	ARE/MEDICAID CERTIFIC	CENTERS FOR ME ATION AND TRANSMITTAL HE STATE SURVEY AGENCY	CDICARE & MEDICAID SERVICES ID: UYZ3 Facility ID: 00984
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245439 2.STATE VENDOR OR MEDICAID NO. (L2) 375542800	3. NAME AND ADDRESS OF FAC (L3) CATHOLIC ELDERCARH (L4) 817 MAIN STREET NORT (L5) MINNEAPOLIS, MN	ILITY E ON MAIN	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGO 01 Hospital 05 HHA	ORY <u>02</u> (L7) 09 ESRD 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 10/08/2020 (L34) 8. ACCREDITATION STATUS:	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	10 NF 14 CORF 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b):	10.THE FACILITY IS CERTIFIED A A. In Compliance With Program Requirements Compliance Based On:		the Following Requirements: el6. Scope of Services Limit

1. Acceptable POC

IID

(L43)

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

ICF

(L42)

174 (L18)

174 (L17)

19 SNF

(L39)

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

_____ 3. 24 Hour RN

* Code:

____ 5. Life Safety Code

А

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

15. FACILITY MEETS

4. 7-Day RN (Rural SNF)

7. Medical Director

8. Patient Room Size

9. Beds/Room

(L15)

(L12)

17. SURVEYOR SIGNATURE		Date :	18. STATE SURVEY AGENCY APPROV	AL Date:		
Susan Frericks, Unit Su	upervisor	12/10/2020 (L19)	Kamala Fiske-Downing, Sr. Health Program F	Rep 12/10/2020 (L20)		
PA	ART II - TO BE COMP	LETED BY HCFA REGIONA	AL OFFICE OR SINGLE STATE AGENCY			
19. DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible	Participate	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 Statement of Financial Solve Ownership/Control Interest I Both of the Above : 			
22. ORIGINAL DATE OF PARTICIPATION 03/01/1987 (L24) 25. LTC EXTENSION DATE: (L27)	 23. LTC AGREEMENT BEGINNING DATE (L41) 27. ALTERNATIVE SANC A. Suspension of Admis B. Rescind Suspension 	ssions: (L44)	26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active		
28. TERMINATION DATE:	03	MEDIARY/CARRIER NO. 001	30. REMARKS			
31. RO RECEIPT OF CMS-1539	(L28) 32. DETER (L32)	(L31) MINATION OF APPROVAL DATE (L33)	DETERMINATION APPROVAL			

12. Total Facility Beds

13. Total Certified Beds

18 SNF

(L37)

14. LTC CERTIFIED BED BREAKDOWN

18/19 SNF

174

(L38)

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE & MEDI	CAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: UYZ3
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00984

	PART I - TO BE COMPLETED BY TH				FE SURVEY	AGENCY		Facility ID: 00984
1. MEDICARE/MEDICAID PROVIDE (L1) 245439 2.STATE VENDOR OR MEDICAID N (L2) 375542800		3. NAME AND AI (L3) CATHOLIC (L4) 817 MAIN S (L5) MINNEAPC	ELDERCAR	RE ON MAI		55413	 TYPE OF A Initial Termination Validation On-Site Vis 	2. Recertification n 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF C (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	UPPLIER CATEO 05 HHA	GORY 09 ESRD	<u>02</u> (L' 13 PTIP	7) 22 CLIA		After Complaint
6. DATE OF SURVEY 10/08/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2020 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	33 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC FISCAL YEAR ENDI				ENDING DATE: (L35)	
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	174 (L18) 174 (L17)	Compliance 1. A X B. Not in Con	nnce With equirements e Based On: cceptable POC	ogram	2. Te 3. 24 4. 7-1	roved Waivers Of chnical Personnel Hour RN Day RN (Rural SN fe Safety Code B *	7. Medic	of Services Limit al Director t Room Size
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY		(112)	
14. LIC CERTIFIED BED BREARDON 18 SNF 18/19 SNF 174	19 SNF	ICF	IID			or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SU	URVEY AGENCY	APPROVAL	Date:
Angela Western, HFE NE	Angela Western, HFE NE II 11/17/2020 (L19				Kamala Fiske-	Downing, Sr. Health	Program Rep	12/06/2020 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA R	EGIONAI	OFFICE C	OR SINGLE S	TATE AGENC	Y
19. DETERMINATION OF ELIGIBILI 1. Facility is Eligible to Pa 2. Facility is not Eligible			IPLIANCE WIT HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMIN	ATION ACTION:		(L30)
OF PARTICIPATION 03/01/1987	BEGINNING	G DATE	ENDING DA	ΔТЕ	<u>VOLUNTARY</u> 01-Merger, Cl			DLUNTARY ail to Meet Health/Safety
(L24)	(L41)		(L25)			tion W/ Reimburse		ail to Meet Agreement
25. LTC EXTENSION DATE:		VE SANCTIONS n of Admissions:	(L44)			oluntary Terminatio on for Withdrawal	OTH	rovider Status Change
(L27)	B. Rescind S	uspension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARK	S		
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVA	L DATE				
	(L32)			(L33)	DETERMI	NATION APPI	ROVAL	



Electronically delivered December 10, 2020

CMS Certification Number (CCN): 245439

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

Dear Administrator:

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 December 9, 2020 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumalu 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: <u>Kamala.Fiske-Downing@state.mn.us</u>



Electronically delivered

December 10, 2020

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

RE: CCN: 245439 Cycle Start Date: October 8, 2020

Dear Administrator:

On December 9, 2020, the Minnesota Department of Health, completed a revisit and on November 16, 2020 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determine:

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective November 28, 2020 be discontinued as of December 9, 2020. (42 CFR 488.417 (b))

As we notified you in our letter of October 29, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 28, 2020.

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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

An equal opportunity employer.



REVISED LETTER

Electronically delivered

December 22, 2020

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

RE: CCN: 245439 Cycle Start Date: October 8, 2020

This letter will replace the letter dated December 10, 2020. Your facility's correction date has been changed from December 9, 2020 to November 24, 2020 so DPNA didn't not go into effect. Also, loss of Nursing Aide Training and/or Competency Evaluation Program (NATCEP) didn't go into effect.

Dear Administrator:

On December 9, 2020 the Minnesota Department(s) of Health, completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 24, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective November 28, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 29, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 28, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 24, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health

Catholic Eldercare On Main December 22, 2020 Page 2 Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>



Electronically delivered October 29, 2020

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

RE: CCN: 245439 Cycle Start Date: October 8, 2020

Dear Administrator:

On October 8, 2020, a survey was completed at your facility by the Minnesota Department(s) 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 28, 2020.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 28, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 28, 2020NO DATA.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial Catholic Eldercare On Main October 29, 2020 Page 2

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

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC tags are cited and this note)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 28, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Catholic Eldercare On Main will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 28, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

Catholic Eldercare On Main October 29, 2020 Page 3

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor Metro D District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health PO Box 64990 St. Paul MN 55164-0900 Email: <u>susan.frericks@state.mn.us</u> Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

Catholic Eldercare On Main October 29, 2020 Page 4 SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 8, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

Catholic Eldercare On Main October 29, 2020 Page 5

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Kumalu Fiste Downing

Kamala Fiske-Downing

Catholic Eldercare On Main October 29, 2020 Page 6 Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			· ·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED
		245439	B. WING				C 08/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2020
CATHOL				81	17 MAIN STREET NORTHEAST		
CATHOL	IC ELDERCARE ON N	MAIN		Μ	IINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		EO	00			
F 000	Emergency Prepare conducted on 10/5/ recertification surve	iance with CMS Appendix Z edness Requirements, was 2020, - 10/8/2020, during a ey. The facility is in compliance Z Emergency Preparedness	FO	000			
	recertification surve facility. Complaint in conducted. Your fac compliance with the	ough 10/8/2020, a standard ey was conducted at your nvestigations were also cility was found not in e requirements of 42 CFR 483, ments for Long Term Care					
	UNSUBSTANTIATE	blaints were found to be ED: H5439051C, H5439052, 9054C, and H5439055C.					
	Control survey was 10/8/2020, at your f Department of Hea with §483.80 Infect	D-19 Focused Infection conducted 10/5/2020, through facility by the Minnesota Ith to determine compliance ion Control. The facility was be in compliance. A cited at F880.					
		f correction (POC) will serve of compliance upon the ptance.					
		nrolled in ePOC, your uired at the bottom of the first 567 form.					
	Upon receipt of an	acceptable electronic POC, a					
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	l	TITLE		(X6) DATE
Electron	ically Signed						11/05/2020

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.

PRINTED: 11/19/2020

		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245439	B. WING			C 10/08/2020	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	IAIN			17 MAIN STREET NORTHEAST IINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	substantial complia been attained in activerification.	y will be conducted to validate nce with the regulations has cordance with your	FC				
F 550 SS=D	Resident Rights/Ex CFR(s): 483.10(a)(F 5	50			11/24/20
	self-determination, access to persons a	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in					
	with respect and dig resident in a manner promotes maintena her quality of life, re	ility must treat each resident gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's cility must protect and of the resident.					
	access to quality ca severity of condition must establish and practices regarding provision of service	facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the es under the State plan for all s of payment source.					
		e right to exercise his or her of the facility and as a citizen					
	resident can exercis	facility must ensure that the se his or her rights without on, discrimination, or reprisal					

If continuation sheet Page 2 of 50

		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED C	
		245439	B. WING))8/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	I AIN		817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From pa from the facility.	ge 2	F 5	50			
	free of interference reprisal from the fac- rights and to be sup exercise of his or his subpart. This REQUIREMEN by: Based on observat review, the facility fac- and waited for a res- resident rooms, for was reviewed for re- Findings include: R74's admission m 8/11/2020, indicated mental status (BIMS indicating intact cog- indicated diagnoses injury (TBI) related post-traumatic stres- attention-deficit hyp R74's care plan, da interventions for alt related to cognitive alteration in mood/t use and PTSD. During an observat at 7:34 p.m., nursin observed to knock room without waitin knock; NA-A also d	resident has the right to be , coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this NT is not met as evidenced tion, interview, and document ailed to ensure staff knocked sponse before entering 1 of 2 residents (R74) who esident right to privacy. inimum data set (MDS), dated d R74 had a brief interview for S) score of 15 out of 15, gnition. The MDS also is that included traumatic brain to a fall, history of falls, as disorder (PTSD), and beratcitity disorder. ted 9/21/20, included ered thought processes impairment and TBI, and behavior related to anxiolytic ion and interview on 10/5/20, g assistant (NA)-A was on R74's door and enter R74's g for R74 to respond to the id not announce himself. After R74 said "this happens all the			F550 It is the Policy for Catholic Eldercare follow state and federal regulations Resident Rights. R74 was interviewed and states satisfaction with how staff are current entering her room at this time. All residents will be interviewed to iden others are affected. Staff will be re-trained in the require to knock and wait for the resident to respond before entering. Department Managers will conduct Random aud across all shifts of staff entering roo will be done daily for one week, we one month and quarterly thereafter. Results will be reviewed and monito the nurse managers and forward information to the QAPI committee to further review and recommendation	for ntly tify if ment oms ent dits bms ekly for ored by for	

Facility ID: 00984

If continuation sheet Page 3 of 50

		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245439	B. WING	;		10/08/2020	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	MAIN			817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	time. They just fling knocking." R74 also but he would never announce himself b had to be patient w During an observat at 7:43 p.m., NA-D knocking or annour NA-D had a new dr removed the old dri table, placed the ne bedside table, and acknowledge or spo room, R74 stated, " people just come in said she has compl nothing changed. During an interview NA-G stated they w wait" and then let th were entering the ro During an interview licensed practical n should knock on the before entering the happen every time room. During an interview trained medication supposed to knock for an answer befor stated if there was	g the door open without o stated NA-A would knock, wait for a response or pefore entering. R74 said she	F	550			

Facility ID: 00984

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245439	B. WING			C 10/08/2020	
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	I AIN			17 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550 F 585 SS=D	During an interview registered nurse (R was staff knock on for a response befor should happen eve resident's room. During an interview RN-A verified staff s announce themselv room. During an interview director of nursing (was for staff to kno wait for an answer Grievances CFR(s): 483.10(j)(1) §483.10(j) Grievand §483.10(j) Grievand §483.10(j)(1) The ro grievances to the fa that hears grievand reprisal and without reprisal. Such griev respect to care and furnished as well as furnished, the beha residents, and othe facility stay. §483.10(j)(2) The ro facility must make p resolve grievances accordance with thi §483.10(j)(3) The fa	 on 10/8/20, at 1:15 p.m., (N)-A verified the expectation the resident's door and wait or entering. RN-A stated this ry time a staff entered a on 10/8/20, at 2:00 p.m., should knock on the door and ves when entering a resident's on 10/8/20, at 2:15 p.m., the (DON) verified the expectation ck on resident's doors and before entering the room.)-(4) ces. esident has the right to voice acility or other agency or entity es without discrimination or taraces include those with treatment which has been s that which has not been vior of staff and of other r concerns regarding their LTC esident has the right to and the prompt efforts by the facility to the resident may have, in 		550			11/24/20

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245439	B. WING				C 08/2020
NAME OF F	PROVIDER OR SUPPLIER			0	STREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	IAIN			817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 585	Continued From pa to the resident.	-	F	585	5		
	grievance policy to of all grievances reg contained in this pa provider must give a to the resident. The include: (i) Notifying residen postings in promine facility of the right to (meaning spoken) of	acility must establish a ensure the prompt resolution garding the residents' rights ragraph. Upon request, the a copy of the grievance policy grievance policy must t individually or through ent locations throughout the o file grievances orally or in writing; the right to file ously; the contact information					
	of the grievance off can be filed, that is, address (mailing ar number; a reasonal completing the revie to obtain a written d grievance; and the independent entities be filed, that is, the Quality Improvement Agency and State L	icial with whom a grievance his or her name, business ad email) and business phone ble expected time frame for ew of the grievance; the right lecision regarding his or her contact information of s with whom grievances may pertinent State agency, nt Organization, State Survey ong-Term Care Ombudsman					
	(ii) Identifying a Grie responsible for over receiving and tracki conclusions; leading by the facility; main information associa example, the identif grievances submitte written grievance de coordinating with st necessary in light o	on and advocacy system; evance Official who is rseeing the grievance process, ng grievances through to their g any necessary investigations taining the confidentiality of all ted with grievances, for ty of the resident for those ed anonymously, issuing ecisions to the resident; and ate and federal agencies as f specific allegations; aking immediate action to					

Facility ID: 00984

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STATEMENT OF DEFICIENCIES AND PLANOF CORRECTION (X1) DENTFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245439 IS VING ISTREET ADDRESS, CITY, STATE, ZIP CODE MAME OF PROVIDER OR SUPPLIER ISTREET ADDRESS, CITY, STATE, ZIP CODE ISTREET ADDRESS, CITY, STATE, ZIP CODE CATHOLIC ELDERCARE ON MAIN ISTREET ADDRESS, CITY, STATE, ZIP CODE INNEAPOLIS, MN 55413 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG DREEX (CODS-REFERENCE) TO THE ADDRESS, CITY, STATE, ZIP CODE (M1) (COD CONSTRUCT ACTION NOLLOBE OWNER (CODE F 585 Continued From page 6 prevent further potential violations of any resident right while the alleged violation is being investigated; F 585 F 585 (V) Consistent with \$483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone fumishing services on behalf of the provider, to the administrator of the provider, and as required by State law; F 585 (V) Taking appropriate corrective action taken or to be taken by the facility as a result of the grievance, and the date the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the size or reproprise is corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facili			AND HUMAN SERVICES				FORM	APPROVED 0938-0391
Image: Continued From page 6 F 585 F 585 Continued From page 6 prevent further potential violations of any resident right while the alleged violations of any resident right while the alleged violations of any resident right while the alleged violations of the provider, and as required by State law; (v) Consistent with \$483.12(c)(1), immediately reporting all alleged violations of the provider, and as required by State law; (v) Consistent with \$483.12(c)(1), immediately reporting all alleged violations of the provider, and as required by State law; (v) Consistent with \$483.12(c)(1), immediately reporting all alleged violations of the provider, and as required by State law; (v) Consistent with \$483.12(c)(1), immediately reporting all alleged violation surves, and/or misappropriation of resident provider, and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was confirmed or not confirmed, any corrective action in accordance with State law if the alleged violation of the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action in accordance with State law if the alleged violation of the resident's concerns(s), a statement as the State Survey Agency, Quality improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility, and (vi) Maintaining evidence demonstrating the result of all grievances of the grievance decision. This REQUIREMENT is not met as evidenced				(X2) MUL	TIPLI		(X3) DATE SURVEY	
245439 B. WING 10/08/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 317 MAIN STREET NORTHEAST STREET ADDRESS, CITY, STATE, ZIP CODE 10/08/2020 (MAI) D SUMMARY STREET OF DEFICIENCIES 117 MAIN STREET NORTHEAST 117 MAIN STREET NORTHEAST 110/08/2020 (MAI) D SUMMARY STREET OF DEFICIENCIES PROVIDER PLAN OF CORRECTION PROVIDER PLAN OF CORRECTION 00 ET (MAI) TAG SUMMARY STREET OF DEFICIENCIES PROVIDER PLAN OF CORRECTION COULD THE APPROPRIATE COULD THE APPROPRO	AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CUTY, STATE, ZIP CODE CATHOLIC ELDERCARE ON MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413 Main Dig SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PROCEEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER SPLAN OF CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 585 Continued From page 6 prevent further potential violations of any resident right while the alleged violation is being investigated; F 585 (iv) Consistent with \$483.12(c)(1), immediately reporting all alleged violation is involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; F 585 (v) Consistent with \$483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; F 585 (v) (V) Taking appropriate corrective, action taken or to be taken by the facility as a result of the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued, (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the resident's rights is confirmed by the facility or if an outside entity having jurisdicton, such as the S			245439	B. WING				
CATHOLIC ELDERCARE ON MAIN MINNEAPOLIS, MN 55413 [P4] ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OBRIGENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PREFIX TAG PREFIX (EACH OBRIGENCY MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLET TAG F 585 Continued From page 6 prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, and the date the written decision was issued; (w) Taking appropriate corrective action in accordance with State law if the alleged violation of the resident's rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its are of responsibility; and (wii) Maintaining evidence demonstrating the result of all grievances of a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced	NAME OF F	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
CMUID PREEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFX TAG PROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 585 Continued From page 6 prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with \$483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was confirmed or not confirmed, any corrective action in accordance with State law; if the alleged violation of the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law; if the alleged violation of the resident's rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced	CATHOLI		/AIN					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ComMittee DEFICIENCY F 585 Continued From page 6 prevent further potential violations of any resident right while the alleged violation is hoving investigated; (iv) Consistent with \$483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the perivent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was received, a summary of the perivent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance action in accordance with State law if the alleged violation of the resident's rights is confirmed or not confirmed, any corrective action taken or not batken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the resident's rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced					M	IINNEAPOLIS, MN 55413		
prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (iv) Taking appropriate corrective action in accordance with State law if the alleged violation of the resident's rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced	PRÉFIX	FX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION G REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE			(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION	
Based on observation, interview, and document review the facility failed to promptly resolve grievances, for 1 of 1 residents (R74) who was reviewed for grievances. F585 It is the policy of Catholic Eldercare to follow state and federal regulations for Grievances.	F 585	prevent further poter right while the alleg investigated; (iv) Consistent with reporting all alleged abuse, including inj and/or misappropria anyone furnishing s provider, to the adm as required by State (v) Ensuring that all include the date the summary statement the steps taken to in summary of the per- regarding the reside as to whether the g confirmed, any corr taken by the facility and the date the wr (vi) Taking appropri accordance with State of the residents' rigl or if an outside entit the State Survey Ag Organization, or loc confirms a violation rights within its area (vii) Maintaining evi- result of all grievand 3 years from the iss decision. This REQUIREMEN by: Based on observat review the facility fa- grievances, for 1 of	Sential violations of any resident ed violation is being S483.12(c)(1), immediately I violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ninistrator of the provider; and e law; written grievance decisions e grievance was received, a t of the resident's grievance, nvestigate the grievance, a tinent findings or conclusions ent's concerns(s), a statement rievance was confirmed or not ective action taken or to be as a result of the grievance, itten decision was issued; ate corrective action in ate law if the alleged violation hts is confirmed by the facility ty having jurisdiction, such as gency, Quality Improvement cal law enforcement agency for any of these residents' a of responsibility; and dence demonstrating the ces for a period of no less than suance of the grievance NT is not met as evidenced tion, interview, and document iled to promptly resolve 1 residents (R74) who was	F 5	85	F585 It is the policy of Catholic Eldercare follow state and federal regulations		

Facility ID: 00984

PRINTED: 11/19/2020

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245439	B. WING				C 08/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	I AIN		-	17 MAIN STREET NORTHEAST IINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	8/11/2020, indicated mental status (BIM: indicating intact cog indicated diagnoses injury (TBI) related post-traumatic stree attention-deficit hyp R74's care plan, da interventions for alt related to cognitive alteration in mood/t use and PTSD. During an interview at 3:18 p.m., R74 s because another re- room and "sat on th had told the nurse r changed. At 3:22 p and entered into R7 crying. R74 said thi who entered her roo stated "others comit the time." During an interview RN-A verified R74 f residents wandering these complaints w interventions as a p stated there wasn't done as this was th floor, stating, "these unsure at what poir	inimum data set (MDS), dated d R74 had a brief interview for S) score of 15 out of 15, gnition. The MDS also s that included traumatic brain to a fall, history of falls, ss disorder (PTSD), and	F 5	585	R74 was interviewed. A grievance of completed, she requested a room of which has taken place and states satisfaction with resolution of grieva. The facility currently does not have outstanding grievances. All residen be interviewed to identify others that be affected. The grievance policy will be reviewed updated as needed. Managers will educated on the policies and proce and their responsibilities in responsigrievances. Front line staff will be re-trained on how to report a grieva Nursing management and Social S will do random audits of residents to they are satisfied with the follow-up their concerns daily for one week, w for one month and then quarterly thereafter. Results will be reviewed monitored by dept managers and w forward information to the QAPI committee for further review and recommendations	change ance. ts will at may ed and be dures ding to ance. ervice o see if to weekly and	

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245439	B. WING			C 10/08/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	I AIN			17 MAIN STREET NORTHEAST IINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa grievances, "nursing During an interview director of social se of nursing (DON) by resolutions were first voiced complaints of the issue recurred, facility changed it to SW-A stated what we the severity of the is For wandering reside interdisciplinary tea discussed wandering rooms. SW-A stated from the third floor for verified staff were effort to write grievances. Although they were grievances of reside the facility had not r R74 to alleviate ong The facility's Sugge policy, dated 9/30/2 make every effort to suggestions, conce made verbally or in supervisory respons concern." The polic	nge 8 g did not do that." on 10/8/20, at 2:15 p.m., the ervices (SW)-A and the director oth agreed point of care st attempted when residents or concerns. SW-A stated if it was readdressed and the o a grievance "if appropriate." was appropriate depended on ssue, frequency, impact, etc. dents, SW-A stated the im (IDT) met daily and ng residents to brainstorm ated some interventions used resident doors and redirecting dered into other residents' d they had "no grievances for a very long time." The DON expected to help residents e aware of R74's ongoing ents coming into their room, re-addressed this issue with going grievances. estion, Concern and Grievance 20, indicated the facility "would o address and resolved laints and grievances	F	585		NATE	DATE
		sident right while the alleged					

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		AND HUMAN SERVICES & MEDICAID SERVICES	_		FOR	D: 11/19/2020 M APPROVED D. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY		
		245439	B. WING		1)/08/2020		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CATHOL	IC ELDERCARE ON M	IAIN	817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 686 SS=D		Prevent/Heal Pressure Ulcer 1)(i)(ii)	F6	86		11/24/20		
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review, the facility fa interventions to red related injuries, and a new pressure ulco reviewed for pressu facility to accurately resulted in an unsta R64's left heel. Findings include: R64's face sheet, p had diagnoses whic rheumatoid arthritis cerebral infarction, weakness. R64's admission Mi 8/5/20, indicated R6	sure ulcers. rehensive assessment of a must ensure that- es care, consistent with ards of practice, to prevent dividual's clinical condition hey were unavoidable; and pressure ulcers receives at and services, consistent andards of practice, to event infection and prevent veloping. NT is not met as evidenced ion, interview, and document ailed to follow care plan uce the risk of pressure I failed to identify and assess er for 1 of 3 residents (R64) ire ulcers. The failure of the complete weekly skin audits ageable pressure ulcer to			F686 It is the policy of Catholic Eldercare to follow state and federal regulations for treatment/Svcs to Prevent/Heal Pressure Ulcers. The care plan and documentation for R6 were reviewed and updated. The plan of care was reviewed by primary NP. Records of other residents with pressure ulcers will be reviewed for care planning and documentation. Wound care identification and prevention policies and procedures will be reviewed and updated as needed. The nursing staff will be re-educated on the policies and procedures, emphasizing the weekly skir audit tool that is completed on bath day a a wound identification.Random weekly audits on the completion of weekly skin audit tool will be conducted on all four	4		

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FATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	E SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:		G		IPLETED		
		245439	B. WING			C 108/2020		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO				
CATHOL	IC ELDERCARE ON	MAIN		817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE		
F 686	indicated R64 was had no skin issues assessment. R64's Care Area As 8/5/20, indicated th triggered due to be of developing press score dated 8/6/20 risk due to factors assistance with be incontinence of boy indicated R64 did r ulcers, required ex transfers, required ex transfers, required ex indicated R64 was	age 10 ansfers. The MDS further at risk for pressure ulcers and at the time of the admission ssessment (CAA), dated he pressure ulcers CAA ed mobility and R64 was at risk sure ulcers/injuries. A Braden , indicated R64 was at high that included extensive d mobility and frequent wel and bladder. The CAA not currently have pressure tensive assistance of one for bed positioning to keep bony direct contact and to elevate then R64 was in bed. The CAA to receive a daily full body rsing assistant (NA) and a	F 68	6 units by nursing managemen compliance is observed. Re forwarded to QAPI committee review and recommendation	esults will be be for further			
	shower day. The C be turned and repo- staff were to encou- independently ever Finally, the CAA inc checks for safety a R64's care plan da at risk for skin brea mobility (chairfast/k was to be free from care planned appro- keep bony promine one another; to use	spection by a nurse on her AA also indicated R64 was to ositioned every two hours and urage R64 to position ry 15-30 minutes if able. dicated R64 required frequent and positioning. ted 9/11/20, indicated R64 was akdown related to limited bedfast) and listed R64's goal n pressure related injuries. The baches were to position R64 to ences from direct contact with e pillows, foam wedges, etc. to ed; to use bed positioning						

Facility ID: 00984

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	E SURVEY PLETED
		245439	B. WING			C 08/2020
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	MAIN		17 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	temporary care plan issues. R64's care assistants to compl performing a.m./p.r report any signs of red, or broken area The memory care u lacked any informat assistants to use pi for R64. R64's admission pr skin observation oc completed and sign on 8/26/20. The adu R64 slept for 8 hou nap. The PN indica extremities, and sw lower extremities an additional skin abno R64's weekly Body observation dated 9 was "intact" with no callous, open areas changes in feet fror R64's Weekly Body observation dated 9 was "intact" with no callous, open areas changes in feet fror R64's Weekly Body observation dated 9 was "intact" with no callous, open areas changes in feet fror R64's Weekly Body observation dated 9 was "intact" with no callous, open areas	it observations, and initiate a n (TCP) for any new skin plan further directed nursing lete a daily skin check when m. cares and directed staff to skin breakdown (sore, tender,	F 686	· · · ·		

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		AND HUMAN SERVICES			FORM	11/19/2020 APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		245439	B. WING		C 10/08/2020		
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
CATHOL	IC ELDERCARE ON M	MAIN		317 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 686	lower extremities and abnormalities (blister redness, etc.) noted the previous week. R64's fingernails and A second weekly Bo observation dated S indicated R64 receins skin was "intact" and (blisters, callous, op noted and no chang week. The observa fingernails and toer R64's weekly Body observation dated of was "intact" and no callous, open areas changes in feet from On 10/5/20, at 4:57 her lie down in bed until like 6 p.m.", ar in her bed all night On 10/5/20, at 5:30 assisted R64 with p incontinence care. bed using a mecha in bed and had a vi When asked what th how her feet are" and care. NA-B placed and R64's nightgown do sheet and blanket, adjusted foot of bed the call light to R64	age 12 nd feet were "dry" with no foot ers, callous, open areas, d and no changes in feet from The observation noted that nd toenails were trimmed. ody Audit and Foot Exam 9/24/20, at 10:27 a.m. ived a tub bath / whirlpool, and nd no foot abnormalities pen areas, redness, etc.) ges in feet from the previous tion noted that R64's nails were not trimmed. Audit and Foot Exam 10/1/20, indicated R64's skin foot abnormalities (blisters, s, redness, etc.) noted and no m the previous week. Y p.m. R64 asked staff to help . LPN-B suggested "lets wait nd stated R64 would be laying once they assisted her to bed. D p.m. nursing assistant (NA)-B bersonal hygiene and R64 was transferred into her nical device lift. R64 was lying sible scab on her left heel. this was, NA-B stated, "that is nd continued with incontinence a clean brief on R64, pulled own, covered R64 with the adjusted the head of bed, d, turned TV on and attached 's sheet. At 5:52 p.m. NA-B rned off the bathroom light,	F 686				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245439	B. WING				C 08/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	/AIN			17 MAIN STREET NORTHEAST /IINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	and exited the room readily available an positioning devices elevate her heels of prominences in acc At 5:35p.m. NA-B v down and stated "w long time so we like say anything about positioning devices When interviewed of stated R64 liked to asked to go to bed When interviewed of stated R64 spent a wanted to lay down time day shift staff and the evening shi to dinner time. LPN assisted to bed, she following morning a sores we try to kee after dinner, becaus next morning." LPN R64 had any currer R64 had not had ar admission. When interviewed of registered nurse (R out of bed in the more R64 to lay back dow RN-B stated when a R64 up for dinner. F always wanted "to g	n. There were no pillows d no pillows or other placed under R64's feet to ff of the bed and protect bony cordance with R64's care plan. erbalized R64 likes to lay re don't want her in bed for a to get her out." NA-B did not the need for pillows or	F	586			

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STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIERCIAL (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLY AND PLAN OF CORRECTION 245439 (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLY CATHOLIC ELDERCARE ON SUPPLIER 245439 STREET ADDRESS, CITY, STATE, ZIP CODE 10/08/2020 CATHOLIC ELDERCARE ON MAIN STREET ADDRESS, CITY, STATE, ZIP CODE 817 MAIN STREET NORTHEAST 00/08/2020 CATHOLIC ELDERCARE ON MAIN SUMMARY STATEMENT OF DEFICIENCIES PRERX EGON DEFICIENCY MUST BE PRECEDED BY PULL PRERX PRERX TEGOL DEFICIENCY MUST BE PRECEDED BY PULL PRERX CROSS-REFERENCED OT NETON SUPPLIER OMMETTER PROVIDER PLAN OF CORRECTION TAG SUMMARY STATEMENT OF DEFICIENCIES PRERX CROSS-REFERENCED OT NETON SUPPLY DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCIES PRERX CROSS-REFERENCED OT NET APPROPRIATE DOMET PROVEMENT TAG SUMMARY STATEMENT OF DEFICIENCIES PRECX PREXX CROSS-REFERENCED OT NET APPROPRIATE DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCIES PRECX PREXX CROSS-REFERENCED OT THE APPROPRIATE DEFICIENCY TAG SUMMARY STATEMENT OF DEFICIENCIES PREXX THAN STREET ADDRESS, CITY STATEMENT <th></th> <th></th> <th>AND HUMAN SERVICES & MEDICAID SERVICES</th> <th></th> <th></th> <th></th> <th>FORM</th> <th>APPROVED 0938-0391</th>			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
Image: Control of the set o	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP		(X3) DATE SURVEY	
245439 B. WING 10/08/2020 NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZP CODE 817 MAIN STREET NORTHEAST CATHOLIC ELDERCARE ON MAIN BI STREET NORTHEAST 817 MAIN STREET NORTHEAST (P4] ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS FLAN OF CORRECTION BE (EACH CORRECTIVE ACTION SHOULD BE CORSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (vs), (vs), (vs), (CACH CORRECTIVE ACTION SHOULD BE CORSS-REFERENCED TO THE APPROPRIATE (vs), (vs), (DATE F 686 Continued From page 14 R64 asked what time it was and when told the time, R64 stated, "g I should not be in bed at this hour, I want to get up!" R64 stated she was unsure of how long she had been in bed. R64 further stated, "It is only 3:30 though, I should still be up in my chair." At 3:27, pm. nursing staff entered R64's room and asked R64 if she wanted to get up for dinner. R64 stated, "well that sounds like a good idea." F 686 On 10/7/20, at 8:31 a.m. and again at 9:07 a.m. R64 was observed lying in bed sleeping. R64 had no positioning pillows in place and R64's heels were not elevated off of the bed by pillows or any other devices, in accordance with R64's care plan. No. 10/7/20, at 9:20 a.m. R64 indicated she had been awake for a long time and had wanted to get out of bed for "quite a while now". When interviewed on 10/7/20, at 9:35 a.m. NA-F stated he had not see an pillows being used under R64's feet or around her body for positioning in bed and stated, "No. I, don't think so, she only has one pillow she uses behind the head, that is what I know." NA-F verified there were no pillows in pla	AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	;		
CATHOLIC ELDERCARE ON MAIN B17 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413 Image: Construction of the set of th			245439	B. WING				
MINNEAPOLIS, MN 55413 Maji D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WAST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREVIXE CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 686 Continued From page 14 R64 asked what time it was and when told the time, R64 stated, "g I should not be in bed at this hour, I want to get up!" R64 stated she was unsure of how long she had been in bed. R64 further stated, "it is only 3:30 though, I should still be up in my chair." At 3:27 p.m. nursing staff entered R64's room and asked R64 if she wanted to get up for dinner. R64 stated, "well that sounds like a good idea." F 686 On 10/7/20, at 8:31 a.m. and again at 9:07 a.m. R64 was observed lying in bed sleeping. R64 had no positioning pillows in place and R64's heels were not elevated of of the bed by pillows or any other devices, in accordance with R64's care plan. On 10/7/20, at 9:20 a.m. R64 indicated she had been awake for a long time and had wanted to get out of bed for "quite a while now". When interviewed on 10/7/20, at 9:35 a.m. NA-F stated he had not seen pillows being used under R64's feet or around her body for positioning in bed and stated, "No, I don't think so, she only has one pillow she uses behind the head, that is what I know." NA-F verified there were no pillows in place around R64's bed or under R64's feet and stated, "I do not see any pillows around [R64] for	NAME OF F	ROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CECH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DEFICIENCY) F 686 Continued From page 14 R64 asked what time it was and when told the time, R64 stated, "g I should not be in bed at this hour, I want to get up!" R64 stated she was unsure of how long she had been in bed. R64 further stated, "it is only 3:30 though, I should still be up in my chair." At 3:27 p.m. nursing staff entered R64's room and asked R64 if she wanted to get up for dinner. R64 stated, "well that sounds like a good idea." F 686 On 10/7/20, at 8:31 a.m. and again at 9:07 a.m. R64 was observed lying in bed sleeping. R64 had no positioning pillows in place and R64's neets were not elevated off of the bed by pillows or any other devices, in accordance with R64's care plan. On 10/7/20, at 9:20 a.m. R64 indicated she had been awake for a long time and had wanted to get out of bed for "quite a while now". When interviewed on 10/7/20, at 9:35 a.m. NA-F stated he had not seen pillows being used under R64's feet or around her body for positioning in bed and stated, "No, I don't think so, she only has one pillow she uses behind the heed, that is what I know." NA-F verified there were no pillows in place around R64's body or under R64's feet and stated, "No not see any pillows around [R64] for	CATHOLI	C ELDERCARE ON M	IAIN					
 R64 asked what time it was and when told the time, R64 stated, "g I should not be in bed at this hour, I want to get up!" R64 stated she was unsure of how long she had been in bed. R64 further stated, "it is only 3:30 though, I should still be up in my chair." At 3:27 p.m. nursing staff entred R64's room and asked R64 if she wanted to get up for dinner. R64 stated, "well that sounds like a good idea." On 10/7/20, at 8:31 a.m. and again at 9:07 a.m. R64 was observed lying in bed sleeping. R64 had no positioning pillows in place and R64's heels were not elevated off of the bed by pillows or any other devices, in accordance with R64's care plan. On 10/7/20, at 9:20 a.m. R64 indicated she had been awake for a long time and had wanted to get out of bed for "quite a while now". When interviewed on 10/7/20, at 9:35 a.m. NA-F stated he had not seen pillows being used under R64's feet or around her body for positioning in bed and stated, "No, I don't think so, she only has one pillow we uses behind the head, that is what I know." NA-F verified there were no pillows in place around R64's feet and stated, If don't seen any alfore around R64's feet and stated, If don't seen any alfore and R64's feet and stated, If don't seen any alfore around R64's feet and stated, If don't seen any alfore around R64's feet and stated, If don't seen any alfore around R64's feet and stated, If don't seen any alfore around R64's feet and stated, If don't seen any alfore around R64's feet and stated, If don't seen any pillows around [R64] for 	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLÉTION
positioning, no I don't see anything under her feet." When interviewed on 10/7/20, at 12:44 p.m. LPN-G stated she was not aware of any skin issues for R64 and stated R64 had just moved up here "not too long" ago. At 12:52 p.m. LPN-G assessed R64's heel and stated, "Yeah there is a scab, it is not red, it looks like something was there and then it dried up." LPN-G further stated,	F 686	R64 asked what tim time, R64 stated, "g this hour, I want to g unsure of how long further stated, "it is be up in my chair." entered R64's room to get up for dinner. like a good idea." On 10/7/20, at 8:31 R64 was observed no positioning pillow were not elevated of other devices, in ac plan. On 10/7/20, at 9:20 been awake for a lo get out of bed for "o When interviewed of stated he had not s R64's feet or aroum bed and stated, "No one pillow she uses I know." NA-F verifi place around R64's stated, "I do not see positioning, no I don feet." When interviewed of LPN-G stated she w issues for R64 and here "not too long" assessed R64's here scab, it is not red, it	a.m. and again at 9:07 a.m. lying in bed seeping. R64 indicated she was she had been in bed. R64 only 3:30 though, I should still At 3:27 p.m. nursing staff and asked R64 if she wanted . R64 stated, "well that sounds a.m. and again at 9:07 a.m. lying in bed sleeping. R64 had vs in place and R64's heels off of the bed by pillows or any cordance with R64's care a.m. R64 indicated she had ong time and had wanted to quite a while now". on 10/7/20, at 9:35 a.m. NA-F een pillows being used under d her body for positioning in b, I don't think so, she only has a behind the head, that is what ed there were no pillows in body or under R64's feet and e any pillows around [R64] for n't see anything under her on 10/7/20, at 12:44 p.m. vas not aware of any skin stated R64 had just moved up ago. At 12:52 p.m. LPN-G el and stated, "Yeah there is a clooks like something was	F	586			

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		AND HUMAN SERVICES			FORM	11/19/2020 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE COM	(X3) DATE SURVEY COMPLETED C	
		245439	B. WING			08/2020	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
CATHOL	IC ELDERCARE ON N	MAIN		817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 686	"I don't think it is a p would be on the ca of the feet every ba R64's care plan dire pressure ulcers and yes. I don't work nig pillow under her he hands if she is layir why it wouldn't have yesterday I did see her feet." When interviewed of stated that staff put "sometimes." R64 f pillows around her When interviewed of verbalized she was directed for the use pressure injuries ar specific in the care RN-A verbalized the prevent pressure in would involve havin her calves." RN-A a aware whether or m and stated, "I would if this is being done plan and noted the heels off of the bed expectation would I heels elevated. RA process in place to were being placed care, and it is not s electronic medicatio (EMAR); there was	pressure ulcer, otherwise it re plan. We do assessments ith day." LPN-G confirmed that ected use of pillows to prevent d stated, "Pillows? At night, ghts but she usually has a els and on the sides of her ng on her back. I don't know e been done today but in the morning a pillow under on 10/7/20, at 12:58 p.m. R64	F 686				

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		AND HUMAN SERVICES			FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245439	B. WING			C 08/2020
NAME OF F	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	ИАІМ		17 MAIN STREET NORTHEAST /INNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 686	Continued From par feet and stated the nurse (RN-D) that of and determine the P When interviewed of registered nurse (R used to monitor for for the NA's to do b RN's to do weekly a had a shower or bar recent skin assess dated 10/7/20. RN-7 "nothing noted about and stated she was issues with R64's h reporting process for resident's skin was issues and start a to further stated she do could have been m recent skin assess 10/1/20, and finished that the previous th Sepember were als stated her expectat asssessment with t before the next batt than that". On 10/08/20, at 12: interviewed and RN R64's heel and info heel and measured stated the wound w think it is likely a pro- she believed staff w	age 16 facility also had a wound could look at R74's heel today best treatment for R64. on 10/8/20, at 9:49 a.m. RN)-A indicated the process pressure related injuries was ody audits with cares and assessment when the resident ath. RN-A reviewed R64's most ment initiated 10/1/20, and A confirmed there was ut heels" on this assessment a previously unaware of any leels. RN-A verbalized the or any concerns or changes to for staff to report any skin emporary care plan. RN-A didn't know how or why this issed. RN-A verified the most ment for R64 was created on ed on 10/7/20. RN-A verified tree skin assessments from so finished on 10/7/20. RN-A tion was to close a skin the week of the observation, h assessment, "not any longer	TAG F 686	DEFICIENCY)	RATE	DATE
	stated she knew the	ep her feet up off the bed and ese interventions were in RN-D described the pressure				

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DATE SURVEY COMPLETED C	
		245439	B. WING) 08/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CATHOL	IC ELDERCARE ON M	I AIN			17 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	injury as unstageab monitor the area go she thought the inju- bed. RN-D was unsi injury may have bee is hard to say, with has significant peel verified the pressur effects on R64 and become infected." If should have noticed further indicated sh chance that it is from compromised. My p in place for bed." When interviewed of and RN-D describe concerns or change skin checks, and if was then inspected "The NAR's do the would expect that it were not aware of t indicated a compre completed by a cha admission and inclu- noting the temperation completing the Brace weekly body audit at the process when a staff should be: the RN who finds who then would cal Together they would determine cause; each Friday it woult team;	age 17 ble and indicated staff would bing forward. RN-D indicated ury was probably from being in sure how long the pressure en on R64's feet and stated, "It how compromised she is; it ing on the edges." RN-D re injury could have negative stated, "If it opened up it could RN-A stated the day shift d the pressure injury and e felt there was a "90% m bed, because she is so blan will be to put interventions on 10/8/20, at 12:22 p.m. RN-A d the reporting process for any es to resident's skin as weekly a wound was discovered it d daily. RN-D further stated, cares daily on the people so I is would have been seen. Staff his issue until today." RN-A hensive skin assessment was arge nurse upon a resident's uded a head to toe screening, ture and color of the skin, den scale, and completing a assessment. RN-A explained a pressure ulcer was found by area tells the floor manager I RN-D (the wound nurse); uld assess and try to uld be discussed in the IDT plan would be initiated;	F	586			

		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY IPLETED
		245439	B. WING				C 08/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	<i>I</i> AIN			17 MAIN STREET NORTHEAST /INNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	RN-A would do we injury was improving daily inspections b pressure area obse once weekly, the nurse practitio RN-A stated this pro- until this morning w pressure injury. RN of pressure injuries During an interview LPN-A and RN-A, L complete weekly sk do a weekly skin ch should have a bed I the morning and do will call me to do a I assessment."LPN-A distracted and forgo in a timely manner. been completing the R64 and stated, "I le on her shower days he did not see the p during previous skir know I did one toda she didn't have it las When interviewed of director of nursing ("pretty serious arter indicated she had re from R64's most rea "nothing reflected o injuries. The DON in about starting basic raising R64's heels	eekly rounds to make sure the g and update the care plan; by a RN would be initiated, and ervation with measurements oner would assess the injury. occess was not initiated for R64 then she became aware of the I-A stated R64 had no history while in the facility. on 10/8/20, at 12:47 p.m. with .PN-A verified that staff kin checks and stated, "Yes we neck, especially with R64. She bath, the aide usually goes in bes the whole thing and she	F	586			

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245439	B. WING				08/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	I AIN			17 MAIN STREET NORTHEAST /INNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	to position people to stated R64's care p preventing pressure followed and stated follow a care plan; i necessary, the expe- would follow the can skin checks were o purpose of being at whole body so that as possible. The D0 pressure ulcer was weekly skin assess sounds to me that if the purpose of doin to notice if there is a very beginning that ordinary to report it. The facility policy P and Prevention, rev residents would be developing pressure in the risk assess developing a preven appropriate care an further indicated, re risk for pressure uld for prevention of sk Interventions should factors. Basic preven a) Daily monitoring b) Weekly skin ins c) Appropriate sea d) Assessment of e) Keeping skin cl f) Individualized re	o release pressure." The DON blanned interventions for e injuries should have been d her expectation was that staff if that was determined to be ectation would be that staff re plan. The DON stated the in bath days for the sole ble to take a look at someone's staff could intervene as soon ON confirmed that R64's not noticed by staff during ments and stated, "It sure t should have been noticed, ig a regular skin assessment is a problem. We teach from the anything you notice out of the """ tressure Ulcer Assessment <i>vised</i> 1/15/16, indicated all assessed for risk of e ulcers. Information obtained then would be used for ntative plan of care, nd interventions. The policy esidents at moderate and high cers are to have a care plan in integrity concerns initiated. d be made considering all risk ention interventions include: g of the skin by NARs spection by a licensed nurse ating and sleeping surfaces proper footwear	Fé	586			
	plan	epositioning and officiating ss will also be used to identify					

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		AND HUMAN SERVICES			FORM	11/19/2020 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245439	B. WING _		C 10/08/2020			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
CATHOLIC ELDERCARE ON MAIN			817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 686	Continued From page 20		F 68	96				
F 697 SS=D	0		F 69	07		11/24/20		
				F697 It is the policy of Catholic Eldercare follow state and federal regulations pain management. The care plan a pain assessment of R74 will be up as necessary. R74 states pain curr managed well. Care plan and pain assessment of all residents will be reviewed to identify others that may affected. Policy and procedures on pain management and assessment will reviewed and updated as needed. staff will be educated on pain polici procedures. Random audits of pair management plans will be done by Nursing Management on all units a shifts weekly until compliance is determined. Results will be reviewed monitored by nurse managers and information forwarded to the QAPI committee for further review and recommendations.	on and dated rently y be be Nursing es and n ind ad and			

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245439	B. WING			C 10/08/2020			
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE				
CATHOL	IC ELDERCARE ON M	I AIN	817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 697	side. The care plan 1) administer sched 2) encourage reside 3) monitor effective 4) observe for non- 5) ask how her pair Rate pain before ar 6) Flowsheet: treatrevenings. R74's treatment flor pain ratings or asses R74's progress note monitoring for pain following dates: 8/4 8/18/20,8/19/20; 8 8/26/20,8/29/20; 8 9/4/20,9/11/20; 9/2 R74's progress note indicated R74 was complained about r further indicated R77 ten on a scale of zec Tylenol for the pain complained of groir notified and x-rays pain assessment in Tylenol was effective R74's progress note indicated R74 had r had a fracture of the fifth and sixth ribs aresult of the fall ear	fractured ribs on her right included interventions of: duled analgesic per MD order; ent to report pain at onset; ness of pain interventions; verbal signs of pain; n is every shift when awake. ad after receiving PRN; and ments every shift: nights, days, wsheet did not include any essments. es indicated there was no in the progress notes on the /20,8/9/20; 8/13/20; 8/21/20,8/24/20; 8/31/20,9/1/20; 13/20; and 9/15/20,9/17/20. e, dated 9/18/20, at 9:51 a.m., found on the floor and ight rib cage pain. The note 74 rated her pain three out of ero to ten and she requested . The note also indicated R74 n pain. The provider was were ordered. There was no idicating whether or not the re for relieving the pain. e, dated 9/18/20, at 2:50 p.m., no hip or pelvis fracture, but e right posterior medial fourth, and possibly the seventh as a	F	\$97					

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		AND HUMAN SERVICES			FORM	11/19/2020 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
245439		B. WING		C 10/08/2020		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	IAIN		817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	there was no rating R74's progress not p.m., indicated R74 but there was no ra assessment. R74's interdisciplina 9/21/20, at 11:43 a. fractured ribs from indicated recomme to assess and man R74's progress not indicated R74 repor and current medica note further indicate Tylenol 650 milligra and as needed twic the nurse practition was no assessmen R47's progress not indicated R74's had acetominiophen 10 day and ibuprofen 4 (PRN). R47's provider prog indicated upon phys "intermittent rib pain the site as "right lat R47's progress not p.m., indicated R74 careplan for comfor	nued to have body pain but of pain or pain assessment. e, dated 9/20/20, at 10:06 still complained of body pain ting of pain or pain ary team (IDT) note, dated m., indicated R74 suffered her fall on 9/18/20. The note ndations for staff to continue age pain. e, dated 9/21/20, at 2:22 p.m., rted continuing rib cage pain tions were not effective. The ed R74 was on scheduled ms (mg) three times a day se a day. The note indicated er was contacted, but there t or rating of pain. e, dated 9/21/20, at 3:45 p.m., d new orders for 00 miligrams (mg) four times a 400 mg twice a day as needed gress note, dated 9/23/20, sical exam, R74 had n when moving" and described eral to posterior rib pain." e, dated 9/23/29, at 12:56 staff would continue with	F 697			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0397				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
			A. DOILDI				C		
		245439	B. WING			10/08/2020			
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE					
CATHOL	IC ELDERCARE ON M	AIN			17 MAIN STREET NORTHEAST				
			MINNEAPOLIS, MN 55413						
(X4) ID			ID				(X5) COMPLETION		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	Χ.	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE		
					DEFICIENCY)				
E 007									
F 697	Continued From pa	-	F 6	97					
		in the progress notes from							
	9/24/20, through 10	//8/20.							
	During an observat	ion and interview on 10/5/20,							
	at 7:50 p.m., R74 w	as laying on her right side and							
		sit up, she moaned and							
		her right side. R74 stated she nt side if she took a deep							
		ed she fell in the bathroom and							
		ibs." She stated staff gave her							
		n't really help." R74 reported							
	she was still having right sided pain, she has told the staff, and "nothing changes."								
	the stan, and nothing	ng changes.							
	During an interview on 10/6/20, at 8:45 a.m.,								
		aide (TMA)-A verified R74							
		I medication, Tylenol, for pain							
		who completed any pain verified she did not complete							
	any pain rating.	veniled she did hot complete							
	,, ,,								
		ion and interview on 10/7/20,							
		rimaced when moving from							
		letting out a soft moan and over rib cage. R74 stated she							
		right side when she moved.							
		-							
		ion and interview on 10/8/20,							
		noaned while rubbing her . R74 stated she felt							
		ind was not sure how or why							
	she had pain that d								
		on 10/8/20, at 1:15 p.m., N)-A confirmed that a pain							
		have been completed after							
		ed her ribs. RN-A confirmed							
		ere completed through the							
	MDS assessment a	and none was completed after							

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PRINTED: 11/19/2020
		AND HUMAN SERVICES			FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245439	B. WING _			C 08/2020
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	<i>I</i> AIN		817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697 F 880 SS=E	R74's fall. RN-A als staff would do pain after PRN medication pain ratings were me record. RN-A verifier ratings should have but RN-A had not an RN-A explained if n initiated, then staff y any ratings. RN-A y were missing from the During an interview director of nursing (should be monitore pain was assessed or when there was a explained if a reside be assessed and me A pain policy was as Infection Prevention CFR(s): 483.80(a)(1 §483.80 Infection C The facility must es infection prevention designed to provide comfortable enviror development and tr diseases and infection program. The facility must es	a confirmed the expectation ratings, especially before and on was given. RN-A verified hissing from the medical ed the care plan indicated pain a been on the treatment record dded to the treatment record dded to the treatment record would not be able to record rerified pain ratings/monitoring the medical record. To n 10/8/20, at 2:15 p.m., the (DON), verified pain status d daily. The DON confirmed using the MDS assessment a change in condition. She ent had an injury, pain should nonitored. sked for but not received. n & Control 1)(2)(4)(e)(f) Control tablish and maintain an a and control program a safe, sanitary and nent and to help prevent the ransmission of communicable tions. n prevention and control stablish an infection prevention n (IPCP) that must include, at	F 69	97		11/24/20

Facility ID: 00984

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245439	B. WING				C 08/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOLI	C ELDERCARE ON M	<i>I</i> AIN			17 MAIN STREET NORTHEAST /INNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the p but are not limited to (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tra to be followed to pro (iv)When and how i resident; including to (A) The type and du depending upon the involved, and (B) A requirement th least restrictive pos circumstances. (v) The circumstance must prohibit employ disease or infected contact with resider contact with resider with the type and hygier by staff involved in the	stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ing to §483.70(e) and following standards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; ioom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a out not limited to: uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility oyees with a communicable skin lesions from direct ints or their food, if direct	F 8	380			

		AND HUMAN SERVICES			FC	DRM /	11/19/2020 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	(X3) DATE SU COMPLE		
		245439	B. WING			10/08/2020		
	PROVIDER OR SUPPLIER	MAIN		8	TREET ADDRESS, CITY, STATE, ZIP CODE 17 MAIN STREET NORTHEAST IINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E	(X5) COMPLETION DATE	
F 880	identified under the corrective actions ta §483.80(e) Linens. Personnel must hat transport linens so infection. §483.80(f) Annual r The facility will cond IPCP and update th This REQUIREMEN by: Based on observat review, the facility fi comprehensive infe include the Centers Services (CMS) CC including proper us equipment (PPE) b performance of har residents, and com procedures. These affect 78 of 139 res facility. Findings include: RESIDENT USE O DISTANCING, and During an observat on the third floor, th were seated in whe (TV) without masks the TV viewing area residents were sittin and with bedside ta	facility's IPCP and the aken by the facility. ndle, store, process, and as to prevent the spread of review. duct an annual review of its heir program, as necessary. NT is not met as evidenced tion, interview, and document ailed to thoroughly conduct a ection control program to a for Medicare and Medicaid DVID-19 recommendations e of personal protective y both staff and residents, nd hygiene by both staff and pliance with quarantine practices had the potential to sidents who resided at the F MASKS, SOCIAL	F	380	F880 It is the policy of Catholic Eldercare to follow state and federal regulations on Infection Prevention and Control Memory care residents will be assess for the ability of wearing a mask and ca plans will be updated as needed. Resid hand hygiene program for memory car residents will be implemented. Plan of care for residents on quarantine will be adjusted to reflect resident care that complies with infection control guidelin Environmental assessment of the men care unit will be completed by an interdisciplinary team and adjustments be made to ensure compliance with infection control practices. Policies and procedures regarding infection control, including hand hygien PPE, Isolation practices, and screening those entering the building will be reviewed and adjusted as needed. Sta will educated on these policies and procedures. Hand hygiene competent	ed are dent re fe es. nory will ne, g of ff		

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245439		B. WING		C 08/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/	00/2020
	IC ELDERCARE ON I	MAIN	:			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 880	placed a bedside ta Unidentified nursing of the residents but social distancing. During an observat the third floor dining were wearing a ma apart at a square ta close and talked to dolls, and drank jui visual distance but distancing. During an observat third floor dining ar juice glass and plac front of her. R385 t and drank some of were in visual dista intervene before R3 During an observat the third floor dining were not wearing n apart in chairs whill were in visual dista assist residents wit During continuous 4:42 p.m. to 4:45 p clean clothing protectors. remove the clothing cart and redirected	Age 27 Nursing assistant (NA)-A able in front of R95. g staff were in visual distance t did not assist with masking or tion on 10/5/20, at 1:18 p.m. in g area, R59 and R95, neither isk, sat approximately one foot able in the dining room, leaned one another, played with baby ce. Unidentified staff were in did not assist with social tion on 10/5/20, at 1:35 p.m. in ea, R317 drank juice from a cd the glass on the table in hen picked up R317's glass the juice. Unidentified staff ince but did not attempt to 385 drank the juice. tion on 10/5/20, at 4:15 p.m. g area, R385, R119, and R95 hasks and sat about two feet e they talked. Unidentified staff ince but did not attempt to h masking or social distancing. observation on 10/5/20, from .m. on third floor, a cart of ectors was uncovered in the a. R55 came out of her room mask and touched the cart and . An unidentified staff did not g protectors, just covered the R55 back to her room. The R55 to put on a mask.	F 880	Assessment of the active screeni process will be completed by the preventionist and revisions will be as needed. Random audits will be done by m Dept Mangers across various day shifts to ensure compliance with i control practices specifically staff resident hand hygiene, staff and r PPE use, screening, and isolation practices weekly until compliance determined. Results will be review monitored by the managers and f information to the QAPI committee further review and recommendati	infection made ultiple s and nfection and esident is ved and orward e for	

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245439	B. WING _				C 08/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	I AIN			I7 MAIN STREET NORTHEAST IINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 28	F 88	80			
	third floor, R95 stoo showed her a baby mask. Unidentified but did not attempt social distancing. During an observati	ion on 10/5/20, at 6:40 p.m. on od within two feet of R58 and doll; neither resident wore a staff were in visual distance to assist with masking or					
	same table about tw a mask. Registered past the table and k	g area, R95 and R96 sat at the wo feet apart and neither wore I nurse (RN)-A walked directly poked at the residents. RN-A ssist the residents with istancing.					
	the third floor dining the same table less neither wore a mas	ion on 10/6/20, at 9:01 a.m. in g area, R95 and R107 sat at than six feet apart and k. RN-A served R95 coffee. pt to assist the residents with					
	the third floor dining about one foot apar closely to one anoth wore a mask. Nursi	ion on 10/6/20, at 3:01 p.m. in g area, R385 and R44 stood t, held hands, and spoke her's face; neither resident ng staff were in visual t attempt to assist with istancing.					
	the third floor, R385 and touched R55's neither resident wor in visual distance be with masking or soo	ion on 10/6/20, at 3:04 p.m. on 5 stood within one foot of R55 face, hair, and shoulders; re a mask. Nursing staff were ut did not attempt to assist cial distancing. ion on 10/6/20, at 3:20 p.m. on					

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245439	B. WING				C 08/2020
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	MAIN			17 MAIN STREET NORTHEAST IINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	the third floor, R55 donned a mask whi usually ask her to w to wear one to go d second floor. During an observat third floor, R385 ap two feet of R95 and neither resident wo R385's hand away, away. During continuous of between 8:01 a.m. floor, staff served R area. R95 got up ar any of the food and entered R434's qua open door and touc then exited R434's doorway of R6's roo then entered the din at the same table, I neither resident wo nurse (LPN)-A said attempt to have the During an observat the third floor, R95 opened cupboards approached R95 ar sugar?" LPN-A gav poured herself coffe took a used meal tr the donuts that wer another resident. LI R95 with social dist	age 29 started to leave her room and en asked, stating staff didn't vear one. She stated she had lown to therapy, located on the ion on10/6/20, at 3:44 p.m. on proached R95, stood within d touched R95 on the shoulder; re a mask. R95 pushed stated "get off", and walked observation on 10/7/20, and 8:05 a.m. on the third R95 breakfast in the common nd walked away without eating I was not wearing a mask. R95 arantine room through the ched the privacy curtain. R95 room, and stood in the om, and talked to R6. R95 ning area and sat next to R59 less than two feet apart; re a mask. Licensed practical "Hi" to R95 but did not e residents socially distance. ion on 10/7/20, at 8:20 a.m. on moved from a dining table and in the kitchenette. LPN-A nd asked R95 "do you want re R95 a sugar packet. R95 ee from the coffee dispenser, ray off of another table, and ate re left on the meal tray of PN-A did not attempt to assist tancing, hand hygiene, or eating food off another	F 8	380			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL	O		0930-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
		045400					C
	PROVIDER OR SUPPLIER	245439	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	10/	08/2020
					17 MAIN STREET NORTHEAST		
CATHOL	IC ELDERCARE ON M	<i>I</i> AIN			/INNEAPOLIS, MN 55413		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
1/10		,			DEFICIENCY)		
F 000			1				
F 880	Continued From pa	-	F 88	80			
	resident's meal tray	<i>.</i>					
	During continuous of	observation on 10/8/20, from					
		a.m. on the third floor, R130,					
		e seated in the hallway across ation without masks and less					
		NA-C brought toast and rolls					
	to the residents; no	hand hygiene was offered or					
		ood being given to the					
		bottles or hand wipes were ba. NA-C did not attempt to					
		e residents. Trained					
	medication aide (TM	MA)-A placed R95 in a chair					
		64 who was seated in a					
		aned over and touched R64's other nurisng staff were in					
		did not attempt to socially					
	distance the resider						
	During continuous o	observation on 10/8/20, from					
		m. on the third floor, NA-C					
	gave snacks to R55	5, R83, R95, R130, and other					
		hygiene was performed					
	Defore NA-C distrib	uted snacks to the residents.					
	No hand hygiene of	residents before or after					
		d during the evening of					
		ne daytime meals on 10/6/20, 0. No hand hygiene spray was					
		ing area or the TV room where					
	meals were also se						
	During on interview	$an \frac{10}{9}$					
		on 10/8/20, at 9:42 a.m., expectation was staff perform					
		residents before and after					
	meals and after boy	wel/bladder care. LPN-A stated					
		ind it was "somewhere." No					
		d at the nursing station, on t, in the dining area, or in the					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245439	B. WING				C 08/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	10/00/2020	
САТИОІ	IC ELDERCARE ON M	4.4.151		8	317 MAIN STREET NORTHEAST		
CATHOL	IC ELDERCARE ON I	MAIN		N	MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 880	Continued From pa TV area. LPN-A ver STAFF USE OF M/ PROTECTION On 10/5/20, R103's reported she had of masks and not soci cigarette breaks. During an observat on the third floor, LI nose and stayed un from the dining area without masks, and residents without m feet from each othe distance residents of During an observat third floor, LPN-B w forehead, with her of At 4:53 p.m. LPN-B again on her foreher positioned high on upward, covering o face. During continuous of 5:10 p.m. through 5	ge 31 rified he did not see the spray. ASKS AND EYE family member (FM)-A bserved facility staff without ially distancing during lunch or ion on 10/5/20, at 12:32 p.m. PN-C's mask was under his nder his nose as he walked a where three residents were, into the TV area where six tasks were sitting less than six er. LPN-C did not attempt to or ask them to wear a mask. ion on 10/5/20, at 4:44 p.m. on vore goggles on top of her eyes uncovered and exposed. I's goggles were observed ead and a face shield was now LPN-B's forehead and tilted nly the top half of LPN-B's observation on 10/5/20, from 5:20 p.m. on the third floor, ed with her mask below her	F 8	80	DEFICIENCY)	RATE	DATE
	to where it was bard sitting at the nursing the nursing station R6's room, poked h quarantine room, p nose as she was le	Id raised above her forehead ely reaching her nose, while g station. LPN-B walked from into the hallway, walked past her head into R434's ulled her mask up over her aving R434's room, and then 's room. LPN-B walked back					

Facility ID: 00984

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245439	B. WING				C 08/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL		MAIN			17 MAIN STREET NORTHEAST /INNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	into the nursing sta nose. An unidentific and asked LPN-B a resident with her m time, RN-B was obs his chin, sitting nex station. LPN-B ther her mask still under barely reaching her feet of unmasked re unidentified resider question and she le ear, "what do you w During four observa observed sitting at with his mask unde p.m., 5:30 p.m., and During an observat the third floor, NA-E dining area with his During an observat on the first floor, the sitting in an office w The office opened of unidentified resider mask was in the ha During continuous of 2:31 p.m. and 2:40 were in line for CON NA-E were standing apart. NA-A wore a NA-D's mask was u was under his nose	tion with her mask under her ed resident walked up to her a question. LPN-B talked to the ask below her nose. At this served to have his mask under t to LPN-B at the nursing n left the nursing station with r her nose and face shield still r nose, and walked within three esidents: R96 and two other nts. R95 asked LPN-B a eaned into him to shout in his vant?" ations on 10/5/20, RN-B was the third floor nursing station er his chin at: 5:10 p.m., 5:14 d 5:59 p.m. tion on 10/6/20, at 7:59 p.m. on D was observed sitting in the s mask off. tion on 10/6/20, at 11:55 a.m. e dietary director (DD-A) was vithout mask or eye protection. directly into hallway while an nt in a wheelchair without a	F	380			

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES		(X2) MU	TIC	PLE CONSTRUCTION		. 0938-0391 E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:			G		IPLETED
			_				С
		245439	B. WING			10/	08/2020
NAME OF F	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CATHOL	IC ELDERCARE ON M	MAIN			817 MAIN STREET NORTHEAST		
					MINNEAPOLIS, MN 55413		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
F 880	Continued From pa	ige 33	F 8	380	0		
		ion on 10/7/20 at 7:27 and an					
		ion on 10/7/20, at 7:27 a.m. on nidentified staff were in the					
		g less than six feet apart from					
	each other. One sta	aff wore eye protection and					
		staff did not have mask or eye					
	floor hallway.	ffing office was just off the first					
	noor nailway.						
		ion on 10/7/20, 7:59 a.m. on					
		ousekeeper (HK)-B wore a					
		gloves but her goggles were ad while standing in front of					
	R99's room.	ead while standing in none of					
		ion on 10/7/20, at 10:01 a.m.					
		PN-E lifted her face shield to					
		, exposing her eyes, when htified staff while standing less					
		the other staff in front of					
	R75's room.						
	.						
		ion on 10/7/20, at 10:24 a.m. A- F was observed without a					
		while seated in the nursing					
		d he was not interacting with					
		ould wear them when he was					
	around residents.						
	During an observat	ion on 10/7/20, at 2:14 p.m.,					
		f was outside the nurse					
	-	ith his mask on but face shield					
	off, working on a co	omputer in the hallway.					
	During an observat	iona 10/7/20, at 2:15 p.m.,					
		at the nursing station with his					
		n and face shield off. LPN-A					
		ion without his face shield and					
	walked near numer	ous residents in the hallway.					

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		AND HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE	& MEDICAID SERVICES	(X2) MUL	TIPL	LE CONSTRUCTION		. 0938-0391 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	```			СОМ	IPLETED
		245439	B. WING				C
NAME OF PF	ROVIDER OR SUPPLIER	243433	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	10/	08/2020
CATHOLIC	C ELDERCARE ON M				17 MAIN STREET NORTHEAST		
CATHOLIC	C ELDERCARE ON N			N	AINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 34	F 8	80			
	During an observati the third floor, radio was standing at the goggles on the top of N95 mask with exhi- standing within thre she only wore eye p resident. When poin feet of R64, she put LPN-A and TMA-A did not interact with During an observati on the first floor, the staffing office witho During an observati on third floor, RN-A chin and googles or During an observati three unidentified st dining tables and ta protection; staff wer During an interview receptionist (R)-D s every staff in the bu building and eye pro areas or when inter STAFF HAND HYG During continuous of 5:30 p.m. through 6 brought a basin of w	ion on 10/8/20, at 9:49 a.m. on logy technologist (RadT)-C nursing station with her of her head and wearing an alation valve. RadT-C was e feet of R64. RadT-C stated protection when around a nted out she was within three t her goggles over her eyes. were at the nursing station and RadT-C. ion on 10/8/20, at 12:11 p.m. ere was one staff in the ut a mask or eye protection. ion on 10/8/20, at 01:08 p.m. was wearing mask under her n her head while in her office. ion on 10/8/20, mid-afternoon, taff were seated at first floor lking without masks or eye re not eating at the time. on 10/5/20, at 11:54 a.m., tated the expectation was ilding wore masks when in the ptection when in resident care acting with residents.					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/19/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY IPLETED
		245439	B. WING	;			C 108/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	IAIN			817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	changes. NA-B und soiled brief, and use peri-area. NA-B ren then retrieved a box on the bedside table glove with no hand changes. NA-B place pulled R64's nightge sheet and blanket of head of bed, adjust on the TV, rotated t up the volume of th light to R64's sheet one bag, gathered t new trash bag in the basin of water in the the basin back in th her dirty gloves, tun exited the room, with hygiene. NA-B then linen room and ther interview, NA-B state gloves, you only thr to wipe the peri-are glove to put the clea "When you take off between, but some close to you and yo when the resident is stated, "Yes, you ar hands before you le out the trash." NA-E monthly training on computer trainings, education from nurs	d hygiene between glove ressed R64, removed her ed a wash cloth to clean R64's noved one soiled glove and of gloves, which she placed e. NA-B donned the one new hygiene between glove ced a clean brief on R64, then own down, and placed the over R64. NA-B adjusted R64's ed the foot of the bed, turned he TV screen, and then turned e TV. NA-B attached the call gathered the soiled linens in rash in another bag, placed a e trash can, dumped a dirty e bathroom sink, and placed e closet. NA-B then removed ed off the bathroom light, and took the soiled linens to the n used hand sanitizer. During ted when you are changing ow away the soiled glove used a, and then you get a new an brief on. NA-B stated, your gloves you can sanitize times the sanitizer will not be u cannot go far from the bed s on their side." NA-B further e supposed to wash your eave the room but I was taking 8 verbalized she received hand hygiene via Relias as well as frequent audits and sing staff.	F	880			
		:41 a.m. on third floor, NA-C					

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245439	B. WING			C 10/08/2020	
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CATHOL		MAIN			17 MAIN STREET NORTHEAST IINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	escorted R118 from bathroom. NA-C do R118 to the toilet. A finished, NA-C wipe removed her dirty g gloves, with no han changes. NA-C pull assisted R118 to way washed her hands. was for staff to have we leave her standi hands before puttin fall, if you have to w gloves we might ha further stated, "You before applying clea- care you need to washe really had to go I just applied the glo During an observat third floor, LPN-A w of R434, leaning clo on her shoulder. R4 in quarantine, was y and R59 in the dinin wore masks. LPN-A his hand on her sho foot of her face. LP and placed his ham not perform hand h residents. LPN-A w closely, placing his picking up empty pl placing it on R434's table.	The dining area to her onned gloves and transferred After R118 indicated she was ed R118's peri-area with wipes, gloves, and donned clean ad hygiene between glove led up R118's brief and pants, ash hands, and then NA-C NA-C verbalized the priority e a clean glove and stated, "if ing there and then wash your bg on a clean glove they might wash your hands and get clean ave a lot of them falling." NA-C should wash your hands an gloves, before and after ash your hands, but for her o and my hands were clean so	F 8	80			

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		AND HUMAN SERVICES			FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245439	B. WING		C 10/08/2020	
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	MAIN		17 MAIN STREET NORTHEAST /INNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	and stated, staff sh before and after the doffed and betweer were to become so gloves should be re ISOLATION/QUAR During continuous of 1:00 p.m. through 1 NA-A entered R434 next to the door that quarantine. The sig room should always entering should be and eye protection. was asked about the did not see the sign for the isolation car was 20 yards away placed the cart nex and verified there w cart. NA-A stated the the storage closet. R434's door open. During continuous of 4:42 p.m. through 4 obtained gowns and and placed in the is room. NA-B did not donning gown and the door to R434's door to R434's roor she was in quarant During continuous of	ormed between glove changes ould perform "hand hygiene e gloves are donned and n resident care if the gloves iled." RA-A further stated both emoved after peri-care. ANTNE observation on 10/5/20, from 1:15 p.m. on the third floor, I's room, which had a sign at indicated R434 was on gn indicated the door to the s be closed and anyone wearing gown, gloves, masks, When exiting the room, NA-A ne quarantine and he stated he n. NA-A said he always looked t and pointed to a cart that from the door. NA-A then t to the entry into R434's room were no gowns or gloves in the nere were gowns and gloves in NA-A left the area and left observation on 10/5/20, from 4:50 p.m. on third floor, NA-B d gloves out of storage closet solation cart outside of R434's t perform hand hygiene prior to gloves. NA-B exited leaving room open. NA-B stated the m should be closed because ine and then shut the door.	F 880			
		p.m. through 5:25 p.m. on the				

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DEPART	FORM	APPROVED					
	COF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TID	LE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
						(С
		245439	B. WING			10/	08/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL		/AIN			817 MAIN STREET NORTHEAST		
		TEMENT OF DEFICIENCIES	I		MINNEAPOLIS, MN 55413		
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIJ		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
}			 				
F 880	Continued From pa	ae 38	F 8	380			
		ited R434's quarantine room					
		l placed the food tray on the					
		then doffed gown and gloves ash can which was located in					
		34's room. NA-B performed					
	hand hygiene and t	hen donned gloves. NA-B					
		n the isolation cart to the					
		she placed the dirty food tray er in the kitchenette area.					
	NA-B removed glov	es and performed hand					
		disinfect the top of the					
	on it.	he dirty food tray was placed					
		ion on 10/6/20, around 10:00					
	a.m. on the third flo	or, an unidentified bist (OT)-A entered R434's					
		thout gown or gloves, and					
	brought R434 out ir	nto the TV area in a					
	wheelchair. R434 w	vas not wearing a mask.					
	During an observat	ion on 10/7/20, at 7:31 a.m. on					
	the third floor, R434	1, who was in quarantine, was					
		et of R95 and R96 in the TV					
		esidents were wearing masks. but did not attempt to assist					
		ks, social distancing, or assist					
	R434 back to her q	uarantine room.					
	During an observat	ion on 10/7/20, at 7:44 a.m. on					
	0	ntified occupational therapist					
	(OT)-B walked to R	434, who was seated in the					
		upposed to be in quarantine.					
		434 and told her he was hing area. OT-B did not ask					
	R434 to wear a mag						
	Dunia a continuo						
		observation on 10/7/20, from 12:30 p.m., the door to					

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		AND HUMAN SERVICES			FORM	11/19/2020 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMI	(X3) DATE SURVEY COMPLETED	
		245439	B. WING		C 10/08/2020		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
CATHOL	IC ELDERCARE ON M	I AIN		817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	in a wheelchair and herself into R434's wheelchair in the ro- minutes, R46 whee room. During an interview LPN-A verified R43 quarantine because stated staff should but if R434 came o staff should not be bringing the resider who was in quarant and staff should rer mask. He verified th multiple times. SCREENING - ENT During continuous of 7:01 a.m. through 7 screening desks by screening desk was screening desk, was staff and visitors en four other staff enter the hallway and had get to the screening and one staff with a verified she could n not see which staff entered took their to automatic temperature in	room was open. R46, who was not wearing a mask, wheeled room. R434 was in her oom at the time. After several led herself out of R434's to on 10/7/20, at 10:20 a.m., 4 was supposed to be in e she was newly admitted. He try to keep R434 in the room, ut, it was hard. LPN-A agreed going into the room and to out. LPN-A stated a resident time should be wearing a mask mind the resident to wear a ney should remind residents	F 880				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/19/2020 APPROVED . 0938-0391		
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED		
		245439	B. WING	i			C 08/2020		
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
CATHOL	IC ELDERCARE ON M	IAIN		817 MAIN STREET NORTHEAST					
					MINNEAPOLIS, MN 55413				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 880	Continued From pa	ge 40	F	380)				
	with infection prever IP-B, several topics *Resident use of m hand hygiene - IP-A residents was they areas or when staff stated some reside encouragement but She stated the expe- residents, including "it may be difficult, ft to help the resident residents should be before and after me *Staff use of masks stated the expectat protective equipme were expected to w while in the facility, areas or around resident were alone in their off. IP-A said there people can't tolerate requirement and no should speak up if the as they have many IP-A stated the facil Department of Hea (LTC)'s PPE grid, w version of the grid of to wear masks. IP-/ expectation was that wearing PPE impro speak up and corre- managers audited st	asks, social distancing, and A stated the expectation for wear masks when in common entered their room. IP-A nts might need reminding or they usually did cooperate. ectation was the same for all those on third floor and while he expectation is to always try s wear masks." IP-A stated a provided hand hygiene eals and after toileting. and eye protection - IP-A ton for staff use of personal nt (PPE) was that all staff ear masks and eye protection especially in resident care sidents. IP-A stated if staff office, their masks could be may be a few instances where e a mask, but it was a t an option. IP-A stated staff hey had an issue with a mask different types of masks to try. ity used Minnesota Ith (MDH)'s long-term care hich was dated 5/29/20. This did not indicate office staff had							

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245439	B. WING			C 10/08/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	MAIN			17 MAIN STREET NORTHEAST IINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	have the updated 6 *Staff hand hygiene was staff performed after donning glove *Isolation/Quarantir expectation for qua resident to their roo stated an exception resident needed to to the therapy depa other residents wer equipment was disi resident. IP-A state with dementia, but the would frequently try room during quarar *Staff screening and stated the expectat front entry. She star some staff might er staff have keys to the door, but if they ent doors, it was expect lobby to be screene would have to walk were screened, pot and other staff. During an interview RN-A, noted the thi related to infection of the residents who Several topics were *Resident use of m hand hygiene - RN- encouraged to wea staff should be aski wear a mask. If res	 a - IP-A stated the expectation d hand hygiene before and estimate and hygiene before and estimation was to limit the prantine with the door closed. IP-A is present, wore a mask, and infected after use by the d it was a challenge for those the expectation was staff / to keep the resident in their ntine. d entry into the facility - IP-A is a back entry inter through and some limited the transitional care unit (TCU) thered the facility through those pred the facility through those pred they come to the front ed. IP-A and IP-B verified staff through the facility before they tentially exposing residents a on 10/8/20, at 10:19 a.m., ind floor had "challenges" control because of the nature o had cognitive/memory. 		380			

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		AND HUMAN SERVICES			FORM	: 11/19/2020 APPROVED . 0938-0391
STATEMEN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	`́сом	E SURVEY IPLETED
		245439	B. WING		C 10/08/2020	
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	IAIN		817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	be "cared planned i the care plan. RN-/ trying but after a wf "we know which on are not." RN-A state mask if they left the mask, they did not she expected staff residents before an peri-care if the resid *Staff use of masks stated the expectat masks and eye pro She added she mig her office but it was go to the nursing st would wear it. RN-/ the mouth and nose cover the eyes. *Staff hand hygiene around hand hygiene should not be in co look at risk/benefit was calmer in the co stated a resident in a mask if in the cor	for" and verified it was not on A stated staff should keep hile they quit trying, stating, es are able and which ones ed residents had to wear a e floor; if they could not wear a leave the floor. RN-A stated to offer hand hygiene to d after meals and after dent participated in peri-care. s and eye protection - RN-A ion for staff was to wear tection while in the care area. thave her mask off while in a nearby, so if she needed to ation or into the hallway, she A verified masks should cover e and eye protection should e - RN-A's expectation of staff ne was staff were expected to requently and always" while hygiene policy. ne - RN-A verified when dmitted to the unit they are in een days. She stated the e door to the room should be dent was a fall risk, it might en; staff have to balance the stated a resident in quarantine mmon areas but again would of being isolated if the resident common area. RN-A also quarantine should be wearing	F 880	,		

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245439	B. WING	·		C 10/08/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				8	817 MAIN STREET NORTHEAST		
CATHOL	IC ELDERCARE ON N	/AIN		Ν			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	•	-	F٤	380			
	hand hygiene - The	asks, social distancing, and DON stated the expectation					
		o wear a mask when a staff if they are out of their room in					
	common areas. The	e DON verified the expectation third floor, commenting if a					
	resident could wear	r a mask, they should. She					
		ight need more reminders but s staff must attempt to have					
		sks. The DON expected staff					
		residents to wear a mask; staff					
		e attempts - they might not					
		t day they might wear it." The					
		pectation was staff provide					
		lents before and after meals care; if wipes were not					
		e to offer a washcloth with					
		regards to social distancing,					
		sidents should be encouraged					
	to maintain a social	l distance of at least six feet					
		ake it harder for residents to be					
		so stated it was important to					
		lent to sit at a table, verifying					
	move them apart.	ff should remind residents and					
		s and eye protection - The					
		pectation was for everyone to					
		sk and eye protection while					
		ilding or on duty. If staff had					
		, they were expected to					
		ship as they had a variety of					
	,	tection that could be used.					
		e - The DON verified she o follow the facility's hand					
	hygiene policy.	Tonow the facility's fland					
		ne - When a resident was in					
		N expected residents to stay	I				
		ne door closed. She noted that					
		idents might wander out of the	I				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	11/19/2020 APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		245439	B. WING		C 10/08/2020		
NAME OF	PROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE			
CATHOL	IC ELDERCARE ON M	MAIN		317 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 880	room, "it's not one a staff to redirect the time they came out resident in the room things like give sna resident in the room something wasn't w have a back-up pla The facility's Hand indicated staff shout the following times: contact; 2) before a after entering isolat before and after as: 5) after handling so or procedures done prevent cross conta parts; and 7) before washing with soap The facility's PPE g Department of Hea but an older versior version did not indig masks while in the Prevention and Cor Healthcare Person Pandemic dated Ju indicated health can universal source co health care person facemask at all time and HCP working in moderate to substa should wear eye pri facemask. The Mir PPE Grid, dated 6/	and done." The DON expected resident to their room each t and be creative to keep the n. She stated staff could do tecks or activities to keep the n. The DON stated if vorking, she expected staff to an and to keep trying. Hygiene policy, dated 3/13/20, and perform hand hygiene at t 1) before and after resident and after gloving; 3) before and tion precaution settings; 4) sisting a resident with toileting; biled linens; 6) between tasks e on the same resident to amination of different body e and after handling food (hand	F 880				

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		AND HUMAN SERVICES & MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE COM	E SURVEY PLETED	
		245439	B. WING _			C 08/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CATHOL	IC ELDERCARE ON M	IAIN		817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880 F 921 SS=E	Medicaid Services ((COVID-19) Long-T dated 4/2/20, long-t accordance with pro- limit access points a entrances have a s- accordance with pro- Control (CDC) guid the facility should b The CDC's Conside Units in Long-term 2020, recommende Infection Prevention addition, including: *Reminding and as hygiene, social dist coverings *Providing structure or at staggered time maintain social dist *Limiting the number areas to maintain s with gentle redirect close proximity to o Safe/Functional/Sa CFR(s): 483.90(i) Other Er The facility must pro-	enters for Medicare and Coronavirus Disease 2019 Term Care Facility Guidance term care facilities, in evious CMS guidance, should and ensure that all accessible creening station. In evious Center for Disease ance, every person entering e actively screened. erations for Memory Care Care Facilities, dated May 12, ed memory care units follow in and Control guidelines and in sisting with frequent hand ancing, and use of cloth face ed activities in resident rooms es throughout the day to	F 88			11/24/20	
	residents, staff and This REQUIREMEN by:			F921			

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TATEMEN	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
		245439	B. WING _			C 08/2020	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE		
CATHOL	IC ELDERCARE ON N	MAIN		817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
F 921	review, the facility f were maintained in manner. This had t residents (R32, R1 ⁻ R64) who resided in environmental cond Findings include: On 10/5/20, at 6:06 was observed to ha bed. During an interview nursing assistant (N needed to be clean nurse manager or r During a facility tou environmental direc R32's carpet and st to be cleaned. The was a room that ne due to R32 spitting On 10/5/20, at 6:31 room was observed bed. During a facility tou ED verified the stai R113's carpet was On 10/5/20, at 4:11 was observed to be table.	ailed to ensure 7 of 11 rooms good repair and in a sanitary he potential to affect 7 13, R49, R80, R28, R57, and in the rooms reviewed for cerns. a p.m. the carpet in R32's room ave several stains near the on 10/8/20, at 11:32 a.m. NA)-N stated if something ed, then she would notify her maintenance personal. r on 10/8/20, at 12:07 p.m. the ctor (ED) verified the stains on tated that R32's carpet needed ED also stated R32's room eded to be checked everyday	F 92	 It is the Policy of Catholic E follow state and federal reg Safe/Functional/Sanitary/C Environment. The 7 rooms identified wit environmental concerns, F R80, R28, R57, R64 carpe cleaned on 11/2/20. Audit was done on all room center and rooms identifie environmental concerns cater and rooms identified environmental concerns cater and rooms identified environmental concerns cater and schedule, audits of performed to ensure cleaned. All Rooms will be placed o cleaning schedule, audits of performed to ensure cleaned. Audits will be performed by Director daily for 1 week, w month, and every quarter thaudits will be monitored by Environmental Director and forwarded to QAPI commit recommendation and follow Policy and procedure for C of resident rooms was creat Light bulb in R64 is entry w replaced on 10/8/20 	gulations on comfortable h 32, R113, R49, ets were hs in care d as arpets were also n regular carpet on carpet will be environment. / Environmental / eekly for a hereafter. / the d results will be tee for further //-up. arpet cleaning ated.		

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245439	B. WING	i		C 10/08/2020	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	/ AIN			17 MAIN STREET NORTHEAST /INNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 921	cleaned she would the room number a would let maintenan During a facility tou ED verified the stain and stated the stain On 10/5/20, at 2:03 was observed to ha bed. During a facility tou ED verified the stain stains were from fo red stain in the carp from a previous res and the stain could On 10/5/20, at 3:50 was observed to ha During a facility tou ED verified the stain the stains were from they had a full time and that R28's carp On 10/5/20, at 1:26 was observed to ha around the bed. R5 There were also sta between R57's roor room. During a facility tou	let the nurse manager know nd then the nurse manager nce know about it. r on 10/8/20, at 12:16 p.m. the ns on the carpet in R49's room as were from food. g.p.m. the carpet in R80's room ave white stains in front of the r on 10/8/20, at 12:14 p.m. the ns and stated R80's carpet od. The ED also stated R80's bet was from finger nail polish sident who resided in the room	FS	921			

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		AND HUMAN SERVICES				FORM	11/19/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245439	B. WING	i			C 08/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	MAIN			17 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 921	R57's room was a r checked daily and t cleaned. On 10/5/20, at 5:32 light bulb between t door was observed During an interview NA-G stated she way pointed to a clear b nurse's station. During facility tour of ED stated he would right then. During an interview ED stated he would right then. During an interview ED stated that they that they used daily that work well for sr he came in every m orders, then went a the rooms that were cleaning. The ED th signed off and retur work order had bee stated housekeepe day and could write that needed to be fi stated because of t eating in their room amount of carpet cl housekeeping need carpet specialist for	P.m. R64's room entry way the bathroom door and entry	FS	921			
	A policy for carpet of	cleaning was requested but not					

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		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES	1			0938-0391
				IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN			C
		245439	B. WING _			- 08/2020
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		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
	1					
F 921	Continued From pa	ae 49	F 92	21		
	provided.	90 - 0	1 52	- '		
	P					

Facility ID: 00984

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/10/2020 APPROVED 0938-0391
			IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED	
		245439	B. WING _		10/(06/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	IAIN		817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	-S	K 00	00		
	FIRE SAFETY					
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA ACCORDANCE WI An annual Life Safe conducted by the M Public Safety, State October 06, 2020. Catholic Eldercare of compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) 101, Life Safe edition of National F (NFPA) 101, Life Safe Existing Health Car NFPA 99, the Health PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION. ety Code survey was linnesota Department of Fire Marshal Division on At the time of this survey, on Main was found not in e requirements for participation id at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 e and the 2012 edition of h Care Facilities Code. THE PLAN OF R THE FIRE SAFETY				
	IS NOT REQUIRED).				
	director's or provid	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 11/05/2020

F5439031

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.

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/10/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245439	B. WING		10/0	06/2020
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
САТИОІ	IC ELDERCARE ON M	4.4.151	8	17 MAIN STREET NORTHEAST		
CAINOL	IC ELDERCARE ON I		Ν	/INNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K 000			
	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55101	Division Suite 145				
	By email to: FM.HC.Inspections	@state.mn.us				
		RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION:				
	1. A description of v to correct the defici	vhat has been, or will be, done ency.				
	2. The actual, or pro	oposed, completion date.				
	•	r title of the person rection and monitoring to ence of the deficiency.				
	building with no bas constructed at five of building was constr determined to be of 1983, an addition w side of the building type II(222) constru	on Main is a three story sement. The building was different times. The original ucted in 1977 and was Type II(222) construction. In vas constructed to he South that was determined to be of ction. In 1994, an addition was East side of the building that				
	was determined to construction. In 199 constructed to the V was determined to construction. In 201 constructed to the S was determined to	be of Type II(222) 95, an addition was West side of the building that be of Type II(222) 15, an addition was South side of the building and				

Facility ID: 00984

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		AND HUMAN SERVICES				FORM	: 11/10/2020 APPROVED . 0938-0391
				E CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245439	B. WING			10/	06/2020
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CATHOLIC ELDERCARE ON MAIN					7 MAIN STREET NORTHEAST INNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	for existing building one building. The fa throughout by an au and has a fire alarm in the corridors and that is monitored fo notification. The facility has a ca census of 140 at th The requirement at NOT MET as evide Maintenance, Inspe CFR(s): NFPA 101 Maintenance, Inspe Fire doors assembl annually in accorda for Fire Doors and of Non-rated doors, in patient rooms and s routinely inspected maintenance progra Individuals perform testing possess knot that demonstrates a Written records of i maintained and are 19.7.6, 8.3.3.1 (LSO 5.2, 5.2.3 (2010 NF This REQUIREMEN by: Based on document the facility failed to	the construction type allowed is, the facility was surveyed as acility is fully protected utomatic fire sprinkler system in system with smoke detection is spaces open to the corridors in automatic fire department apacity of 174 beds and had a e time of the survey. 42 CFR, Subpart 483.70(a) is inced by: ection & Testing - Doors lies are inspected and tested ince with NFPA 80, Standard Other Opening Protectives. icluding corridor doors to smoke barrier doors, are as part of the facility am. ing the door inspections and owledge, training or experience ability. nspection and testing are available for review. C)	К 0		K761 All fire doors will be inspected and documented and will be completed	by	11/13/20

Facility ID: 00984

If continuation sheet Page 3 of 5

		AND HUMAN SERVICES			FORM	11/10/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245439	B. WING _		10/	06/2020
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE,		
CATHOLIC ELDERCARE ON MAIN				817 MAIN STREET NORTHEAS MINNEAPOLIS, MN 55413	т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
K 761 K 914 SS=F	NFPA 80 (2010), Si Other Opening Pro deficient practice co Findings included: On a facility tour be and 1:00 PM on 10 the facility could no door inspection. Th dated June 2019. This deficient pract Administrator at the Electrical Systems CFR(s): NFPA 101 Electrical Systems Hospital-grade rece locations and when anesthesia is administrallation, replace testing is performed documented perfor listed as hospital-grit tested at intervals r isolation monitors (intervals of less tha actuating the LIM to which activates bot LIM circuits with au manual test is perfor equal to 12 months 6.3.3.3.2 after any re- electric distribution	Code, Section 7.2.1.15.2, and tandard for Fire Doors and tectives, Section 5.2.1. This ould affect all 140 residents. etween the hours of 10:00 AM /06/2020, it was revealed that t provide a current annual fire he last fire door inspection was	K 76	11-13-2020. All fire door annually by the mainten the maintenance director for the correction and m prevent recurrence.	ance team and or is responsible	11/13/20

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		AND HUMAN SERVICES			FORM	11/10/2020 APPROVEI 0938-039
			IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245439	B. WING _		10/	06/2020
NAME OF F	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
CATHOLIC ELDERCARE ON MAIN				817 MAIN STREET NORTHEAST MINNEAPOLIS, MN 55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 914	repairs or modificat area tested, and re 6.3.4 (NFPA 99) This REQUIREMEN by: Based on docume the facility failed to receptacles in care Health Care Faciliti 6.3.4.1 and NFPA 7 Code, Section 406. affect all 140 reside Findings include: On a facility tour be and 1:00 PM on 01 the facility could no electrical receptacle resident bed locatio was dated Septemb	tions, containing date, room or sults. NT is not met as evidenced nt review and staff interview, test and maintain electric areas per NFPA 99 (2012), es Code, Sections 6.3.2.1, 70 (2011) National Electrical 6. This deficient practice could ents. etween the hours of 10:00 AM /14/2020, it was revealed that t provide a current annual e test for receptacles at ons. The last receptacle test ber 2019.	K 91	K914 All resident room receptacles of tested and completed by 11-13 resident room receptacles will and documented hereafter and maintenance team and the maintenance team and the maintenance team and the maintenance director is responsible for the of and monitoring to prevent recu	3-2020. All be tested nually by the aintenance correction	

Facility ID: 00984

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 29, 2020

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

Re: State Nursing Home Licensing Orders Event ID: UYZ311

Dear Administrator:

The above facility was surveyed on October 5, 2020 through October 8, 2020 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

Catholic Eldercare On Main October 29, 2020 Page 2

"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:

Susan Frericks, Unit Supervisor Metro D District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health PO Box 64990 St. Paul MN 55164-0900 Email: <u>susan.frericks@state.mn.us</u> Mobile: (218) 368-4467

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

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

Please feel free to call me with any questions.

Sincerely,

Kumalu Piske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program

Catholic Eldercare On Main October 29, 2020 Page 3 Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

Minnesc	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00984	B. WING		0 10/0) 8/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	ΛΔΙΝ	STREET NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	surveyors of this De	rS:), through October 8, 2020, epartment's staff visited the the following correction				
	following complaint	aints were investigated and the s were found to be				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 11/05/20

6899

If continuation sheet 1 of 48

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00984			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING			C 10/08/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, S	TATE, ZIP CODE		
ATHOL	IC ELDERCARE ON	MAIN	N STREET NO	-		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	COMPLE
2 000	Continued From pa	age 1	2 000			
	UNSUBSTANTIAT H5439052C,H5439 H5439055C.	ED: H5439051C, 9053C, H5439054C, and				
	Although no State orders were cited as a result of the complaints, based on additional concerns identified during the recertification/licensing survey, correction orders were issued.		of			
	Control survey was 10/8/2020, at your Department of Hea with §483.80 Infec	ID-19 Focused Infection s conducted 10/5/2020 through facility by the Minnesota alth to determine compliance tion Control. The facility was o be in compliance.	n			
	the State Licensing federal software. T assigned to Minne Nursing Homes. T appears in the far Tag." The state sta listed in the "Summ column and replace the correction order the findings which statute after the sta as evidence by." F	nent of Health is documenting g Correction Orders using ag numbers have been sota state statutes/rules for he assigned tag number left column entitled " ID Prefix atute/rule out of compliance is nary Statement of Deficiencies es the "To Comply" portion of er. This column also includes are in violation of the state atement, "This Rule is not met ollowing the surveyors findings Method of Correction and prection.	, "			
	receipt of State lice the Minnesota Dep Informational Bulle http://www.health.s obul.htm The Stat delineated on the a	o participate in the electronic ensure orders consistent with partment of Health tin 14-01, available at state.mn.us/divs/fpc/profinfo/in e licensing orders are attached Minnesota alth orders being submitted to	f			

BMBN11
	NT OF DEFICIENCIES	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED C
		00984	B. WING			08/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I		N STREET NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 000	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departn PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO MINNESOTA STAT MN Rule 4658.040 Resident Assessme Subp. 3. Frequent assessments must A. within 14 day B. within 14 day C. at least once This MN Requirem by: Based on observat review, the facility f hearing, speech an	Although no plan of correction ate Statutes/Rules, please rected" in the box available for a indicate in the electronic cess, under the heading le date your orders will be lectronically submitting to the nent of Health. ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF TE STATUTES/RULES. 0 Subp. 3 A-C Comprehensive ent; Frequency cy. Comprehensive resident be conducted: ys after the date of admission; ys after a significant change in ical or mental condition; and e every 12 months. ent is not met as evidenced ion, interview and document failed to complete an accurate ind vision assessment for 1 of 1	. 2 545	corrected	Y)	11/24/20
	hearing, speech an					

Minnesota Department of Health STATE FORM

BMBN11

If continuation sheet 3 of 48

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
			A. BUILDING.			С
		00984	B. WING			08/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON	MAIN	I STREET NO POLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI		(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	DATE
2 545	Continued From pa	age 3	2 545			
	6/16/20, indicated	linimum Data Set (MDS) dated intact cognition, adequate a hearing aide or other hearing used.				
	readmission to the indicated intact coo	hange in status MDS due to a facility, dated 8/21/20, gnition, adequate ability to g aid or other hearing used.				
		ndicated R97 had an audiology professional for hearing loss)				
		al form dated 9/29/20, under mention hearing loss or				
		ted 10/8/20, did not include ociated with communication or				
	stated. "I have thes of them is not work to hear better again and I have address over two months a what is happening. the two hearing aid	v on 10/7/20, at 11:02 a.m. R97 se hearing aides here and one king and I would like to be able n, I am not hearing well now sed this issue with them for nd I haven't heard back on " R97 indicated that with one of des not working it made it d R97's hearing was better with g aides out.				
	R97's resident repl R97 has had heari admission to the fa frustration for R97	v on 10/7/20, at 12:26 p.m. resentative (RR)-M, indicated ng aides since before acilty and it had been a that R97 has not been able to 7 was at the facility. RR-M				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00984	B. WING			08/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON	ΜΔΙΝ	N STREET NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 545	Continued From pa	age 4	2 545			
	seen by an audiolo back. RR-M stated	y was working on having R97 gist but RR-M had not heard that staff had not inquired with R97 used hearing aides.				
	medicine dealing w request form, date to the audiologist (e Audiology (branch of vith hearing loss) Group d 8/26/29, indicated a request hearing loss specialist) to the audiologist regarding				
	licensed practicle r knowledge R97 ha readmission on 8/2 had been working to have R97's hear indicated an audiol August and when t September, R97 w being in COVID qu September hospita	n 10/7/20, at 11:10 a.m. hurse (LPN)-F indicated d hearing aides since before 21/20, and was aware facility on obtaining an audiology visit ring aides repaired. LPN-F logy request was submitted in he audiologist came in as not able to be seen due to larantine following a al admission and R97 was on udiology in October.				
	registered nurse (F reviewed R97's me and hearing aides R97 regarding hea	v on 10/8/20, at 11:28 a.m. RN)-E, indicated RN-E edical record for hearing loss and may not have interviewed ring loss and hearing aides ed on medical records when MDS.				
	director of nursing was interviewable interview the reside	v on 10/8/20, at 11:37 a.m. the (DON) indicated if a resident then RN-E was expected to ent to get information for the Id be the case for R97.				
	The facility policy t	itled Admissions and				

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
		00984	B. WING			C 08/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I	ΜΔΙΝ	N STREET NOI POLIS, MN 55	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 545	Continued From pa	ige 5	2 545			
	"For all new admiss MDS coordinator of review the MDS sc	cy, dated 8/25/16, indicated, sions and re-admissions, the r designee will review the data hedule and set up an cessary and notify staff of	,			
	Conference and MI comprehensive ass in accordance with "Procedure: 1. See	tled Care Planning, Care DS, dated 6/29/16, indicated a sessment was to be completed state and federal guidelines. CMS (Centers for Medicare ces) guidelines and MDS				
	Assessment Instru- indicated in section to beginning the he resident if he or she hearing appliance a nursing home. 2. If write the question of read it. 3. If the res	are Facility Resident ment 3.0 User's Manual B0300: Hearing Aid; 1. Prior aring assessment, ask the e owns a hearing aid or other and, if so, whether it is at the the resident cannot respond, lown and allow the resident to sident is still unable, check with ff about hearing aid or other	1			
	The director of nurs review and revise p to development of a of each individual r nursing or designed educate staff and d	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related a care plan to meet the needs esident. The director of e could develop a system to evelop a monitoring system to are plans are comprehensively	,			
		R CORRECTION: Twenty-one				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPLI	
		00984	B. WING		C 10/08/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	ΛΔΙΝ				
			POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLET DATE
2 900	Continued From pa	ge 6	2 900			
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			11/24/20
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observati review, the facility fa interventions to red related injuries, and a new pressure ulco reviewed for pressu facility to accurately	ent is not met as evidenced on, interview, and document ailed to follow care plan uce the risk of pressure I failed to identify and assess er for 1 of 3 residents (R64) ure ulcers. The failure of the complete weekly skin audits ageable pressure ulcer to		corrected		
	had diagnoses which rheumatoid arthritis	rinted 10/8/20, indicated R64 ch included juvenile , Alzheimer's disease, and generalized muscle				

	T OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00984		E CONSTRUCTION	`́сом	E SURVEY PLETED C 08/2020
	PROVIDER OR SUPPLIER		ADDRESS, CITY, S		10,	00/2020
	TROVIDER OR SOFFEIER		VIN STREET NO			
ATHOL	IC ELDERCARE ON	MAIN	APOLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T		
		,		DEFICIENC	Y)	
2 900	Continued From p	age 7	2 900			
	weakness.	0				
	weakiiess.					
		/inimum Data Set (MDS) date	d			
		R64 had a moderate cognitive				
		quired extensive assistance for ansfers. The MDS further	or			
		at risk for pressure ulcers an	d			
		s at the time of the admission	-			
	assessment.					
		ssessment (CAA), dated				(08/2020
		ed mobility and R64 was at ris	k			
		sure ulcers/injuries. A Braden				
), indicated R64 was at high				
		that included extensive				
		ed mobility and frequent wel and bladder. The CAA				
		not currently have pressure				
		tensive assistance of one for				
		bed positioning to keep bony	,			
	•	direct contact and to elevate				
		vhen R64 was in bed. The CA to receive a daily full body	A			
		rsing assistant (NA) and a				
		spection by a nurse on her				
	shower day. The C	CAA also indicated R64 was to				
		ositioned every two hours and				
		urage R64 to position ry 15-30 minutes if able.				
		dicated R64 required frequent	t			
	checks for safety a		•			
		ated 9/11/20, indicated R64 wa	as			
		akdown related to limited				
		bedfast) and listed R64's goal n pressure related injuries. Th				
		oaches were to position R64 t				
	keep bony promine	ences from direct contact with	1			
	one another: to us	e pillows, foam wedges, etc. t	o			

linnesota Department of Heal		alth			1.01.01	IAPPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			0
		00984	B. WING		C 10/08/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
ATHOL	IC ELDERCARE ON M	ΛΑΙΝ	IN STREET NO			
		MINNEA	APOLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	ge 8	2 900			
	elevate heels off be devices including p sheet. R64's care p perform a weekly fu complete body audi temporary care plan issues. R64's care assistants to compl performing a.m./p.r report any signs of red, or broken area The memory care u lacked any informat assistants to use pi for R64. R64's admission pr skin observation oc completed and sign on 8/26/20. The adu R64 slept for 8 hou nap. The PN indica extremities, and sw	ed; to use bed positioning ositioning pillows/rolls and a li lan further directed nursing to all body audit with shower, it observations, and initiate a n (TCP) for any new skin plan further directed nursing ete a daily skin check when n. cares and directed staff to skin breakdown (sore, tender s). unit group sheet, undated, tion directing the nursing llows or positioining devices ogress notes (PN) indicated a courred on 7/29/20, and was ned by registered nurse (RN)- mission observation indicated rs a day and took an afternoo	fft o a A A			
	R64's weekly Body observation dated 9 was "intact" with no callous, open areas	Audit and Foot Exam 0/10/20 indicated R64's skin foot abnormalities (blisters, s, redness, etc.) noted and no m the previous week.				
	observation dated 9 was "intact" with no callous, open areas	Audit and Foot Exam 0/17/20 indicated R64's skin foot abnormalities (blisters, s, redness, etc.) noted and no n the previous week.				
		Audit and Foot Exam				
nesota D TE FORI	epartment of Health M		6899 BI	MBN11	lf continue	tion sheet 9 d

Image: Name of provider or supplier Street Address CATHOLIC ELDERCARE ON MAIN 817 MAIN STRIMINNEAPOLIS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PREFIX (EACH CORREC TAG CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5)
CATHOLIC ELDERCARE ON MAIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PF 2 900 Continued From page 9 2 9 observation dated 9/24/20, at 9:02 a.m. indicated R64 received a bed bath, and skin was "other" with "pink peri area lantiseptic applied". Skin on lower extremities and feet were "dry" with no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week. The observation noted that R64's fingernails and toenails were trimmed. A second weekly Body Audit and Foot Exam observation dated 9/24/20, at 10:27 a.m. indicated R64 received a tub bath / whirlpool, and skin was "intact" and no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week. The observation noted that R64's fingernails and toenails were not trimmed. R64's weekly Body Audit and Foot Exam observation dated 10/1/20, indicated R64's skin was "intact" and no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week. The observation noted that R64's fingernails and toenails were not trimmed. R64's weekly Body Audit and Foot Exam observation dated 10/1/20, indicated R64's skin was "intact" and no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week. On 10/5/20, at 4:57 p.m. R64 asked staff to help her lie down in bed. LPN-B suggested "lets wait until like 6 p.m.", and stated R64 would be laying in her bed all night once they assisted her to bed. On 10/5/20, at 5:30 p.m. nursing assistant (NA)-B assisted	REET NORTHEAST IS, MN 55413 ID PROVIDER'S PREFIX (EACH CORREC TAG CROSS-REFEREN	CTIVE ACTION SHOULD BE	COMPLET
CATHOLIC ELDERCARE ON MAIN MINNEAPOLIS (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PF 2 900 Continued From page 9 2 9 observation dated 9/24/20, at 9:02 a.m. indicated R64 received a bed bath, and skin was "other" with "pink peri area lantiseptic applied". Skin on lower extremities and feet were "dry" with no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week. The observation noted that R64's fingernails and toenails were trimmed. A second weekly Body Audit and Foot Exam observation dated 9/24/20, at 10:27 a.m. indicated R64 received a tub bath / whirlpool, and skin was "intact" and no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week. The observation noted that R64's fingernails and toenails were not trimmed. R64's weekly Body Audit and Foot Exam observation dated 10/1/20, indicated R64's skin was "intact" and no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week. The observation noted that R64's fingernails and toenails were not trimmed. R64's weekly Body Audit and Foot Exam observation dated 10/1/20, indicated R64's skin was "intact" and no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week. On 10/5/20, at 4:57 p.m. R64 asked staff to help her lie down in bed. LPN-B suggested "lets wait until like 6 p.m.", and stated R64 would be laying in her bed all night once they assisted her to bed. </th <th>IS, MN 55413 ID PREFIX (EACH CORREC TAG CROSS-REFEREI</th> <th>CTIVE ACTION SHOULD BE</th> <th>COMPLETI</th>	IS, MN 55413 ID PREFIX (EACH CORREC TAG CROSS-REFEREI	CTIVE ACTION SHOULD BE	COMPLETI
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incontinence care. R64 was transferred into her			
bed using a mechanical device lift. R64 was lying			
in bed and had a visible scab on her left heel.			
When asked what this was, NA-B stated, "that is			
how her feet are" and continued with incontinence			
care. NA-B placed a clean brief on R64, pulled			
R64's nightgown down, covered R64 with the			
sheet and blanket, adjusted the head of bed, adjusted foot of bed, turned TV on and attached			

Minneso	ta Department of He	ealth			FORM	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00984	B. WING		C 10/08/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	ΜΔΙΝ	N STREET NO POLIS, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ige 10	2 900			
	the call light to R64	's sheet. At 5:52 p.m. NA-B				
		rned off the bathroom light,				
		n. There were no pillows				
		d no pillows or other				
		placed under R64's feet to ff of the bed and protect bony				
		cordance with R64's care plan.				
	At 5:35p.m. NA-B v	erbalized R64 likes to lay				
		ve don't want her in bed for a				
		e to get her out." NA-B did not				
	say anything about positioning devices	the need for pillows or for R64.				
		on 10/5/20, at 7:30 p.m. NA-D				
		go to bed early and typically for the night around 6:00 p.m.				
	stated R64 spent a	on 10/5/20, at 7:39 p.m. LPN-E lot of time in bed and always . LPN-B stated most of the	3			
		would lay her down for a nap				
		ift staff would get her up close				
		I-B also stated once R64 was e would remain there until the				
		and added, "To prevent bed				
	5 5	p her up for at least an hour				
		se she will not be up until the				
		I-B stated she did not believe				
	,	nt skin concerns and indicated ny skin breakdown since				
	admission.	.,				
		on 10/5/20, at 7:45 p.m.				
		N)-B stated staff assist R64				
		orning at 8:30 a.m. and assist wn at 1:30 p.m. for a nap.				
		afternoon staff come they get				
	R64 up for dinner. I	Finally, RN-B stated R64				
	always wanted "to g	go back to bed right away."				
	opartmont of Hoalth					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00984	B. WING			08/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S ⁻	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I	ΜΔΙΝ	IN STREET NO APOLIS, MN 55			
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	FION SHOULD BE	(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC		DATE
2 900	Continued From pa	age 11	2 900			
	On 10/6/20, at 3:24	p.m. R64 was lying in bed.				
		ne it was and when told the				
		g I should not be in bed at				
		get up!" R64 stated she was she had been in bed. R64				
		only 3:30 though, I should sti				
	be up in my chair."	At 3:27 p.m. nursing staff				
		n and asked R64 if she wante				
	to get up for dinner like a good idea."	. R64 stated, "well that sound	S			
		a.m. and again at 9:07 a.m.	-			
	no positioning pillow were not elevated of	lying in bed sleeping. R64 ha ws in place and R64's heels off of the bed by pillows or any ccordance with R64's care				
	plan.					
) a.m. R64 indicated she had ong time and had wanted to				
	get out of bed for "					
		on 10/7/20, at 9:35 a.m. NA-F				
		seen pillows being used under nd her body for positioning in				
		o, I don't think so, she only ha	IS			
		s behind the head, that is wha				
		ied there were no pillows in				
		s body or under R64's feet and				
		e any pillows around [R64] for n't see anything under her	ſ			
	feet."					
		on 10/7/20, at 12:44 p.m.				
		was not aware of any skin				
		stated R64 had just moved u	IP			
		ago. At 12:52 p.m. LPN-G el and stated, "Yeah there is a	a			
		t looks like something was				
		ied up." LPN-G further stated				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00984	B. WING		10/08/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	VIAIN	N STREET NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	would be on the call of the feet every back R64's care plan dire pressure ulcers and yes. I don't work nig pillow under her her hands if she is layir why it wouldn't have yesterday I did see her feet." When interviewed of stated that staff put "sometimes." R64 f pillows around her " When interviewed of verbalized she was directed for the use pressure injuries ar specific in the care RN-A verbalized that prevent pressure in would involve havin her calves." RN-A at aware whether or m and stated, "I would if this is being done plan and noted the heels off of the bed expectation would b heels elevated. RA- process in place to were being placed b care, and it is not se	pressure ulcer, otherwise it re plan. We do assessments th day." LPN-G confirmed that ected use of pillows to prevent d stated, "Pillows? At night, ghts but she usually has a els and on the sides of her ng on her back. I don't know e been done today but in the morning a pillow under on 10/7/20, at 12:58 p.m. R64 pillows around her further stated she felt staff put "Maybe every couple days." on 10/8/20, at 9:49 a.m. RN-A not aware R64's care plan e of pillows for prevention of nd stated, "There is nothing plan if there are any pillows." at if pillows were needed to juries to R64's heels, "that ng some sort of pillows under again indicated she was not ot this was being done for R64 d have to dig into that and see bar RN-A reviewed R64's care direction to elevate R64's , and then stated her be to find R64 in bed with her -A further stated there was no record whether the pillows because it was a standard of omething they initial off on the on administration record				
	being done. RA-A s	no way to confirm if it was stated she would assess R64's facility also had a wound				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00984	B. WING			C 08/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I	ΜΔΙΝ	N STREET NO POLIS, MN 55	-		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	, ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 13	2 900			
		could look at R74's heel today best treatment for R64.				
		on 10/8/20, at 9:49 a.m.				
		RN)-A indicated the process				
		pressure related injuries was body audits with cares and				
		assessment when the resident				
		ath. RN-A reviewed R64's most				
		ment initiated 10/1/20, and				
		A confirmed there was				
		ut heels" on this assessment s previously unaware of any				
		neels. RN-A verbalized the				
		or any concerns or changes to				
		for staff to report any skin				
		emporary care plan. RN-A				
		didn't know how or why this				
		issed. RN-A verified the most ment for R64 was created on				
		ed on 10/7/20. RN-A verified				
		ree skin assessments from				
		so finished on 10/7/20. RN-A				
	•	tion was to close a skin				
		the week of the observation,				
	than that".	h assessment, "not any longer				
		:22 p.m. RN-A and RN-D were				
		N-D stated she had assessed				
		ormed the injury was on the left				
		d 1.3 cm in diameter. RN-D vas "100% eschar, I would				
		essure area." RN-D verbalized				
		vere putting a pillow under				
	R64's calves to kee	ep her feet up off the bed and				
		ese interventions were in				
		RN-D described the pressure				
		ble and indicated staff would bing forward. RN-D indicated				
	epartment of Health	Sing for ward. The indicated				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00984	B. WING		10/	08/2020
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
CATHOL	IC ELDERCARE ON N	MAIN	N STREET NOI POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ige 14	2 900			
	bed. RN-D was uns injury may have be is hard to say, with has significant peel verified the pressur effects on R64 and become infected." I should have noticed further indicated sh chance that it is fro compromised. My p in place for bed."	ury was probably from being in sure how long the pressure en on R64's feet and stated, "I' how compromised she is; it ing on the edges." RN-D re injury could have negative stated, "If it opened up it could RN-A stated the day shift d the pressure injury and the felt there was a "90% m bed, because she is so plan will be to put interventions	t			
	and RN-D describe concerns or change skin checks, and if was then inspected "The NAR's do the would expect that if were not aware of t indicated a compre completed by a cha admission and inclu- noting the temperation completing the Brack weekly body audit at the process when a staff should be: the RN who finds who then would cal Together they would determine cause;	on 10/8/20, at 12:22 p.m. RN-A ad the reporting process for any es to resident's skin as weekly a wound was discovered it I daily. RN-D further stated, cares daily on the people so I t would have been seen. Staff this issue until today." RN-A hensive skin assessment was arge nurse upon a resident's uded a head to toe screening, ture and color of the skin, den scale, and completing a assessment. RN-A explained a pressure ulcer was found by area tells the floor manager I RN-D (the wound nurse); uld assess and try to uld be discussed in the IDT	/			
	RN-A would do we injury was improvin	plan would be initiated; eekly rounds to make sure the g and update the care plan; by a RN would be initiated, and				

STATEMEN	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00984	B. WING		10/	08/2020
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I	MAIN	IN STREET NO APOLIS, MN 55			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 15	2 900			
	pressure area obse	ervation with measurements				
	once weekly,					
		oner would assess the injury.				
		ocess was not initiated for Re	64			
		/hen she became aware of th				
		I-A stated R64 had no history				
	of pressure injuries	while in the facility.				
	Dumin n an interview		41-			
		/ on 10/8/20, at 12:47 p.m. wi	In			
		_PN-A verified that staff kin checks and stated, "Yes w	10			
		neck, especially with R64. Sh				
		bath, the aide usually goes in				
		bes the whole thing and she				
	will call me to do a	5				
	assessment."LPN-	A stated he may have been				
	distracted and forge	otten to close the assessmen	its			
		LPN-A verbalized that he ha				
		e weekly skin inspections for				
		look at R64's skin all the time				
		s and bath days." LPN-A state	ed			
		pressure ulcer on R64's heel				
		n inspections and stated, "you				
		ay, and seriously I didn't see i ist week, I did not see it."	ι,			
	She didit t have it ia	ist week, I did hot see it.				
	When interviewed	on 10/8/20, at 1:08 p.m. the				
		(DON) verified that R64 had				
		rial issues". The DON				
		eviewed the skin assessmen	t			
		ecent bath day and there was				
		on there" regarding pressure				
		indicated she and RN-A talke				
		c nursing interventions such a	as			
		off of the bed, and stated,				
		basic interventionyou want				
		o release pressure." The DO	N			
		blanned interventions for				
		e injuries should have been I her expectation was that sta	ff			
	epartment of Health	a nor expectation was that Sta				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00984	B. WING			C)/08/2020	
	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE			
	IC ELDERCARE ON	MAIN 817 MA	IN STREET NO	RTHEAST			
CATHOL	IC ELDERCARE ON	MINNE/	APOLIS, MN 55	6413			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From page 16		2 900				
foll new wo ski pu wh as pre so the to ve	necessary, the exp would follow the ca skin checks were of purpose of being a whole body so that as possible. The D pressure ulcer was weekly skin assess sounds to me that the purpose of doin to notice if there is very beginning that ordinary to report if		is e				
	and Prevention, re- residents would be developing pressur- in the risk assessm developing a preve- appropriate care and further indicated, re- risk for pressure ul- for prevention of sk- Interventions shou factors. Basic preve- a) Daily monitorin- b) Weekly skin in c) Appropriate se d) Assessment of e) Keeping skin of f) Individualized of plan	repositioning and offloading ess will also be used to identify	n (
		THOD OF CORRECTION: sing or designee, could reviev	v				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00984	B. WING			08/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	ΙΔΙΝ	STREET NOP OLIS, MN 554			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	they are receiving they are receiving the treatment/services from developing an pressure ulcers. The designee, could condelivery of care; to a services are implement pressure ulcer development.	for pressure ulcers to assure ne necessary to prevent pressure ulcers d to promote healing of ne director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for	2 900			
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service ed prevention and com E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health po practices, including defined in part 4658 G. a system for H. a system for	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; nent and implementation of licies and infection control a tuberculosis program as	21390			11/24/20

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМ	E SURVEY PLETED C	
		00984	B. WING			0/08/2020	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CATHOL	IC ELDERCARE ON M	ΛΔΙΝ	NSTREET NO POLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
21390	current standards of This MN Requireme by: Based on observati review, the facility for comprehensive infe- include the Centers Services (CMS) CC including proper us equipment (PPE) b performance of har residents, and com procedures. These	eptics, gloves, and	21390	corrected			
	DISTANCING, and During an observat on the third floor, th were seated in whe (TV) without masks the TV viewing area residents were sittin and with bedside ta down in a chair less residents in chairs. placed a bedside ta Unidentified nursing	ion on 10/05/20, at 12:09 p.m. iree unidentified residents elchairs facing a television and less than six feet apart in a. Two other unidentified ng in chairs without masks on bles in front of them. R95 sat s than four feet from the Nursing assistant (NA)-A					

	IT OF DEFICIENCIES OF CORRECTION	ÍDENTI	DER/SUPPLIER/CLIA	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	COM	E SURVEY PLETED
		0098				10/	08/2020
NAME OF I	PROVIDER OR SUPPLIER			DRESS, CITY, ST			
CATHOL	IC ELDERCARE ON	MAIN		STREET NOP OLIS, MN 55			
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC REGULATORY OR L	Y MUST BE PF	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From page 19		21390				
	the third floor dinin were wearing a ma apart at a square ta	g area, R59 ask, sat app able in the o one anoth- ice. Uniden	roximately one foot dining room, leaned er, played with baby tified staff were in				
	During an observat third floor dining ar juice glass and pla front of her. R385 t and drank some of were in visual dista intervene before R	ea, R317 d cd the glass hen picked the juice. I nce but dic	s on the table in up R317's glass Jnidentified staff not attempt to				
	were in visual dista	g area, R38 nasks and s e they talke ince but dic	85, R119, and R95 sat about two feet d. Unidentified staff				
	During continuous 4:42 p.m. to 4:45 p clean clothing prote resident dining are without wearing a r clothing protectors remove the clothing cart and redirected staff did not assist	.m. on thirc ectors was a. R55 cam nask and to . An uniden g protectors I R55 back	floor, a cart of uncovered in the e out of her room buched the cart and tified staff did not s, just covered the to her room. The				
	During an observat third floor, R95 stor showed her a baby mask. Unidentified but did not attempt social distancing.	od within tw v doll; neithe staff were	er resident wore a in visual distance				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			-		С	
		00984	B. WING		10/	08/2020
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
CATHOL	IC ELDERCARE ON	MAIN	N STREET NOI POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 20	21390			
	During an observation on 10/6/20, at 8:52 a.m. in the third floor dining area, R95 and R96 sat at the same table about two feet apart and neither wore a mask. Registered nurse (RN)-A walked directly past the table and looked at the residents. RN-A did not attempt to assist the residents with masking or social distancing.					
	the third floor dinin the same table less neither wore a mas	tion on 10/6/20, at 9:01 a.m. in g area, R95 and R107 sat at s than six feet apart and sk. RN-A served R95 coffee. npt to assist the residents with				
	the third floor dinin about one foot apa closely to one anot wore a mask. Nurs	tion on 10/6/20, at 3:01 p.m. in g area, R385 and R44 stood Irt, held hands, and spoke ther's face; neither resident sing staff were in visual ot attempt to assist with distancing.				
	the third floor, R38 and touched R55's neither resident wo	tion on 10/6/20, at 3:04 p.m. or 5 stood within one foot of R55 face, hair, and shoulders; ore a mask. Nursing staff were out did not attempt to assist icial distancing.	1			
	the third floor, R55 donned a mask wh usually ask her to v	tion on 10/6/20, at 3:20 p.m. or started to leave her room and nen asked, stating staff didn't wear one. She stated she had down to therapy, located on the				
		tion on10/6/20, at 3:44 p.m. on pproached R95, stood within				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00984		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/08/2020	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		10/	00/2020
		817 MAIN	STREET NOI			
CATHOL	IC ELDERCARE ON N	MAIN	OLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From page 21 two feet of R95 and touched R95 on the shoulder; neither resident wore a mask. R95 pushed R385's hand away, stated "get off", and walked away.		21390			
	between 8:01 a.m. floor, staff served F area. R95 got up ar any of the food and entered R434's qua open door and touc then exited R434's doorway of R6's roo then entered the dir at the same table, I neither resident wo nurse (LPN)-A said	observation on 10/7/20, and 8:05 a.m. on the third R95 breakfast in the common nd walked away without eating I was not wearing a mask. R95 arantine room through the ched the privacy curtain. R95 room, and stood in the om, and talked to R6. R95 ning area and sat next to R59 ess than two feet apart; re a mask. Licensed practical "Hi" to R95 but did not e residents socially distance.				
	the third floor, R95 opened cupboards approached R95 ar sugar?" LPN-A gav poured herself coffe took a used meal tr the donuts that wer another resident. LI R95 with social dist	ion on 10/7/20, at 8:20 a.m. on moved from a dining table and in the kitchenette. LPN-A nd asked R95 "do you want e R95 a sugar packet. R95 ee from the coffee dispenser, ray off of another table, and ate re left on the meal tray of PN-A did not attempt to assist tancing, hand hygiene, or eating food off another /.				
	8:45 a.m. and 9:00 R434, and R95 wer from the nursing sta than six feet apart. to the residents; no	observation on 10/8/20, from a.m. on the third floor, R130, re seated in the hallway across ation without masks and less NA-C brought toast and rolls hand hygiene was offered or food being given to the				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00984	B. WING			08/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N		N STREET NOP POLIS, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21390	Continued From pa	ge 22	21390			
	visualized in the are socially distance the medication aide (TM within two feet of Re wheelchair. R95 lea feet. The TMA and visual distance but distance the residen During continuous of 1:05 p.m. to 1:15 p. gave snacks to R55 residents. No hand	MA)-A placed R95 in a chair 64 who was seated in a aned over and touched R64's other nurisng staff were in did not attempt to socially				
	meals was observe 10/5/20, or during th 10/7/20, and 10/8/2	residents before or after d during the evening of ne daytime meals on 10/6/20, 0. No hand hygiene spray was ing area or the TV room where rved.	5			
	LPN-A verified the e hand hygiene with r meals and after boy they used a spray a spray was visualize any medication card	on 10/8/20, at 9:42 a.m., expectation was staff perform esidents before and after wel/bladder care. LPN-A stated ind it was "somewhere." No d at the nursing station, on t, in the dining area, or in the ified he did not see the spray.				
	STAFF USE OF MA PROTECTION	ASKS AND EYE				
	reported she had ol	family member (FM)-A oserved facility staff without ally distancing during lunch or				

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00984	B. WING			08/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I		N STREET NO POLIS, MN 55			
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21390	Continued From page 23		21390			
	on the third floor, L nose and stayed ur from the dining are without masks, and residents without m feet from each othe distance residents During an observat third floor, LPN-B w forehead, with her At 4:53 p.m. LPN-E again on her forehe positioned high on upward, covering of face. During continuous 5:10 p.m. through & LPN-B was observen nose and face shie to where it was bar sitting at the nursin the nursing station R6's room, poked f quarantine room, p nose as she was le walked toward R23 into the nursing stat nose. An unidentific and asked LPN-B a resident with her m time, RN-B was ob	ion on 10/5/20, at 12:32 p.m. PN-C's mask was under his oder his nose as he walked a where three residents were, d into the TV area where six masks were sitting less than six er. LPN-C did not attempt to or ask them to wear a mask. ion on 10/5/20, at 4:44 p.m. or vore goggles on top of her eyes uncovered and exposed. I's goggles were observed ead and a face shield was now LPN-B's forehead and tilted nly the top half of LPN-B's observation on 10/5/20, from 5:20 p.m. on the third floor, ed with her mask below her Id raised above her forehead ely reaching her nose, while g station. LPN-B walked from into the hallway, walked past her head into R434's ulled her mask up over her eaving R434's room, and then i's room. LPN-B walked back tion with her mask under her ed resident walked up to her a question. LPN-B talked to the ask below her nose. At this served to have his mask under t to LPN-B at the nursing				
	station. LPN-B ther her mask still unde barely reaching her feet of unmasked r	n left the nursing station with r her nose and face shield still r nose, and walked within three esidents: R96 and two other nts. R95 asked LPN-B a				

STATEMEN	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		COM	E SURVEY PLETED
		00984	B. WING			C 08/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON	ΜΔΙΝ	N STREET NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From page 24		21390			
	question and she lo ear, "what do you v	eaned into him to shout in his vant?"				
	observed sitting at	ations on 10/5/20, RN-B was the third floor nursing station er his chin at: 5:10 p.m., 5:14 id 5:59 p.m.				
		tion on 10/5/20, at 7:59 p.m. or D was observed sitting in the s mask off.	ו			
	on the first floor, th sitting in an office v The office opened	tion on 10/6/20, at 11:55 a.m. e dietary director (DD-A) was without mask or eye protection directly into hallway while an nt in a wheelchair without a allway.				
	2:31 p.m. and 2:40 were in line for CO NA-E were standin apart. NA-A wore a NA-D's mask was was under his nose	observation on 10/6/20, from p.m. on the third floor, staff VID testing. NA-A, NA-D, and g approximately three feet a mask and no eye protection. under his chin. NA-E's mask e. At 2:38 p.m., an unidentified selchair with R49 in it within				
	the first floor, two used staffing office, sittir each other. One st mask. The second	tion on 10/7/20, at 7:27 a.m. or inidentified staff were in the ng less than six feet apart from aff wore eye protection and staff did not have mask or eye ffing office was just off the first	•			
	the second floor, h	tion on 10/7/20, 7:59 a.m. on ousekeeper (HK)-B wore a gloves but her goggles were				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	·····		
		00984	B. WING			C 08/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	ΜΔΙΝ	STREET NO	-		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21390	Continued From pa	ge 25	21390			
	on the top of her head while standing in front of R99's room.					
	on the first floor, LF the top of her head talking to an unider	ion on 10/7/20, at 10:01 a.m. PN-E lifted her face shield to , exposing her eyes, when ntified staff while standing less in the other staff in front of				
	on the third floor, N mask or face shield station. NA-F stated	ion on 10/7/20, at 10:24 a.m. A- F was observed without a d while seated in the nursing d he was not interacting with build wear them when he was				
	an unidentified staft manager's office wi	ion on 10/7/20, at 2:14 p.m., f was outside the nurse ith his mask on but face shield omputer in the hallway.				
	LPN-A was sitting a mask under his chi left the nursing stat	iona 10/7/20, at 2:15 p.m., at the nursing station with his n and face shield off. LPN-A ion without his face shield and rous residents in the hallway.				
	the third floor, radio was standing at the goggles on the top N95 mask with exh standing within thre she only wore eye p resident. When point	ion on 10/8/20, at 9:49 a.m. on ology technologist (RadT)-C e nursing station with her of her head and wearing an alation valve. RadT-C was be feet of R64. RadT-C stated protection when around a nted out she was within three t her goggles over her eyes.				
		were at the nursing station and				

If continuation sheet 26 of 48

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00984	B. WING	B. WING		10/08/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
CATHOL	IC ELDERCARE ON M	MAIN	N STREET NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21390	Continued From pa	ige 26	21390				
	on the first floor, the	ion on 10/8/20, at 12:11 p.m. ere was one staff in the out a mask or eye protection.					
	on third floor, RN-A	ion on 10/8/20, at 01:08 p.m. was wearing mask under her n her head while in her office.					
	three unidentified s dining tables and ta	ion on 10/8/20, mid-afternoon taff were seated at first floor alking without masks or eye re not eating at the time.	,				
	receptionist (R)-D s every staff in the building and eye pr	on 10/5/20, at 11:54 a.m., stated the expectation was uilding wore masks when in the otection when in resident care racting with residents.					
	STAFF HAND HYG	SIENE					
	5:30 p.m. through 6 brought a basin of v wiped the underarm NA-B removed dirty gloves, with no han changes. NA-B und soiled brief, and use	observation on 10/5/20, from 5:00 p.m. on third floor, NA-B water from the bathroom and ns of R64 with a wash cloth, y gloves and donned new id hygiene between glove dressed R64, removed her ed a wash cloth to clean R64's noved one soiled glove and	5				
	on the bedside tabl glove with no hand	x of gloves, which she placed e. NA-B donned the one new hygiene between glove ced a clean brief on R64, then					
	pulled R64's nightg sheet and blanket of head of bed, adjust	own down, and placed the over R64. NA-B adjusted R64' and the foot of the bed, turned the TV screen, and then turned	s				
	up the volume of th	e TV. NA-B attached the call g gathered the soiled linens in					

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
		00984	B. WING		10/08/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I	ΜΔΙΝ	N STREET NO POLIS, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21390	Continued From pa	age 27	21390			
	new trash bag in th basin of water in th the basin back in th her dirty gloves, tur exited the room, wi hygiene. NA-B ther linen room and ther interview, NA-B sta gloves, you only the to wipe the peri-are glove to put the cle "When you take off between, but some close to you and you when the resident i stated, "Yes, you ar hands before you le out the trash." NA-F monthly training on computer trainings, education from nur During continuous 8:33 a.m. through & escorted R118 from bathroom. NA-C do R118 to the toilet. A finished, NA-C wipe removed her dirty g gloves, with no han changes. NA-C pul assisted R118 to w	trash in another bag, placed a e trash can, dumped a dirty e bathroom sink, and placed he closet. NA-B then removed hed off the bathroom light, and thout performing hand n took the soiled linens to the n used hand sanitizer. During ted when you are changing row away the soiled glove used a, and then you get a new an brief on. NA-B stated, ' your gloves you can sanitize times the sanitizer will not be ou cannot go far from the bed s on their side." NA-B further re supposed to wash your eave the room but I was taking B verbalized she received hand hygiene via Relias , as well as frequent audits and sing staff. observation on 10/6/20, from 8:41 a.m. on third floor, NA-C n the dining area to her onned gloves and transferred After R118 indicated she was ed R118's peri-area with wipes gloves, and donned clean ad hygiene between glove led up R118's brief and pants, ash hands, and then NA-C NA-C verbalized the priority				
	we leave her stand hands before puttin fall, if you have to v	e a clean glove and stated, "if ing there and then wash your og on a clean glove they might vash your hands and get clean				
	gioves we might ha	ive a lot of them falling." NA-C				1

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED C
		00984	B. WING		10/	08/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON M	ΜΔΙΝ	N STREET NOI POLIS, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21390	Continued From pa	ige 28	21390			
	before applying cle	an gloves, before and after				
	care you need to w	ash your hands, but for her				
	she really had to go I just applied the glo	o and my hands were clean so oves.")			
	During an observat	ion on 10/7/20, at 7:56 a.m. o	n			
	third floor, LPN-A was standing within three feet					
	, 0	ose to her face with his hand				
		434, who was supposed to be				
		within six feet distance of R6 ng area. None of the residents				
		wore masks. LPN-A walked from R434 to R6, put				
	his hand on her shoulder, and leaned within one					
		N-A then walked back to R434	4			
		d on her shoulder. LPN-A did ygiene between touching				
		ent back to R6 and leaned in				
		hands on R6's table, then				
		late from R6's table and				
	table.	s table and leaving it on the				
		on 10/8/20, at 9:58 a.m.,				
		r expectation was for hand				
		rmed between glove changes ould perform "hand hygiene				
		e gloves are donned and				
		n resident care if the gloves				
		iled." RA-A further stated both				
	gioves should be re	emoved after peri-care.				
	ISOLATION/QUAR	ANTNE				
	During continuous	observation on 10/5/20, from				
	1:00 p.m. through 1	1:15 p.m. on the third floor,				
		l's room, which had a sign				
		at indicated R434 was on In indicated the door to the				
		s be closed and anyone				
		wearing gown, gloves, masks				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00984	B. WING		C 10/08/2020	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ATHOL	IC ELDERCARE ON	ΜΔΙΝ	N STREET NOI			
			POLIS, MN 55	PROVIDER'S PLAN OF		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21390	Continued From pa	age 29	21390			
	was asked about th did not see the sign for the isolation can was 20 yards away placed the cart ney and verified there w cart. NA-A stated th	When exiting the room, NA-A ne quarantine and he stated he n. NA-A said he always looked rt and pointed to a cart that r from the door. NA-A then to the entry into R434's room were no gowns or gloves in the here were gowns and gloves ir NA-A left the area and left				
	4:42 p.m. through a obtained gowns an and placed in the is room. NA-B did no donning gown and the door to R434's door to R434's roo	observation on 10/5/20, from 4:50 p.m. on third floor, NA-B ad gloves out of storage closet solation cart outside of R434's t perform hand hygiene prior to gloves. NA-B exited leaving room open. NA-B stated the m should be closed because tine and then shut the door.				
	10/5/20, from 5:20 third floor, NA-B ex with a food tray and isolation cart. NA-E and placed in the tr the bathroom in R4 hand hygiene and carried the tray from dining area where on top of the count NA-B removed gloo hygiene but did not	observation and interview on p.m. through 5:25 p.m. on the cited R434's quarantine room d placed the food tray on the 8 then doffed gown and gloves rash can which was located in 134's room. NA-B performed then donned gloves. NA-B m the isolation cart to the she placed the dirty food tray ter in the kitchenette area. ves and performed hand t disinfect the top of the the dirty food tray was placed				
	a.m. on the third flo	tion on 10/6/20, around 10:00 oor, an unidentified pist (OT)-A entered R434's				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	Сом	E SURVEY PLETED C
		00984	B. WING		10/08/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	MAIN	N STREET NO			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21390	Continued From pa	ige 30	21390			
	brought R434 out ir	thout gown or gloves, and nto the TV area in a /as not wearing a mask.				
	the third floor, R434 sitting within four fe area. None of the ru Staff were present	ion on 10/7/20, at 7:31 a.m. of 4, who was in quarantine, was eet of R95 and R96 in the TV esidents were wearing masks but did not attempt to assist ks, social distancing, or assist uarantine room.				
	third floor, an unide (OT)-B walked to R TV area and was s OT-B leaned into R	ion on 10/7/20, at 7:44 a.m. or ntified occupational therapist 434, who was seated in the upposed to be in quarantine. 434 and told her he was hing area. OT-B did not ask sk.	n			
	12:23 p.m. through R434's quarantine in a wheelchair and herself into R434's wheelchair in the ro	observation on 10/7/20, from 12:30 p.m., the door to room was open. R46, who wa I not wearing a mask, wheeled room. R434 was in her bom at the time. After several led herself out of R434's				
	LPN-A verified R43 quarantine because stated staff should but if R434 came o staff should not be bringing the resider who was in quarant and staff should rer	on 10/7/20, at 10:20 a.m., 4 was supposed to be in e she was newly admitted. He try to keep R434 in the room, ut, it was hard. LPN-A agreed going into the room and nt out. LPN-A stated a residen tine should be wearing a mask mind the resident to wear a hey should remind residents	t			

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00984	B. WING		- 10/08/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	ΜΔΙΝ	N STREET NOP POLIS, MN 55	-		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETI DATE
21390	Continued From pa	ige 31	21390			
	SCREENING - EN	TRY POINTS				
	7:01 a.m. through 7 screening desks by screening desk was screening table, to screening desk, was staff and visitors en four other staff enter the hallway and had get to the screening and one staff with a verified she could n not see which staff entered took their to automatic temperature in	observation on 10/7/20, from 7:10 a.m., there were two 7 the front entry; the primary 8 unstaffed and the secondary the right of the primary 9 s staffed by NA-J. While other netered through the front entry, 9 red the screening area from 1 to walk through the facility to 10 desk: US-H, LPN-D, NA-A, 10 an unreadable signature. NA-J 10 tread the signature and did 10 signed the book. All who 10 emperature using a stand-up 10 ture taking machine, marked 10 the sign-in book, and 10 questions in the sign-in				
	with infection prever IP-B, several topics *Resident use of m hand hygiene - IP-A residents was they areas or when staff stated some reside encouragement but She stated the expor- residents, including "it may be difficult, it to help the resident residents should be before and after me *Staff use of masks	asks, social distancing, and A stated the expectation for wear masks when in common ⁵ entered their room. IP-A nts might need reminding or t they usually did cooperate. ectation was the same for all those on third floor and while the expectation is to always try is wear masks." IP-A stated e provided hand hygiene eals and after toileting. s and eye protection - IP-A				
	stated the expectat	ion for staff use of personal nt (PPE) was that all staff				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМ	E SURVEY PLETED C
		00984	B. WING		- 10/08/2020	
IAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON	MAIN	N STREET NO POLIS, MN 55			
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
21390	Continued From pa	age 32	21390			
	while in the facility, areas or around re- were alone in their off. IP-A said there people can't toleral requirement and no should speak up if as they have many IP-A stated the fac Department of Hea (LTC)'s PPE grid, No version of the grid to wear masks. IP- expectation was the wearing PPE impro- speak up and corre- managers audited the ones to track if multiple reminders have the updated of *Staff hand hygient was staff performed after donning glove *Isolation/Quaranti expectation for qua- resident to their root stated an exception resident needed to to the therapy depa- other residents we equipment was dis- resident. IP-A states with dementia, but would frequently tr- room during quara *Staff screening and stated the expecta- front entry. She states	e - IP-A stated the expectation d hand hygiene before and es. ne - IP-A stated the arantine was to limit the om with the door closed. IP-A n would be therapy; if a go to therapy, they would go artment at a time when no re present, wore a mask, and infected after use by the ed it was a challenge for those the expectation was staff y to keep the resident in their				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00984			A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
					10/	08/2020
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ N STREET NO			
CATHOL	IC ELDERCARE ON M	ΛΑΙΝ	POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLET DATE
	<u> </u>		0.4000	DEFICIENC	Y)	
21390	Continued From pa	ge 33	21390			
	door, but if they ent doors, it was expec lobby to be screene would have to walk	he transitional care unit (TCU) ered the facility through those ted they come to the front ed. IP-A and IP-B verified staff through the facility before they entially exposing residents				
	RN-A, noted the thi related to infection of the residents who Several topics were *Resident use of m hand hygiene - RN- encouraged to wea staff should be aski wear a mask. If res wearing a mask, RI be "cared planned 1 the care plan. RN-A trying but after a wh "we know which on are not." RN-A state mask if they left the mask, they did not she expected staff residents before an peri-care if the resid *Staff use of masks stated the expectat masks and eye pro She added she mig her office but it was go to the nursing st would wear it. RN-A the mouth and nose cover the eyes.	on 10/8/20, at 10:19 a.m., rd floor had "challenges" control because of the nature o had cognitive/memory. a discussed: asks, social distancing, and A said all residents should be r a mask and she expected ing and reminding residents to idents had an issue with N-A stated it should be should for" and verified it was not on A stated staff should keep hile they quit trying, stating, es are able and which ones ed residents had to wear a a floor; if they could not wear a leave the floor. RN-A stated to offer hand hygiene to d after meals and after dent participated in peri-care. and eye protection - RN-A ion for staff was to wear tection while in the care area. which have her mask off while in a nearby, so if she needed to ation or into the hallway, she A verified masks should cover e and eye protection should e - RN-A's expectation of staff				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00984	B. WING		10/08/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON N	//AIN	N STREET NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21390	wash their hands "f following the hand I *Isolation/Quarantin residents are first a quarantine for fourt expectation was the closed, but if a resid have to be kept ope risk/benefit. RN-A s should not be in co look at risk/benefit was calmer in the co stated a resident in a mask if in the cor During an interview the director of nursi covered: *Resident use of m hand hygiene - The was for residents to enters the room or common areas. Th was the same for th resident could weat stated a resident m the expectation was residents wear mas to reattempt to get "must make multipl wear it now but nex DON stated the exp hand wipes to resid and after bathroom available, staff were	requently and always" while nygiene policy. The - RN-A verified when dmitted to the unit they are in een days. She stated the e door to the room should be dent was a fall risk, it might en; staff have to balance the stated a resident in quarantine mmon areas but again would of being isolated if the resident common area. RN-A also quarantine should be wearing	n	DEFICIENCY)		
	the DON stated res to maintain a social and staff should ma	idents should be encouraged distance of at least six feet ake it harder for residents to be so stated it was important to				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/08/2020	
		00984	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
CATHOL	IC ELDERCARE ON I	MAIN	N STREET NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 35	21390			
	the expectation sta move them apart. *Staff use of masks DON stated the exp wear a surgical mat they were in the bu- issues or concerns discuss with leader masks and eye pro- *Staff hand hygiene expected all staff to hygiene policy. *Isolation/Quarantin quarantine, the DO in their room with the while third floor res- room, "it's not one staff to redirect the time they came out resident in the roor things like give sna- resident in the roor something wasn't w have a back-up pla The facility's Hand indicated staff shou- the following times contact; 2) before a after entering isolar before and after as 5) after handling sc or procedures done prevent cross conta parts; and 7) before washing with soap	dent to sit at a table, verifying iff should remind residents and is and eye protection - The pectation was for everyone to isk and eye protection while ilding or on duty. If staff had i, they were expected to rship as they had a variety of otection that could be used. e - The DON verified she o follow the facility's hand ne - When a resident was in IN expected residents to stay he door closed. She noted that idents might wander out of the and done." The DON expected resident to their room each t and be creative to keep the n. She stated staff could do toks or activities to keep the n. The DON stated if vorking, she expected staff to an and to keep trying. Hygiene policy, dated 3/13/20, uld perform hand hygiene at : 1) before and after resident and after gloving; 3) before and tion precaution settings; 4) isisting a resident with toileting oiled linens; 6) between tasks e on the same resident to amination of different body e and after handling food (hand and water). guide is from the Minnesota	t I I			
		lth's Long-term Care Toolkit				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00984			10/	08/2020
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST N STREET NOI			
CATHOL	IC ELDERCARE ON N	MAIN	POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
	version did not india masks while in the Prevention and Con Healthcare Personn Pandemic dated Ju indicated health car universal source co health care persona	n, dated 5/29/20. The older cate office staff should wear building. The Interim Infection ntrol Recommendations for nel During COVID-19 Ily 15, 2020, by the CDC, re facilities should implement ontrol measure which includes al (HCP) should wear a es while they are in the facility				
	moderate to substa should wear eye pr facemask. The Min PPE Grid, dated 6/	n facilities located in areas with antial community transmission otection in addition to their nnesota Department of Health, 15/20 indicated all staff, f, should wear masks while in				
	Medicaid Services (COVID-19) Long-1 dated 4/2/20, long-1 accordance with pr limit access points entrances have a s accordance with pr Control (CDC) guid	enters for Medicare and Coronavirus Disease 2019 Ferm Care Facility Guidance term care facilities, in evious CMS guidance, should and ensure that all accessible creening station. In evious Center for Disease ance, every person entering e actively screened.				
	Units in Long-term 2020, recommende Infection Prevention addition, including: *Reminding and as hygiene, social dist coverings *Providing structure	erations for Memory Care Care Facilities, dated May 12, ed memory care units follow n and Control guidelines and ir sisting with frequent hand ancing, and use of cloth face ed activities in resident rooms es throughout the day to	1			

STATE FORM

BMBN11

If continuation sheet 37 of 48

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
			A. BOILDING.			С	
		00984	B. WING			10/08/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ATHOL	IC ELDERCARE ON	ΜΔΙΝ	N STREET NO POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21390	Continued From pa	age 37	21390				
	*Limiting the numb areas to maintain s with gentle redirect	ber of residents in common spacing of at least 6 feet apart tion of residents who get in other residents or persons.					
	Director of Nursing could review facility isolation precaution education regardin on appropriate PPI environmental rour anytime isolation p could ensure hand residents and by s formal training to b regulation and the DON and/or design findings/education Performance Impre a determined amore	THOD OF CORRECTION: The g (DON), ICP, or designee y policies/procedures regarding ns for resident and provide sta g the policies and educate sta E wear. They could also do nds, audits, and re-education recautions are placed; they hygience was appropriate for taff. The ICP should have be completed according to above measures. The ICP, nee could take those to the Quality Assurance povement (QAPI) committee for unt of time, until the QAPI ines successful compliance or ng monitoring.	g ff				
	TIME PERIOD FO (twenty-one) DAYS	R CORRECTION: 21					
21665	MN Rule 4658.140	0 Physical Environment	21665			11/24/20	
	functional, comfort environment, allow	ust provide a safe, clean, able, and homelike physical ring the resident to use gs to the extent possible.					
	by:	ent is not met as evidenced					
	Based on observat	tion, interview and document		corrected			

STATE FORM

BMBN11

If continuation sheet 38 of 48

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	00984		B. WING		10/08/2020	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
CATHOL	IC ELDERCARE ON	ΜΔΙΝ	N STREET NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21665	Continued From pa	age 38	21665			
	were maintained ir manner. This had t residents (R32, R1 R64) who resided i environmental con	failed to ensure 7 of 11 rooms a good repair and in a sanitary the potential to affect 7 13, R49, R80, R28, R57, and in the rooms reviewed for cerns.				
	Findings include: On 10/5/20, at 6:06 p.m. the carpet in R32's room was observed to have several stains near the bed.		ו			
	nursing assistant (needed to be clear	v on 10/8/20, at 11:32 a.m. NA)-N stated if something ned, then she would notify her maintenance personal.				
	environmental dire R32's carpet and s to be cleaned. The	ur on 10/8/20, at 12:07 p.m. the ctor (ED) verified the stains on stated that R32's carpet needed ED also stated R32's room seded to be checked everyday on the floor.	Ł			
		1 p.m. the carpet in R113's d to have stains in front of the				
	ED verified the sta	ur on 10/8/20, at 12:11 p.m. the ins in R113's room and stated old and needed to washed.				
		l p.m. the carpet in R49's room e stained around the bedside	1			
	NA-O stated if a re	v on 10/8/20, at 11:52 a.m. sident's carpet needed to be let the nurse manager know				

If continuation sheet 39 of 48

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00984		B. WING		C 10/08/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON	ΜΔΙΝ	N STREET NO POLIS, MN 55	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 39	21665			
	the room number a would let maintena	and then the nurse manager ince know about it.				
		ur on 10/8/20, at 12:16 p.m. the ins on the carpet in R49's roon ns were from food.				
		3 p.m. the carpet in R80's room ave white stains in front of the	ו			
	ED verified the sta stains were from for red stain in the car	ur on 10/8/20, at 12:14 p.m. the ins and stated R80's carpet ood. The ED also stated R80's pet was from finger nail polish sident who resided in the room I not be removed.				
) p.m. the carpet in R28's room ave white stains in front of bed				
	ED verified the sta the stains were fro they had a full time	ur on 10/8/20, at 12:15 p.m. the ins in R28's room and stated m food. The ED then stated e carpet specialist who worked pet needed to be cleaned.	•			
	was observed to have around the bed. Read the bed. Read the bed. Read there were also st	5 p.m. the carpet in R57's room ave large white and dark stains 57 stated milk was spilled. ains observed in the entry way m and the adjoining shared	5			
	ED verified the sta R57's room was a	ur on 10/8/20, at 12:17 p.m. the ins on R57's carpet and stated room that needed to be the carpet needed to be				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
	00984		B. WING			C 08/2020
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I	ΜΔΙΝ	N STREET NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21665	Continued From pa	ige 40	21665			
	cleaned.					
	light bulb between door was observed During an interview NA-G stated she w	2 p.m. R64's room entry way the bathroom door and entry to not be working. 7 on 10/8/20, at 12:01 p.m. ould put in a work order as she asket hanging behind the	•			
		on 10/8/20, at 12:19 p.m. the I get the light bulb changed				
	ED stated that they that they used daily that work well for su- he came in every m orders, then went a the rooms that were cleaning. The ED th signed off and return work order had been stated housekeeped day and could write that needed to be first stated because of the eating in their room amount of carpet of housekeeping need carpet specialist for	on 10/8/20, at 12:20 p.m. the had multiple carpet extractors and had smaller machines mall areas. The ED also stated horning and checked the work around and checked some of e known to need extra then stated the work orders are rised to him to indicate the en completed. The ED also rs went into every room each e a work request for anything ix or cleaned. The ED further the Covid-19 and residents l's, it had increased the leaning carpets and ded to communicate to the r rooms that needed further housekeeping can do.	1			
	A policy for carpet of provided.	cleaning was requested but no	t			
	SUGGESTED MET	HOD OF CORRECTION: The	•			

STATEMEI	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00984		CONSTRUCTION	COM	E SURVEY IPLETED C 108/2020
					10/	08/2020
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST I STREET NOI			
CATHOL	IC ELDERCARE ON N		POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21665	director of nursing (educate staff regard clean, functional an DON or designee, of maintenance and h periodic audits of a ensure a safe, clea environment is mai	ge 41 (DON) or designee, could ding the importance of a safe, id homelike environment. The could coordinate with ousekeeping staff to conduct reas residents frequent to n, functional and homelike ntained to the extent possible. R CORRECTION: Twenty-one	21665			
21800	Residents of HC Fa Subd. 4. Informa residents shall, at a are legal rights for stay at the facility o treatment and main that these are desc written statement o responsibilities set case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and orga advocacy and legal residential program accommodations si communication imp speak a language of facility policies, insp local health authorit the written stateme	tion about rights. Patients and idmission, be told that there their protection during their r throughout their course of itenance in the community and ribed in an accompanying f the applicable rights and forth in this section. In the mitted to residential programs in 253C.01, the written o describe the right of a d or older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide services for patients in				11/24/20

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00984	B. WING			C 08/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I	ΜΔΙΝ	N STREET NO POLIS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLET DATE
21800	chosen representation to the administrator person, consistent	nge 42 tives upon reasonable request or other designated staff with chapter 13, the Data section 626.557, relating to	21800			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to promptly resolve grievances, for 1 of 1 residents (R74) who was reviewed for grievances.			corrected		
	8/11/2020, indicate mental status (BIM indicating intact cog indicated diagnose injury (TBI) related post-traumatic stree attention-deficit hyp	-				
	interventions for alt related to cognitive alteration in mood/l use and PTSD. During an interview	ated 9/21/20, included ered thought processes impairment and TBI, and behavior related to anxiolytic and observation on 10/06/20, tated she had a rough night				
	because another re room and "sat on th had told the nurse in changed. At 3:22 p and entered into R	esident kept coming into her ne floor wailing." R74 said she manager but nothing had .m., R55 opened R74's door 74's room while moaning and s was a different person than				

	D <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
	00984				С	
			B. WING		10/	08/2020
AME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON I	ΜΔΙΝ	N STREET NO POLIS, MN 55	-		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
21800	Continued From pa	age 43	21800			
		om the previous night. R74 ing into my room happened all				
	RN-A verified R74 I residents wanderin these complaints w interventions as a p stated there wasn't done as this was th floor, stating, "these unsure at what poir	on 10/8/20, at 2:00 p.m., had complained about a lot of g into her room. She stated vere handled with nursing point of care concern. RN-A really anything that could be he nature of residents on third e residents wander." RN-A was nt R74's concerns would be a ed social work wrote up ig did not do that."	5			
	director of social see of nursing (DON) b resolutions were fir voiced complaints of the issue recurred, facility changed it to SW-A stated what we the severity of the i For wandering reside interdisciplinary tea discussed wandering solutions. SW-A state were stop signs on residents who wand rooms. SW-A state from the third floor	on 10/8/20, at 2:15 p.m., the ervices (SW)-A and the director oth agreed point of care st attempted when residents or concerns. SW-A stated if it was readdressed and the o a grievance "if appropriate." was appropriate depended on ssue, frequency, impact, etc. dents, SW-A stated the im (IDT) met daily and ng residents to brainstorm ated some interventions used resident doors and redirecting dered into other residents' d they had "no grievances for a very long time." The DON expected to help residents				
	grievances of resid	e aware of R74's ongoing ents coming into their room, re-addressed this issue with going grievances.				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 10/08/2020	
		IDEINTI IOATION NOWIDER.	A. BUILDING:			
00984		00984	B. WING			
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	C ELDERCARE ON	MAIN	N STREET NO			
		MINNEA	POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21800	Continued From pa	age 44	21800			
	policy, dated 9/30/2 make every effort t suggestions, comp properly." The polic suggestions, conce made verbally or in supervisory respon concern." The polic take "immediate ac	estion, Concern and Grievance 20, indicated the facility "would o address and resolved alaints and grievances cy further indicated, erns or grievances could be a writing to "the person who has asibility for the area of cy indicated the facility would ction to prevent further potential sident right while the alleged avestigated."	5			
	The administrator, designee could dev care by the interdis residents grievance The facility could u educate staff on the ensure resident(s) results of these au quality assurance of compliance.	THOD OF CORRECTION: director of social services, or velop and implement a plan of sciplinary team to ensure es are being followed up on. pdate policies and procedures, ese changes, and audit to dignity are maintained. The dits will be reviewed by the committee to ensure				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			11/24/20
	residents have the courtesy and respe	ous treatment. Patients and right to be treated with ect for their individuality by ersons providing service in a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
	00984		B. WING		C 10/08/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	IC ELDERCARE ON	MAIN 817 MAI	N STREET N	ORTHEAST		
		MINNEA	POLIS, MN 8	55413		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	age 45	21805			
	by: Based on observat review, the facility	ent is not met as evidenced ion, interview, and document failed to ensure staff knocked		corrected		
	and waited for a response before entering resident rooms, for 1 of 2 residents (R74) who was reviewed for resident right to privacy.					
	Findings include:					
	8/11/2020, indicate mental status (BIM indicating intact co indicated diagnose injury (TBI) related	ninimum data set (MDS), dated of R74 had a brief interview for S) score of 15 out of 15, gnition. The MDS also s that included traumatic brain to a fall, history of falls, ss disorder (PTSD), and beratcitity disorder.				
	interventions for all related to cognitive	ated 9/21/20, included tered thought processes impairment and TBI, and behavior related to anxiolytic				
	at 7:34 p.m., nursir observed to knock room without waitir knock; NA-A also o NA-A left the room time. They just fling knocking." R74 als but he would never	tion and interview on 10/5/20, ng assistant (NA)-A was on R74's door and enter R74's ng for R74 to respond to the lid not announce himself. After , R74 said "this happens all the g the door open without o stated NA-A would knock, wait for a response or before entering. R74 said she vith NA-A.				
	at 7:43 p.m., NA-D	tion and interview on 10/5/20, entered R74's room without ncing his entry into the room.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
	00984		B. WING	B. WING		C 08/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
CATHOL	IC ELDERCARE ON	ΜΔΙΝ	AN STREET NO APOLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	age 46	21805			
	removed the old dr table, placed the ne bedside table, and acknowledge or sp room, R74 stated, people just come in	rink container in one hand, rink container from the bedsid ew drink container on the left the room. NA-D did not beak to R74. After NA-D left th "he doesn't knock." R74 state n whenever they want. R74 blained to the nurse manger b	ne ed			
	NA-G stated they wait" and then let t	v on 10/7/20, at 12:22 p.m., were educated to "knock and he resident know why they room, "like I'm here to help."				
	licensed practical r should knock on th before entering the	v on 10/7/20, at 10:00 a.m. hurse (LPN)-A stated staff he door and wait for an answe e room. He stated this should a staff entered a resident's	r			
	trained medication supposed to knock for an answer befo stated if there was	v on 10/7/20, at 12:22 p.m., aide (TMA)-A stated staff we c on resident's doors and wait ore entering the room. TMA-A no answer, staff could enter ounce themselves as they				
	registered nurse (F was staff knock on for a response bef	v on 10/8/20, at 1:15 p.m., RN)-A verified the expectation the resident's door and wait ore entering. RN-A stated this ery time a staff entered a				
	RN-A verified staff	v on 10/8/20, at 2:00 p.m., should knock on the door and ves when entering a resident'				

MINIPUENT OF DEFICIENCIES MID PUENT OF DEFICIENCIES MID PUENT PUENT INTEGRITION NUMBERED Depart 0 (02) MULTIPIE CONSTRUCTION A BULDIOS (03) DATE SURVEY C MULD OF PROVIDER OR SUPPLIE CONSTRUCTION NUMBER BUTCH DEPERTURE CATHOLIC STRUCTURE OF MAIN STREET ADDRESS, CITY, STATE, ZIP COOLE BIT MAIN STREET NORTHEAST CC 1008/2020 MULD OF PROVIDER OR SUPPLIE CATHOLIC SC DEFITIFING SUPPLIE PUENT SC DEFIDIENCIES PUENT SC PUENT SC DEFIDIENCIES PUENT SC PUENT SC DEFIDIENCIES PUENT SC PUENT	Minnesota Department of He	ealth			TORMATIKOVED
Image: Note of provider or supplier 00984 B. WING					
BIT MAIN STREET NORTHEAST MINNEADLIS, MN 55413 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WATTOR FOR DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Comment COMPLETE DATE 21805 Continued From page 47 room. 21805 21805 Image: Continued From page 47 room. 21805 During an interview on 10/8/20, at 2:15 p.m., the director of nursing (DON) verified the expectation was for staff to knock on resident's doors and wait for an answer before entering the room. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure resident sdignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident (s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. Image: Here PERIOD FOR CORRECTION: Twenty-one		00984	B. WING		
CATHOLIC ELDERCARE ON MAIN 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) (X3) COMPLETE DATE 21805 Continued From page 47 room. 21805 During an interview on 10/8/20, at 2:15 p.m., the director of nursing (DON) verified the expectation was for staff to knock on resident's doors and wait for an answer before entering the room. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. IIME PERIOD FOR CORRECTION: Twenty-one	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) completer DATE 21805 Continued From page 47 room. 21805 During an interview on 10/8/20, at 2:15 p.m., the director of nursing (DON) verified the expectation was for staff to knock on resident's doors and wait for an answer before entering the room. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	CATHOLIC ELDERCARE ON	MAIN			
room. During an interview on 10/8/20, at 2:15 p.m., the director of nursing (DON) verified the expectation was for staff to knock on resident's doors and wait for an answer before entering the room. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETE
During an interview on 10/8/20, at 2:15 p.m., the director of nursing (DON) verified the expectation was for staff to knock on resident's doors and wait for an answer before entering the room. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21805 Continued From pa	age 47	21805		
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