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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: MB7X
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 **07/06/2017** (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 **174** (L18)

13. Total Certified Beds **174** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	174			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Unit Supervisor 07/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 09/08/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/24/2017
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245439

July 20, 2017

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

Dear Ms. King:

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

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

Effective June 27, 2017 the above facility is certified for:

174 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 174 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 20, 2017

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

RE: Project Number S5439027

Dear Ms. King:

On May 26, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 18, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 18, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 27, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 18, 2017, effective June 27, 2017 and therefore remedies outlined in our letter to you dated May 26, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

An equal opportunity employer.

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

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Facility ID: 00984

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(L4) **817 MAIN STREET NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55413**

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

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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 **05/18/2017** (L34)

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FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE NE II 06/02/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/20/2017 (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)

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(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

INVOLUNTARY
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28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 26, 2017

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

RE: Project Number S5439027

Dear Ms. King:

On May 18, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D),as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

> <u>Opportunity to Correct</u> - **the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> <u>Electronic Plan of Correction</u> - **when a plan of correction will be due and the information to be contained in that document;**
>
> <u>Remedies</u> - **the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> <u>Potential Consequences</u> - **the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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:

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Plaza
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

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 June 27, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 18, 2017 (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 November 18, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Fax: (651) 215-0525

Please contact me if you have questions related to this eNotice.

Sincerely,

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

cc: Licensing and Certification File

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 ______	05/18/2017

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 On May 15, 16, 17, and 18, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 167		6/27/17

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

Electronically Signed — 06/01/2017

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 ______	05/18/2017

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 167	Continued From page 1 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to post the survey results for the last three years to be readily available for residents, visitors and staff. This had the potential to affect all 159 residents, visitors and staff who wished to review this information. Findings include: During the initial tour of the facility on 5/15/17, at 12:00 p.m., a white colored binder labeled "MDH (Minnesota Department of Health) State Survey Results" was found on the first floor lobby of the facility behind the receptionist desk. The survey results inside were dated 5/23/16. There were no additional surveys identified in the binder for review. During a follow up tour on 5/18/17, at 10:15 a.m., the "MDH State Survey Results" binder still only had the survey results dated 5/23/16, in the book. When the receptionist was asked to call the administrator, the receptionist relayed that the administrator stated they (residents, visitors and	F 167	F 167 Prior 3 years of survey results were replaced in the 3 ring binder at each reception desk prior to exit. Receptionist will check the binder daily to ensure the last 3 years of survey results have not been removed. Receptionist will replace as needed. Random audits will be conducted by Lead Receptionist and results reported to Quality Assurance Committee.	

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 ______	05/18/2017

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 167	Continued From page 2 staff) can request it. There was no visible signage that indicated residents, visitors and staff could ask for additional surveys. During an interview with the administrator on 5/18/17, at 10:19 a.m., when asked how residents, visitors and staff were able to access previous survey results, the administrator stated that "they've been told at the resident council and that they have communicated with families." Administrator further stated that there are people constantly taking the survey results so they are checking it daily to make sure it is in the binder. The administrator stated "we will make a previous survey sign to add in book." On 5/18/17, at 3:58 p.m., a policy for the posting of survey results being was requested but none was provided.	F 167		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 221		6/27/17

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 ______	05/18/2017

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 221

Continued From page 3

corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.

(a) The facility must-

(1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents reviewed (R228) was free from the use of restraints.

Findings include:

R228's admission Minimum Data Set (MDS) dated 3/17/17, indicated she was severely cognitively impaired and required extensive assistance with all activities of daily living. The MDS indicated R228 did not use physical restraints in the chair or in bed. A Care Area Assessment dated 3/23/17, indicated R228 attempts to stand up out of wheel chair and get out of bed. R228's care plan dated 5/11/17, identified an alteration in mood/behavior related to the use of anti-anxiety medications and anxiety. The care plan identified a behavior of repetitively moving feet and attempting to stand.

On 5/17/17, at 8:14 a.m., R228 was observed in

F 221

F 221
Body pillow was removed from resident□s room on the same day it was noted. Care plan reviewed and updated. All residents with body pillows will be evaluated for use and body pillows will be allowed to be used for personal comfort and to help identify edge of bed. Education on restraint use will be provided for nursing staff. Nursing Management team will conduct random audits twice weekly by observation of body pillow use until compliance is ensured. Charge nurses will monitor use of body pillows each shift. Reports will be made to QA.

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

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F 221	Continued From page 4 bed lying on her back. She had a body pillow placed on both sides of her, a perimeter mattress on the bed, and a fall mat on the floor. At 12:37 p.m., R228 was observed lying in bed. A large body pillow was tucked under the fitted sheet on the bed, preventing R228 from moving it or pushing it out of the way. On 5/17/17, at 8:15 a.m. nursing assistant (NA)-B stated R228 attempts to get out of bed on her own. She stated the pillows were placed to "keep her from falling." On 5/17/17, at 12:48 p.m., licensed practical nurse (LPN)-A stated R228 was at high risk for falls. He stated R228 tried to get out of bed all the time and that was why she had a low bed and a fall mat. LPN-A stated the body pillows were initiated as a fall precaution. On 5/17/17, at 12:58 p.m., registered nurse (RN)-C stated she was aware staff was using the body pillow under R228's fitted sheet. RN-C stated R228 squirmed a lot and she was physically capable of getting out of bed on her own, but she would likely fall. RN-C stated there was no assessment or consent for the body pillow. On 5/17/17, at 1:18 p.m., the director of nursing referred to a facility restraint policy. She stated the list did not identify a body pillow as a restraint and stated R228 had not been discussed with regard to restraint use.	F 221		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must-	F 225		6/27/17

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F 225	Continued From page 5 (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 225		

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F 225	Continued From page 6 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to timely report and investigate allegations of abuse for 1 of 1 residents (R117) reviewed for abuse. Findings include: R117's significant change Minimum Data Set (MDS) dated 3/23/17, indicated she had intact cognition and required assistance with activities of daily living. Her care plan dated 2/17/17, identified a self-care deficit related to weakness and directed staff to assist with cares. On 5/15/17, at 5:55 p.m., R117 stated she had been abused by a staff member. R117 stated	F 225	F 225 OHFC Report and investigation was made on May 18th, 2017. Facility reporting requirements/expectations will be reviewed will all staff. Vulnerable reporting and abuse prohibition policies have been reviewed and updated. Weekly IDT meetings will be utilized to monitor and audit that reporting guidelines have been followed. Administrator and DON are responsible for compliance and monitoring that reports are made timely. Results will be brought to the Quality Assurance Committee.	

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F 225	Continued From page 7	F 225		

when she was new to the facility, a staff member told her she had a stroke and needed to sit with other residents who needed help in the dining room. She stated the staff member "dragged me by the belt," and "she wanted to humiliate me." R117 stated she reported the incident to [registered nurse (RN)-A] at the time of the incident.

On 5/17/17, at 9:43 a.m., RN-A stated allegations of abuse get reported to the supervisor on duty. RN-A stated he had access to the on-line reporting system and could report abuse allegations that are reported to him. RN-A stated he was not aware of R117's allegation. At this time, RN-A was informed of R117's allegation of mental abuse and humiliation and that she had reported it to him. RN-A stated it should be reported immediately.

During a subsequent interview on 5/18/17, at 10:07 a.m., RN-A stated he spoke to the nursing assistants (NA)'s and the nurses on the floor. He stated none of them could recall anything about R117's allegation. RN-A stated he had informed the director of nursing (DON), but had not spoken to R117.

On 5/18/17, at 9:57 a.m., the DON stated RN-A had spoken to her the previous day. She stated RN-A reported R117 had concerns that her transfer belt was being left on all day and that he would ensure it got removed. At 10:07 a.m., with the DON, RN-A stated he had just spoken to R117. RN-A stated according to R117, she was by the elevator and the NA came and dragged her by the belt, and stated she felt the NA was trying to humiliate her. RN-A stated R117 was able to name the NA.

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F 225	Continued From page 8 During an interview on 5/18/17, at 10:10 a.m., the administrator stated the allegation should have been reported to the state agency on 5/17/17 when the allegation was reported. A facility policy titled Catholic Eldercare and Affiliated Covered Entities, Abuse Prohibition, Investigation, and Reporting, dated 9/14/16 was reviewed. The policy indicated: It is the policy to provide a setting in which each resident shall be free from abuse. Incidents and reports of abuse will be reported immediately to the facility administrator and the state agency. The policy directed staff to report to the state agency and complete an investigation of the alleged incident.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also	F 226		6/27/17

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F 226	Continued From page 9 provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to operationalize their policy for reporting and investigating allegations of abuse for 1 of 1 resident (R117) reviewed for abuse. Findings include: A facility policy titled Catholic Eldercare and Affiliated Covered Entities, Abuse Prohibition, Investigation, and Reporting, dated 9/14/16 was reviewed. The policy indicated: It is the policy to provide a setting in which each resident shall be free from abuse. Incidents and reports of abuse will be reported immediately to the facility administrator and the state agency. The policy directed staff to report to the state agency and complete an investigation of the alleged incident. R117's significant change Minimum Data Set (MDS) dated 3/23/17, indicated she had intact cognition and required assistance with activities of daily living. Her care plan dated 2/17/17, identified a self-care deficit related to weakness	F 226	F 226 OHFC report and investigation was made on May 18th, 2017. Facility reporting requirements/expectations will be reviewed will all staff. Vulnerable reporting and abuse prohibition policies have been examined and updated. Weekly IDT meetings will be utilized to monitor and audit that reporting guidelines have been followed. Administrator and DON are responsible for compliance and monitoring that reports are made timely. Results will be brought to the Quality Assurance Committee	

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F 226	Continued From page 10	F 226		

and directed staff to assist with cares.

On 5/15/17, at 5:55 p.m., R117 stated she had been abused by a staff member. R117 stated when she was new to the facility, a staff member told her she had a stroke and needed to sit with other residents who needed help in the dining room. She stated the staff member "dragged me by the belt," and "she wanted to humiliate me." R117 stated she reported the incident to [registered nurse (RN)-A] at the time of the incident.

On 5/17/17, at 9:43 a.m., RN-A stated allegations of abuse get reported to the supervisor on duty. RN-A stated he had access to the on-line reporting system and could report abuse allegations that are reported to him. RN-A stated he was not aware of R117's allegation. At this time, RN-A was informed of R117's allegation of mental abuse and humiliation and that she had reported it to him. RN-A stated it should be reported immediately.

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On 5/18/17, at 9:57 a.m., the DON stated RN-A had spoken to her the previous day. She stated RN-A reported R117 had concerns that her transfer belt was being left on all day and that he would ensure it got removed. At 10:07 a.m., with the DON, RN-A stated he had just spoken to R117. RN-A stated according to R117, she was

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F 226	Continued From page 11 by the elevator and the NA came and dragged her by the belt, and stated she felt the NA was trying to humiliate her. RN-A stated R117 was able to name the NA. During an interview on 5/18/17, at 10:10 a.m., the administrator stated the allegation should have been reported to the state agency on 5/17/17 when the allegation was reported.	F 226		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and	F 280		6/27/17

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F 280	Continued From page 12 shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 280		

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F 280	Continued From page 13 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care plan interventions to minimize the risk of falls for 2 of 5 residents (R122, R143) reviewed for accidents. Findings include: R122's admission Minimum Data Set (MDS) dated 2/9/17, indicated she was cognitively intact and required extensive assistance with activities of daily living (ADL's). A Care Area Assessment dated 2/15/17, indicated R122 did not have any falls during the assessment period but identified a risk for falls related to ability to stabilize only with staff assistance .A Catholic Eldercare on Main Fall Risk Assessment Tool dated 2/3/17, indicated R122 had no falls in the previous six months and identified her as a low fall risk. R122's care plan dated 2/6/17, identified a risk for falls related to a history of falls, dyspnea and weakness. The care plan directed staff to notify family of event, elevate affected area (insert site) to decrease swelling, and review current mobility device. The care plan did not address individualized fall interventions for R122.	F 280	F 280 Fall care plans of residents named have been reviewed and updated. Expectations on updating care plans will be discussed with nursing staff. Fall care plans of all residents will be examined and adjusted. All falls will be discussed at weekly IDT, and care plans will be updated at this time as well. Staff will be trained in documenting interventions. Nursing management will monitor compliance and complete random audits of fall care plans. Reports will be made to QA.	

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A review of Catholic Eldercare on Main Resident Progress Notes revealed the following falls:
2/6/17, R122 lost her balance and fell to the floor. R122 stated she was on her way to the bathroom.
2/11/17, R122 was found on the floor at her bedside around 5:45 a.m.
2/11/17, R122 was sitting on the edge of her bed and self transferred.
2/12/17, R122 was found sitting on the floor with her back against the bed.
2/12/17, R122 attempting to get out of bed unassisted at beginning of shift.
2/15/17, R122 was found sitting on the floor by her bedside.
2/18/17, R122 slid out of her recliner.
2/19/17, R122 found lying on the floor in front of her bed.

On 5/18/17, at 11:56 a.m., registered nurse (RN) -E stated the facility has an interdisciplinary team (IDT) that meets to discuss falls every Friday. She stated the IDT looks at what triggered the falls, risk factors and interventions for fall preventions. She stated an intervention put in place for R122 was to bring her out to the nurses station.

On 5/18/17, at 11:50 a.m., the director of nursing (DON) stated the IDT went over R122's falls, but stated she was unable to provide documentation the falls were reviewed for potential causes and interventions.

On 5/18/17, at 2:21 p.m., RN-E stated there was no documentation of fall interventions for R122.
R143 had falls on 4/5/17, and 4/29/17. The current care plan had not been updated with any new interventions to minimize risk and/or prevent

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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 280	Continued From page 15 potential injury from further falls. R143's diagnoses obtained from the undated face sheet included dementia, Choreiform movement (repetitive and rapid, jerky, involuntary movement that appears to be well-coordinated; often seen in Huntington's disease), repeated falls, and weakness. On 5/18/17, at 9:07 a.m. R143 was observed with supervision ambulating with walker in room and at 9:23 a.m. was observed ambulating with walker to the dining table. Quarterly Minimum Data Set (MDS) dated 2/8/17, indicated R143's Brief Interview for Mental Status (BIMS-a tool used to determine cognitive status) was rated at a 7 out of a possible 15 score (0 to 7 denotes severe cognitive impairment). In addition, the MDS indicated R143 required one person physical assist supervision for walking in room, corridor and on unit. The care plan dated 10/24/16, indicated R143 was "at risk for falls related to: history of falls, dx: Choreiform movements, weakness, anorexia, gait/balance problems, visual impairments and impaired cognition. Approach indicated When falls occur investigate root cause through interdisciplinary team (IDT) meeting protocol. When falls occur nursing to monitor using CEOM fall protocol." The care plan lacked evidence of any individualized interventions following falls. The Care Area Assessment (CAA) dated 11/22/16, indicated "11. FALLS: Triggered due to wandering daily with unsteady balance transitions. HX OF FALLS: 3 falls without injury since admission see IDT progress notes 9/11,	F 280		

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	245439	A. BUILDING ______ B. WING ______	05/18/2017

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F 280	Continued From page 16	F 280		

9/24 and 10/11. PERFORMANCE ISSUES: Impaired balance during transitions. Resident has had a recent improvement in her mobility status. She ambulates on her own with a seated walker. She often does not have her walker with her when ambulating staff locates the walker and positions it in-front of her. INTERNAL RISK FACTORS: Abnormal involuntary movements per dx list. ANALYSIS: Resident is at high risk of falls r/t hearing deficits and complicated by impaired balance and mobility. Potential for falls r/t impaired balance as well as hearing. Care remains to prevent falls and fall related injuries with interventions. Staff will assist with anticipating her needs. Will maintain bed in low position when in bed and use perimeter mattress."

Review of event report dated 4/5/17, revealed "interventions in place: remind resident to use her walker, f/u." Review of IDT note dated 4/14/17, revealed R143 had a history of not using her walker, received frequent staff reminders to use walker, gait was spastic-like and unsteady, had independent spirit, and refused hip protectors in the past.

Review of event report dated 4/29/17, revealed no interventions. Review of IDT note dated 5/5/17, revealed resident frequently needed reminder to utilize walker safety and maintain hand support for balance. IDT note further indicated cognitive deficits impaired follow-through to safely use walker.

On 5/18/17, at 9:07 a.m. nursing assistant (NA)-A stated R143 walked around the hallway with walker and sometimes walked fast.

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F 280	Continued From page 17 On 5/18/17, at 9:33 a.m. registered nurse (RN)-B stated R143 walked independently with walker but sometimes forgot the walker. During interview on 5/18/17, at 1:42 p.m. RN-C stated R143 had a history of falls and would fall backwards. RN-C stated they tried interventions and sometimes R143 refused to use her walker. On 5/18/17, at 2:26 p.m. the director of nursing (DON) stated when a resident fell, the responding nurse should review and implement interventions at that time. On Fridays, the IDT reviewed falls and looked at the care plan to ensure it was adjusted. The care planning, care conference and MDS policies and procedures dated 6/1/04, indicated, the care plan was to be updated routinely with the RAI process and as needed with resident changes.	F 280		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual’s clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with	F 314		6/27/17

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F 314	Continued From page 18 professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess pressure ulcers to include, stage, size and progress toward healing for 1 of 4 resident's (R228) reviewed for pressure ulcers. Findings include: R228's Admission Minimum Data Set (MDS) dated 3/17/17, indicated she was severely cognitively impaired and required extensive assistance with all activities of daily living (ADL's). The MDS identified a risk for pressure ulcers, but indicated skin was intact. R228's care plan dated 4/10/17, indicated impaired skin integrity related to:"probable trauma to right outer melleous [sic] caused from w/c [wheel chair] foot pedals and continuous motion of feet hitting ankle on pedals." The care plan directed staff to inspect right ankle open area daily and complete daily wound observation. The care plan further directed staff to document in non-pressure observations weekly on bath day. A Catholic Eldercare on Main Skin - Non-Pressure Wound - Weekly Documentation dated 4/10/17, indicated R228 had an "abrasion" to her right lateral malleolus. Length 1 centimeter (cm) x width 1 cm. Foot pedals added and repetition movement of foot continued likely causing trauma to area. A Catholic Eldercare on Main Resident Progress Note dated 4/10/17, indicated: On 4/9/17, it was discovered that R228	F 314	F 314 Medical Director will review wound of R228 on next facility visit to ensure proper wound treatment is being provided. Care plan and documentation in record of R228 is updated. Plan of care reviewed by primary NP and MD will see on their next rounds. All residents with wounds have been reviewed for proper assessment, treatment and documentation; Medical Director will see these 5 residents on next rounds. Wound care policies and procedures will be reviewed and updated as necessary. Nursing staff will be receive education on wound care assessment, treatment and documentation. All licensed nurses complete wound assessment competency annually. All wounds will be regularly reviewed at weekly IDT meetings where assessment and interventions will be discussed. Compliance will be monitored by Nursing Management team by weekly chart review and observation of treatments. Reports will be made at QA meetings.	

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F 314	Continued From page 19	F 314		

had an open area to the right outer malleolus. She has a 1 cm diameter open area with 0.1 cm depth that is visible and a thin layer of eschar covering the wound.

A Catholic Eldercare on Main Skin - Body Audit and Foot Exam - Weekly, dated 4/13/17, indicated R228 had an open area on right ankle. No assessment of the wound, including measurements was identified.

A Catholic Eldercare on Main Skin - Body Audit and Foot Exam - Weekly, dated 4/20/17, indicated R228 had an area on right ankle. No assessment of the wound, including measurements was identified.

A Catholic Eldercare on Main Resident Progress Note dated 5/3/17, indicated: Inspected right outer malleolus. Affected area is 3 cm x 1.6 cm, 100% eschar. "pressure area vs. trauma area." Wound nurse to inspect on 5/5/17. A progress note dated 5/5/17, indicated Ulcer on right malleolus slightly larger perhaps from suspected trauma just in daily activity. "she does not have a dx [diagnosis] of arterial insufficiency."

On 5/11/17, A Catholic Eldercare on Main Skin - Body Audit and Foot Exam - Weekly indicated open area on right malleolus. No further assessment was noted.

There was no evidence an assessment of the wound to include: measurements, staging, assessment of wound bed and surrounding tissue or progress toward healing was completed again until 5/18/17, following surveyor inquiry.

During an observation on 5/17/17, at 8:14 a.m.,

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R228 was lying on her back in bed. She had body pillows placed on both her right and left sides.

During an observation on 5/18/17, at 9:20 a.m., R228 was seated in a standard wheel chair in the dining room. She was wearing socks and slippers on her feet.

During an interview on 5/17/17, at 12:34 p.m., R228's responsible party (RP)-A stated she was aware of the open area on her ankle RP-A stated, they finally got the foam boots after she got a "big pressure ulcer."

During interview on 5/17/17, at 12:48 p.m., licensed practical nurse (LPN)-A stated "I don't think she (R228) has a pressure ulcer." He stated the wound nurse ruled that out and stated she tried to get up and moves around a lot, we think it came from the foot pedals.

During an interview on 5/17/17, at 1:30 p.m., registered nurse (RN)-D stated she had viewed the area on 4/9/17 and determined it had been caused by trauma related to the wheel chair pedals. She stated she saw the wound again on 5/5/17, and identified it was larger, but still felt it was caused by trauma in daily activity. She stated she was not completing weekly assessments of the wound because it was not pressure and stated RN-C was following the wound. The nurse practitioner who was present during the interview stated she had not seen the wound lately.

During interview on 5/17/17, at 1:48 p.m., RN-C stated she looked at the wound briefly that day and stated she had not seen it for "a while" before that. She stated R228 is fidgety and when the foot pedals are in place, her feet rub against them.

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F 314	Continued From page 21 RN-C stated R228 made frequent repetitive movements. During an interview on 5/17/17, at 1:48 p.m., the director of nursing (DON) stated, "it sounds like the assessment was done, but not a correct identification." She stated the wound was caused from friction and shear and stated friction and shear was pressure. While R228 was identified at risk for pressure ulcers on admission. There was no evidence of weekly skin inspections as directed in the plan of care. Further, while R228 developed an open area on her right ankle after admission to the facility, there was no evidence of weekly assessment that included, staging, measurements, assessment of the wound bed and surrounding tissue or progress toward healing. A facility policy titled Catholic Eldercare and Affiliated Covered Entities, Skin Inspection Weekly, dated 1/15/16, was reviewed. The policy directed staff to complete a weekly skin inspection on bath day performed by a licensed nurse.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		6/27/17

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F 323	Continued From page 22 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ongoing assessment and implementation of appropriate interventions in an effort to prevent falls for 2 of 4 residents (R122, R143) reviewed for accidents. Findings include: R122's admission Minimum Data Set (MDS) dated 2/9/17, indicated she was cognitively intact and required extensive assistance with activities of daily living (ADL's). A Care Area Assessment dated 2/15/17, indicated R122 did not have any falls during the assessment period but identified a risk for falls related to ability to stabilize only with staff assistance .A Catholic Eldercare on Main Fall Risk Assessment Tool dated 2/3/17, indicated R122 had no falls in the previous six months and identified her as a low fall risk.	F 323	F 323 Fall care plans of residents named have been reviewed and updated with proper fall interventions. Expectations on updating care plans will be discussed with nursing staff. Fall care plans of all residents will be reviewed and adjusted. All falls will be reviewed at weekly IDT where team will discuss current interventions and suggest new interventions; care plans will be updated at this time. Staff will be trained on documenting interventions on care plans and in IDT notes. Nursing management will monitor compliance and complete random audits of fall interventions. Reports will be made to QA.	

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F 323	Continued From page 23 R122's care plan dated 2/6/17, identified a risk for falls related to a history of falls, dyspnea and weakness. The care plan directed staff to notify family of event, elevate affected area (insert site) to decrease swelling, and review current mobility device. The care plan did not address individualized fall interventions for R122. A review of Catholic Eldercare on Main Resident Progress Notes revealed the following: - 2/6/17 - Nursing assistant (NA) walking past room and noted R122 standing next to her bed. R122 lost her balance and fell to the floor. R122 stated she was on her way to the bathroom. - 2/11/17 - R122 was found on the floor at her bedside around 5:45 a.m. She laid on left side of her face with her hand behind her. Redness noted to both knees. - 2/11/17 - self transfer attempt. R122 sitting on the edge of her bed attempting to get up. - 2/12/17 - R122 was found sitting on the floor with her back against the bed. - 2/12/17 - R122 2 falls in past 24 hours. Staff noticed superficial skin removal on left leg measuring 2.0 centimeters (cm) x 2 cm. - 2/12/17 - R122 attempting to get out of bed unassisted at beginning of shift. -2/15/17 - R122 made frequent attempts to get out of bed. - 2/15/17 - R122 was found sitting on the floor by	F 323		

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her bedside. An abrasion measuring 3.0 cm x 2.7 cm noted on left knee.

- 2/18/17 - R122 found sliding down from her recliner. Already on the floor before staff could get to her.

- 2/19/17 - R122 fell at 7:30 p.m., found lying on the floor in front of her bed.

- 2/21/17 - R122 expired at facility.

On 5/18/17, at 11:56 a.m., registered nurse (RN) - E stated the facility has an interdisciplinary team (IDT) that meets to discuss falls every Friday. She stated the IDT looks at what triggered the falls, risk factors and interventions for fall preventions. She stated an intervention put in place for R122 was to bring her out to the nurses station.

On 5/18/17, at 11:50 a.m., the director of nursing (DON) stated the IDT went over R122's falls, but stated she was unable to provide documentation the falls were reviewed for potential causes and interventions.

On 5/18/17, at 2:21 p.m., RN-E stated the falls process changed in October of 2016 and there was a "learning curve" trying to get the nurses to document the falls on paper as well as using the on-line event tool. She stated the IDT had evaluated R122's falls but was unable to provide documentation of the reviews. She stated, during the IDT review a progress note was documented but she was not sure how R122's got missed. RN-E further stated there was no documentation of fall interventions for R122.

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F 323	Continued From page 25 While R122 sustained six falls between 2/6/17, at 2/19/17, there was no evidence the facility reviewed the falls in an effort to determine causal factors, nor was there evidence individualized interventions to minimize risk had been developed and implemented. A facility policy titled Fall Risk Assessment, dated 7/1/16, indicated all residents would be assessed for safety on admission, readmission, annually, quarterly and with significant changes to maintain their safety. R143's diagnoses obtained from the undated face sheet included dementia, Choreiform movement (repetitive and rapid, jerky, involuntary movement that appears to be well-coordinated; often seen in Huntington's disease), repeated falls, weakness, and history of transient ischemic attack (TIA). On 5/18/17, at 9:07 a.m. R143 was observed with supervision ambulating with walker in room and at 9:23 a.m. was observed ambulating with walker to the dining table. Quarterly Minimum Data Set (MDS) dated 2/8/17, indicated R143's Brief Interview for Mental Status (BIMS-a tool used to determine cognitive status) was rated at a 7 out of a possible 15 score (0 to 7 denotes severe cognitive impairment). In addition, the MDS indicated R143 required one person physical assist supervision for walking in room, corridor and on unit. The care plan dated 10/24/16, indicated R143 was "at risk for falls related to: history of falls, dx: choreiform movements, weakness, anorexia, gait/balance problems, visual impairments and impaired cognition. Approach indicated When falls occur investigate root cause through	F 323		

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F 323	Continued From page 26 interdisciplinary team (IDT) meeting protocol. When falls occur nursing to monitor using CEOM fall protocol." The care plan lacked evidence of any individualized interventions after the falls. Care Area Assessment (CAA) dated 11/22/16, indicated "11. FALLS: Triggered due to wandering daily with unsteady balance transitions. HX OF FALLS: 3 falls without injury since admission see IDT progress notes 9/11, 9/24 and 10/11. PERFORMANCE ISSUES: Impaired balance during transitions. Resident has had a recent improvement in her mobility status. She ambulates on her own with a seated walker. She often does not have her walker with her when ambulating staff locates the walker and positions it in-front of her. INTERNAL RISK FACTORS: Abnormal involuntary movements per dx list. ANALYSIS: Resident is at high risk of falls r/t hearing deficits and complicated by impaired balance and mobility. Potential for falls r/t impaired balance as well as hearing. Care remains to prevent falls and fall related injuries with interventions. Staff will assist with anticipating her needs. Will maintain bed in low position when in bed and use perimeter mattress." Review of event report dated 4/5/17, revealed "interventions in place: remind resident to use her walker, f/u." Review of IDT note dated 4/14/17, revealed R143 had a history of not using her walker, received frequent staff reminders to use walker, gait was spastic-like and unsteady, had independent spirit, and refused hip protectors in the past. Review of event report dated 4/29/17, revealed no interventions in place or were any added.	F 323		

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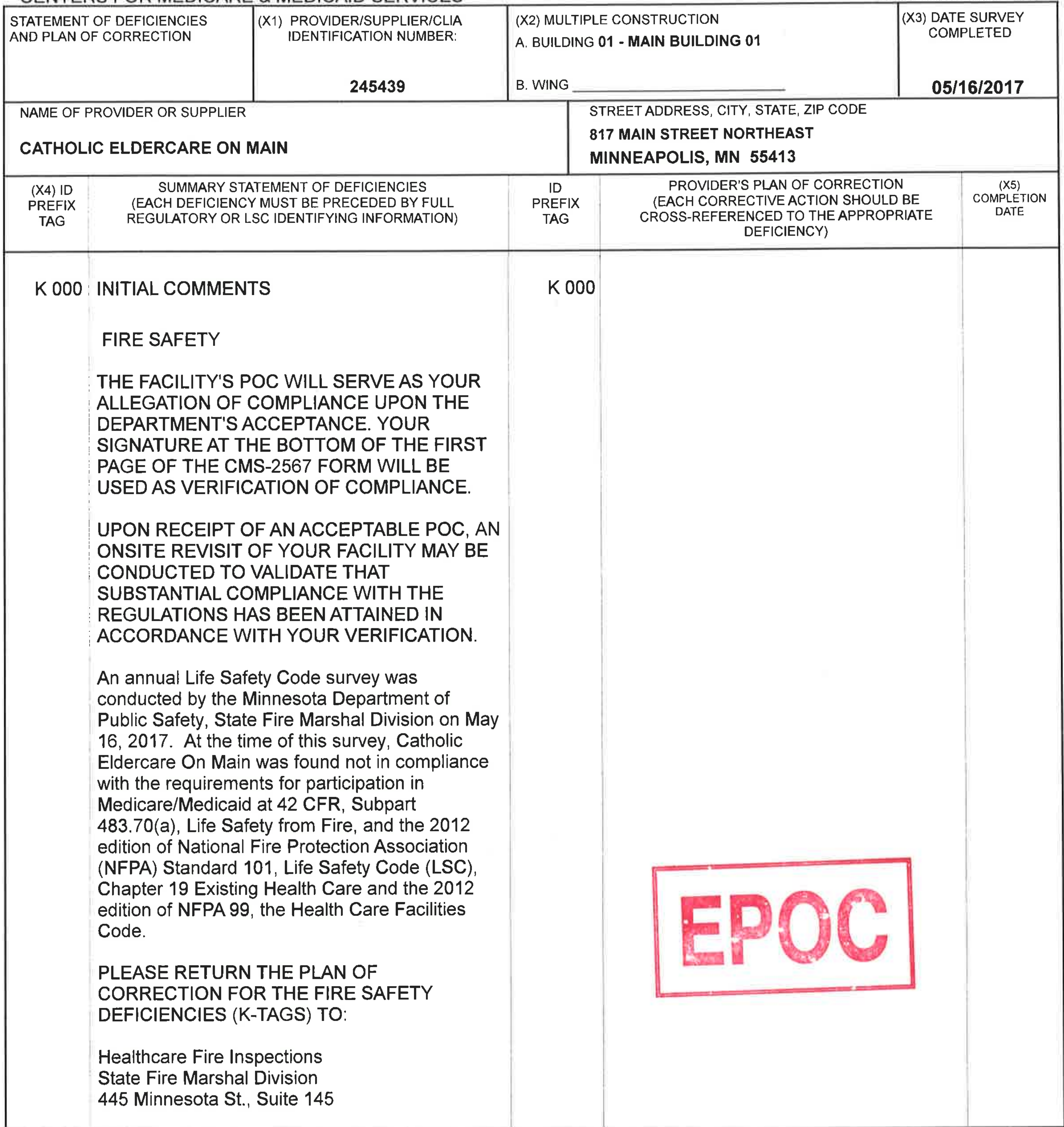
F 323	Continued From page 27 Review of IDT note dated 5/5/17, revealed resident frequently needed reminder to utilize walker safety and maintain hand support for balance. IDT note further indicated cognitive deficits impaired follow-through to safely use walker. On 5/18/17, at 9:07 a.m. nursing assistant (NA)-A stated R143 walked around the hallway with walker and sometimes walked fast. On 5/18/17, at 9:33 a.m. registered nurse (RN)-B stated R143 walked independently with walker but sometimes forgot walker and could fall. During interview on 5/18/17, at 1:42 p.m. RN-C stated R143 had a history of falls and would fall backwards. RN-C stated they tried interventions and sometimes R143 refused to use her walker. RN-C stated they tried hip protectors but R143 refused. RN-C further stated R143's mobility could be jerky every now and then. On 5/18/17, at 2:26 p.m. the director of nursing (DON) stated when a resident fell, the responding nurse should review and implement interventions at that time. On Fridays, the IDT reviewed falls and looked at the care plan to ensure it was adjusted. The DON further stated, continue to monitor per protocol does not provide a clear statement and staff had been taught not to use that statement as it does not give credit for things done.	F 323		

F5439026



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/16/2017**

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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 16, 2017. At the time of this survey, Catholic Eldercare On Main was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/01/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/16/2017**

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

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K 000	Continued From page 1 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Catholic Eldercare on Main is a three story building with no basement. The building was constructed at five different times. The original building was constructed in 1977 and was determined to be of Type II(222) construction. In 1983, an addition was constructed to he South side of the building that was determined to be of type II(222) construction. In 1994, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. In 1995, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. In 2015, an addition was constructed to the South side of the building and was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully protected	K 000		

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	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/16/2017**

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

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K 000	Continued From page 2 throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 174 beds and had a census of 159 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 351 SS=C	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This **STANDARD** is not met as evidenced by: Based on observation and staff interview, the facility failed to install and approved automatic sprinkler system in accordance with the NFPA 13, Standard for Installation of Sprinkler Systems.	K 351	Tag 0351 On May 17, 2017 Frana Construction Company sent out subcontractor. The domestic water pipe was removed and the	6/27/17

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

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	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/16/2017**

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

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K 351	Continued From page 3 LSC 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1). This deficient practice could affect all 159 residents. Findings include: On a facility tour between the hours of 1000 and 1630 on May 16, 2017, observation revealed that there was a domestic water pipe anchored to a pipe which supplies water to the sprinkler system from the fire department connection. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 351	connection is now up to code. Director of Maintenance is responsible for completion. Director of Maintenance will conduct random audits to ensure system is meeting code. Results will be reported at QA.	