comply with the FDA guidelines. On 2/13/13, at 8:39 a.m. maintenance (M)-A measured the space between the bed rail and the mattress with the largest gap at 6 1/2 inches near the head of the bed. M-A confirmed there was nothing in place to prevent the mattress from sliding towards the wall. M-A reported this was one of the older bed frames, and was not sure who decided it was appropriate for this resident. In addition, M-A confirmed the bed rail was loose. M-A raised the head of the bed to show this surveyor where the two bolts were placed to hold the bed rail tight. The bolt closest to the head board was missing and the side rail was able to slide out of the bed frame. M-A stated he needed to fix that. M-A confirmed he did not have any work orders on the bed. On 2/13/13, at 2:14 p.m. the Administrator, director of nursing (DON) and RN-A confirmed the facility was not monitoring the older metal brown bed rails for dimensional safety related to	F 323		

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F 323	Continued From page 49 entrapment. Administrator stated there were three beds in the facility that had the bed rails and maintenance had already changed them out. DON confirmed the policy did not address bed mobility devices related to dimensional safety and the facility did not have the manufactures recommendations for these devices as they were the older model of bed. The Fall Prevention: Physical Restraint policy did not address how the facility would monitor dimensional safety of devices such as bed side rails. The facility did not ensure the environment was free of accident hazards related to ice on the side walk in the Atrium courtyard. On 2/14/13, beginning at 10:00 a.m. and ending at approximately 11:00 a.m., a tour of the facility's environment was conducted with the Director of Housekeeping and Laundry. The following was observed: The Atrium courtyard had two doors for entrance/exit which was both unlocked and was accessible to residents. The entire length of the sidewalk was covered in ice. The ice was thicker on the south end of the sidewalk and became thinner going towards the door on the north end. At the time of the observation, the director of housekeeping and laundry confirmed the above findings and stated maintenance was responsible for salting the area. On 2/14/13, at 12:40 p.m. the administrator was shown the ice on the side walk. The administrator stated she would have someone take care of it right away and stated it must have been from the snow "last night."	F 323		

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F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication error rate of less than 5% for 4 of 13 residents (R102, R56, R74, R44) observed during the medication administration observation. The facility had a medication error rate 10.9%. Findings include: R102's diagnoses included hypothyroidism and iron deficiency anemia. R102 received levothyroxine (a medication used to treat hypothyroidism) and ferrous sulfate (an iron supplement) together with directions to be administered four hours apart. During the medication administration observation on 2/13/13, at 10:43 a.m. trained medication aide (TMA)-A administered levothyroxine 25 micrograms (mcg) and ferrous sulfate 325 milligrams (mg) to R102. An alert sticker was observed on the card of levothyroxine which indicated the medication should not be administered within four hours of iron. TMA-A verified both the levothyroxine and ferrous sulfate were administered to R102. Review of R102's record revealed a thyroid stimulating hormone (TSH) level of 9.17 on	F 332	**F 332** TMA meeting was held on 2/21/13. Expectations for following med administration directions were reviewed. A copy of the do not crush list was handed out. Nurses and TMA's communication expectations restated. Consultant Pharmacist will be asked to review deficiency and provide guidance on his next visit to the facility. Nurse consultant who conducts TMA observations will be asked to focus on this deficiency. Members of the nursing management team will conduct random audits of TMA med pass. Reports will be made to the quality assurance committee.	**3/26/13**

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	245439	A. BUILDING _____ B. WING _____	02/14/2013

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

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F 332	Continued From page 51 1/31/13. The reference range for a TSH level was noted on the Chemistry Report as 0.20-4.50. The Physician Order Report for 2/1/13 through 2/14/13, indicated levothyroxine was ordered on 2/1/13, and the ferrous sulfate had an order date of 2/7/13. Review of the Medication Administration History for 2/1/13 through 2/14/13, revealed both the levothyroxine and ferrous sulfate were scheduled for once daily at 8:00 a.m. Upon interview on 2/14/13, at 8:56 a.m. registered nurse (RN)-B indicated the TMA's were responsible for checking medications for special instructions. RN-B further indicated nurses, nurse practitioners and physicians enter medication orders into the computerized medication administration system with times for administration. When interviewed on 2/14/13, at 9:34 a.m. the consultant pharmacist stated if given together, ferrous sulfate would decrease the effectiveness of levothyroxine. The consultant pharmacist also verified a TSH level would be elevated if levothyroxine was not absorbed. The director of nursing (DON) was interviewed on 2/14/13, at 1:43 p.m. and verified TMA's were expected to read and follow directions on medication bottles and cards. The General Dose Preparation and Medication Administration Policy revised 5/1/10 section 5.8, directed, " Follow manufacturer medication administration guidelines." The Food and Drug Administration website advises levothyroxine and ferrous sulfate should	F 332		

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F 332	Continued From page 52 be administered at least four hours apart as, "concurrent use may reduce the efficacy of levothyroxine by binding and delaying or preventing absorption, potentially resulting in hypothyroidism." R56's diagnoses included anemia and Alzheimer's disease with progressive aphasia (difficulty with communication). R56 received aspirin (ASA) and ferrous sulfate which had been crushed with directions not to crush these medications. During the medication administration observation on 2/13/13, at 7:40 a.m., TMA-A prepared R56's medications which included ferrous sulfate and delayed release ASA and crushed them. The bottles of ferrous sulfate and ASA both included directions not to crush the medications. TMA-A administered the crushed medications to R56. TMA-A verified the ferrous sulfate and ASA were crushed and stated R56 had difficulty swallowing. The Physician Order Report dated 2/1/13 through 2/14/13, included an order for delayed release ASA 81 mg once a day. The Physician Order Report also included an order for, "OK to crush medications if condition warrants and it is not contraindicated by medication directions or pharmacy recommendations." When interviewed on 2/14/13, at 9:34 a.m. the consultant pharmacist stated crushing ferrous sulfate and enteric coated ASA could increase gastrointestinal upset. A Medications Not To Be Crushed form (undated) was provided by the director of nursing on	F 332		

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F 332	Continued From page 53 2/14/13, at 12:03 p.m., which included Aspirin EC (enteric coated) and Feosol [ferrous sulfate]. The General Dose Preparation and Medication Administration Policy revised 5/01/10 section 3.8, directed, " Facility staff should crush oral medications only in accordance with Pharmacy guidelines." R74's diagnosis included Alzheimer's disease. R74 received omeprazole while eating breakfast which had directions to give 30 minutes before eating. During the medication administration observation on 2/13/13, at 7:53 a.m. TMA-A administered omeprazole 20 mg to R74. The directions on the medication card indicated omeprazole should be given 30 minutes before a meal. R74 was finishing breakfast when TMA-A administered the medication. TMA-A verified she had administered omeprazole to R74 while R74 was eating. When interviewed on 2/13/13, at 8:54 a.m. TMA-A was asked if she knew why some medications were administered before meals. TMA-A responded "some medications should be taken before eating." When interviewed on 2/14/13, at 9:34 a.m. the consultant pharmacist stated omeprazole only inhibits actively secreting pumps which was why it was given prior to a meal. The Food and Drug Administration website advises omeprazole be taken on an empty stomach with water at least one hour before a meal.	F 332		

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F 332	Continued From page 54 R44's diagnoses included dementia and hypothyroidism. R44 received levothyroxine while eating breakfast with directions to be taken on an empty stomach, one half to one hour prior to eating. During the medication pass observation on 2/13/13, at 7:25 a.m. TMA-A administered levothyroxine 75 mcg to R44. R44 was eating breakfast when the levothyroxine was administered. TMA-A verified she had given the medication to R44 while he was eating. Review of R44's record revealed a TSH level of 10.12 on 11/15/12 and 4.00 on 1/17/13. The reference range for a TSH level was noted on the Chemistry report as 0.20-4.50. A nurse practitioner (NP) note dated 12/6/12, indicated levothyroxine was increased on 11/15/12 to 75 mcg daily and noted R44 had weight loss. A physician's progress note dated 1/14/13, noted the levothyroxine was changed and new lab work was to be checked in 60 days. The Physician Order Report for 2/1/13 through 2/14/13, indicated levothyroxine was ordered for once a day. Review of the Medication Administration History for 2/1/13 through 2/14/13, revealed the levothyroxine was scheduled for once daily at 8:00 a.m. The Food and Drug Administration website advises levothyroxine be taken on an empty stomach, one-half to one hour before breakfast.	F 332		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 55 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 431	F 431 Nurses and TMA's retrained in expectations that all med carts be locked at all times. Management staff will audit that carts are locked as they walk by and intervene immediately as necessary. Reports will be made to the quality assurance committee.	3/26/13

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F 431	Continued From page 56 review, the facility failed to ensure medications were stored in locked carts on 3 of 3 units. This had the potential to affect all 100 of 148 residents residing on all three units. Findings include: During observation on 2/11/13, at 5:07 p.m. on first floor the trained medication aide (TMA)-D was observed to leave the medication cart unlocked when he left to administer medications. TMA-D had his back to the unlocked cart and no other staff was in the area of the cart. Eight residents were observed near the unlocked medication cart. TMA-D returned at 5:09 p.m. and locked the cart. On 2/11/13, at 6:30 p.m. R90 was observed trying to open drawers on a locked medication cart on first floor. R90's diagnosis included senile dementia with delusions. R90's quarterly Minimum Data Set (MDS) dated 12/2/12, revealed a Brief Interview of Mental Status (BIMS) score of three which indicated severe cognitive impairment. During observation on 2/12/13, at 10:08 a.m. an unlocked medication cart was observed by the second floor nursing station. No other staff was noted by the unlocked cart. The licensed practical nurse (LPN)-A returned to the cart at 10:09 a.m. and verified she had left the cart unlocked when she went to administer medications. Twelve residents were observed near the unlocked medication cart. LPN-A stated, "Many residents go by here [the carts]." On 2/12/13, at 3:35 p.m. LPN-D was observed	F 431		

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F 431	Continued From page 57 walking away from an unlocked medication cart on second floor. Twenty-three residents were observed to be near the unlocked medication cart. TMA-B walked up to the cart at 3:36 p.m. and locked it. TMA-B told LPN-D she could not walk away from an unlocked cart. During medication pass observation on 3rd floor 2/13/13, at 7:51 a.m. TMA-A walked away from an unlocked medication cart. There was no other staff near the unlocked cart. TMA-A had her back to the cart while administering medications. TMA-A verified the medication cart was unlocked while not in her view. Multiple medications were stored in the unlocked cart which included blood thinning medications, heart medications and psychotropic medications. R155 was observed standing next to the unlocked medication cart and there were 17 other residents near the cart. R155's diagnosis included dementia. R155's quarterly MDS dated 1/3/13, revealed a BIMS score of three which indicated severe cognitive impairment. The director of nursing (DON) was interviewed on 2/14/13, at 9:50 a.m. and stated there had been no incidents of residents getting into medication carts. When interviewed on 2/14/13, at 1:43 p.m. the DON stated it was not acceptable for staff to walk away from an unlocked medication cart. The General Dose Preparation and Medication Administration policy revised 5/1/10, directed, "Facility should ensure that medication carts are always locked when out of sight or unattended."	F 431		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=D	Continued From page 58 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F 441 Hand washing expectations and training will be provided to all staff on how to handle personal care items that have been contaminated. Housekeeping, dietary and nursing manager will conduct random audits. Reports will be made to the quality assurance committee.	3/26/13

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F 441	Continued From page 59 This REQUIREMENT is not met as evidenced by: Based observation, interview, and record review the facility failed to complete proper hand hygiene and provide clean personal care equipment (toothbrush) in sanitary manner to reduce the spread of infection for 1 of 3 residents (R66) whose was observed for personal cares. Findings include: R66 had a diagnosis of Alzheimer's disease. The annual Minimum Data Set dated 10/26/12, identified R66 required extensive assistantance of one staff with bed mobility, toileting and personal hygiene. On 2/13/13, at 8:03 a.m. nursing assistant (NA)-A assisted R66 out of bed into her wheelchair. R66's cream colored draw sheet had a strong urine odor, and was observed wet in two area's. R66 was brought into the bathroom and sat on the toilet. NA-A left the room to get oral care supplies. NA-A returned, helped R66 to the sink and provided her with oral care supplies. NA-A stated R66's incontinence product was wet, but not soaked. NA-A proceeded to make R66's bed. NA-A stated R66's linens were changed yesterday when she had a shower and would not need to be changed again today. NA-A was asked to observe the draw sheet after the bed was fully made. NA-A took down the blank and sheet and stated the bed was not wet. The surveyor pointed out the two wet areas on the draw sheet and NA-A felt the areas with her bare hand, pulled the draw sheet back and felt the fitted sheet then pulled the fitted sheet off and felt	F 441		

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F 441	Continued From page 60 mattress protector. NA-A reported the sheets were soaked through three layers of bedding. NA-A stated she had not notice it before because the draw sheet was cream colored. NA-A proceeded to remove the linens, at that time R66 had dropped her toothbrush on the floor in the bathroom and was calling out for NA-A to come help her. NA-A walked directly into the bathroom, picked the tooth brush off the floor, turned on the water, rinsed the toothbrush with warm water and set it on the sink. R66 told NA-A she was not done brushing her teeth. At that time, NA-A put toothpaste on the toothbrush and handed it to R66. NA-A did not complete hand hygiene prior to assisting R66 and did not provide a clean toothbrush. On 2/13/13, at 2:08 p.m. NA-A stated she was very flustered that morning and did not remember not washing her hands or handing the toothbrush back to R66 once it fell on the floor. On 2/14/13, at 12:45 p.m. the director of nursing and registered nurse (RN)-A case manager confirmed they expected NA-A to wash her hands after handling soiled linens and dispose of personal care items such as a toothbrush after it fell on the floor.	F 441		

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	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2013**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety Fire Marshal Division on February 12, 2013. At the time of this survey, Catholic Eldercare On Main was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Catholic Eldercare on Main is a 3-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1977 and was determined to be of Type II(222) construction. In 1983, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction. In 1994, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. In 1995, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 150 beds and had a	K 000		

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

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K 000	Continued From page 1 census of 149 beds at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) are MET.	K 000		