MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UNJK

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 **07/30/2018** (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:

X A. In Compliance With Program Requirements Compliance Based On:

____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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:
Susanne Reuss, Unit Supervisor - 16022 07/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 07/30/2018 (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
07/16/2018
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245439 July 30, 2018

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 July 24, 2018 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 located in rooms .

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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered July 30, 2018

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

RE: Project Number S5439028

Dear Ms. King:

On June 28, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 14, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 30, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 14, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 24, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 14, 2018, effective July 24, 2018 and therefore remedies outlined in our letter to you dated June 28, 2018, 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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

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: UNJK
Facility ID: 00984

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/14/2018** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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: **B*** (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: Barbara White, HFE NE II — Date: 07/09/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL: Alison Helm, Enforcement Specialist — Date: 07/13/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
June 28, 2018

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

RE: Project Number S5439028

Dear Ms. King:

On June 14, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically 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:

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 24, 2018, 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 September 14, 2018 (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 December 14, 2018 (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

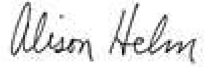
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

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

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 ______	06/14/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 11, 2018 through June 14, 2018 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On June11, 2018 through June 14, 2018 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 plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC 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 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(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.	F 700		7/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/03/2018

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 ______	06/14/2018

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 700	Continued From page 1 §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to attempt the use of appropriate alternatives prior to installing side rails/grab bars, and failed to adequately assess and review the risks and benefits of bed rails/grab bars and obtain informed consent prior installation for 4 of 6 residents (R37, R107, R83, R62) reviewed who used assistive devices. Findings include: R37 On 6/11/18, at 8:44 a.m. during the initial observation and interview R37's bed was observed with quarter side rails on both sides of the bed in up position. One side of the bed was against the wall. R37 stated she fell in the bathroom on 6/10/18. Review of R37's medical recorded indicated R37 had 13 falls since admission. R37's diagnoses list from the undated resident face sheet indicated history of left femur fracture, general anxiety disorder, history of falls, and transient ischemic attacks (small strokes),	F 700	Resident #37, #107, #83 and #62 have all had their use of side rails/grab bars assessed and care plans have been updated. A tool for assessment of need for side rails/grab bars will be developed and used before implementation of side rails/grab bars, when alternate interventions have previously failed. The assessment will include the risks and benefits of the use of these enablers(including entrapment), and will be reviewed with resident/resident representative. Nursing management team will be responsible for implementing and monitoring this process. Education on the use of side rails/grab bars for nursing staff will be provided. Routine care conferences and the MDS process will be utilized for routine review. Concerns will be reported and reviewed at weekly IDT and quarterly QA meetings.	

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 ______	06/14/2018

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 700	Continued From page 2 and cerebral infarction without residual deficits. Review of R37's Minimum Data Set (MDS) Care Area Assessment Progress Note dated 3/8/18, indicated R37 had intact cognition. R37's medical record lacked evidence of alternative interventions prior installation, assessment for use of side rails, assessment of the risk for entrapment, review of the risk and benefits of bed rails with resident or representative, and informed consent. On 6/13/18, at 12:57 a.m. registered nurse (RN)-A was interviewed and stated did not know if a side rail assessment had been done, and was unsure if alternative interventions had been tried. R107 On 6/11/18, 9:31 a.m. during the initial interview with R107 grab bars were observed on both sides of the bed. One side of the bed was up against the wall. R107 stated the grab bars were used to help her not fall out of bed. R107 did not indicate that she used the grab bars for repositioning in bed or for transfers into and out of bed. On 6/12/18, review of R107's medical record indicated R107 had diagnoses of Alzheimer's disease, diabetes mellitus, dizziness, and chronic pain R107's Care Area Assessment (CAA) Summary dated 3/26/18, indicated a gradual decline in mobility and was at risk for falls. The CAA did not indicate the use of grab bars or side rails. R107's medical record lacked evidence of alternative interventions prior installation, assessment for use of side rails, risk for entrapment, review of of the risk and benefits of bed rails with resident or representative, and informed consent.	F 700		

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 ______	06/14/2018

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 700	Continued From page 3 On 6/13/18, at 12:57 a.m. RN-A was interviewed and stated did not know if a side rail assessment had been done, and was unsure if alternative interventions had been tried. R83 On 6/12/18, 2:04 p.m. grab bars were observed on both sides of the bed for R83, one side of the bed was against the wall. R83 stated he fell because of seizures. R83 stated the grab bars were used to transfer and turn over in bed. R107's medical record lacked evidence of alternative interventions prior installation, assessment for use of side rails, risk for entrapment, and review of of the risk and benefits of bed rails with resident or resident's representative and informed consent. On 6/13/18, at 1:00 p.m. during an interview, RN-A stated R83 had not had any seizures since being admitted. RN-A was interviewed about a side rail assessment or an assessment for alternative interventions. RN-A stated he didn't know if those assessments had been completed. On 6/14/18, at 9:57 a.m. the director of nursing (DON) stated the assessment for side rails and grab bars should have been written on the care plan. DON also stated there should be documentation of the bed mobility, use of side rails, and grab bars on the CAA's. The DON stated the expectation was for every resident to have an assessment for safe use of side rails or grab bars, a risk and benefits review with the resident or the resident's representative, documentation of the alternative interventions attempted prior to the installation of the grab bar or side rails, and a risk for entrapment completed	F 700		

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F 700	Continued From page 4 prior to the grab bars or side rails being installed on a bed. The DON stated the facility did not have an assessment tool for use of side rails. R62 During interview on 6/11/18, at 9:28 a.m. R62 stated, "I have fallen often. I am not sure why I fall, my legs are weak. I hurt my right arm and do exercises for it." R62's significant change MDS dated 3/30/18, indicated R62's cognition was moderately impaired and R62 needed extensive staff assistance for transfers and toileting, and was not steady on her feet and only able to stabilize with staff assistance. On 6/13/18, at 9:09 a.m. bilateral grab bars were observed on R62's bed. Review of R62's incident reports indicated R62 had fallen four times in her room from January to May 2018. On 6/14/18, at 9:41 a.m. the nursing assistant (NA)-D stated R62 needed staff contact guard assistance with transfers as R62 could be confused and sometimes would forget to walk with her walker. NA-D stated R62 could walk by herself but needed supervision and she would check on R62 right away in the morning and then keep an eye on her throughout the day. NA-D stated R62's walker had been changed to a different walker. NA-D stated R62 used the grab bar to get out of bed and placed her hand on the grab bar to stand up.	F 700		

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F 700	Continued From page 5 On 6/14/18, at 1:20 p.m. NA-C stated R62 could usually get in and out of bed by herself, but not always. During interview on 6/14/18, at 11:10 a.m. RN-A stated he had not completed a grab bar safety assessment for R62, nor had he completed a risks/benefits review for the grab bars with her. RN-A stated when he did complete a safety assessment for side rails or grab bars he would usually write a progress note which included that he checked for entrapment, reviewed the grab bars with the resident, and with the staff, discussed use of the grab bars with both resident and the staff, included what the resident had to say and then would care plan it. RN-A stated he had not yet completed the assessment or care plan for the use of grab bars for R62. RN-A stated R62 had come to the second floor on 9/14/17. Review of R62's assessments, progress notes and care plan revealed no evidence of a safety assessment, risks/benefits, informed consent, or alternatives tried prior to the grab bars for R62. The facility's side rail/grab bar policy was requested on 6/14/18, but none provided.	F 700		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and	F 740		7/24/18

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F 740	Continued From page 6 mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, develop, and implement individualized interventions that promotes psychosocial well-being for 1 of 4 residents (R66) reviewed for signs and symptoms of depression. Findings include: According to the resident face sheet, R66 was admitted to the transitional care unit on 4/4/18, after sustaining an injury at her assisted living. R66's admission Minimum Data Set (MDS) assessment dated 4/10/18, identified R66 has being admitted with a diagnosis of depression. Section D-Mood of the MDS, question D0100 indicated that R66 should complete a Resident Mood Interview. The Resident Mood Interview items A-I had been dashed (not completed). The score that would have identified the severity of R66's depression was unavailable and and as conclusion the care area assessment (CAA) did not trigger for comprehensive review, and no care plan was developed to alleviate R66's symptoms of depression. The nurse practitioner's progress notes dated 4/12/18, indicated R66 had depression, with no signs of depression, and no medications at that time. A progress note dated 4/5/18, indicated that R66 was quiet during a visit with staff and had a flat affect (lack of emotional expression). A Care conference note dated 5/24/18, identified the R66 had multiple losses, including the death of both	F 740	It is the practice of Catholic Eldercare to comprehensively assess all residents using the RAI process. Resident #66 is being assessed for mood and depression. The MDS interview process is being changed and the IDT is being trained on a traditional method of each discipline completing their own sections which should ensure that the mood section is always complete. The MDS nurses will monitor completion of the interviews and report concerns to the DON. Weekly IDT and quarterly QA meetings will be used to address any ongoing issues.	

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F 740	Continued From page 7	F 740		

her sons and her siblings, along with her recent move from her apartment to the dementia unit. An initial assessment by activities on 5/25/18, also identified additional losses including the death of her mother when R66 was 3 years old. R66 also was no longer able to attend card club with her friends and her sisters as they have all died. The care plan dated 6/12/18, indicated R66 had cognitive impairment and dementia, and identified there was potential alteration in mood and behavior due to life long history of loss, but depressions was not addressed.

During an observation and interview on 6/11/18, at 8:50 a.m. R66 was not communicative, had a flat affect and was sitting with peers in the kitchenette but was not interacting with anyone.

During an observation and interview on 6/12/18, at 6:42 p.m. R66 was sitting in a chair in the hallway outside her room. Stated "I don't want to go in there, I am tired of all the people coming and going in and out of there."

During an interview with registered nurse (RN)-D, a manager, on 6/13/18, at 10:36 a.m. RN-D stated Section D of the MDS was completed by the interdisciplinary team, and the MDS coordinators input the data.

During an interview with MDS coordinator (MDS)-D on 6/13/18, at 11:02 a.m. she verified the data was missing. MDS-D stated the person responsible for the assignment was no longer employed with the facility so the assignments were redistributed. MDS-D was unable to state who would have been responsible for the Resident Mood Interview because all disciplines were doing all sections. In other words, dieticians

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F 740	Continued From page 8 could be assigned Section K-Swallowing/Nutritional Status, and social workers would have Section D- Mood assigned to complete. MDS-D stated the MDS coordinators monitored the process. If the section was not done, it would fall to the nurse managers. If it was not done by the time the window closes, the missed section would be dashed. During an interview with the director of nurses (DON) on 6/13/18, she verified that the MDS assessment process was interdisciplinary and although started with good intentions, now it will going to be changed to the traditional method of each discipline completed their own sections. The DON verified that the Resident Mood Interview should have been completed to gauge the severity of R66's current level of depression, and develop individualized interventions.	F 740		

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

F5439028

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 ______	**06/13/2018**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 13, 2018. 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 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. 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 throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection	K 000		

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

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

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	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	06/13/2018

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K 000	Continued From page 1 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 168 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Electronically delivered
June 28, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5439028

Dear Ms. King:

The above facility was surveyed on June 11, 2018 through June 14, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

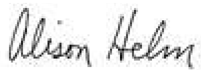
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor at (651) 201-3793 or susanne.reuss@state.mn.us.

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

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

Please feel free to call me with any questions.



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00984	A. BUILDING: ______ B. WING ______	06/14/2018

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/03/18

Minnesota Department of Health

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. Surveyors of this Department, visited the above provider from June 11, 2018 through June 14, 2018, and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences.	2 540		7/24/18

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

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2 540	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to attempt the use of appropriate alternatives prior to installing side rails/grab bars, and failed to adequately assess and review the risks and benefits of bed rails/grab bars and obtain informed consent prior installation for 4 of 6 residents (R37, R107, R83, R62) reviewed who used assistive devices. In addition the facility failed to comprehensively assess, develop, and implement individualized interventions that promotes psychosocial well-being for 1 of 4 residents (R66) reviewed for signs and symptoms of depression. Findings include: R37 On 6/11/18, at 8:44 a.m. during the initial observation and interview R37's bed was observed with quarter side rails on both sides of the bed in up position. One side of the bed was against the wall. R37 stated she fell in the bathroom on 6/10/18. Review of R37's medical recorded indicated R37 had 13 falls since admission. R37's diagnoses list from the undated resident face sheet indicated history of left femur fracture, general anxiety disorder, history of falls, and transient ischemic attacks (small strokes), and cerebral infarction without residual deficits. Review of R37's Minimum Data Set (MDS) Care Area Assessment Progress Note dated 3/8/18, indicated R37 had intact cognition. R37's medical record lacked evidence of alternative interventions prior installation, assessment for use of side rails, assessment of the risk for entrapment, review of the risk and benefits of bed rails with resident or representative, and informed	2 540	See correction plan for side rails and behavioral health. The comprehensive assessment policy, side rail/grab bar policy will be reviewed and updated and staff educated on changes and additions. Nursing management will be responsible for auditing compliance. IDT and QA meetings will be used to address concerns.	

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consent.

On 6/13/18, at 12:57 a.m. registered nurse (RN)-A was interviewed and stated did not know if a side rail assessment had been done, and was unsure if alternative interventions had been tried.

R107
On 6/11/18, 9:31 a.m. during the initial interview with R107 grab bars were observed on both sides of the bed. One side of the bed was up against the wall. R107 stated the grab bars were used to help her not fall out of bed. R107 did not indicate that she used the grab bars for repositioning in bed or for transfers into and out of bed.

On 6/12/18, review of R107's medical record indicated R107 had diagnoses of Alzheimer's disease, diabetes mellitus, dizziness, and chronic pain R107's Care Area Assessment (CAA) Summary dated 3/26/18, indicated a gradual decline in mobility and was at risk for falls. The CAA did not indicate the use of grab bars or side rails. R107's medical record lacked evidence of alternative interventions prior installation, assessment for use of side rails, risk for entrapment, review of of the risk and benefits of bed rails with resident or representative, and informed consent.

On 6/13/18, at 12:57 a.m. RN-A was interviewed and stated did not know if a side rail assessment had been done, and was unsure if alternative interventions had been tried.

R83
On 6/12/18, 2:04 p.m. grab bars were observed on both sides of the bed for R83, one side of the bed was against the wall. R83 stated he fell because of seizures. R83 stated the grab bars

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were used to transfer and turn over in bed.

R107's medical record lacked evidence of alternative interventions prior installation, assessment for use of side rails, risk for entrapment, and review of of the risk and benefits of bed rails with resident or resident's representative and informed consent.

On 6/13/18, at 1:00 p.m. during an interview, RN-A stated R83 had not had any seizures since being admitted. RN-A was interviewed about a side rail assessment or an assessment for alternative interventions. RN-A stated he didn't know if those assessments had been completed.

On 6/14/18, at 9:57 a.m. the director of nursing (DON) stated the assessment for side rails and grab bars should have been written on the care plan. DON also stated there should be documentation of the bed mobility, use of side rails, and grab bars on the CAA's. The DON stated the expectation was for every resident to have an assessment for safe use of side rails or grab bars, a risk and benefits review with the resident or the resident's representative, documentation of the alternative interventions attempted prior to the installation of the grab bar or side rails, and a risk for entrapment completed prior to the grab bars or side rails being installed on a bed. The DON stated the facility did not have an assessment tool for use of side rails.
R62
During interview on 6/11/18, at 9:28 a.m. R62 stated, "I have fallen often. I am not sure why I fall, my legs are weak. I hurt my right arm and do exercises for it."

R62's significant change MDS dated 3/30/18, indicated R62's cognition was moderately

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impaired and R62 needed extensive staff assistance for transfers and toileting, and was not steady on her feet and only able to stabilize with staff assistance.

On 6/13/18, at 9:09 a.m. bilateral grab bars were observed on R62's bed.

Review of R62's incident reports indicated R62 had fallen four times in her room from January to May 2018.

On 6/14/18, at 9:41 a.m. the nursing assistant (NA)-D stated R62 needed staff contact guard assistance with transfers as R62 could be confused and sometimes would forget to walk with her walker. NA-D stated R62 could walk by herself but needed supervision and she would check on R62 right away in the morning and then keep an eye on her throughout the day. NA-D stated R62's walker had been changed to a different walker. NA-D stated R62 used the grab bar to get out of bed and placed her hand on the grab bar to stand up.

On 6/14/18, at 1:20 p.m. NA-C stated R62 could usually get in and out of bed by herself, but not always.

During interview on 6/14/18, at 11:10 a.m. RN-A stated he had not completed a grab bar safety assessment for R62, nor had he completed a risks/benefits review for the grab bars with her. RN-A stated when he did complete a safety assessment for side rails or grab bars he would usually write a progress note which included that he checked for entrapment, reviewed the grab bars with the resident, and with the staff, discussed use of the grab bars with both resident and the staff, included what the resident had to

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say and then would care plan it. RN-A stated he had not yet completed the assessment or care plan for the use of grab bars for R62. RN-A stated R62 had come to the second floor on 9/14/17. Review of R62's assessments, progress notes and care plan revealed no evidence of a safety assessment, risks/benefits, informed consent, or alternatives tried prior to the grab bars for R62.

The facility's side rail/grab bar policy was requested on 6/14/18, but none provided.

R66
According to the resident face sheet, R66 was admitted to the transitional care unit on 4/4/18, after sustaining an injury at her assisted living. R66's admission Minimum Data Set (MDS) assessment dated 4/10/18, identified R66 has being admitted with a diagnosis of depression. Section D-Mood of the MDS, question D0100 indicated that R66 should complete a Resident Mood Interview. The Resident Mood Interview items A-I had been dashed (not completed). The score that would have identified the severity of R66's depression was unavailable and and as conclusion the care area assessment (CAA) did not trigger for comprehensive review, and no care plan was developed to alleviate R66's symptoms of depression. The nurse practitioner's progress notes dated 4/12/18, indicated R66 had depression, with no signs of depression, and no medications at that time.

A progress note dated 4/5/18, indicated that R66 was quiet during a visit with staff and had a flat affect (lack of emotional expression). A Care conference note dated 5/24/18, identified the R66 had multiple losses, including the death of both her sons and her siblings, along with her recent

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2 540	Continued From page 8 move from her apartment to the dementia unit. An initial assessment by activities on 5/25/18, also identified additional losses including the death of her mother when R66 was 3 years old. R66 also was no longer able to attend card club with her friends and her sisters as they have all died. The care plan dated 6/12/18, indicated R66 had cognitive impairment and dementia, and identified there was potential alteration in mood and behavior due to life long history of loss, but depressions was not addressed. During an observation and interview on 6/11/18, at 8:50 a.m. R66 was not communicative, had a flat affect and was sitting with peers in the kitchenette but was not interacting with anyone. During an observation and interview on 6/12/18, at 6:42 p.m. R66 was sitting in a chair in the hallway outside her room. Stated "I don't want to go in there, I am tired of all the people coming and going in and out of there." During an interview with registered nurse (RN)-D, a manager, on 6/13/18, at 10:36 a.m. RN-D stated Section D of the MDS was completed by the interdisciplinary team, and the MDS coordinators input the data. During an interview with MDS coordinator (MDS)-D on 6/13/18, at 11:02 a.m. she verified the data was missing. MDS-D stated the person responsible for the assignment was no longer employed with the facility so the assignments were redistributed. MDS-D was unable to state who would have been responsible for the Resident Mood Interview because all disciplines were doing all sections. In other words, dieticians could be assigned Section K-Swallowing/Nutritional Status, and social	2 540		

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workers would have Section D- Mood assigned to complete. MDS-D stated the MDS coordinators monitored the process. If the section was not done, it would fall to the nurse managers. If it was not done by the time the window closes, the missed section would be dashed.

During an interview with the director of nurses (DON) on 6/13/18, she verified that the MDS assessment process was interdisciplinary and although started with good intentions, now it will going to be changed to the traditional method of each discipline completed their own sections. The DON verified that the Resident Mood Interview should have been completed to gauge the severity of R66's current level of depression, and develop individualized interventions.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the comprehensive assessment for each individual resident is completed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure professional staff are completing the comprehensive assessments in a timely manner.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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