Electronically delivered
December 10, 2021

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

RE: CCN: 245439
Cycle Start Date: November 18, 2021

Dear Administrator:

On November 18, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) , as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 18, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 18, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

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.

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 11/18/2021

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

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F 000	INITIAL COMMENTS On 11/17/21, to 11/18/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be 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 SUBSTANTIATED: H5439077C (MN78551), with a deficiency cited at F600, F609, F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		1/3/22

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

Electronically Signed | 12/16/2021

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

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prevent abuse for 4 of 4 residents (R4, R5, R6, R1) who were physically abused by R2. R2 attacked R4, and R5 got hurt when he tried to intervene, R2 tried to pull R6 out of the wheelchair, and R2 hit R1 in the face causing bruising and scratches. Findings include: R2's Face Sheet dated 11/18/21, indicated diagnoses of Alzheimer's, delusional disorder, and vascular dementia with behavioral disturbances. R2's admission Minimum Data Set (MDS) dated 8/18/21, indicated severe cognitive impairment. R2 wandered four to six days a week which significantly intruded on the privacy of activities of others. R2 was independent with bed mobility, transfers, walking, and had no impairment in range of motion (ROM). R2's care plan dated 11/15/21, indicated an alteration in mood/behavior which staff were to monitor for increased anxiety, fears, delusion, hallucinations. R2 wandered throughout the memory care unit. Staff were to keep others safe while R2 wandered and do well checks every 30 minutes. R2 physically and verbally yelled at his hands, kneeled on the floor, and made frustrated comments. Staff were to assess whether the behavior endangered R2 or others. When R2	F 600	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility does not agree with the alleged deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance F600 R4, R5, and R6 have no recollection of the incident and have not displayed any signs of distress related to the interaction. No changes to the care plans were necessary. R5 scratch has healed without incident. R1 has developed a positive relationship with R2 and expresses no fear or changes in mood or behavior. R1 has no further signs of injury. R1□s care plan is updated to include weekly check-ins with social service. All residents on memory care have the potential to be impacted by interactions with other cognitively impaired residents. In the case of R2□s care plan has been updated to include psychiatrist consult	

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F 600	Continued From page 2 became physically abusive to keep distance between R2 and others. R2's PN dated 9/11/21, at 3:00 p.m. indicated at 1:30 p.m. R2 walked in front of the nurse's station and found R4 who sat in his wheelchair. R2 started to yell at R4 to get out of here. R2 became physically aggressive and attempted to tip R4 out of his wheelchair. R2 was not able to state what triggered him to become upset. R2's Provider PN dated 9/11/21, indicated R2 had an altercation with another resident [R4]. R2 hit and tried to pick up this resident [R4] in his wheelchair and tip him over. Staff stated another resident [R5] tried to intervene. R2 became upset with the other resident [R5] and scratched him. R5 had an 8.0 cm scratch on his forearm. R2 also broke the glasses of R5. Staff felt watching 9/11 documentary likely triggered R2's behavior. R2's Behavior and Mood Event dated 9/12/21, indicated R5 was injured from R2's behavioral episode on 9/11/21. R2's PN dated 9/15/21, at 5:14 p.m. indicated interdisciplinary team (IDT) met to review the incident on 9/11/21. During investigation staff noted that R2 got upset with the news regarding 9/11. R2 yelled at the television, believed war was going on and it appeared to upset him. R2's Behavior and Mood Event dated 10/27/21, indicated R2 had aggressive and combative behavior. R2 grabbed the right ankle of [R6] "pulling her from the dining room chair." R2 punched a staff member three times in the stomach when they tried to intervene. Before the incident, R2 was wandering before dinner and	F 600	and ongoing medication adjustments that result in reduction of delusions. R2 will be guided to his room as he allows when he is delusional, if he is uncooperative then staff are to ensure a safe environment by removing obstacles and people from the immediate area. Staff will attempt to engage R2 in singing activities. 911 will be contacted if the environment is not safe due to R2□s escalated delusions. Charge nurses will be responsible to know the whereabouts of R2 and to redirect as needed. Licensed nurses, social workers and department managers will be re-educated on resident-to- resident abuse. Random audits of environment and resident interactions will be conducted by nursing management and social services daily for 2 weeks, weekly for 4 weeks and monthly thereafter, results will be reported to QAPI committee for further evaluation and recommendation.	

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F 600	Continued From page 3	F 600		

then had dinner in the dining room. R2 exhibited to hallucinate. R2 had altered perception or awareness of surrounding, episodes of disorganized speech, periods of restlessness and his mental function varied through out the day. Behavioral symptoms included wandering, physically abusive and socially inappropriate or disruptive. Staff reported R2 was very agitated and hallucinating.

R2's PN dated 11/2/21, at 11:42 a.m. indicated R2 had a couple aggressive outbursts since admission The PN also indicated on 10/27/21, the incident was "very" out of character for R2. The plan was to ensure R2 was fed early in the dining room so staff could assist him out of the dining room prior to other residents to prevent further altercations.

R2's Provider PN dated 11/2/21, indicated staff reported on 10/27/21, that R2 had unprovoked physical aggression toward another resident [R6]. When staff tried to intervene R2 hit the staff member in the stomach. R2 had been observed walking around the unit muttering to himself and cursing. R2 had delusional thought of someone shooting him and shooting someone else. R2 was tearful and fearful. Nurse Practitioner (NP)-B planned to start Abilify (antipsychotic) 2 mg daily and for psychology and psychiatry consult.

R2's Psychology Note 11/10/21, indicated R2 had moderate distress which affected his overall well-being. R2 had periods of agitation, aggression, and a history of anxiety. R2 was somewhat irritable and agitated, particularly when others get in the way of fixing the floor. Staff reported several incidents of aggression toward others.. Earlier in the week became agitated and

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was difficult to redirect. R2 remained delusional and agitated during visit. R2 became more agitated when people attempted to help him move to a less busy area. Treatment recommendations included flowing with delusion and validation of the work R2 did; clear the space of other residents when R2 was focused on a delusion over trying to redirect him.

R2's PN dated 11/12/21, at 2:00 p.m. indicated it was alleged that R2 scratched R1's face in R1's room. Staff did not witness the incident. R1 and R2 were on memory care unit and were poor historians. R2 was placed on 30-minute checks. Staff separated, kept R2 away from R1 to ensure both residents did not interact and were kept safe.

R2's Provider PN dated 11/12/21, at 3:22 p.m. indicated NP-B spoke with R2's daughter and updated on recent visit. R2 had increased disturbing visual hallucinations, and unprovoked anger outbursts. NP-B recommended Olanzapine (antipsychotic) 2.5 e.g. every day and explained the risk versus benefits. NP-B indicated a conversation with nursing about a physical alteration when R2 hit another resident [R1].

R2's PN dated 11/13/21, at 4:38 a.m. indicated a resident-to-resident altercation. A resident reported that R2 was physical with her in her room. The resident [R1] reported she had a scratch on her face and lips. R2 moved independently on the floor and placed on 30 minute checks.

R2's PN dated 11/16/21, at 3:02 p.m. indicated social service (SS)-A spoke with R2's NP today. R2's NP recommended a psychiatry appointment

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to be made for R2. SS-A scheduled an appointment.

R4's Face Sheet dated 11/17/21, indicated intervertebral disc degeneration of lumbar region, Parkinson's disease, cognitive communication deficit, aphasia, muscle weakness, Lewy bodies dementia, delusional disorders, and pain.

R4's annual MDS dated 8/20/21, indicated severe cognitive impairment. R4 required extensive assist with bed mobility, transfers, and locomotion on the unit. R4 used a walker and wheelchair for mobility.

R4's PN dated 9/11/21, at 2:00 p.m. indicated R4 sat in his wheelchair in front of the nurses station facing the dining hall. Around 1:30 p.m. R2 stood behind R4 and started to yell at him. R2 punched R4 a few times on his upper arm area and tried to tip him off his wheelchair before staff could get to him. R4 reported, "I got hurt" and pain level of 5/10. R4 complained of pain of his right upper arm. R4 was provided Tylenol.

R5's Face Sheet dated 11/17/21, indicated diagnoses of Alzheimer's with behavioral disturbances and anxiety.

R5's quarterly MDS dated 8/13/21, indicated severe cognitive impairment. R4 was independent with bed mobility, transfers, and walking.

R5's PN dated 9/11/21, at 3:05 p.m. indicated R5 tried to intervene in an altercation between R2 and R4. R2 held R5's hand which resulted in a scratch which measured 8 cm long on left forearm. The altercation also caused the left side

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of R5's gasses frame to became loose and bent. R5's injury site was cleaned.

R5's Incident/Injury report dated 9/11/21, indicated R5 got into an alteration which involved two other residents [R2, R4]. R5 obtained a scratch on left lower arm.

R6's Face Sheet dated 11/18/21, indicated diagnoses of Alzheimer's, pain, pain in left ankle and joints of left foot, and superficial injury of left ankle.

R6's significant change MDS dated 10/4/21, indicated severe cognitive impairment. R6 required extensive assist with bed mobility, limited assist with transfers, and walked independently.

There was no documentation related to the incident when R2 grabbed R6's right ankle and tried to pull R6 out of her wheelchair.

R1's Face Sheet dated 11/17/21, indicated vascular dementia, pain, weakness, and anxiety disorder.

R1's significant change MDS dated 9/9/21, indicated severe cognitive impairment. R1 did not wear corrective lenses and her vision was adequate. R1 required limited assist for transfers and walking. R1 required extensive assist with locomotion on the unit and used a walker or wheelchair for mobility.

R1's Care Plan dated 11/18/21, indicated psychosocial well-being resident alleged resident came into her room. The goal would be for R1 to feel safe from harm.

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R1's PN dated 11/12/21, at 2:43 p.m. indicated the PN was edited on 11/16/21, at 3:27 p.m. The PN indicated R1 had an altercation. R1 reported there was a man in her room. R1 told him "Goodbye" about 2 or 3 times, then the man hit R1 in the face per R1's report. The incident was unwitnessed. R1 sustained a scratch to her left jaw which measured 1.3 cm, a scratch to her lower lip and redness to the bridge of her nose which measured 1.8 cm. R1's scratches were cleaned with nasal saline and gauze. R1's left jaw was covered with a bandage.

R1's PN dated 11/15/21, indicated there was a purple bruise noted under R1's left eye. R1 alleged that she was hit in her eye, and she obtained the bruise.

R1's skin observation dated 11/15/21, indicated a dark, purple bruise under R1's left eye which measured 3 cm by 2 cm. The surrounding area was swollen. R1 had as needed Tylenol for discomfort. It was unknown the activity R1 did prior. The type of injury was an altercation. RN-B was notified of an incident which involved two residents. R1 was interviewed and reported a man was in her room. R1 stated goodbye about 2-3 times then the man hit her in the face. Both residents were kept far apart to make sure they do not interact.

During an observation on 11/17/21, at 10:27 a.m. R1 and R2 had rooms next to each other. R2's room was the last room down the hallway to the right and R1's room was 2nd to last room down the same hallway on the right.

During an observation and interview on 11/17/21, at 11:15 a.m. there was a room which was

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separated by a curtain and R1 was to the right. R1 sat in a chair in her room. R1 had no glasses on. R1 had a large dark bruise on the left side of her face near her nose. There was also a scar to the left side of her lip. When asked what happened R1 stated, "It was a man who decided to punch me." R1 stated the staff spoke to the man and stated they would keep a better eye on him. R1 stated she could point him out if she saw him. R1 further stated when she has seen him since the incident she just walks away quickly as she did not want to cause any trouble or have anyone act like that to her again. R1 further stated she had never had anyone "attack" her before. R1 stated her face hurt, was tender and thought the man broke her nose. R1 stated she felt safe at the facility but did not feel safe if the man who assaulted her was around.

During an observation and interview on 11/18/21, at 1:53 p.m. R1's door frame had a Velcro sign which hung to one side and did not connect to the other side of the door frame. R1 sat in her room in a chair in her room. R1 had no glasses on and stated she did not wear glasses. R1 stated her nose was still tender. R1 showed her right arm which had an approximate 6 inch by 2-inch bruise on the inner side of her elbow which extended from the radius to the humerus.

During an interview on 11/17/21, at 11:02 a.m. LPN-A stated when R2 hallucinated he swung his hands. R2 got upset when there was a lot of noise. LPN-A stated R2 wandered and was often on the floor picking up stuff. LPN-A stated R2 yelled, shouted, and screamed sometimes during cares as he appeared to not want people to touch him. LPN-A stated there was an incident on 11/12/21, when R1 came out of her room and told

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

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her and companion (C)-A that a man hit her. LPN-A stated R1 stated R2 hit her after R1 told R2 to get out of her room. LPN-A stated shortly after the incident, R1 stated that was him, he was still there and pointed at R2 whom was in the hallway right outside R1's door. LPN-A stated registered nurse (RN)-A came and R1 told RN-A that a man hit her and again pointed to R2. LPN-A stated R2 caused R1 to have a scratch on her lip and under her eye.

During an interview on 11/17/21, at 11:22 a.m. C-A stated on 11/12/21, she had been in the lobby area by the community television with other residents when R1 came out of her room looking for help. C-A stated R1 appeared distressed and looked different than usual. C-A further stated she asked R1 what happened when she saw R1's lip was bleeding, and a cut on her lower cheek. C-A stated R1 told her someone went into her room and punched her. C-A stated R1 pointed to R2 as the man who hurt her. C-A stated LPN-A helped clean R1 up. C-A stated about 15 minutes later she went to give R1's roommate linen and found the roommate was really worked up about the incident. C-A stated someone hurt R1 and she thought it was R2 who assaulted R1. C-A further stated she thought it was R2 as R2 was the only one in the hall outside R1's door right after the incident. R2 had recent aggressive behaviors which no one else on that wing had and R1 pointed to R2 twice that he was the one who assaulted her and her conversation with R1's roommate.

During an interview on 11/17/21, at 11:48 a.m. RN-A stated on 11/12/21, LPN-A came to her and told her there was an incident that involved R2 and R1. RN-A stated R1 was by the nurse's

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station, and she asked her what happened. RN-A stated R1 told her that she told a man "goodbye" and to leave when he came into her room. RN-A further stated R1 stated the man hit her in the face then pointed to R2. RN-A stated she thought it was R2 as she pointed directly at him and she could see him by R1's door. RN-A stated R1 had a scratch on her left jaw, redness on the bridge of her nose and blood on her lip. RN-A stated she put a band aide on her jaw, cleaned up the blood and tried to assure R1 she was ok. RN-A further stated she thought a staff member spoke to R2 and R2 stated he had hit someone but was not able to say who due to his dementia.

During an interview on 11/17/21, at 1:10 p.m. LPN-B stated R2 was a good resident but had his moments. LPN-B stated there was an incident recently when R2 suddenly got upset, lifted a chair and aggressively shook it in front of the nurse's station. LPN-B stated there was another incident on 9/11/21, when R2 came from the hall up to R4 whom sat at the nurses station and shook his wheelchair. LPN-B further stated R5 tried to intervene the altercation between R2 and R4. LPN-B stated R5 tried to pull R2 away from R4 but R5 but ended up getting scratched. LPN-B stated he was not sure if the incident or if R2 caused R5 to get scratched on his forearm. LPN-B further stated R5 was not successful when he tried to pull R2 from R4 before staff intervened. After the incident R4 ended up with pain in his right arm.

During an interview on 11/17/21, at 1:36 p.m. RN-B stated after the incident on 11/12/21, thirty-minute checks were put into place for R2 and R1. The social worker who saw all residents monthly continued to see R2, and placed a stop

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sign on R1's door and kept R1's door shut. RN-B further stated R1 did not like her door shut but staff shut it anyway to keep R2 from wandering into her room. RN-B stated the interdisciplinary team (IDT) felt the incident on 9/11/21, was related to the programing of war on television as R2 was a war vet therefore staff were going to be mindful of their programing. RN-B stated before the incident on 9/11/21, R2 yelled and talked load about the war. RN-B stated R4 could have also said something that set R2 off as R4 had a history to do this. RN-B stated the facility discussed this incident but did not feel it needed to be reported as it was an "off situation" and R5 only got a scratch. RN-B did not mention that R4 had a pain level nor that he stated he got hurt after the incident. RN-B further stated there was an incident on 10/27/21, when R2 grabbed R6's foot and tried to pull R6 out her wheelchair. RN-B stated this was a one time thing. RN-B further stated after the incident the facility decided to make sure everyone was out of the dining room, and lock the dining room doors so the residents can be supervised. RN-B stated she concluded that the incident was unsubstantiated on 11/12/21, as both residents had cognition issues and there were no staff who witnessed the incident. RN-B did not comment when asked if she took into consideration when R1 pointed out R2 as the man who punched her and that he was the only one outside of R1's room after the incident. RN-B further stated the facility did put a stop sign in front or R1's door to prevent R2 from entering and were in the process of medication changes for R2.

During an interview on 11/17/21, at 2:14 p.m. SS-A stated on 11/12/21, LPN-A came to her and stated R2 hit R1 and wanted direction on what to

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do. SS-A called the director of nursing (DON) and informed her of the situation. SS-A stated she hung out with R2 after R1 stated R2 hit her. SS-A further stated R2 was agitated and was not sure why therefore SS-A sang to him. SS-A stated it was uncommon for R2 to get aggressive towards other residents, only staff.

During an interview on 11/18/21, at 12:11 p.m. SS-A stated she was involved in the investigation after the incident. SS-A stated she conducted resident interviews and asked if they felt safe. SS-A stated she did not look into R1's schedule prior to the incident as R1 was in her room. SS-A stated R1 continued to state that a man hit her following the incident on 11/15/21. SS-A stated R2 was the only one that wandered and was aggressive on the unit but since staff did not see what happened there could be no conclusion made. SS-A stated she did not explore what R1 or R2 were doing prior to the incident. SS-A verified she did not explore other ways R1 obtained the bruising and cuts when asked. SS-A stated the conclusion was undetermined as it was unwitnessed by staff. SS-A also stated she did not explore abuse from staff or conduct an investigation related to how she obtained the injuries after the conclusion was made. SS-A stated R1 may have gotten the bruise from falling asleep with her glasses on.

During an interview on 11/18/21, at 12:31 p.m. the administrator stated "allegedly" R1 came into the lounge area from her room which was down the hallway and told LPN-A and C-A that a man had hit her. The administrator stated there were other residents in the lobby when R1 pointed at R2 and R2 was the only person in the hallway by R1's room. The administrator stated it was

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unwitnessed by staff therefore the facility did not think R2 hit R1. The administrator stated R2 did not typically wander into other residents' room therefore the facility felt R2 likely fell asleep with her glasses on. (R2 wandered into another resident's room the following day and R2 does not wear glasses regularly). The administrator stated the bruise under R1's left eye could have been from her glasses but was not aware of R1's bloody lip when asked.

During an interview on 11/18/21, at 12:58 p.m. family member (FM)-A stated she was informed the facility planned to make changes to R2's medication since it was reported by R1 that R2 hit her.

During an interview on 11/18/21, at 1:12 p.m.. FM-B stated the facility informed her that R1 was assaulted by another resident on the unit. FM-B stated the facility informed her they knew who the resident was. FM-B stated R1 told her on 11/12/21, she was in her recliner and a man came into her room and started to "monkey around" with her things. FM-B stated R1 told the man "good bye, good bye" but the man would not leave. FM-B stated R1 said the man got angry and hit her in the eye, face and grabbed her arm real hard. FM-B stated R1 obtained a cut lip and bruises from the incident. FM-B stated she was initially mad and concerned for R1 when she heard what happened. FM-B further stated on 11/17/21, she visited R1 and saw the bruises. FM-B stated R1 looked like she hurt and had been beaten up. FM-B stated she still had a bruise on her arm with scratches and bruises on her face. FM-B also stated R1 never wore glasses, and the bruises could not be from glasses as they were too large. FM-B stated R1

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had dementia but was not one to come up with an allegation against people and would never state something about another person hurting her if it was not true. FM-B further stated again the facility informed her that another resident hurt R1 and put interventions in place to prevent it from happening again.

During two separate interviews 11/18/21, at 2:00 p.m. and 2:07 p.m. NA-B and NA-C stated R2 did not wear glasses.

During an interview on 11/18/21, at 2:13 p.m. RN-B stated she was not aware of the large bruise on R1's arm as R1 refused a skin assessment after the incident. RN-B verified R1 had a large bruise on her face but could not make the conclusion that R2 assaulted R1. RN-B further stated R1 had not made an allegation against another resident before and there was no other resident on the unit who were physically aggressive. Although R1 pointed to staff twice that R2 assaulted her, R2 was the only one in the hall after the incident, R2 was the only resident with physical aggression on the unit, R2 was found in another resident room the following day. RN-B stated she could not conclude R2 punched R1 as staff did not witness despite all the evidence.

During an interview on 11/18/21, at 2:52 p.m. the administrator stated they could not prove that R1 had assaulted R2 as no staff witnessed. The administrator stated again that R2's injury could have been from the glasses she wore or rolled out of bed but was unsure. The administrator stated she trusted that RN-B and her team would have investigated other reasons for how R2 obtained the facial injury and directed details to

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F 600	Continued From page 15 the investigation to them. The administrator stated again she believed it was to related to R1 falling asleep with her glasses on. The facility policy Abuse Prohibition, Investigation, and Reporting Policy dated 2/21, indicated each resident shall be free from physical, verbal, sexual, emotional, neglect or mental abuse and financial exploitation by staff, family, visitor, or another resident. Incidents and reports will be reported to the SA per the most recent State Operations Manual (SOM) and Federal regulation. If the event that caused the allegations involve abuse or result in serious bodily injury the incident should be reported to the SA immediately but no later than two hours after the allegation was made. If the event does not involve abuse and does not result in serious bodily injury the incident should be reported no later than 24 hours.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		1/3/22

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F 609	Continued From page 16 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State Agency (SA) was notified within two hours of all allegations of abuse, when R2 was physically abusive towards 2 of 4 residents (R3, R4) on the memory care unit. Findings include: R2's Face Sheet dated 11/18/21, indicated diagnoses of Alzheimer's, delusional disorder, vascular dementia with behavioral disturbances. R2's Provider progress note (PN) dated 9/11/21, indicated R2 had an altercation with another resident [R4]. R2 hit and tried to pick up this resident [R4] in his wheelchair and tip him over. Staff stated another resident [R5] tried to intervene. R2 became upset with the other resident [R5] and scratched him. [R5] had an 8.0 cm scratch on his forearm. R2 also broke the glasses of another resident [R5]. Staff felt watching 9/11/21, documentary likely triggered R2.	F 609	F609 There is no record of R3 interacting with R2 at any time. R3 is at baseline and expresses she is safe in the environment. R4 has no recollection of the incident and has not displayed any signs of distress related to the interaction. No changes to the care plans were necessary. All residents have the potential to be impacted by late reporting to the SA. The policy and procedure for Abuse Prevention investigation and reporting has been reviewed. Licensed nurses, social workers and department managers will be re-educated on timely reporting. Facility incident reports from November 18, 2021, to current will be reviewed for the potential to be affected by the same deficient practice. Random audits of facility events to identify late reporting of abuse will be done by Nurse Management five times a week for one month, then three times a week until compliance is achieved. Nurse	

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F 609	Continued From page 17 R4's Face Sheet dated 11/17/21, indicated diagnoses of Parkinson's disease, cognitive communication deficit, aphasia, Lewy bodies dementia. R4's PN dated 9/11/21, at 2:00 p.m. indicated R4 sat in his wheelchair in front of the nurses station facing the dining hall. Around 1:30 p.m. R2 stood behind R4 and started to yell at him. R2 punched R4 a few times on his upper arm area and tried to tip him off his wheelchair before staff could get to him. R4 reported, "I got hurt" and pain level of 5/10. R4 complained of pain of his right upper arm. R4 was provided Tylenol. R4's PN dated 9/13/21, at 12:00 p.m. indicated RN-B completed an investigation and no action taken as R4 was not unaffected by the altercation. R5's Face Sheet dated 11/17/21, indicated diagnoses of Alzheimer's with behavioral disturbances and anxiety. R5's PN dated 9/11/21, at 3:05 p.m. indicated R5 tried to intervene an altercation between R2 and R4. R2 held R5's hand which resulted in a scratch which measured 8 cm long on left forearm. The altercation also caused the left side of R5's gasses frame to became loose and bent. R5's injury site was cleaned. The facility Vulnerable Adult (VA) reported incident log dated 11/17/21, had no indication the incident on 9/11/21, was reported to the SA. During an interview on 11/17/21, at 1:10 p.m. licensed practical nurse (LPN)-B stated there was	F 609	Management will monitor and review information and forward results to the QAPI committee for further review and recommendations.	

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F 609	Continued From page 18 an incident on 9/11/21, when R2 came from the hall up to R4 whom sat at the nurse's station and shook his wheelchair. LPN-B further stated R5 tried to intervene in the situation between R2 and R4. LPN-B stated R5 tried to pull R2 away from R4 but R5 ended up getting scratched. LPN-B stated R4 ended up with pain in his right arm and was sore after the incident. During an interview on 11/17/21, at 2:52 p.m. the administrator stated when the facility looks to report they see if it was willful. The administrator further stated people do accidentally run into people therefore they did not report the incident between R2, R4 and R5. The administrator also stated they did not think they needed to report as there was no serious harm or injury to R4 or R5. The administrator stated she would expect allegation of abuse to be reported to the SA immediately. The facility policy, Abuse Prohibition, Investigation, and Reporting Policy dated 2/21, indicated each resident shall be free from physical, verbal, sexual, emotional, neglect or mental abuse and financial exploitation by staff, family, visitor, or another resident. Incidents and reports will be reported to the SA per the most recent State Operations Manual (SOM) and Federal regulation. If the event that caused the allegations involve abuse or result in serious bodily injury the incident should be reported to the SA immediately but no later than two hours after the allegation was made. If the event does not involve abuse and does not result in serious bodily injury the incident should be reported no later than 24 hours.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation	F 610		1/3/22

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F 610	Continued From page 19 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 1 residents (R1) who alleged she was hit in the face by R2. Findings include: The facility R1's Allegation Conclusion dated 11/17/21, indicated R1 told two staff members, "he hit me." The alleged perpetrator [R2] was in the hallway at the time R1 reported this to staff. Social service (SS)-A met with R2 whom was nonsensical. R1's story remained consistent that she was hit in the face by the alleged perpetrator [R2]. R2 had a history to wander but the report indicated R2 did not wander into other residents' room. Staff who were interviewed did not observe	F 610	F610 An investigation was completed on the allegations by R1. All residents have the potential to be impacted by failure to investigate an allegation of abuse. The policy and procedure for Abuse Prevention Investigation and Reporting has been reviewed. Licensed nurses, social workers and department managers will be educated on investigation of allegations of abuse on December 20th, 2021. Random audits of facility events to identify failure to investigate abuse will be done by Nurse Management five times a week for one month, then three times a week until compliance is achieved. Nurse Management will monitor and review	

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F 610	Continued From page 20 or hear the allegation. R2 and R1 were put on 30-minute checks, R2's medications were reviewed and was recommended for psychiatric visit. R1 received a stop sign on her door as well as a Velcro net stop sign across her door. R1's daughter was interviewed which indicated she was ok her mom got punched in the face as, "as these things happen." The allegation note indicated there was no reason to believe that the two residents were in the same room or had an interaction with each other. R2's Face Sheet dated 11/18/21, indicated diagnoses of Alzheimer's, delusional disorder, and vascular dementia with behavioral disturbances. R2's admission Minimum Data Set (MDS) dated 8/18/21, indicated severe cognitive impairment. R2 wandered four to six days a week which significantly intruded on the privacy of activities of others. R2's progress note (PN) dated 11/12/21, at 2:00 p.m. indicated it was alleged that R2 scratched R1's face in R1's room. Staff did not witness the incident. R1 and R2 were on memory care and were poor historians. R2 was placed on 30-minute checks. Staff kept R2 away from R1 to ensure both residents did not interact and were kept safe. R1's Face Sheet dated 11/17/21, indicated vascular dementia, pain, weakness, and anxiety disorder. R1's PN dated 11/12/21, at 2:43 p.m. indicated the PN was edited on 11/16/21 at 3:27 p.m. R1 reported there was a man in her room. R1 told	F 610	information and forward results to the QAPI committee for further review and recommendations.	

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	245439	A. BUILDING _____ B. WING _____	C 11/18/2021

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F 610	Continued From page 21	F 610		

him "goodbye" about 2 or 3 times, then the man hit R1 in the face per R1's report. The incident was unwitnessed. R1 sustained a scratch to her left jaw which measured 1.3 cm, a scratch to her lower lip and redness to the bridge of her nose which measured 1.8 cm. R1's scratches were cleaned with nasal saline and gauze. R1's left jaw was covered with a bandage.

R1's PN dated 11/15/21, indicated there was a purple bruise noted under R1's left eye. R1 alleged that she was hit in her eye, and she obtained the bruise.

R1's Skin Observation dated 11/15/21, indicated a dark, purple bruise under R1's left eye which measured 3 cm by 2 cm. The surrounding area was swollen. R1 had as needed Tylenol for discomfort. It was unknown the activity R1 did prior. The type of injury was an altercation. Registered nurse (RN)-B was notified of an incident which involved two residents. R1 was interviewed and reported a man was in her room. R1 stated "goodbye" about 2-3 times then the man hit her in the face. Both residents were kept far apart to make sure they do not interact.

During an observation on 11/17/21, at 10:27 a.m. R1 and R2 had room next to each other. R2's room was the last room down the hallway to the right and R1's room was 2nd to last room on the right.

During an observation and interview on 11/17/21, at 11:15 a.m. R1 sat in a chair in her room with no glasses on. R1 had a large dark bruise on the left side of her face near her nose. There was also a scar to the left side of her lip. When asked what happened R1 stated, "It was a man who decided

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F 610	Continued From page 22	F 610		

to punch me." R1 stated the staff spoke to the man and stated they will keep a better eye on him. R1 stated she could point him out if she saw him. R1 further stated when she has seen him since the incident she just walks away quickly as she did not want to cause any trouble or have anyone act like that to her again. R1 further stated she had never had anyone "attack" her before. R1 stated her face hurt, was tender and thought the man broke her nose. R1 stated she felt safe at the facility but did not feel safe if the man who assaulted her was around.

During an observation and interview on 11/18/21, at 1:53 p.m. R1 sat in her room in a chair and wore no glasses. R1 stated she did not wear glasses. R1 stated her nose was still tender she felt the man broke it. R1 stated the man hurt her arm too. R1 showed her right arm which had an approximate 6 inch by 2 inch bruise on the inner side of her elbow which extended from the radius to the humerus.

During an interview on 11/17/21, at 11:02 a.m. LPN-A stated R1 went to companion (C)-A and told C-A that R2 hit her after R1 told R2 to get out of her room. LPN-A stated R1 said that was him, he was still there and pointed at R2 whom was in the hallway right outside R1's door. LPN-A stated RN-A came and R1 told RN-A that a man hit her and again pointed to R2. LPN-A stated R2 had a scratch on her lip and under her eye.

During an interview on 11/17/21, at 11:22 a.m. C-A stated on 11/12/21, she had been in the lobby area by the community television with other residents when R1 came out of her room looking for help. C-A stated R1 appeared distressed and looked different than usual. C-A further stated she

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asked R1 what happened when she saw R1's lip was bleeding, and a cut on her lower cheek. C-A stated R1 told her someone went into her room and punched her. C-A stated R1 pointed to R2 as the man who hurt her. C-A further stated she thought it was R2 as R2 was the only one in the hall outside R1's door right after the incident, R2 had recent aggrieve behaviors which no one else on that wing had and R1 pointed to R2 twice that R2 was the one who assaulted her.

During an interview on 11/17/21, at 1:36 p.m. RN-B stated she concluded that the incident was unsubstantiated on 11/12/21, as both residents had cognition issues and there were no staff who witnessed the incident. RN-B did not comment when asked if she took into consideration that R1 pointed out R2 as the man who punched her and that he was the only one outside of R1's room after the incident. RN-B stated again since no staff saw the incident it was not substantiated. RN-B verified the facility did not start an investigation until 11/15/21, which was three days after the incident was made on 11/12/21.

During an interview on 11/18/21, at 12:11 p.m. SS-A stated the conclusion of the incident was undetermined as it was unwitnessed by staff. SS-A stated she was involved in the investigation after the incident. SS-A stated she conducted resident interviews and asked if they felt safe. SS-A stated R1 continued to state that a man hit her following the incident. SS-A stated R2 was the only one that wandered and was aggressive on the unit but since staff did not see what happened there could be no conclusion made. SS-A also verified she did not investigate other ways R1 obtained the bruising and cuts when asked. SS-A also stated she did not explore abuse from staff

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or conduct an investigation related to how she obtained the injuries after the conclusion was made. SS-A stated she believed R1 got hurt from falling asleep with her glasses on.

During an interview on 11/18/21, at 12:31 p.m. the administrator stated "allegedly" R1 came into the lounge area from her room which was down the hallway and told LPN-A and C-A that a man had hit her and pointed at R2 whom was the only man down the hallway by R1's room. The administrator stated there were residents in the lobby but R2 was the only person in the hallway. The administrator stated there were no staff who observed the incident therefore the facility did not think R2 hit R1. The administrator stated R2 does not typically wander into other residents' rooms therefore the facility felt R2 likely fell asleep with her glasses on. The administrator stated the bruise under R1's left eye could have been from her glasses but was not aware of R1's bloody lip. The administrator left and stated she would come back with details related to the investigation.

During an interview on 11/18/21, at 1:21 p.m.. FM-B stated on 11/17/21, she visited R1 and saw the bruises. FM-B stated R1 looked like she hurt and had been beaten up. FM-B stated she still had a bruise on her arm with scratches and bruises on her face. FM-B also stated R1 never wore glasses, and the bruises could not be from glasses as they were too large. FM-B stated R1 was not one to come up with an allegation against people and would never state something about another person hurting her if it was not true. FM-B further stated again the facility informed her that another resident hurt R1.

During two separate interviews 11/18.21, at 2:00

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F 610	Continued From page 25 p.m. and 2:07 p.m. NA-B and NA-C stated R2 did not wear glasses. During an interview on 11/18/21, at 2:13 p.m. RN-B stated she was not aware of the large bruise on R1's arm since R1 refused a skin assessment after the incident. RN-B stated she was involved with conducting the investigation related to the incident on 11/12/21. RN-B stated she did not start an investigation until 11/15/21, as she was not aware of the allegation. RN-B verified R1 had a large bruise on her face but could not make the conclusion that R2 had been the one who assaulted R1. Although R1 pointed out to staff twice that R2 assaulted her, R2 was the only one in the hall after the incident, and R2 was the only resident with physical aggression on the unit. RN-B stated she could not conclude R2 punched her as staff did not witness despite all the evidence that R2 had done it. RN-B further stated R1 had not made an allegation against another resident before and there was no other resident on the floor who were physically aggressive. RN-B verified she did not conduct another investigation to find out other alternatives to how R2 obtained the facial wounds when she did not substantiate that R2 punched R1. RN-B did not comment when asked how she would substantiate an investigation or if she looked into potential abuse from staff. During an interview on 11/18/21, at 2:52 p.m. the administrator stated they could not prove that R1 had been assaulted by R2 as no staff witnessed the incident. The administrator stated again that R2's injury could have been from the glasses she wore or rolled out of bed but was unsure. The administrator stated she trusted that RN-B and her team would have investigated other reasons	F 610		

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F 610	Continued From page 26 for how R2 obtained the facial injury and directed details to the investigation to them. The administrator stated again she believed it was to relate to R1 falling asleep with her glasses on. The facility policy, Abuse Prohibition, Investigation, and Reporting Policy dated 2/21, indicated each resident shall be free from physical, verbal, sexual, emotional, neglect or mental abuse and financial exploitation by staff, family, visitor, or another resident. When a complaint or abuse is suspected the investigation will include any and all persons, whether staff or visitors present at the time of the alleged incident. The investigation will include interview with other residents and staff who may have had interactions with the alleged perpetrator. The investigation would be written in detail when concluded.	F 610		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 10, 2021

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

Re: Event ID: GV7V11

Dear Administrator:

The above facility survey was completed on November 18, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with 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
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