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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: UYZ3
Facility ID: 00984

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245439**
2. STATE VENDOR OR MEDICAID NO. (L2) **375542800**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/08/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **174** (L18)
13. Total Certified Beds **174** (L17)

10. THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Susan Frericks, Unit Supervisor — 12/10/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Sr. Health Program Rep — 12/10/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/08/2020** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Angela Western, HFE NE II 11/17/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 12/06/2020 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

Electronically delivered
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,

Kamala Fiske-Downing

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

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

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,

Kamala Fiske-Downing

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

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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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

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

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

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

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: susan.frericks@state.mn.us
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

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.

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

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

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

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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING ______ B. WING ______	C 10/08/2020

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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 10/5/2020, - 10/8/2020, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 10/5/2020, through 10/8/2020, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5439051C, H5439052, H5439053C, H5439054C, and H5439055C. In addition, a COVID-19 Focused Infection Control survey was conducted 10/5/2020, through 10/8/2020, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. A deficiency is being cited at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a	F 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING ______ B. WING ______	C 10/08/2020

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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		11/24/20

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F 550	Continued From page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff knocked 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: R74's admission minimum data set (MDS), dated 8/11/2020, indicated R74 had a brief interview for mental status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS also indicated diagnoses that included traumatic brain injury (TBI) related to a fall, history of falls, post-traumatic stress disorder (PTSD), and attention-deficit hyperatcitity disorder. R74's care plan, dated 9/21/20, included interventions for altered thought processes related to cognitive impairment and TBI, and alteration in mood/behavior related to anxiolytic use and PTSD. During an observation and interview on 10/5/20, at 7:34 p.m., nursing assistant (NA)-A was observed to knock on R74's door and enter R74's room without waiting for R74 to respond to the knock; NA-A also did not announce himself. After NA-A left the room, R74 said "this happens all the	F 550	F550 It is the Policy for Catholic Eldercare to follow state and federal regulations for Resident Rights. R74 was interviewed and states satisfaction with how staff are currently entering her room at this time. All residents will be interviewed to identify if others are affected. Staff will be re-trained in the requirement to knock and wait for the resident to respond before entering. Department Managers will conduct Random audits across all shifts of staff entering rooms will be done daily for one week, weekly for one month and quarterly thereafter. Results will be reviewed and monitored by the nurse managers and forward information to the QAPI committee for further review and recommendations	

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F 550	Continued From page 3 time. They just fling the door open without knocking." R74 also stated NA-A would knock, but he would never wait for a response or announce himself before entering. R74 said she had to be patient with NA-A. During an observation and interview on 10/5/20, at 7:43 p.m., NA-D entered R74's room without knocking or announcing his entry into the room. NA-D had a new drink container in one hand, removed the old drink container from the bedside table, placed the new drink container on the bedside table, and left the room. NA-D did not acknowledge or speak to R74. After NA-D left the room, R74 stated, "he doesn't knock." R74 stated people just come in whenever they want. R74 said she has complained to the nurse manger but nothing changed. During an interview on 10/7/20, at 12:22 p.m., NA-G stated they were educated to "knock and wait" and then let the resident know why they were entering the room, "like I'm here to help." During an interview on 10/7/20, at 10:00 a.m. licensed practical nurse (LPN)-A stated staff should knock on the door and wait for an answer before entering the room. He stated this should happen every time a staff entered a resident's room. During an interview on 10/7/20, at 12:22 p.m., trained medication aide (TMA)-A stated staff were supposed to knock on resident's doors and wait for an answer before entering the room. TMA-A stated if there was no answer, staff could enter the room and announce themselves as they entered.	F 550		

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F 550	Continued From page 4 During an interview on 10/8/20, at 1:15 p.m., registered nurse (RN)-A verified the expectation was staff knock on the resident's door and wait for a response before entering. RN-A stated this should happen every time a staff entered a resident's room. During an interview on 10/8/20, at 2:00 p.m., RN-A verified staff should knock on the door and announce themselves when entering a resident's 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.	F 550		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available	F 585		11/24/20

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to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to

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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, 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 residents' 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 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.	F 585	F585 It is the policy of Catholic Eldercare to follow state and federal regulations for Grievances.	

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F 585	Continued From page 7 Findings include: R74's admission minimum data set (MDS), dated 8/11/2020, indicated R74 had a brief interview for mental status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS also indicated diagnoses that included traumatic brain injury (TBI) related to a fall, history of falls, post-traumatic stress disorder (PTSD), and attention-deficit hyperatcitity disorder. R74's care plan, dated 9/21/20, included interventions for altered thought processes related to cognitive impairment and TBI, and alteration in mood/behavior related to anxiolytic use and PTSD. During an interview and observation on 10/06/20, at 3:18 p.m., R74 stated she had a rough night because another resident kept coming into her room and "sat on the floor wailing." R74 said she had told the nurse manager but nothing had changed. At 3:22 p.m., R55 opened R74's door and entered into R74's room while moaning and crying. R74 said this was a different person than who entered her room the previous night. R74 stated "others coming into my room happened all the time." During an interview on 10/8/20, at 2:00 p.m., RN-A verified R74 had complained about a lot of residents wandering into her room. She stated these complaints were handled with nursing interventions as a point of care concern. RN-A stated there wasn't really anything that could be done as this was the nature of residents on third floor, stating, "these residents wander." RN-A was unsure at what point R74's concerns would be a grievance and stated social work wrote up	F 585	R74 was interviewed. A grievance was completed, she requested a room change which has taken place and states satisfaction with resolution of grievance. The facility currently does not have outstanding grievances. All residents will be interviewed to identify others that may be affected. The grievance policy will be reviewed and updated as needed. Managers will be educated on the policies and procedures and their responsibilities in responding to grievances. Front line staff will be re-trained on how to report a grievance. Nursing management and Social Service will do random audits of residents to see if they are satisfied with the follow-up to their concerns daily for one week, weekly for one month and then quarterly thereafter. Results will be reviewed and monitored by dept managers and will forward information to the QAPI committee for further review and recommendations	

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grievances, "nursing did not do that."

During an interview on 10/8/20, at 2:15 p.m., the director of social services (SW)-A and the director of nursing (DON) both agreed point of care resolutions were first attempted when residents voiced complaints or concerns. SW-A stated if the issue recurred, it was readdressed and the facility changed it to a grievance "if appropriate." SW-A stated what was appropriate depended on the severity of the issue, frequency, impact, etc. For wandering residents, SW-A stated the interdisciplinary team (IDT) met daily and discussed wandering residents to brainstorm solutions. SW-A stated some interventions used were stop signs on resident doors and redirecting residents who wandered into other residents' rooms. SW-A stated they had "no grievances from the third floor for a very long time." The DON verified staff were expected to help residents write grievances.

Although they were aware of R74's ongoing grievances of residents coming into their room, the facility had not re-addressed this issue with R74 to alleviate ongoing grievances.

The facility's Suggestion, Concern and Grievance policy, dated 9/30/20, indicated the facility "would make every effort to address and resolved suggestions, complaints and grievances properly." The policy further indicated, suggestions, concerns or grievances could be made verbally or in writing to "the person who has supervisory responsibility for the area of concern." The policy indicated the facility would take "immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated."

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow care plan interventions to reduce the risk of pressure related injuries, and failed to identify and assess a new pressure ulcer for 1 of 3 residents (R64) reviewed for pressure ulcers. The failure of the facility to accurately complete weekly skin audits resulted in an unstageable pressure ulcer to R64's left heel. Findings include: R64's face sheet, printed 10/8/20, indicated R64 had diagnoses which included juvenile rheumatoid arthritis, Alzheimer's disease, cerebral infarction, and generalized muscle weakness. R64's admission Minimum Data Set (MDS) dated 8/5/20, indicated R64 had a moderate cognitive impairment and required extensive assistance for	F 686	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 R64 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 skin audit tool that is completed on bath day as a wound identification.Random weekly audits on the completion of weekly skin audit tool will be conducted on all four	11/24/20

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F 686	Continued From page 10 bed mobility and transfers. The MDS further indicated R64 was at risk for pressure ulcers and had no skin issues at the time of the admission assessment. R64's Care Area Assessment (CAA), dated 8/5/20, indicated the pressure ulcers CAA triggered due to bed mobility and R64 was at risk of developing pressure ulcers/injuries. A Braden score dated 8/6/20, indicated R64 was at high risk due to factors that included extensive assistance with bed mobility and frequent incontinence of bowel and bladder. The CAA indicated R64 did not currently have pressure ulcers, required extensive assistance of one for transfers, required bed positioning to keep bony prominences from direct contact and to elevate heels off the bed when R64 was in bed. The CAA indicated R64 was to receive a daily full body inspection by a nursing assistant (NA) and a weekly full body inspection by a nurse on her shower day. The CAA also indicated R64 was to be turned and repositioned every two hours and staff were to encourage R64 to position independently every 15-30 minutes if able. Finally, the CAA indicated R64 required frequent checks for safety and positioning. R64's care plan dated 9/11/20, indicated R64 was at risk for skin breakdown related to limited mobility (chairfast/bedfast) and listed R64's goal was to be free from pressure related injuries. The care planned approaches were to position R64 to keep bony prominences from direct contact with one another; to use pillows, foam wedges, etc. to elevate heels off bed; to use bed positioning devices including positioning pillows/rolls and a lift sheet. R64's care plan further directed nursing to perform a weekly full body audit with shower,	F 686	units by nursing management team until compliance is observed. Results will be forwarded to QAPI committee for further review and recommendations.	

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complete body audit observations, and initiate a temporary care plan (TCP) for any new skin issues. R64's care plan further directed nursing assistants to complete a daily skin check when performing a.m./p.m. cares and directed staff to report any signs of skin breakdown (sore, tender, red, or broken areas).

The memory care unit group sheet, undated, lacked any information directing the nursing assistants to use pillows or positioining devices for R64.

R64's admission progress notes (PN) indicated a skin observation occurred on 7/29/20, and was completed and signed by registered nurse (RN)-A on 8/26/20. The admission observation indicated R64 slept for 8 hours a day and took an afternoon nap. The PN indicated weakness in all extremities, and swelling and inflammation in both lower extremities and ankles; there were no additional skin abnormalities or concerns noted.

R64's weekly Body Audit and Foot Exam observation dated 9/10/20 indicated R64's skin was "intact" with no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week.

R64's weekly Body Audit and Foot Exam observation dated 9/17/20 indicated R64's skin was "intact" with no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week.

R64's Weekly Body Audit and Foot Exam 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

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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.

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 R64 with personal hygiene and 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 the call light to R64's sheet. At 5:52 p.m. NA-B removed gloves, turned off the bathroom light,

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F 686	Continued From page 13 and exited the room. There were no pillows readily available and no pillows or other positioning devices placed under R64's feet to elevate her heels off of the bed and protect bony prominences in accordance with R64's care plan. At 5:35p.m. NA-B verbalized R64 likes to lay down and stated "we don't want her in bed for a long time so we like to get her out." NA-B did not say anything about the need for pillows or positioning devices for R64. When interviewed on 10/5/20, at 7:30 p.m. NA-D stated R64 liked to go to bed early and typically asked to go to bed for the night around 6:00 p.m. When interviewed on 10/5/20, at 7:39 p.m. LPN-B stated R64 spent a lot of time in bed and always wanted to lay down. LPN-B stated most of the time day shift staff would lay her down for a nap and the evening shift staff would get her up close to dinner time. LPN-B also stated once R64 was assisted to bed, she would remain there until the following morning and added, "To prevent bed sores we try to keep her up for at least an hour after dinner, because she will not be up until the next morning." LPN-B stated she did not believe R64 had any current skin concerns and indicated R64 had not had any skin breakdown since admission. When interviewed on 10/5/20, at 7:45 p.m. registered nurse (RN)-B stated staff assist R64 out of bed in the morning at 8:30 a.m. and assist R64 to lay back down at 1:30 p.m. for a nap. RN-B stated when afternoon staff come they get R64 up for dinner. Finally, RN-B stated R64 always wanted "to go back to bed right away." On 10/6/20, at 3:24 p.m. R64 was lying in bed.	F 686		

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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."

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 she uses behind the head, 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, "I do not see any pillows around [R64] for 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,

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"I don't think it is a pressure ulcer, otherwise it would be on the care plan. We do assessments of the feet every bath day." LPN-G confirmed that R64's care plan directed use of pillows to prevent pressure ulcers and stated, "Pillows? At night, yes. I don't work nights but she usually has a pillow under her heels and on the sides of her hands if she is laying on her back. I don't know why it wouldn't have been done today but yesterday I did see in the morning a pillow under her feet."

When interviewed on 10/7/20, at 12:58 p.m. R64 stated that staff put pillows around her "sometimes." R64 further stated she felt staff put pillows around her "Maybe every couple days."

When interviewed on 10/8/20, at 9:49 a.m. RN-A verbalized she was not aware R64's care plan directed for the use of pillows for prevention of pressure injuries and stated, "There is nothing specific in the care plan if there are any pillows." RN-A verbalized that if pillows were needed to prevent pressure injuries to R64's heels, "that would involve having some sort of pillows under her calves." RN-A again indicated she was not aware whether or not this was being done for R64 and stated, "I would have to dig into that and see if this is being done." RN-A reviewed R64's care plan and noted the direction to elevate R64's heels off of the bed, and then stated her expectation would be to find R64 in bed with her heels elevated. RA-A further stated there was no process in place to record whether the pillows were being placed because it was a standard of care, and it is not something they initial off on the electronic medication administration record (EMAR); there was no way to confirm if it was being done. RA-A stated she would assess R64's

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F 686	Continued From page 16 feet and stated the facility also had a wound nurse (RN-D) that could look at R74's heel today and determine the best treatment for R64. When interviewed on 10/8/20, at 9:49 a.m. registered nurse (RN)-A indicated the process used to monitor for pressure related injuries was for the NA's to do body audits with cares and RN's to do weekly assessment when the resident had a shower or bath. RN-A reviewed R64's most recent skin assessment initiated 10/1/20, and dated 10/7/20. RN-A confirmed there was "nothing noted about heels" on this assessment and stated she was previously unaware of any issues with R64's heels. RN-A verbalized the reporting process for any concerns or changes to resident's skin was for staff to report any skin issues and start a temporary care plan. RN-A further stated she didn't know how or why this could have been missed. RN-A verified the most recent skin assessment for R64 was created on 10/1/20, and finished on 10/7/20. RN-A verified that the previous three skin assessments from Sepember were also finished on 10/7/20. RN-A stated her expectation was to close a skin asssessment with the week of the observation, before the next bath assessment, "not any longer than that". On 10/08/20, at 12:22 p.m. RN-A and RN-D were interviewed and RN-D stated she had assessed R64's heel and informed the injury was on the left heel and measured 1.3 cm in diameter. RN-D stated the wound was "100% eschar, I would think it is likely a pressure area." RN-D verbalized she believed staff were putting a pillow under R64's calves to keep her feet up off the bed and stated she knew these interventions were in R64's plan of care. RN-D described the pressure	F 686		

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F 686	Continued From page 17 injury as unstageable and indicated staff would monitor the area going forward. RN-D indicated she thought the injury was probably from being in bed. RN-D was unsure how long the pressure injury may have been on R64's feet and stated, "It is hard to say, with how compromised she is; it has significant peeling on the edges." RN-D verified the pressure injury could have negative effects on R64 and stated, "If it opened up it could become infected." RN-A stated the day shift should have noticed the pressure injury and further indicated she felt there was a "90% chance that it is from bed, because she is so compromised. My plan will be to put interventions in place for bed." When interviewed on 10/8/20, at 12:22 p.m. RN-A and RN-D described the reporting process for any concerns or changes to resident's skin as weekly skin checks, and if a wound was discovered it was then inspected daily. RN-D further stated, "The NAR's do the cares daily on the people so I would expect that it would have been seen. Staff were not aware of this issue until today." RN-A indicated a comprehensive skin assessment was completed by a charge nurse upon a resident's admission and included a head to toe screening, noting the temperature and color of the skin, completing the Braden scale, and completing a weekly body audit assessment. RN-A explained the process when a pressure ulcer was found by staff should be: --the RN who finds area tells the floor manager who then would call RN-D (the wound nurse); --Together they would assess and try to determine cause; --each Friday it would be discussed in the IDT team; --a short term care plan would be initiated;	F 686		

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--RN-A would do weekly rounds to make sure the injury was improving and update the care plan;
--daily inspections by a RN would be initiated, and pressure area observation with measurements once weekly,
--the nurse practitioner would assess the injury.
RN-A stated this process was not initiated for R64 until this morning when she became aware of the pressure injury. RN-A stated R64 had no history of pressure injuries while in the facility.

During an interview on 10/8/20, at 12:47 p.m. with LPN-A and RN-A, LPN-A verified that staff complete weekly skin checks and stated, "Yes we do a weekly skin check, especially with R64. She should have a bed bath, the aide usually goes in the morning and does the whole thing and she will call me to do a head to toe skin assessment."LPN-A stated he may have been distracted and forgotten to close the assessments in a timely manner. LPN-A verbalized that he had been completing the weekly skin inspections for R64 and stated, "I look at R64's skin all the time on her shower days and bath days." LPN-A stated he did not see the pressure ulcer on R64's heel during previous skin inspections and stated, "you know I did one today, and seriously I didn't see it, she didn't have it last week, I did not see it."

When interviewed on 10/8/20, at 1:08 p.m. the director of nursing (DON) verified that R64 had "pretty serious arterial issues". The DON indicated she had reviewed the skin assessment from R64's most recent bath day and there was "nothing reflected on there" regarding pressure injuries. The DON indicated she and RN-A talked about starting basic nursing interventions such as raising R64's heels off of the bed, and stated, "We teach that is a basic intervention--you want

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to position people to release pressure." The DON stated R64's care planned interventions for preventing pressure injuries should have been followed and stated her expectation was that staff follow a care plan; if that was determined to be necessary, the expectation would be that staff would follow the care plan. The DON stated the skin checks were on bath days for the sole purpose of being able to take a look at someone's whole body so that staff could intervene as soon as possible. The DON confirmed that R64's pressure ulcer was not noticed by staff during weekly skin assessments and stated, "It sure sounds to me that it should have been noticed, the purpose of doing a regular skin assessment is to notice if there is a problem. We teach from the very beginning that anything you notice out of the ordinary to report it."

The facility policy Pressure Ulcer Assessment and Prevention, revised 1/15/16, indicated all residents would be assessed for risk of developing pressure ulcers. Information obtained in the risk assessment would be used for developing a preventative plan of care, appropriate care and interventions. The policy further indicated, residents at moderate and high risk for pressure ulcers are to have a care plan for prevention of skin integrity concerns initiated. Interventions should be made considering all risk factors. Basic prevention interventions include:

a) Daily monitoring of the skin by NARs
b) Weekly skin inspection by a licensed nurse
c) Appropriate seating and sleeping surfaces
d) Assessment of proper footwear
e) Keeping skin clean and dry
f) Individualized repositioning and offloading plan
g) The RAI process will also be used to identify

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F 686	Continued From page 20 possible risk factors.	F 686		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement interventions to reduce pain for 1 of 4 residents (R74) who voiced concerns about pain management. Findings include: R74's admission Minimum Data Set (MDS), dated 8/11/20, lacked any pain relevant diagnoses. R74's Admission Observation form, dated 8/10/20, indicated R74 did not have pain. R74's Pain Assessment Interview form, dated 8/14/20, indicated R74 did not have pain. R74's Pain Assessment Interview form, dated 8/20/20, indicated R74 did not have any pain. There were no further pain assessments in R74's medical record. There was no pain care area assessment (CAA). R74's care plan, dated 9/21/20, indicated R74	F 697	F697 It is the policy of Catholic Eldercare to follow state and federal regulations on pain management. The care plan and pain assessment of R74 will be updated as necessary. R74 states pain currently managed well. Care plan and pain assessment of all residents will be reviewed to identify others that may be affected. Policy and procedures on pain management and assessment will be reviewed and updated as needed. Nursing staff will be educated on pain policies and procedures. Random audits of pain management plans will be done by Nursing Management on all units and shifts weekly until compliance is determined. Results will be reviewed and monitored by nurse managers and information forwarded to the QAPI committee for further review and recommendations.	11/24/20

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F 697	Continued From page 21 had pain related to fractured ribs on her right side. The care plan included interventions of: 1) administer scheduled analgesic per MD order; 2) encourage resident to report pain at onset; 3) monitor effectiveness of pain interventions; 4) observe for non-verbal signs of pain; 5) ask how her pain is every shift when awake. Rate pain before and after receiving PRN; and 6) Flowsheet: treatments every shift: nights, days, evenings. R74's treatment flowsheet did not include any pain ratings or assessments. R74's progress notes indicated there was no monitoring for pain in the progress notes on the following dates: 8/4/20,--8/9/20; 8/13/20; 8/18/20,--8/19/20; 8/21/20,--8/24/20; 8/26/20,--8/29/20; 8/31/20,--9/1/20; 9/4/20,--9/11/20; 9/13/20; and 9/15/20,--9/17/20. R74's progress note, dated 9/18/20, at 9:51 a.m., indicated R74 was found on the floor and complained about right rib cage pain. The note further indicated R74 rated her pain three out of ten on a scale of zero to ten and she requested Tylenol for the pain. The note also indicated R74 complained of groin pain. The provider was notified and x-rays were ordered. There was no pain assessment indicating whether or not the Tylenol was effective for relieving the pain. R74's progress note, dated 9/18/20, at 2:50 p.m., indicated R74 had no hip or pelvis fracture, but had a fracture of the right posterior medial fourth, fifth and sixth ribs and possibly the seventh as a result of the fall earlier in the day. R74's progress note, dated 9/18/20, at 8:41 p.m.,	F 697		

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F 697	Continued From page 22 indicated R74 continued to have body pain but there was no rating of pain or pain assessment. R74's progress note, dated 9/20/20, at 10:06 p.m., indicated R74 still complained of body pain but there was no rating of pain or pain assessment. R74's interdisciplinary team (IDT) note, dated 9/21/20, at 11:43 a.m., indicated R74 suffered fractured ribs from her fall on 9/18/20. The note indicated recommendations for staff to continue to assess and manage pain. R74's progress note, dated 9/21/20, at 2:22 p.m., indicated R74 reported continuing rib cage pain and current medications were not effective. The note further indicated R74 was on scheduled Tylenol 650 milligrams (mg) three times a day and as needed twice a day. The note indicated the nurse practitioner was contacted, but there was no assessment or rating of pain. R47's progress note, dated 9/21/20, at 3:45 p.m., indicated R74's had new orders for acetominiophen 1000 miligrams (mg) four times a day and ibuprofen 400 mg twice a day as needed (PRN). R47's provider progress note, dated 9/23/20, indicated upon physical exam, R74 had "intermittent rib pain when moving" and described the site as "right lateral to posterior rib pain." R47's progress note, dated 9/23/29, at 12:56 p.m., indicated R74 staff would continue with careplan for comfort. R74's progress notes indicated there was no	F 697		

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monitoring for pain in the progress notes from 9/24/20, through 10/8/20.

During an observation and interview on 10/5/20, at 7:50 p.m., R74 was laying on her right side and when she turned to sit up, she moaned and grimaced, grabbing her right side. R74 stated she had pain on her right side if she took a deep breath. R74 reported she fell in the bathroom and fractured "several ribs." She stated staff gave her Tylenol but it "doesn't really help." R74 reported she was still having right sided pain, she has told the staff, and "nothing changes."

During an interview on 10/6/20, at 8:45 a.m., trained medication aide (TMA)-A verified R74 received scheduled medication, Tylenol, for pain but it was the nurse who completed any pain assessments. R74 verified she did not complete any pain rating.

During an observation and interview on 10/7/20, at 1:28 p.m., R74 grimaced when moving from bed to wheelchair, letting out a soft moan and grabbing her right lower rib cage. R74 stated she still felt pain on the right side when she moved.

During an observation and interview on 10/8/20, at 9:47 a.m., R74 moaned while rubbing her lower right rib cage. R74 stated she felt "miserable today" and was not sure how or why she had pain that day.

During an interview on 10/8/20, at 1:15 p.m., registered nurse (RN)-A confirmed that a pain assessment should have been completed after R74 fell and fractured her ribs. RN-A confirmed fall assessments were completed through the MDS assessment and none was completed after

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F 697	Continued From page 24 R74's fall. RN-A also confirmed the expectation staff would do pain ratings, especially before and after PRN medication was given. RN-A verified pain ratings were missing from the medical record. RN-A verified the care plan indicated pain ratings should have been on the treatment record but RN-A had not added to the treatment record. RN-A explained if no treatment record was initiated, then staff would not be able to record any ratings. RN-A verified pain ratings/monitoring were missing from the medical record. During an interview on 10/8/20, at 2:15 p.m., the director of nursing (DON), verified pain status should be monitored daily. The DON confirmed pain was assessed using the MDS assessment or when there was a change in condition. She explained if a resident had an injury, pain should be assessed and monitored. A pain policy was asked for but not received.	F 697		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		11/24/20

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 26 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to thoroughly conduct a comprehensive infection control program to include the Centers for Medicare and Medicaid Services (CMS) COVID-19 recommendations including proper use of personal protective equipment (PPE) by both staff and residents, performance of hand hygiene by both staff and residents, and compliance with quarantine procedures. These practices had the potential to affect 78 of 139 residents who resided at the facility. Findings include: RESIDENT USE OF MASKS, SOCIAL DISTANCING, and HAND HYGIENE During an observation on 10/05/20, at 12:09 p.m. on the third floor, three unidentified residents were seated in wheelchairs facing a television (TV) without masks and less than six feet apart in the TV viewing area. Two other unidentified residents were sitting in chairs without masks on and with bedside tables in front of them. R95 sat down in a chair less than four feet from the	F 880	F880 It is the policy of Catholic Eldercare to follow state and federal regulations on Infection Prevention and Control Memory care residents will be assessed for the ability of wearing a mask and care plans will be updated as needed. Resident hand hygiene program for memory care residents will be implemented. Plan of care for residents on quarantine will be adjusted to reflect resident care that complies with infection control guidelines. Environmental assessment of the memory care unit will be completed by an interdisciplinary team and adjustments will be made to ensure compliance with infection control practices. Policies and procedures regarding infection control, including hand hygiene, PPE, Isolation practices, and screening of those entering the building will be reviewed and adjusted as needed. Staff will educated on these policies and procedures. Hand hygiene competency will be completed on all staff. be re-	

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F 880	Continued From page 27 residents in chairs. Nursing assistant (NA)-A placed a bedside table in front of R95. Unidentified nursing staff were in visual distance of the residents but did not assist with masking or social distancing. During an observation on 10/5/20, at 1:18 p.m. in the third floor dining area, R59 and R95, neither were wearing a mask, sat approximately one foot apart at a square table in the dining room, leaned close and talked to one another, played with baby dolls, and drank juice. Unidentified staff were in visual distance but did not assist with social distancing. During an observation on 10/5/20, at 1:35 p.m. in third floor dining area, R317 drank juice from a juice glass and placd the glass on the table in front of her. R385 then picked up R317's glass and drank some of the juice. Unidentified staff were in visual distance but did not attempt to intervene before R385 drank the juice. During an observation on 10/5/20, at 4:15 p.m. the third floor dining area, R385, R119, and R95 were not wearing masks and sat about two feet apart in chairs while they talked. Unidentified staff were in visual distance but did not attempt to assist residents with masking or social distancing. During continuous observation on 10/5/20, from 4:42 p.m. to 4:45 p.m. on third floor, a cart of clean clothing protectors was uncovered in the resident dining area. R55 came out of her room without wearing a mask and touched the cart and clothing protectors. An unidentified staff did not remove the clothing protectors, just covered the cart and redirected R55 back to her room. The staff did not assist R55 to put on a mask.	F 880	Assessment of the active screening process will be completed by the infection preventionist and revisions will be made as needed. Random audits will be done by multiple Dept Mangers across various days and shifts to ensure compliance with infection control practices specifically staff and resident hand hygiene, staff and resident PPE use, screening, and isolation practices weekly until compliance is determined. Results will be reviewed and monitored by the managers and forward information to the QAPI committee for further review and recommendations.	

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F 880	Continued From page 28 During an observation on 10/5/20, at 6:40 p.m. on third floor, R95 stood within two feet of R58 and showed her a baby doll; neither resident wore a mask. Unidentified staff were in visual distance but did not attempt to assist with masking or social distancing. 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. During an observation on 10/6/20, at 9:01 a.m. in the third floor dining area, R95 and R107 sat at the same table less than six feet apart and neither wore a mask. RN-A served R95 coffee. RN-A did not attempt to assist the residents with social distancing. During an observation on 10/6/20, at 3:01 p.m. in the third floor dining area, R385 and R44 stood about one foot apart, held hands, and spoke closely to one another's face; neither resident wore a mask. Nursing staff were in visual distance but did not attempt to assist with masking or social distancing. During an observation on 10/6/20, at 3:04 p.m. on the third floor, R385 stood within one foot of R55 and touched R55's face, hair, and shoulders; neither resident wore a mask. Nursing staff were in visual distance but did not attempt to assist with masking or social distancing. During an observation on 10/6/20, at 3:20 p.m. on	F 880		

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the third floor, R55 started to leave her room and donned a mask when asked, stating staff didn't usually ask her to wear one. She stated she had to wear one to go down to therapy, located on the second floor.

During an observation on10/6/20, at 3:44 p.m. on third floor, R385 approached R95, stood within 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.

During continuous observation on 10/7/20, between 8:01 a.m. and 8:05 a.m. on the third floor, staff served R95 breakfast in the common area. R95 got up and walked away without eating any of the food and was not wearing a mask. R95 entered R434's quarantine room through the open door and touched the privacy curtain. R95 then exited R434's room, and stood in the doorway of R6's room, and talked to R6. R95 then entered the dining area and sat next to R59 at the same table, less than two feet apart; neither resident wore a mask. Licensed practical nurse (LPN)-A said "Hi" to R95 but did not attempt to have the residents socially distance.

During an observation on 10/7/20, at 8:20 a.m. on the third floor, R95 moved from a dining table and opened cupboards in the kitchenette. LPN-A approached R95 and asked R95 "do you want sugar?" LPN-A gave R95 a sugar packet. R95 poured herself coffee from the coffee dispenser, took a used meal tray off of another table, and ate the donuts that were left on the meal tray of another resident. LPN-A did not attempt to assist R95 with social distancing, hand hygiene, or prevent R95 from eating food off another

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F 880	Continued From page 30 resident's meal tray. During continuous observation on 10/8/20, from 8:45 a.m. and 9:00 a.m. on the third floor, R130, R434, and R95 were seated in the hallway across from the nursing station without masks and less than six feet apart. NA-C brought toast and rolls to the residents; no hand hygiene was offered or performed prior to food being given to the residents. No spray bottles or hand wipes were visualized in the area. NA-C did not attempt to socially distance the residents. Trained medication aide (TMA)-A placed R95 in a chair within two feet of R64 who was seated in a wheelchair. R95 leaned over and touched R64's feet. The TMA and other nurisng staff were in visual distance but did not attempt to socially distance the residents. During continuous observation on 10/8/20, from 1:05 p.m. to 1:15 p.m. on the third floor, NA-C gave snacks to R55, R83, R95, R130, and other residents. No hand hygiene was performed before NA-C distributed snacks to the residents. No hand hygiene of residents before or after meals was observed during the evening of 10/5/20, or during the daytime meals on 10/6/20, 10/7/20, and 10/8/20. No hand hygiene spray was observed in the dining area or the TV room where meals were also served. During an interview on 10/8/20, at 9:42 a.m., LPN-A verified the expectation was staff perform hand hygiene with residents before and after meals and after bowel/bladder care. LPN-A stated they used a spray and it was "somewhere." No spray was visualized at the nursing station, on any medication cart, in the dining area, or in the	F 880		

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TV area. LPN-A verified he did not see the spray.

STAFF USE OF MASKS AND EYE PROTECTION

On 10/5/20, R103's family member (FM)-A reported she had observed facility staff without masks and not socially distancing during lunch or cigarette breaks.

During an observation on 10/5/20, at 12:32 p.m. on the third floor, LPN-C's mask was under his nose and stayed under his nose as he walked from the dining area where three residents were, without masks, and into the TV area where six residents without masks were sitting less than six feet from each other. LPN-C did not attempt to distance residents or ask them to wear a mask.

During an observation on 10/5/20, at 4:44 p.m. on third floor, LPN-B wore goggles on top of her forehead, with her eyes uncovered and exposed. At 4:53 p.m. LPN-B's goggles were observed again on her forehead and a face shield was now positioned high on LPN-B's forehead and tilted upward, covering only the top half of LPN-B's face.

During continuous observation on 10/5/20, from 5:10 p.m. through 5:20 p.m. on the third floor, LPN-B was observed with her mask below her nose and face shield raised above her forehead to where it was barely reaching her nose, while sitting at the nursing station. LPN-B walked from the nursing station into the hallway, walked past R6's room, poked her head into R434's quarantine room, pulled her mask up over her nose as she was leaving R434's room, and then walked toward R23's room. LPN-B walked back

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into the nursing station with her mask under her nose. An unidentified resident walked up to her and asked LPN-B a question. LPN-B talked to the resident with her mask below her nose. At this time, RN-B was observed to have his mask under his chin, sitting next to LPN-B at the nursing station. LPN-B then left the nursing station with her mask still under her nose and face shield still barely reaching her nose, and walked within three feet of unmasked residents: R96 and two other unidentified residents. R95 asked LPN-B a question and she leaned into him to shout in his ear, "what do you want?"

During four observations on 10/5/20, RN-B was observed sitting at the third floor nursing station with his mask under his chin at: 5:10 p.m., 5:14 p.m., 5:30 p.m., and 5:59 p.m.

During an observation on 10/5/20, at 7:59 p.m. on the third floor, NA-D was observed sitting in the dining area with his mask off.

During an observation on 10/6/20, at 11:55 a.m. on the first floor, the dietary director (DD-A) was sitting in an office without mask or eye protection. The office opened directly into hallway while an unidentified resident in a wheelchair without a mask was in the hallway.

During continuous observation on 10/6/20, from 2:31 p.m. and 2:40 p.m. on the third floor, staff were in line for COVID testing. NA-A, NA-D, and NA-E were standing approximately three feet apart. NA-A wore a mask and no eye protection. NA-D's mask was under his chin. NA-E's mask was under his nose. At 2:38 p.m., an unidentified staff pushed a wheelchair with R49 in it within three feet of NA-A.

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During an observation on 10/7/20, at 7:27 a.m. on the first floor, two unidentified staff were in the staffing office, sitting less than six feet apart from each other. One staff wore eye protection and mask. The second staff did not have mask or eye protection. The staffing office was just off the first floor hallway.

During an observation on 10/7/20, 7:59 a.m. on the second floor, housekeeper (HK)-B wore a surgical mask and gloves but her goggles were on the top of her head while standing in front of R99's room.

During an observation on 10/7/20, at 10:01 a.m. on the first floor, LPN-E lifted her face shield to the top of her head, exposing her eyes, when talking to an unidentified staff while standing less than three feet from the other staff in front of R75's room.

During an observation on 10/7/20, at 10:24 a.m. on the third floor, NA- F was observed without a mask or face shield while seated in the nursing station. NA-F stated he was not interacting with residents but he would wear them when he was around residents.

During an observation on 10/7/20, at 2:14 p.m., an unidentified staff was outside the nurse manager's office with his mask on but face shield off, working on a computer in the hallway.

During an observationa 10/7/20, at 2:15 p.m., LPN-A was sitting at the nursing station with his mask under his chin and face shield off. LPN-A left the nursing station without his face shield and walked near numerous residents in the hallway.

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During an observation on 10/8/20, at 9:49 a.m. on the third floor, radiology technologist (RadT)-C was standing at the nursing station with her goggles on the top of her head and wearing an N95 mask with exhalation valve. RadT-C was standing within three feet of R64. RadT-C stated she only wore eye protection when around a resident. When pointed out she was within three feet of R64, she put her goggles over her eyes. LPN-A and TMA-A were at the nursing station and did not interact with RadT-C.

During an observation on 10/8/20, at 12:11 p.m. on the first floor, there was one staff in the staffing office without a mask or eye protection.

During an observation on 10/8/20, at 01:08 p.m. on third floor, RN-A was wearing mask under her chin and googles on her head while in her office.

During an observation on 10/8/20, mid-afternoon, three unidentified staff were seated at first floor dining tables and talking without masks or eye protection; staff were not eating at the time.

During an interview on 10/5/20, at 11:54 a.m., receptionist (R)-D stated the expectation was every staff in the building wore masks when in the building and eye protection when in resident care areas or when interacting with residents.

STAFF HAND HYGIENE

During continuous observation on 10/5/20, from 5:30 p.m. through 6:00 p.m. on third floor, NA-B brought a basin of water from the bathroom and wiped the underarms of R64 with a wash cloth, NA-B removed dirty gloves and donned new

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F 880	Continued From page 35 gloves, with no hand hygiene between glove changes. NA-B undressed R64, removed her soiled brief, and used a wash cloth to clean R64's peri-area. NA-B removed one soiled glove and then retrieved a box of gloves, which she placed on the bedside table. NA-B donned the one new glove with no hand hygiene between glove changes. NA-B placed a clean brief on R64, then pulled R64's nightgown down, and placed the sheet and blanket over R64. NA-B adjusted R64's head of bed, adjusted the foot of the bed, turned on the TV, rotated the TV screen, and then turned up the volume of the TV. NA-B attached the call light to R64's sheet, gathered the soiled linens in one bag, gathered trash in another bag, placed a new trash bag in the trash can, dumped a dirty basin of water in the bathroom sink, and placed the basin back in the closet. NA-B then removed her dirty gloves, tuned off the bathroom light, and exited the room, without performing hand hygiene. NA-B then took the soiled linens to the linen room and then used hand sanitizer. During interview, NA-B stated when you are changing gloves, you only throw away the soiled glove used to wipe the peri-area, and then you get a new glove to put the clean brief on. NA-B stated, "When you take off your gloves you can sanitize between, but sometimes the sanitizer will not be close to you and you cannot go far from the bed when the resident is on their side." NA-B further stated, "Yes, you are supposed to wash your hands before you leave the room but I was taking out the trash." NA-B verbalized she received monthly training on hand hygiene via Relias computer trainings, as well as frequent audits and education from nursing staff. During continuous observation on 10/6/20, from 8:33 a.m. through 8:41 a.m. on third floor, NA-C	F 880		

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escorted R118 from the dining area to her bathroom. NA-C donned gloves and transferred R118 to the toilet. After R118 indicated she was finished, NA-C wiped R118's peri-area with wipes, removed her dirty gloves, and donned clean gloves, with no hand hygiene between glove changes. NA-C pulled up R118's brief and pants, assisted R118 to wash hands, and then NA-C washed her hands. NA-C verbalized the priority was for staff to have a clean glove and stated, "if we leave her standing there and then wash your hands before putting on a clean glove they might fall, if you have to wash your hands and get clean gloves we might have a lot of them falling." NA-C further stated, "You should wash your hands before applying clean gloves, before and after care you need to wash your hands, but for her she really had to go and my hands were clean so I just applied the gloves."

During an observation on 10/7/20, at 7:56 a.m. on third floor, LPN-A was standing within three feet of R434, leaning close to her face with his hand on her shoulder. R434, who was supposed to be in quarantine, was within six feet distance of R6 and R59 in the dining area. None of the residents wore masks. LPN-A walked from R434 to R6, put his hand on her shoulder, and leaned within one foot of her face. LPN-A then walked back to R434 and placed his hand on her shoulder. LPN-A did not perform hand hygiene between touching residents. LPN-A went back to R6 and leaned in closely, placing his hands on R6's table, then picking up empty plate from R6's table and placing it on R434's table and leaving it on the table.

During an interview on 10/8/20, at 9:58 a.m., RN-A verbalized her expectation was for hand

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

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hygiene to be performed between glove changes and stated, staff should perform "hand hygiene before and after the gloves are donned and doffed and between resident care if the gloves were to become soiled." RA-A further stated both gloves should be removed after peri-care.

ISOLATION/QUARANTNE

During continuous observation on 10/5/20, from 1:00 p.m. through 1:15 p.m. on the third floor, NA-A entered R434's room, which had a sign next to the door that indicated R434 was on quarantine. The sign indicated the door to the room should always be closed and anyone entering should be wearing gown, gloves, masks, and eye protection. When exiting the room, NA-A was asked about the quarantine and he stated he did not see the sign. NA-A said he always looked for the isolation cart and pointed to a cart that was 20 yards away from the door. NA-A then placed the cart next to the entry into R434's room and verified there were no gowns or gloves in the cart. NA-A stated there were gowns and gloves in the storage closet. NA-A left the area and left R434's door open.

During continuous observation on 10/5/20, from 4:42 p.m. through 4:50 p.m. on third floor, NA-B obtained gowns and gloves out of storage closet and placed in the isolation cart outside of R434's room. NA-B did not perform hand hygiene prior to donning gown and gloves. NA-B exited leaving the door to R434's room open. NA-B stated the door to R434's room should be closed because she was in quarantine and then shut the door.

During continuous observation and interview on 10/5/20, from 5:20 p.m. through 5:25 p.m. on the

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F 880	Continued From page 38 third floor, NA-B exited R434's quarantine room with a food tray and placed the food tray on the isolation cart. NA-B then doffed gown and gloves and placed in the trash can which was located in the bathroom in R434's room. NA-B performed hand hygiene and then donned gloves. NA-B carried the tray from the isolation cart to the dining area where she placed the dirty food tray on top of the counter in the kitchenette area. NA-B removed gloves and performed hand hygiene but did not disinfect the top of the isolation cart after the dirty food tray was placed on it. During an observation on 10/6/20, around 10:00 a.m. on the third floor, an unidentified occupational therapist (OT)-A entered R434's quarantine room without gown or gloves, and brought R434 out into the TV area in a wheelchair. R434 was not wearing a mask. During an observation on 10/7/20, at 7:31 a.m. on the third floor, R434, who was in quarantine, was sitting within four feet of R95 and R96 in the TV area. None of the residents were wearing masks. Staff were present but did not attempt to assist residents with masks, social distancing, or assist R434 back to her quarantine room. During an observation on 10/7/20, at 7:44 a.m. on third floor, an unidentified occupational therapist (OT)-B walked to R434, who was seated in the TV area and was supposed to be in quarantine. OT-B leaned into R434 and told her he was taking her to the dining area. OT-B did not ask R434 to wear a mask. During continuous observation on 10/7/20, from 12:23 p.m. through 12:30 p.m., the door to	F 880		

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R434's quarantine room was open. R46, who was in a wheelchair and not wearing a mask, wheeled herself into R434's room. R434 was in her wheelchair in the room at the time. After several minutes, R46 wheeled herself out of R434's room.

During an interview on 10/7/20, at 10:20 a.m., LPN-A verified R434 was supposed to be in quarantine because she was newly admitted. He stated staff should try to keep R434 in the room, but if R434 came out, it was hard. LPN-A agreed staff should not be going into the room and bringing the resident out. LPN-A stated a resident who was in quarantine should be wearing a mask and staff should remind the resident to wear a mask. He verified they should remind residents multiple times.

SCREENING - ENTRY POINTS

During continuous observation on 10/7/20, from 7:01 a.m. through 7:10 a.m., there were two screening desks by the front entry; the primary screening desk was unstaffed and the secondary screening table, to the right of the primary screening desk, was staffed by NA-J. While other staff and visitors entered through the front entry, four other staff entered the screening area from the hallway and had to walk through the facility to get to the screening desk: US-H, LPN-D, NA-A, and one staff with an unreadable signature. NA-J verified she could not read the signature and did not see which staff signed the book. All who entered took their temperature using a stand-up automatic temperature taking machine, marked their temperature in the sign-in book, and answered screening questions in the sign-in book.

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During an interview on 10/8/20, at 10:19 a.m., with infection prevention specialist (IP)-A and IP-B, several topics were discussed:
*Resident use of masks, social distancing, and hand hygiene - IP-A stated the expectation for residents was they wear masks when in common areas or when staff entered their room. IP-A stated some residents might need reminding or encouragement but they usually did cooperate. She stated the expectation was the same for all residents, including those on third floor and while "it may be difficult, the expectation is to always try to help the residents wear masks." IP-A stated residents should be provided hand hygiene before and after meals and after toileting.
*Staff use of masks and eye protection - IP-A stated the expectation for staff use of personal protective equipment (PPE) was that all staff were expected to wear masks and eye protection while in the facility, especially in resident care areas or around residents. IP-A stated if staff were alone in their office, their masks could be off. IP-A said there may be a few instances where people can't tolerate a mask, but it was a requirement and not an option. IP-A stated staff should speak up if they had an issue with a mask as they have many different types of masks to try. IP-A stated the facility used Minnesota Department of Health (MDH)'s long-term care (LTC)'s PPE grid, which was dated 5/29/20. This version of the grid did not indicate office staff had to wear masks. IP-A further stated the expectation was that if staff saw another staff wearing PPE improperly or not at all, they should speak up and correct the staff. IP-A stated nurse managers audited staff use of PPE and would be the ones to track if any particular staff needed multiple reminders on PPE use. They did not

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have the updated 6/15/20 grid.
*Staff hand hygiene - IP-A stated the expectation was staff performed hand hygiene before and after donning gloves.
*Isolation/Quarantine - IP-A stated the expectation for quarantine was to limit the resident to their room with the door closed. IP-A stated an exception would be therapy; if a resident needed to go to therapy, they would go to the therapy department at a time when no other residents were present, wore a mask, and equipment was disinfected after use by the resident. IP-A stated it was a challenge for those with dementia, but the expectation was staff would frequently try to keep the resident in their room during quarantine.
*Staff screening and entry into the facility - IP-A stated the expectation staff were screened at the front entry. She stated there was a back entry some staff might enter through and some limited staff have keys to the transitional care unit (TCU) door, but if they entered the facility through those doors, it was expected they come to the front lobby to be screened. IP-A and IP-B verified staff would have to walk through the facility before they were screened, potentially exposing residents and other staff.

During an interview on 10/8/20, at 10:19 a.m., RN-A, noted the third floor had "challenges" related to infection control because of the nature of the residents who had cognitive/memory. Several topics were discussed:
*Resident use of masks, social distancing, and hand hygiene - RN-A said all residents should be encouraged to wear a mask and she expected staff should be asking and reminding residents to wear a mask. If residents had an issue with wearing a mask, RN-A stated it should be should

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F 880	Continued From page 42 be "cared planned for" and verified it was not on the care plan. RN-A stated staff should keep trying but after a while they quit trying, stating, "we know which ones are able and which ones are not." RN-A stated residents had to wear a mask if they left the floor; if they could not wear a mask, they did not leave the floor. RN-A stated she expected staff to offer hand hygiene to residents before and after meals and after peri-care if the resident participated in peri-care. *Staff use of masks and eye protection - RN-A stated the expectation for staff was to wear masks and eye protection while in the care area. She added she might have her mask off while in her office but it was nearby, so if she needed to go to the nursing station or into the hallway, she would wear it. RN-A verified masks should cover the mouth and nose and eye protection should cover the eyes. *Staff hand hygiene - RN-A's expectation of staff around hand hygiene was staff were expected to wash their hands "frequently and always" while following the hand hygiene policy. *Isolation/Quarantine - RN-A verified when residents are first admitted to the unit they are in quarantine for fourteen days. She stated the expectation was the door to the room should be closed, but if a resident was a fall risk, it might have to be kept open; staff have to balance the risk/benefit. RN-A stated a resident in quarantine should not be in common areas but again would look at risk/benefit of being isolated if the resident was calmer in the common area. RN-A also stated a resident in quarantine should be wearing a mask if in the common area. During an interview on 10/8/20, at 2:15 p.m., with the director of nursing (DON), several topics were covered:	F 880		

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F 880	Continued From page 43 *Resident use of masks, social distancing, and hand hygiene - The DON stated the expectation was for residents to wear a mask when a staff enters the room or if they are out of their room in common areas. The DON verified the expectation was the same for the third floor, commenting if a resident could wear a mask, they should. She stated a resident might need more reminders but the expectation was staff must attempt to have residents wear masks. The DON expected staff to reattempt to get residents to wear a mask; staff "must make multiple attempts - they might not wear it now but next day they might wear it." The DON stated the expectation was staff provide hand wipes to residents before and after meals and after bathroom care; if wipes were not available, staff were to offer a washcloth with soap and water. In regards to social distancing, the DON stated residents should be encouraged to maintain a social distance of at least six feet and staff should make it harder for residents to be close. The DON also stated it was important to have only one resident to sit at a table, verifying the expectation staff should remind residents and move them apart. *Staff use of masks and eye protection - The DON stated the expectation was for everyone to wear a surgical mask and eye protection while they were in the building or on duty. If staff had issues or concerns, they were expected to discuss with leadership as they had a variety of masks and eye protection that could be used. *Staff hand hygiene - The DON verified she expected all staff to follow the facility's hand hygiene policy. *Isolation/Quarantine - When a resident was in quarantine, the DON expected residents to stay in their room with the door closed. She noted that while third floor residents might wander out of the	F 880		

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room, "it's not one and done." The DON expected staff to redirect the resident to their room each time they came out and be creative to keep the resident in the room. She stated staff could do things like give snacks or activities to keep the resident in the room. The DON stated if something wasn't working, she expected staff to have a back-up plan and to keep trying.

The facility's Hand Hygiene policy, dated 3/13/20, indicated staff should perform hand hygiene at the following times: 1) before and after resident contact; 2) before and after gloving; 3) before and after entering isolation precaution settings; 4) before and after assisting a resident with toileting; 5) after handling soiled linens; 6) between tasks or procedures done on the same resident to prevent cross contamination of different body parts; and 7) before and after handling food (hand washing with soap and water).

The facility's PPE guide is from the Minnesota Department of Health's Long-term Care Toolkit but an older version, dated 5/29/20. The older version did not indicate office staff should wear masks while in the building. The Interim Infection Prevention and Control Recommendations for Healthcare Personnel During COVID-19 Pandemic dated July 15, 2020, by the CDC, indicated health care facilities should implement universal source control measure which includes health care personal (HCP) should wear a facemask at all times while they are in the facility and HCP working in facilities located in areas with moderate to substantial community transmission should wear eye protection in addition to their facemask. The Minnesota Department of Health, PPE Grid, dated 6/15/20 indicated all staff, including office staff, should wear masks while in

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F 880	Continued From page 45 the building. According to the Centers for Medicare and Medicaid Services Coronavirus Disease 2019 (COVID-19) Long-Term Care Facility Guidance dated 4/2/20, long-term care facilities, in accordance with previous CMS guidance, should limit access points and ensure that all accessible entrances have a screening station. In accordance with previous Center for Disease Control (CDC) guidance, every person entering the facility should be actively screened. The CDC's Considerations for Memory Care Units in Long-term Care Facilities, dated May 12, 2020, recommended memory care units follow Infection Prevention and Control guidelines and in addition, including: *Reminding and assisting with frequent hand hygiene, social distancing, and use of cloth face coverings *Providing structured activities in resident rooms or at staggered times throughout the day to maintain social distancing *Limiting the number of residents in common areas to maintain spacing of at least 6 feet apart with gentle redirection of residents who get in close proximity to other residents or persons.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 921	F921	11/24/20

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F 921	Continued From page 46 review, the facility failed to ensure 7 of 11 rooms were maintained in good repair and in a sanitary manner. This had the potential to affect 7 residents (R32, R113, R49, R80, R28, R57, and R64) who resided in the rooms reviewed for environmental concerns. 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. During an interview on 10/8/20, at 11:32 a.m. nursing assistant (NA)-N stated if something needed to be cleaned, then she would notify her nurse manager or maintenance personal. During a facility tour on 10/8/20, at 12:07 p.m. the environmental director (ED) verified the stains on R32's carpet and stated that R32's carpet needed to be cleaned. The ED also stated R32's room was a room that needed to be checked everyday due to R32 spitting on the floor. On 10/5/20, at 6:31 p.m. the carpet in R113's room was observed to have stains in front of the bed. During a facility tour on 10/8/20, at 12:11 p.m. the ED verified the stains in R113's room and stated R113's carpet was old and needed to washed. On 10/5/20, at 4:11 p.m. the carpet in R49's room was observed to be stained around the bedside table. During an interview on 10/8/20, at 11:52 a.m. NA-O stated if a resident's carpet needed to be	F 921	It is the Policy of Catholic Eldercare to follow state and federal regulations on Safe/Functional/Sanitary/Comfortable Environment. The 7 rooms identified with environmental concerns, R32, R113, R49, R80, R28, R57, R64 carpets were cleaned on 11/2/20. Audit was done on all rooms in care center and rooms identified as environmental concerns carpets were also cleaned. All Rooms will be placed on regular carpet cleaning schedule, audits on carpet will be performed to ensure clean environment. Audits will be performed by Environmental Director daily for 1 week, weekly for a month, and every quarter thereafter. Audits will be monitored by the Environmental Director and results will be forwarded to QAPI committee for further recommendation and follow-up. Policy and procedure for Carpet cleaning of resident rooms was created. Light bulb in R64 s entry way was replaced on 10/8/20	

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F 921	Continued From page 47 cleaned she would let the nurse manager know the room number and then the nurse manager would let maintenance know about it. During a facility tour on 10/8/20, at 12:16 p.m. the ED verified the stains on the carpet in R49's room and stated the stains were from food. On 10/5/20, at 2:03 p.m. the carpet in R80's room was observed to have white stains in front of the bed. During a facility tour on 10/8/20, at 12:14 p.m. the ED verified the stains and stated R80's carpet stains were from food. The ED also stated R80's red stain in the carpet was from finger nail polish from a previous resident who resided in the room and the stain could not be removed. On 10/5/20, at 3:50 p.m. the carpet in R28's room was observed to have white stains in front of bed. During a facility tour on 10/8/20, at 12:15 p.m. the ED verified the stains in R28's room and stated the stains were from food. The ED then stated they had a full time carpet specialist who worked and that R28's carpet needed to be cleaned. On 10/5/20, at 1:26 p.m. the carpet in R57's room was observed to have large white and dark stains around the bed. R57 stated milk was spilled. There were also stains observed in the entry way between R57's room and the adjoining shared room. During a facility tour on 10/8/20, at 12:17 p.m. the ED verified the stains on R57's carpet and stated	F 921		

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R57's room was a room that needed to be checked daily and the carpet needed to be cleaned.

On 10/5/20, at 5:32 p.m. R64's room entry way light bulb between the bathroom door and entry door was observed to not be working.

During an interview on 10/8/20, at 12:01 p.m. NA-G stated she would put in a work order as she pointed to a clear basket hanging behind the nurse's station.

During facility tour on 10/8/20, at 12:19 p.m. the ED stated he would get the light bulb changed right then.

During an interview on 10/8/20, at 12:20 p.m. the ED stated that they had multiple carpet extractors that they used daily, and had smaller machines that work well for small areas. The ED also stated he came in every morning and checked the work orders, then went around and checked some of the rooms that were known to need extra cleaning. The ED then stated the work orders are signed off and returned to him to indicate the work order had been completed. The ED also stated housekeepers went into every room each day and could write a work request for anything that needed to be fix or cleaned. The ED further stated because of the Covid-19 and residents eating in their room's, it had increased the amount of carpet cleaning carpets and housekeeping needed to communicate to the carpet specialist for rooms that needed further cleaning than what housekeeping can do.

A policy for carpet cleaning was requested but not

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 06, 2020. At the time of this survey, Catholic Eldercare on Main was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/05/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**10/06/2020**

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Catholic Eldercare on Main is a three story building with no basement. The building was constructed at five different times. The original building was constructed in 1977 and was determined to be of Type II(222) construction. In 1983, an addition was constructed to he South side of the building that was determined to be of type II(222) construction. In 1994, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. In 1995, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. In 2015, an addition was constructed to the South side of the building and was determined to be of Type II(222) construction. Because the original building and	K 000		

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	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____________	**10/06/2020**

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

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K 000	Continued From page 2 the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 174 beds and had a census of 140 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and inspect fire doors on an annual basis on accordance with NFPA 101	K 761	K761 All fire doors will be inspected and documented and will be completed by	11/13/20

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K 761	Continued From page 3 (2012), Life Safety Code, Section 7.2.1.15.2, and NFPA 80 (2010), Standard for Fire Doors and Other Opening Protectives, Section 5.2.1. This deficient practice could affect all 140 residents. Findings included: On a facility tour between the hours of 10:00 AM and 1:00 PM on 10/06/2020, it was revealed that the facility could not provide a current annual fire door inspection. The last fire door inspection was dated June 2019. This deficient practice was verified by the Administrator at the time of discovery.	K 761	11-13-2020. All fire doors will be inspected annually by the maintenance team and the maintenance director is responsible for the correction and monitoring to prevent recurrence.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated	K 914		11/13/20

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	245439	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/06/2020**

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K 914	Continued From page 4 repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain electric receptacles in care areas per NFPA 99 (2012), Health Care Facilities Code, Sections 6.3.2.1, 6.3.4.1 and NFPA 70 (2011) National Electrical Code, Section 406.6. This deficient practice could affect all 140 residents. Findings include: On a facility tour between the hours of 10:00 AM and 1:00 PM on 01/14/2020, it was revealed that the facility could not provide a current annual electrical receptacle test for receptacles at resident bed locations. The last receptacle test was dated September 2019. This deficient practice was verified by the Administrator at the time of discovery.	K 914	K914 All resident room receptacles will be tested and completed by 11-13-2020. All resident room receptacles will be tested and documented hereafter annually by the maintenance team and the maintenance director is responsible for the correction and monitoring to prevent recurrence.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

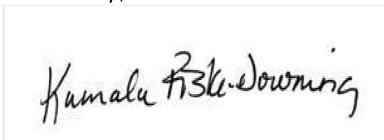
Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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,



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

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00984	A. BUILDING: ____ B. WING ____	C 10/08/2020

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On October 5, 2020, through October 8, 2020, surveyors of this Department's staff visited the above provider and the following correction orders are issued.

Additionally, complaints were investigated and the following complaints were found to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 UNSUBSTANTIATED: H5439051C, H5439052C,H5439053C, H5439054C, and H5439055C. 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. In addition, a COVID-19 Focused Infection Control survey was conducted 10/5/2020 through 10/8/2020, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to	2 000		

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2 000	Continued From page 2 you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete an accurate hearing, speech and vision assessment for 1 of 1 residents (R97) reviewed for communication concerns. Findings include:	2 545	corrected	11/24/20

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2 545	Continued From page 3 R97's admission Minimum Data Set (MDS) dated 6/16/20, indicated intact cognition, adequate ability to hear, and a hearing aide or other hearing appliance was not used. R97's significant change in status MDS due to a readmission to the facility, dated 8/21/20, indicated intact cognition, adequate ability to hear, and a hearing aid or other hearing appliance was not used. R97's face sheet indicated R97 had an audiology consultant (health professional for hearing loss) listed. R97's facility referral form dated 9/29/20, under diagnoses, did not mention hearing loss or hearing aides. R97's care plan dated 10/8/20, did not include any problems associated with communication or hearing loss. During an interview on 10/7/20, at 11:02 a.m. R97 stated. "I have these hearing aides here and one of them is not working and I would like to be able to hear better again, I am not hearing well now and I have addressed this issue with them for over two months and I haven't heard back on what is happening." R97 indicated that with one of the two hearing aides not working it made it difficult to hear and R97's hearing was better with both of the hearing aides out. During an interview on 10/7/20, at 12:26 p.m. R97's resident representative (RR)-M, indicated R97 has had hearing aides since before admission to the facilty and it had been a frustration for R97 that R97 has not been able to hear well since R97 was at the facility. RR-M	2 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00984	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 10/08/2020

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2 545	Continued From page 4	2 545		

indicated the facility was working on having R97 seen by an audiologist but RR-M had not heard back. RR-M stated that staff had not inquired with RR-E regarding if R97 used hearing aides.

Facility HealthDrive Audiology (branch of medicine dealing with hearing loss) Group request form, dated 8/26/29, indicated a request to the audiologist (hearing loss specialist) to have R97 seen by the audiologist regarding audiology testing.

During interview on 10/7/20, at 11:10 a.m. licensed practicle nurse (LPN)-F indicated knowledge R97 had hearing aides since before readmission on 8/21/20, and was aware facility had been working on obtaining an audiology visit to have R97's hearing aides repaired. LPN-F indicated an audiology request was submitted in August and when the audiologist came in September, R97 was not able to be seen due to being in COVID quarantine following a September hospital admission and R97 was on the schedule for audiology in October.

During an interview on 10/8/20, at 11:28 a.m. registered nurse (RN)-E, indicated RN-E reviewed R97's medical record for hearing loss and hearing aides and may not have interviewed R97 regarding hearing loss and hearing aides and may have relied on medical records when completing R97's MDS.

During an interview on 10/8/20, at 11:37 a.m. the director of nursing (DON) indicated if a resident was interviewable then RN-E was expected to interview the resident to get information for the MDS and that would be the case for R97.

The facility policy titled Admissions and

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2 545	Continued From page 5	2 545		

Re-Admission Policy, dated 8/25/16, indicated, "For all new admissions and re-admissions, the MDS coordinator or designee will review the data, review the MDS schedule and set up an assessment as necessary and notify staff of assignment."

The facility policy titled Care Planning, Care Conference and MDS, dated 6/29/16, indicated a comprehensive assessment was to be completed in accordance with state and federal guidelines. "Procedure: 1. See CMS (Centers for Medicare and Medicaid Services) guidelines and MDS manual."

CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual indicated in section B0300: Hearing Aid; 1. Prior to beginning the hearing assessment, ask the resident if he or she owns a hearing aid or other hearing appliance and, if so, whether it is at the nursing home. 2. If the resident cannot respond, write the question down and allow the resident to read it. 3. If the resident is still unable, check with family and care staff about hearing aid or other hearing appliances.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to development of a care plan to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are comprehensively developed.

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

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2 900	Continued From page 6	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow care plan interventions to reduce the risk of pressure related injuries, and failed to identify and assess a new pressure ulcer for 1 of 3 residents (R64) reviewed for pressure ulcers. The failure of the facility to accurately complete weekly skin audits resulted in an unstageable pressure ulcer to R64's left heel. Findings include: R64's face sheet, printed 10/8/20, indicated R64 had diagnoses which included juvenile rheumatoid arthritis, Alzheimer's disease, cerebral infarction, and generalized muscle	2 900	corrected	11/24/20

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

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2 900	Continued From page 7	2 900		

weakness.

R64's admission Minimum Data Set (MDS) dated 8/5/20, indicated R64 had a moderate cognitive impairment and required extensive assistance for bed mobility and transfers. The MDS further indicated R64 was at risk for pressure ulcers and had no skin issues at the time of the admission assessment.

R64's Care Area Assessment (CAA), dated 8/5/20, indicated the pressure ulcers CAA triggered due to bed mobility and R64 was at risk of developing pressure ulcers/injuries. A Braden score dated 8/6/20, indicated R64 was at high risk due to factors that included extensive assistance with bed mobility and frequent incontinence of bowel and bladder. The CAA indicated R64 did not currently have pressure ulcers, required extensive assistance of one for transfers, required bed positioning to keep bony prominences from direct contact and to elevate heels off the bed when R64 was in bed. The CAA indicated R64 was to receive a daily full body inspection by a nursing assistant (NA) and a weekly full body inspection by a nurse on her shower day. The CAA also indicated R64 was to be turned and repositioned every two hours and staff were to encourage R64 to position independently every 15-30 minutes if able. Finally, the CAA indicated R64 required frequent checks for safety and positioning.

R64's care plan dated 9/11/20, indicated R64 was at risk for skin breakdown related to limited mobility (chairfast/bedfast) and listed R64's goal was to be free from pressure related injuries. The care planned approaches were to position R64 to keep bony prominences from direct contact with one another; to use pillows, foam wedges, etc. to

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2 900	Continued From page 8	2 900		

elevate heels off bed; to use bed positioning devices including positioning pillows/rolls and a lift sheet. R64's care plan further directed nursing to perform a weekly full body audit with shower, complete body audit observations, and initiate a temporary care plan (TCP) for any new skin issues. R64's care plan further directed nursing assistants to complete a daily skin check when performing a.m./p.m. cares and directed staff to report any signs of skin breakdown (sore, tender, red, or broken areas).

The memory care unit group sheet, undated, lacked any information directing the nursing assistants to use pillows or positioining devices for R64.

R64's admission progress notes (PN) indicated a skin observation occurred on 7/29/20, and was completed and signed by registered nurse (RN)-A on 8/26/20. The admission observation indicated R64 slept for 8 hours a day and took an afternoon nap. The PN indicated weakness in all extremities, and swelling and inflammation in both lower extremities and ankles; there were no additional skin abnormalities or concerns noted.

R64's weekly Body Audit and Foot Exam observation dated 9/10/20 indicated R64's skin was "intact" with no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week.

R64's weekly Body Audit and Foot Exam observation dated 9/17/20 indicated R64's skin was "intact" with no foot abnormalities (blisters, callous, open areas, redness, etc.) noted and no changes in feet from the previous week.

R64's Weekly Body Audit and Foot Exam

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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.

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 R64 with personal hygiene and 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

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the call light to R64's sheet. At 5:52 p.m. NA-B removed gloves, turned off the bathroom light, and exited the room. There were no pillows readily available and no pillows or other positioning devices placed under R64's feet to elevate her heels off of the bed and protect bony prominences in accordance with R64's care plan. At 5:35p.m. NA-B verbalized R64 likes to lay down and stated "we don't want her in bed for a long time so we like to get her out." NA-B did not say anything about the need for pillows or positioning devices for R64.

When interviewed on 10/5/20, at 7:30 p.m. NA-D stated R64 liked to go to bed early and typically asked to go to bed for the night around 6:00 p.m.

When interviewed on 10/5/20, at 7:39 p.m. LPN-B stated R64 spent a lot of time in bed and always wanted to lay down. LPN-B stated most of the time day shift staff would lay her down for a nap and the evening shift staff would get her up close to dinner time. LPN-B also stated once R64 was assisted to bed, she would remain there until the following morning and added, "To prevent bed sores we try to keep her up for at least an hour after dinner, because she will not be up until the next morning." LPN-B stated she did not believe R64 had any current skin concerns and indicated R64 had not had any skin breakdown since admission.

When interviewed on 10/5/20, at 7:45 p.m. registered nurse (RN)-B stated staff assist R64 out of bed in the morning at 8:30 a.m. and assist R64 to lay back down at 1:30 p.m. for a nap. RN-B stated when afternoon staff come they get R64 up for dinner. Finally, RN-B stated R64 always wanted "to go back to bed right away."

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2 900	Continued From page 11 On 10/6/20, at 3:24 p.m. R64 was lying in bed. 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." 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 she uses behind the head, 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, "I do not see any pillows around [R64] for 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,	2 900		

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"I don't think it is a pressure ulcer, otherwise it would be on the care plan. We do assessments of the feet every bath day." LPN-G confirmed that R64's care plan directed use of pillows to prevent pressure ulcers and stated, "Pillows? At night, yes. I don't work nights but she usually has a pillow under her heels and on the sides of her hands if she is laying on her back. I don't know why it wouldn't have been done today but yesterday I did see in the morning a pillow under her feet."

When interviewed on 10/7/20, at 12:58 p.m. R64 stated that staff put pillows around her "sometimes." R64 further stated she felt staff put pillows around her "Maybe every couple days."

When interviewed on 10/8/20, at 9:49 a.m. RN-A verbalized she was not aware R64's care plan directed for the use of pillows for prevention of pressure injuries and stated, "There is nothing specific in the care plan if there are any pillows." RN-A verbalized that if pillows were needed to prevent pressure injuries to R64's heels, "that would involve having some sort of pillows under her calves." RN-A again indicated she was not aware whether or not this was being done for R64 and stated, "I would have to dig into that and see if this is being done." RN-A reviewed R64's care plan and noted the direction to elevate R64's heels off of the bed, and then stated her expectation would be to find R64 in bed with her heels elevated. RA-A further stated there was no process in place to record whether the pillows were being placed because it was a standard of care, and it is not something they initial off on the electronic medication administration record (EMAR); there was no way to confirm if it was being done. RA-A stated she would assess R64's feet and stated the facility also had a wound

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2 900	Continued From page 13 nurse (RN-D) that could look at R74's heel today and determine the best treatment for R64. When interviewed on 10/8/20, at 9:49 a.m. registered nurse (RN)-A indicated the process used to monitor for pressure related injuries was for the NA's to do body audits with cares and RN's to do weekly assessment when the resident had a shower or bath. RN-A reviewed R64's most recent skin assessment initiated 10/1/20, and dated 10/7/20. RN-A confirmed there was "nothing noted about heels" on this assessment and stated she was previously unaware of any issues with R64's heels. RN-A verbalized the reporting process for any concerns or changes to resident's skin was for staff to report any skin issues and start a temporary care plan. RN-A further stated she didn't know how or why this could have been missed. RN-A verified the most recent skin assessment for R64 was created on 10/1/20, and finished on 10/7/20. RN-A verified that the previous three skin assessments from Sepember were also finished on 10/7/20. RN-A stated her expectation was to close a skin asssessment with the week of the observation, before the next bath assessment, "not any longer than that". On 10/08/20, at 12:22 p.m. RN-A and RN-D were interviewed and RN-D stated she had assessed R64's heel and informed the injury was on the left heel and measured 1.3 cm in diameter. RN-D stated the wound was "100% eschar, I would think it is likely a pressure area." RN-D verbalized she believed staff were putting a pillow under R64's calves to keep her feet up off the bed and stated she knew these interventions were in R64's plan of care. RN-D described the pressure injury as unstageable and indicated staff would monitor the area going forward. RN-D indicated	2 900		

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2 900	Continued From page 14 she thought the injury was probably from being in bed. RN-D was unsure how long the pressure injury may have been on R64's feet and stated, "It is hard to say, with how compromised she is; it has significant peeling on the edges." RN-D verified the pressure injury could have negative effects on R64 and stated, "If it opened up it could become infected." RN-A stated the day shift should have noticed the pressure injury and further indicated she felt there was a "90% chance that it is from bed, because she is so compromised. My plan will be to put interventions in place for bed." When interviewed on 10/8/20, at 12:22 p.m. RN-A and RN-D described the reporting process for any concerns or changes to resident's skin as weekly skin checks, and if a wound was discovered it was then inspected daily. RN-D further stated, "The NAR's do the cares daily on the people so I would expect that it would have been seen. Staff were not aware of this issue until today." RN-A indicated a comprehensive skin assessment was completed by a charge nurse upon a resident's admission and included a head to toe screening, noting the temperature and color of the skin, completing the Braden scale, and completing a weekly body audit assessment. RN-A explained the process when a pressure ulcer was found by staff should be: --the RN who finds area tells the floor manager who then would call RN-D (the wound nurse); --Together they would assess and try to determine cause; --each Friday it would be discussed in the IDT team; --a short term care plan would be initiated; --RN-A would do weekly rounds to make sure the injury was improving and update the care plan; --daily inspections by a RN would be initiated, and	2 900		

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2 900	Continued From page 15 pressure area observation with measurements once weekly, --the nurse practitioner would assess the injury. RN-A stated this process was not initiated for R64 until this morning when she became aware of the pressure injury. RN-A stated R64 had no history of pressure injuries while in the facility. During an interview on 10/8/20, at 12:47 p.m. with LPN-A and RN-A, LPN-A verified that staff complete weekly skin checks and stated, "Yes we do a weekly skin check, especially with R64. She should have a bed bath, the aide usually goes in the morning and does the whole thing and she will call me to do a head to toe skin assessment."LPN-A stated he may have been distracted and forgotten to close the assessments in a timely manner. LPN-A verbalized that he had been completing the weekly skin inspections for R64 and stated, "I look at R64's skin all the time on her shower days and bath days." LPN-A stated he did not see the pressure ulcer on R64's heel during previous skin inspections and stated, "you know I did one today, and seriously I didn't see it, she didn't have it last week, I did not see it." When interviewed on 10/8/20, at 1:08 p.m. the director of nursing (DON) verified that R64 had "pretty serious arterial issues". The DON indicated she had reviewed the skin assessment from R64's most recent bath day and there was "nothing reflected on there" regarding pressure injuries. The DON indicated she and RN-A talked about starting basic nursing interventions such as raising R64's heels off of the bed, and stated, "We teach that is a basic intervention--you want to position people to release pressure." The DON stated R64's care planned interventions for preventing pressure injuries should have been followed and stated her expectation was that staff	2 900		

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follow a care plan; if that was determined to be necessary, the expectation would be that staff would follow the care plan. The DON stated the skin checks were on bath days for the sole purpose of being able to take a look at someone's whole body so that staff could intervene as soon as possible. The DON confirmed that R64's pressure ulcer was not noticed by staff during weekly skin assessments and stated, "It sure sounds to me that it should have been noticed, the purpose of doing a regular skin assessment is to notice if there is a problem. We teach from the very beginning that anything you notice out of the ordinary to report it."

The facility policy Pressure Ulcer Assessment and Prevention, revised 1/15/16, indicated all residents would be assessed for risk of developing pressure ulcers. Information obtained in the risk assessment would be used for developing a preventative plan of care, appropriate care and interventions. The policy further indicated, residents at moderate and high risk for pressure ulcers are to have a care plan for prevention of skin integrity concerns initiated. Interventions should be made considering all risk factors. Basic prevention interventions include:
a) Daily monitoring of the skin by NARs
b) Weekly skin inspection by a licensed nurse
c) Appropriate seating and sleeping surfaces
d) Assessment of proper footwear
e) Keeping skin clean and dry
f) Individualized repositioning and offloading plan
g) The RAI process will also be used to identify possible risk factors.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review

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2 900	Continued From page 17 all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as	21390		11/24/20

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disinfectants, antiseptics, gloves, and incontinence products; and

l. methods for maintaining awareness of current standards of practice in infection control.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to thoroughly conduct a comprehensive infection control program to include the Centers for Medicare and Medicaid Services (CMS) COVID-19 recommendations including proper use of personal protective equipment (PPE) by both staff and residents, performance of hand hygiene by both staff and residents, and compliance with quarantine procedures. These practices had the potential to affect 78 of 139 residents who resided at the facility.

corrected

Findings include:

RESIDENT USE OF MASKS, SOCIAL DISTANCING, and HAND HYGIENE

During an observation on 10/05/20, at 12:09 p.m. on the third floor, three unidentified residents were seated in wheelchairs facing a television (TV) without masks and less than six feet apart in the TV viewing area. Two other unidentified residents were sitting in chairs without masks on and with bedside tables in front of them. R95 sat down in a chair less than four feet from the residents in chairs. Nursing assistant (NA)-A placed a bedside table in front of R95. Unidentified nursing staff were in visual distance of the residents but did not assist with masking or social distancing.

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During an observation on 10/5/20, at 1:18 p.m. in the third floor dining area, R59 and R95, neither were wearing a mask, sat approximately one foot apart at a square table in the dining room, leaned close and talked to one another, played with baby dolls, and drank juice. Unidentified staff were in visual distance but did not assist with social distancing.

During an observation on 10/5/20, at 1:35 p.m. in third floor dining area, R317 drank juice from a juice glass and placd the glass on the table in front of her. R385 then picked up R317's glass and drank some of the juice. Unidentified staff were in visual distance but did not attempt to intervene before R385 drank the juice.

During an observation on 10/5/20, at 4:15 p.m. the third floor dining area, R385, R119, and R95 were not wearing masks and sat about two feet apart in chairs while they talked. Unidentified staff were in visual distance but did not attempt to assist residents with masking or social distancing.

During continuous observation on 10/5/20, from 4:42 p.m. to 4:45 p.m. on third floor, a cart of clean clothing protectors was uncovered in the resident dining area. R55 came out of her room without wearing a mask and touched the cart and clothing protectors. An unidentified staff did not remove the clothing protectors, just covered the cart and redirected R55 back to her room. The staff did not assist R55 to put on a mask.

During an observation on 10/5/20, at 6:40 p.m. on third floor, R95 stood within two feet of R58 and showed her a baby doll; neither resident wore a mask. Unidentified staff were in visual distance but did not attempt to assist with masking or social distancing.

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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.

During an observation on 10/6/20, at 9:01 a.m. in the third floor dining area, R95 and R107 sat at the same table less than six feet apart and neither wore a mask. RN-A served R95 coffee. RN-A did not attempt to assist the residents with social distancing.

During an observation on 10/6/20, at 3:01 p.m. in the third floor dining area, R385 and R44 stood about one foot apart, held hands, and spoke closely to one another's face; neither resident wore a mask. Nursing staff were in visual distance but did not attempt to assist with masking or social distancing.

During an observation on 10/6/20, at 3:04 p.m. on the third floor, R385 stood within one foot of R55 and touched R55's face, hair, and shoulders; neither resident wore a mask. Nursing staff were in visual distance but did not attempt to assist with masking or social distancing.

During an observation on 10/6/20, at 3:20 p.m. on the third floor, R55 started to leave her room and donned a mask when asked, stating staff didn't usually ask her to wear one. She stated she had to wear one to go down to therapy, located on the second floor.

During an observation on10/6/20, at 3:44 p.m. on third floor, R385 approached R95, stood within

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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.

During continuous observation on 10/7/20, between 8:01 a.m. and 8:05 a.m. on the third floor, staff served R95 breakfast in the common area. R95 got up and walked away without eating any of the food and was not wearing a mask. R95 entered R434's quarantine room through the open door and touched the privacy curtain. R95 then exited R434's room, and stood in the doorway of R6's room, and talked to R6. R95 then entered the dining area and sat next to R59 at the same table, less than two feet apart; neither resident wore a mask. Licensed practical nurse (LPN)-A said "Hi" to R95 but did not attempt to have the residents socially distance.

During an observation on 10/7/20, at 8:20 a.m. on the third floor, R95 moved from a dining table and opened cupboards in the kitchenette. LPN-A approached R95 and asked R95 "do you want sugar?" LPN-A gave R95 a sugar packet. R95 poured herself coffee from the coffee dispenser, took a used meal tray off of another table, and ate the donuts that were left on the meal tray of another resident. LPN-A did not attempt to assist R95 with social distancing, hand hygiene, or prevent R95 from eating food off another resident's meal tray.

During continuous observation on 10/8/20, from 8:45 a.m. and 9:00 a.m. on the third floor, R130, R434, and R95 were seated in the hallway across from the nursing station without masks and less than six feet apart. NA-C brought toast and rolls to the residents; no hand hygiene was offered or performed prior to food being given to the

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residents. No spray bottles or hand wipes were visualized in the area. NA-C did not attempt to socially distance the residents. Trained medication aide (TMA)-A placed R95 in a chair within two feet of R64 who was seated in a wheelchair. R95 leaned over and touched R64's feet. The TMA and other nurisng staff were in visual distance but did not attempt to socially distance the residents.

During continuous observation on 10/8/20, from 1:05 p.m. to 1:15 p.m. on the third floor, NA-C gave snacks to R55, R83, R95, R130, and other residents. No hand hygiene was performed before NA-C distributed snacks to the residents.

No hand hygiene of residents before or after meals was observed during the evening of 10/5/20, or during the daytime meals on 10/6/20, 10/7/20, and 10/8/20. No hand hygiene spray was observed in the dining area or the TV room where meals were also served.

During an interview on 10/8/20, at 9:42 a.m., LPN-A verified the expectation was staff perform hand hygiene with residents before and after meals and after bowel/bladder care. LPN-A stated they used a spray and it was "somewhere." No spray was visualized at the nursing station, on any medication cart, in the dining area, or in the TV area. LPN-A verified he did not see the spray.

STAFF USE OF MASKS AND EYE PROTECTION

On 10/5/20, R103's family member (FM)-A reported she had observed facility staff without masks and not socially distancing during lunch or cigarette breaks.

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During an observation on 10/5/20, at 12:32 p.m. on the third floor, LPN-C's mask was under his nose and stayed under his nose as he walked from the dining area where three residents were, without masks, and into the TV area where six residents without masks were sitting less than six feet from each other. LPN-C did not attempt to distance residents or ask them to wear a mask.

During an observation on 10/5/20, at 4:44 p.m. on third floor, LPN-B wore goggles on top of her forehead, with her eyes uncovered and exposed. At 4:53 p.m. LPN-B's goggles were observed again on her forehead and a face shield was now positioned high on LPN-B's forehead and tilted upward, covering only the top half of LPN-B's face.

During continuous observation on 10/5/20, from 5:10 p.m. through 5:20 p.m. on the third floor, LPN-B was observed with her mask below her nose and face shield raised above her forehead to where it was barely reaching her nose, while sitting at the nursing station. LPN-B walked from the nursing station into the hallway, walked past R6's room, poked her head into R434's quarantine room, pulled her mask up over her nose as she was leaving R434's room, and then walked toward R23's room. LPN-B walked back into the nursing station with her mask under her nose. An unidentified resident walked up to her and asked LPN-B a question. LPN-B talked to the resident with her mask below her nose. At this time, RN-B was observed to have his mask under his chin, sitting next to LPN-B at the nursing station. LPN-B then left the nursing station with her mask still under her nose and face shield still barely reaching her nose, and walked within three feet of unmasked residents: R96 and two other unidentified residents. R95 asked LPN-B a

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question and she leaned into him to shout in his ear, "what do you want?"

During four observations on 10/5/20, RN-B was observed sitting at the third floor nursing station with his mask under his chin at: 5:10 p.m., 5:14 p.m., 5:30 p.m., and 5:59 p.m.

During an observation on 10/5/20, at 7:59 p.m. on the third floor, NA-D was observed sitting in the dining area with his mask off.

During an observation on 10/6/20, at 11:55 a.m. on the first floor, the dietary director (DD-A) was sitting in an office without mask or eye protection. The office opened directly into hallway while an unidentified resident in a wheelchair without a mask was in the hallway.

During continuous observation on 10/6/20, from 2:31 p.m. and 2:40 p.m. on the third floor, staff were in line for COVID testing. NA-A, NA-D, and NA-E were standing approximately three feet apart. NA-A wore a mask and no eye protection. NA-D's mask was under his chin. NA-E's mask was under his nose. At 2:38 p.m., an unidentified staff pushed a wheelchair with R49 in it within three feet of NA-A.

During an observation on 10/7/20, at 7:27 a.m. on the first floor, two unidentified staff were in the staffing office, sitting less than six feet apart from each other. One staff wore eye protection and mask. The second staff did not have mask or eye protection. The staffing office was just off the first floor hallway.

During an observation on 10/7/20, 7:59 a.m. on the second floor, housekeeper (HK)-B wore a surgical mask and gloves but her goggles were

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on the top of her head while standing in front of R99's room.

During an observation on 10/7/20, at 10:01 a.m. on the first floor, LPN-E lifted her face shield to the top of her head, exposing her eyes, when talking to an unidentified staff while standing less than three feet from the other staff in front of R75's room.

During an observation on 10/7/20, at 10:24 a.m. on the third floor, NA- F was observed without a mask or face shield while seated in the nursing station. NA-F stated he was not interacting with residents but he would wear them when he was around residents.

During an observation on 10/7/20, at 2:14 p.m., an unidentified staff was outside the nurse manager's office with his mask on but face shield off, working on a computer in the hallway.

During an observationa 10/7/20, at 2:15 p.m., LPN-A was sitting at the nursing station with his mask under his chin and face shield off. LPN-A left the nursing station without his face shield and walked near numerous residents in the hallway.

During an observation on 10/8/20, at 9:49 a.m. on the third floor, radiology technologist (RadT)-C was standing at the nursing station with her goggles on the top of her head and wearing an N95 mask with exhalation valve. RadT-C was standing within three feet of R64. RadT-C stated she only wore eye protection when around a resident. When pointed out she was within three feet of R64, she put her goggles over her eyes. LPN-A and TMA-A were at the nursing station and did not interact with RadT-C.

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During an observation on 10/8/20, at 12:11 p.m. on the first floor, there was one staff in the staffing office without a mask or eye protection.

During an observation on 10/8/20, at 01:08 p.m. on third floor, RN-A was wearing mask under her chin and googles on her head while in her office.

During an observation on 10/8/20, mid-afternoon, three unidentified staff were seated at first floor dining tables and talking without masks or eye protection; staff were not eating at the time.

During an interview on 10/5/20, at 11:54 a.m., receptionist (R)-D stated the expectation was every staff in the building wore masks when in the building and eye protection when in resident care areas or when interacting with residents.

STAFF HAND HYGIENE

During continuous observation on 10/5/20, from 5:30 p.m. through 6:00 p.m. on third floor, NA-B brought a basin of water from the bathroom and wiped the underarms of R64 with a wash cloth, NA-B removed dirty gloves and donned new gloves, with no hand hygiene between glove changes. NA-B undressed R64, removed her soiled brief, and used a wash cloth to clean R64's peri-area. NA-B removed one soiled glove and then retrieved a box of gloves, which she placed on the bedside table. NA-B donned the one new glove with no hand hygiene between glove changes. NA-B placed a clean brief on R64, then pulled R64's nightgown down, and placed the sheet and blanket over R64. NA-B adjusted R64's head of bed, adjusted the foot of the bed, turned on the TV, rotated the TV screen, and then turned up the volume of the TV. NA-B attached the call light to R64's sheet, gathered the soiled linens in

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one bag, gathered trash in another bag, placed a new trash bag in the trash can, dumped a dirty basin of water in the bathroom sink, and placed the basin back in the closet. NA-B then removed her dirty gloves, tuned off the bathroom light, and exited the room, without performing hand hygiene. NA-B then took the soiled linens to the linen room and then used hand sanitizer. During interview, NA-B stated when you are changing gloves, you only throw away the soiled glove used to wipe the peri-area, and then you get a new glove to put the clean brief on. NA-B stated, "When you take off your gloves you can sanitize between, but sometimes the sanitizer will not be close to you and you cannot go far from the bed when the resident is on their side." NA-B further stated, "Yes, you are supposed to wash your hands before you leave the room but I was taking out the trash." NA-B verbalized she received monthly training on hand hygiene via Relias computer trainings, as well as frequent audits and education from nursing staff.

During continuous observation on 10/6/20, from 8:33 a.m. through 8:41 a.m. on third floor, NA-C escorted R118 from the dining area to her bathroom. NA-C donned gloves and transferred R118 to the toilet. After R118 indicated she was finished, NA-C wiped R118's peri-area with wipes, removed her dirty gloves, and donned clean gloves, with no hand hygiene between glove changes. NA-C pulled up R118's brief and pants, assisted R118 to wash hands, and then NA-C washed her hands. NA-C verbalized the priority was for staff to have a clean glove and stated, "if we leave her standing there and then wash your hands before putting on a clean glove they might fall, if you have to wash your hands and get clean gloves we might have a lot of them falling." NA-C further stated, "You should wash your hands

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before applying clean gloves, before and after care you need to wash your hands, but for her she really had to go and my hands were clean so I just applied the gloves."

During an observation on 10/7/20, at 7:56 a.m. on third floor, LPN-A was standing within three feet of R434, leaning close to her face with his hand on her shoulder. R434, who was supposed to be in quarantine, was within six feet distance of R6 and R59 in the dining area. None of the residents wore masks. LPN-A walked from R434 to R6, put his hand on her shoulder, and leaned within one foot of her face. LPN-A then walked back to R434 and placed his hand on her shoulder. LPN-A did not perform hand hygiene between touching residents. LPN-A went back to R6 and leaned in closely, placing his hands on R6's table, then picking up empty plate from R6's table and placing it on R434's table and leaving it on the table.

During an interview on 10/8/20, at 9:58 a.m., RN-A verbalized her expectation was for hand hygiene to be performed between glove changes and stated, staff should perform "hand hygiene before and after the gloves are donned and doffed and between resident care if the gloves were to become soiled." RA-A further stated both gloves should be removed after peri-care.

ISOLATION/QUARANTNE

During continuous observation on 10/5/20, from 1:00 p.m. through 1:15 p.m. on the third floor, NA-A entered R434's room, which had a sign next to the door that indicated R434 was on quarantine. The sign indicated the door to the room should always be closed and anyone entering should be wearing gown, gloves, masks,

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and eye protection. When exiting the room, NA-A was asked about the quarantine and he stated he did not see the sign. NA-A said he always looked for the isolation cart and pointed to a cart that was 20 yards away from the door. NA-A then placed the cart next to the entry into R434's room and verified there were no gowns or gloves in the cart. NA-A stated there were gowns and gloves in the storage closet. NA-A left the area and left R434's door open.

During continuous observation on 10/5/20, from 4:42 p.m. through 4:50 p.m. on third floor, NA-B obtained gowns and gloves out of storage closet and placed in the isolation cart outside of R434's room. NA-B did not perform hand hygiene prior to donning gown and gloves. NA-B exited leaving the door to R434's room open. NA-B stated the door to R434's room should be closed because she was in quarantine and then shut the door.

During continuous observation and interview on 10/5/20, from 5:20 p.m. through 5:25 p.m. on the third floor, NA-B exited R434's quarantine room with a food tray and placed the food tray on the isolation cart. NA-B then doffed gown and gloves and placed in the trash can which was located in the bathroom in R434's room. NA-B performed hand hygiene and then donned gloves. NA-B carried the tray from the isolation cart to the dining area where she placed the dirty food tray on top of the counter in the kitchenette area. NA-B removed gloves and performed hand hygiene but did not disinfect the top of the isolation cart after the dirty food tray was placed on it.

During an observation on 10/6/20, around 10:00 a.m. on the third floor, an unidentified occupational therapist (OT)-A entered R434's

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21390	Continued From page 30 quarantine room without gown or gloves, and brought R434 out into the TV area in a wheelchair. R434 was not wearing a mask. During an observation on 10/7/20, at 7:31 a.m. on the third floor, R434, who was in quarantine, was sitting within four feet of R95 and R96 in the TV area. None of the residents were wearing masks. Staff were present but did not attempt to assist residents with masks, social distancing, or assist R434 back to her quarantine room. During an observation on 10/7/20, at 7:44 a.m. on third floor, an unidentified occupational therapist (OT)-B walked to R434, who was seated in the TV area and was supposed to be in quarantine. OT-B leaned into R434 and told her he was taking her to the dining area. OT-B did not ask R434 to wear a mask. During continuous observation on 10/7/20, from 12:23 p.m. through 12:30 p.m., the door to R434's quarantine room was open. R46, who was in a wheelchair and not wearing a mask, wheeled herself into R434's room. R434 was in her wheelchair in the room at the time. After several minutes, R46 wheeled herself out of R434's room. During an interview on 10/7/20, at 10:20 a.m., LPN-A verified R434 was supposed to be in quarantine because she was newly admitted. He stated staff should try to keep R434 in the room, but if R434 came out, it was hard. LPN-A agreed staff should not be going into the room and bringing the resident out. LPN-A stated a resident who was in quarantine should be wearing a mask and staff should remind the resident to wear a mask. He verified they should remind residents multiple times.	21390		

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SCREENING - ENTRY POINTS

During continuous observation on 10/7/20, from 7:01 a.m. through 7:10 a.m., there were two screening desks by the front entry; the primary screening desk was unstaffed and the secondary screening table, to the right of the primary screening desk, was staffed by NA-J. While other staff and visitors entered through the front entry, four other staff entered the screening area from the hallway and had to walk through the facility to get to the screening desk: US-H, LPN-D, NA-A, and one staff with an unreadable signature. NA-J verified she could not read the signature and did not see which staff signed the book. All who entered took their temperature using a stand-up automatic temperature taking machine, marked their temperature in the sign-in book, and answered screening questions in the sign-in book.

During an interview on 10/8/20, at 10:19 a.m., with infection prevention specialist (IP)-A and IP-B, several topics were discussed:
*Resident use of masks, social distancing, and hand hygiene - IP-A stated the expectation for residents was they wear masks when in common areas or when staff entered their room. IP-A stated some residents might need reminding or encouragement but they usually did cooperate. She stated the expectation was the same for all residents, including those on third floor and while "it may be difficult, the expectation is to always try to help the residents wear masks." IP-A stated residents should be provided hand hygiene before and after meals and after toileting.
*Staff use of masks and eye protection - IP-A stated the expectation for staff use of personal protective equipment (PPE) was that all staff

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21390	Continued From page 32 were expected to wear masks and eye protection while in the facility, especially in resident care areas or around residents. IP-A stated if staff were alone in their office, their masks could be off. IP-A said there may be a few instances where people can't tolerate a mask, but it was a requirement and not an option. IP-A stated staff should speak up if they had an issue with a mask as they have many different types of masks to try. IP-A stated the facility used Minnesota Department of Health (MDH)'s long-term care (LTC)'s PPE grid, which was dated 5/29/20. This version of the grid did not indicate office staff had to wear masks. IP-A further stated the expectation was that if staff saw another staff wearing PPE improperly or not at all, they should speak up and correct the staff. IP-A stated nurse managers audited staff use of PPE and would be the ones to track if any particular staff needed multiple reminders on PPE use. They did not have the updated 6/15/20 grid. *Staff hand hygiene - IP-A stated the expectation was staff performed hand hygiene before and after donning gloves. *Isolation/Quarantine - IP-A stated the expectation for quarantine was to limit the resident to their room with the door closed. IP-A stated an exception would be therapy; if a resident needed to go to therapy, they would go to the therapy department at a time when no other residents were present, wore a mask, and equipment was disinfected after use by the resident. IP-A stated it was a challenge for those with dementia, but the expectation was staff would frequently try to keep the resident in their room during quarantine. *Staff screening and entry into the facility - IP-A stated the expectation staff were screened at the front entry. She stated there was a back entry some staff might enter through and some limited	21390		

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staff have keys to the transitional care unit (TCU) door, but if they entered the facility through those doors, it was expected they come to the front lobby to be screened. IP-A and IP-B verified staff would have to walk through the facility before they were screened, potentially exposing residents and other staff.

During an interview on 10/8/20, at 10:19 a.m., RN-A, noted the third floor had "challenges" related to infection control because of the nature of the residents who had cognitive/memory. Several topics were discussed:
*Resident use of masks, social distancing, and hand hygiene - RN-A said all residents should be encouraged to wear a mask and she expected staff should be asking and reminding residents to wear a mask. If residents had an issue with wearing a mask, RN-A stated it should be should be "cared planned for" and verified it was not on the care plan. RN-A stated staff should keep trying but after a while they quit trying, stating, "we know which ones are able and which ones are not." RN-A stated residents had to wear a mask if they left the floor; if they could not wear a mask, they did not leave the floor. RN-A stated she expected staff to offer hand hygiene to residents before and after meals and after peri-care if the resident participated in peri-care.
*Staff use of masks and eye protection - RN-A stated the expectation for staff was to wear masks and eye protection while in the care area. She added she might have her mask off while in her office but it was nearby, so if she needed to go to the nursing station or into the hallway, she would wear it. RN-A verified masks should cover the mouth and nose and eye protection should cover the eyes.
*Staff hand hygiene - RN-A's expectation of staff around hand hygiene was staff were expected to

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wash their hands "frequently and always" while following the hand hygiene policy.
*Isolation/Quarantine - RN-A verified when residents are first admitted to the unit they are in quarantine for fourteen days. She stated the expectation was the door to the room should be closed, but if a resident was a fall risk, it might have to be kept open; staff have to balance the risk/benefit. RN-A stated a resident in quarantine should not be in common areas but again would look at risk/benefit of being isolated if the resident was calmer in the common area. RN-A also stated a resident in quarantine should be wearing a mask if in the common area.

During an interview on 10/8/20, at 2:15 p.m., with the director of nursing (DON), several topics were covered:
*Resident use of masks, social distancing, and hand hygiene - The DON stated the expectation was for residents to wear a mask when a staff enters the room or if they are out of their room in common areas. The DON verified the expectation was the same for the third floor, commenting if a resident could wear a mask, they should. She stated a resident might need more reminders but the expectation was staff must attempt to have residents wear masks. The DON expected staff to reattempt to get residents to wear a mask; staff "must make multiple attempts - they might not wear it now but next day they might wear it." The DON stated the expectation was staff provide hand wipes to residents before and after meals and after bathroom care; if wipes were not available, staff were to offer a washcloth with soap and water. In regards to social distancing, the DON stated residents should be encouraged to maintain a social distance of at least six feet and staff should make it harder for residents to be close. The DON also stated it was important to

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have only one resident to sit at a table, verifying the expectation staff should remind residents and move them apart.
*Staff use of masks and eye protection - The DON stated the expectation was for everyone to wear a surgical mask and eye protection while they were in the building or on duty. If staff had issues or concerns, they were expected to discuss with leadership as they had a variety of masks and eye protection that could be used.
*Staff hand hygiene - The DON verified she expected all staff to follow the facility's hand hygiene policy.
*Isolation/Quarantine - When a resident was in quarantine, the DON expected residents to stay in their room with the door closed. She noted that while third floor residents might wander out of the room, "it's not one and done." The DON expected staff to redirect the resident to their room each time they came out and be creative to keep the resident in the room. She stated staff could do things like give snacks or activities to keep the resident in the room. The DON stated if something wasn't working, she expected staff to have a back-up plan and to keep trying.

The facility's Hand Hygiene policy, dated 3/13/20, indicated staff should perform hand hygiene at the following times: 1) before and after resident contact; 2) before and after gloving; 3) before and after entering isolation precaution settings; 4) before and after assisting a resident with toileting; 5) after handling soiled linens; 6) between tasks or procedures done on the same resident to prevent cross contamination of different body parts; and 7) before and after handling food (hand washing with soap and water).

The facility's PPE guide is from the Minnesota Department of Health's Long-term Care Toolkit

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21390	Continued From page 36 but an older version, dated 5/29/20. The older version did not indicate office staff should wear masks while in the building. The Interim Infection Prevention and Control Recommendations for Healthcare Personnel During COVID-19 Pandemic dated July 15, 2020, by the CDC, indicated health care facilities should implement universal source control measure which includes health care personal (HCP) should wear a facemask at all times while they are in the facility and HCP working in facilities located in areas with moderate to substantial community transmission should wear eye protection in addition to their facemask. The Minnesota Department of Health, PPE Grid, dated 6/15/20 indicated all staff, including office staff, should wear masks while in the building. According to the Centers for Medicare and Medicaid Services Coronavirus Disease 2019 (COVID-19) Long-Term Care Facility Guidance dated 4/2/20, long-term care facilities, in accordance with previous CMS guidance, should limit access points and ensure that all accessible entrances have a screening station. In accordance with previous Center for Disease Control (CDC) guidance, every person entering the facility should be actively screened. The CDC's Considerations for Memory Care Units in Long-term Care Facilities, dated May 12, 2020, recommended memory care units follow Infection Prevention and Control guidelines and in addition, including: *Reminding and assisting with frequent hand hygiene, social distancing, and use of cloth face coverings *Providing structured activities in resident rooms or at staggered times throughout the day to maintain social distancing	21390		

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21390	Continued From page 37 *Limiting the number of residents in common areas to maintain spacing of at least 6 feet apart with gentle redirection of residents who get in close proximity to other residents or persons. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding isolation precautions for resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-education anytime isolation precautions are placed; they could ensure hand hygience was appropriate for residents and by staff. The ICP should have formal training to be completed according to regulation and the above measures.The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS	21390		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21665	corrected	11/24/20

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review, the facility failed to ensure 7 of 11 rooms were maintained in good repair and in a sanitary manner. This had the potential to affect 7 residents (R32, R113, R49, R80, R28, R57, and R64) who resided in the rooms reviewed for environmental concerns.

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.

During an interview on 10/8/20, at 11:32 a.m. nursing assistant (NA)-N stated if something needed to be cleaned, then she would notify her nurse manager or maintenance personal.

During a facility tour on 10/8/20, at 12:07 p.m. the environmental director (ED) verified the stains on R32's carpet and stated that R32's carpet needed to be cleaned. The ED also stated R32's room was a room that needed to be checked everyday due to R32 spitting on the floor.

On 10/5/20, at 6:31 p.m. the carpet in R113's room was observed to have stains in front of the bed.

During a facility tour on 10/8/20, at 12:11 p.m. the ED verified the stains in R113's room and stated R113's carpet was old and needed to washed.

On 10/5/20, at 4:11 p.m. the carpet in R49's room was observed to be stained around the bedside table.

During an interview on 10/8/20, at 11:52 a.m. NA-O stated if a resident's carpet needed to be cleaned she would let the nurse manager know

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the room number and then the nurse manager would let maintenance know about it.

During a facility tour on 10/8/20, at 12:16 p.m. the ED verified the stains on the carpet in R49's room and stated the stains were from food.

On 10/5/20, at 2:03 p.m. the carpet in R80's room was observed to have white stains in front of the bed.

During a facility tour on 10/8/20, at 12:14 p.m. the ED verified the stains and stated R80's carpet stains were from food. The ED also stated R80's red stain in the carpet was from finger nail polish from a previous resident who resided in the room and the stain could not be removed.

On 10/5/20, at 3:50 p.m. the carpet in R28's room was observed to have white stains in front of bed.

During a facility tour on 10/8/20, at 12:15 p.m. the ED verified the stains in R28's room and stated the stains were from food. The ED then stated they had a full time carpet specialist who worked and that R28's carpet needed to be cleaned.

On 10/5/20, at 1:26 p.m. the carpet in R57's room was observed to have large white and dark stains around the bed. R57 stated milk was spilled. There were also stains observed in the entry way between R57's room and the adjoining shared room.

During a facility tour on 10/8/20, at 12:17 p.m. the ED verified the stains on R57's carpet and stated R57's room was a room that needed to be checked daily and the carpet needed to be

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cleaned.

On 10/5/20, at 5:32 p.m. R64's room entry way light bulb between the bathroom door and entry door was observed to not be working.

During an interview on 10/8/20, at 12:01 p.m. NA-G stated she would put in a work order as she pointed to a clear basket hanging behind the nurse's station.

During facility tour on 10/8/20, at 12:19 p.m. the ED stated he would get the light bulb changed right then.

During an interview on 10/8/20, at 12:20 p.m. the ED stated that they had multiple carpet extractors that they used daily, and had smaller machines that work well for small areas. The ED also stated he came in every morning and checked the work orders, then went around and checked some of the rooms that were known to need extra cleaning. The ED then stated the work orders are signed off and returned to him to indicate the work order had been completed. The ED also stated housekeepers went into every room each day and could write a work request for anything that needed to be fix or cleaned. The ED further stated because of the Covid-19 and residents eating in their room's, it had increased the amount of carpet cleaning carpets and housekeeping needed to communicate to the carpet specialist for rooms that needed further cleaning than what housekeeping can do.

A policy for carpet cleaning was requested but not provided.

SUGGESTED METHOD OF CORRECTION: The

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21665	Continued From page 41 director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their	21800		11/24/20

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21800	Continued From page 42 chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. 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. Findings include: R74's admission minimum data set (MDS), dated 8/11/2020, indicated R74 had a brief interview for mental status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS also indicated diagnoses that included traumatic brain injury (TBI) related to a fall, history of falls, post-traumatic stress disorder (PTSD), and attention-deficit hyperatcitity disorder. R74's care plan, dated 9/21/20, included interventions for altered thought processes related to cognitive impairment and TBI, and alteration in mood/behavior related to anxiolytic use and PTSD. During an interview and observation on 10/06/20, at 3:18 p.m., R74 stated she had a rough night because another resident kept coming into her room and "sat on the floor wailing." R74 said she had told the nurse manager but nothing had changed. At 3:22 p.m., R55 opened R74's door and entered into R74's room while moaning and crying. R74 said this was a different person than	21800	corrected	

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	00984	A. BUILDING: ____ B. WING ____	C 10/08/2020

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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21800	Continued From page 43	21800		

who entered her room the previous night. R74 stated "others coming into my room happened all the time."

During an interview on 10/8/20, at 2:00 p.m., RN-A verified R74 had complained about a lot of residents wandering into her room. She stated these complaints were handled with nursing interventions as a point of care concern. RN-A stated there wasn't really anything that could be done as this was the nature of residents on third floor, stating, "these residents wander." RN-A was unsure at what point R74's concerns would be a grievance and stated social work wrote up grievances, "nursing did not do that."

During an interview on 10/8/20, at 2:15 p.m., the director of social services (SW)-A and the director of nursing (DON) both agreed point of care resolutions were first attempted when residents voiced complaints or concerns. SW-A stated if the issue recurred, it was readdressed and the facility changed it to a grievance "if appropriate." SW-A stated what was appropriate depended on the severity of the issue, frequency, impact, etc. For wandering residents, SW-A stated the interdisciplinary team (IDT) met daily and discussed wandering residents to brainstorm solutions. SW-A stated some interventions used were stop signs on resident doors and redirecting residents who wandered into other residents' rooms. SW-A stated they had "no grievances from the third floor for a very long time." The DON verified staff were expected to help residents write grievances.

Although they were aware of R74's ongoing grievances of residents coming into their room, the facility had not re-addressed this issue with R74 to alleviate ongoing grievances.

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

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21800	Continued From page 44 The facility's Suggestion, Concern and Grievance policy, dated 9/30/20, indicated the facility "would make every effort to address and resolved suggestions, complaints and grievances properly." The policy further indicated, suggestions, concerns or grievances could be made verbally or in writing to "the person who has supervisory responsibility for the area of concern." The policy indicated the facility would take "immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated." SUGGESTED METHOD OF CORRECTION: The administrator, director of social services, or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents grievances are being followed up on. 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 (21) days.	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		11/24/20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00984	A. BUILDING: ______ B. WING ______	C 10/08/2020

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

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This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure staff knocked and waited for a response before entering resident rooms, for 1 of 2 residents (R74) who was reviewed for resident right to privacy.

corrected

Findings include:

R74's admission minimum data set (MDS), dated 8/11/2020, indicated R74 had a brief interview for mental status (BIMS) score of 15 out of 15, indicating intact cognition. The MDS also indicated diagnoses that included traumatic brain injury (TBI) related to a fall, history of falls, post-traumatic stress disorder (PTSD), and attention-deficit hyperatcitity disorder.

R74's care plan, dated 9/21/20, included interventions for altered thought processes related to cognitive impairment and TBI, and alteration in mood/behavior related to anxiolytic use and PTSD.

During an observation and interview on 10/5/20, at 7:34 p.m., nursing assistant (NA)-A was observed to knock on R74's door and enter R74's room without waiting for R74 to respond to the knock; NA-A also did not announce himself. After NA-A left the room, R74 said "this happens all the time. They just fling the door open without knocking." R74 also stated NA-A would knock, but he would never wait for a response or announce himself before entering. R74 said she had to be patient with NA-A.

During an observation and interview on 10/5/20, at 7:43 p.m., NA-D entered R74's room without knocking or announcing his entry into the room.

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21805	Continued From page 46	21805		

NA-D had a new drink container in one hand, removed the old drink container from the bedside table, placed the new drink container on the bedside table, and left the room. NA-D did not acknowledge or speak to R74. After NA-D left the room, R74 stated, "he doesn't knock." R74 stated people just come in whenever they want. R74 said she has complained to the nurse manger but nothing changed.

During an interview on 10/7/20, at 12:22 p.m., NA-G stated they were educated to "knock and wait" and then let the resident know why they were entering the room, "like I'm here to help."

During an interview on 10/7/20, at 10:00 a.m. licensed practical nurse (LPN)-A stated staff should knock on the door and wait for an answer before entering the room. He stated this should happen every time a staff entered a resident's room.

During an interview on 10/7/20, at 12:22 p.m., trained medication aide (TMA)-A stated staff were supposed to knock on resident's doors and wait for an answer before entering the room. TMA-A stated if there was no answer, staff could enter the room and announce themselves as they entered.

During an interview on 10/8/20, at 1:15 p.m., registered nurse (RN)-A verified the expectation was staff knock on the resident's door and wait for a response before entering. RN-A stated this should happen every time a staff entered a resident's room.

During an interview on 10/8/20, at 2:00 p.m., RN-A verified staff should knock on the door and announce themselves when entering a resident's

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21805	Continued From page 47	21805		

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 (21) days.