Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 25, 2024

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

RE: CCN: 245439
Cycle Start Date: February 23, 2024

Dear Administrator:

On April 15, 2024, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 25, 2024

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

Re: Reinspection Results
Event ID: UPEC12

Dear Administrator:

On April 15, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 23, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 29, 2024

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

RE: CCN: 245439
Cycle Start Date: February 23, 2024

Dear Administrator:

On February 23, 2024, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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"and/or an "E" 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 May 23, 2024 (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 August 23, 2024 (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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 29, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: UPEC11

Dear Administrator:

The above facility was surveyed on February 21, 2024 through February 23, 2024, 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:

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

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 02/23/2024

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
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 2/21/24 - 2/23/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed

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 02/23/2024

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
2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed with no licensing orders issued. H54399982C (MN100823) The following complaints were reviewed. H54399850C (MN100854/MN100884) with a licensing orders issued at 0565 and 0435 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 surveyor's 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000		

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 02/23/2024

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
2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to identify, keep resident appraised of ongoing efforts or resolve an ongoing grievance for 1 of 3 residents (R2) reviewed. R2 had a roommate who would cry and scream out at night. In addition, the roommate would wander into R2's side of the room and R2 would have to	2 435	corrected	4/8/24

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 02/23/2024

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
2 435	Continued From page 3	2 435		

call the nurses station almost daily to have the roommate removed.

Finding Include:

R2's nursing progress note dated 1/6/24 at 5:37 a.m. indicated R2 was awake most of the night and concerned about the new roommate. R2 indicated the roommate was disturbing her with noise. She requested the roommate should be moved.

R2's nursing progress note dated 1/6/24 at 3:06 p.m. indicated R2 complained of not being to sleep at night due to disturbances by roommate. Family member (FM)-A spoke with staff about the possibility of relocating the roommate due to the resident not being able to sleep. Staff informed FM-A and R2 that frequent checks would be conducted to prevent disturbances and handle the situation accordingly.

R2's annual Minimum Data Set (MDS) dated 1/10/24, indicated R2 had a Brief Inventory of Mental Status (BIMs) score of 15 indicating no cognitive impairment. R2 required extensive assistance for activities of daily living. R2's pertinent diagnoses included Multiple Sclerosis, acute respiratory failure, displaced comminuted fracture of shaft of humerus right arm, age related osteoporosis and muscle weakness.

R2's social service progress note dated 1/26/24 indicated R2 expressed difficulty adjusting to her new roommate during the care conference. Social worker (SW)-A offered Associated Clinic of Psychology (ACP) visits for psychosocial support. R2 declined the visits.

R1's nursing progress note dated 1/7/24 at 5:03

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 02/23/2024

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
2 435		2 435		

Continued From page 4

a.m. indicated R1 was very confused all night trying to enter other resident's room.

R1's nursing progress note dated 1/11/24 at 10:24 p.m. indicated it was noted that R1 was going into roommates' side of the room (R2) and needed assistance to go back to her room.

R1's admission MDS dated 1/12/24 indicated R1 had a BIMs score of 0 indicating severe cognitive impairment. R1's potential indicator of psychosis indicated R1 hallucinated. R1's behavior significantly interfered with her cares and was significantly intrusive on the privacy or activity of others. The MDS did not indicate that R1 wandered. R1 required substantial assistance of one staff member with activities of daily and required on supervision or touching assistance with transferring. R1's pertinent diagnoses were heart failure, major depressive disorder, recurrent, severe with psychotic symptoms, age-related cognitive decline, hallucinations, delirium, and delusional disorder.

R1's nursing progress note dated 1/16/24 at 2:12 p.m. indicated R1 was noted to into roommates' room and needed assistance to go back to her own room.

R1's nursing progress note dated 1/18/24 at 7:21 a.m. indicated R1 woke at 4:30 a.m. and roommate called that she is yelling and disturbing. She was brought to the wellness desk.

R1's nursing progress note dated 1/21/24 at 10:53 p.m. indicated R1 kept going into roommates' room and R2 kept calling the nurses statin to have the nurse help get her out.

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 02/23/2024

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
2 435	Continued From page 5 R1's nursing progress note dated 1/24/24 at 2:44 p.m. indicated in the early a.m. R1 was making loud noises. R1's nursing progress note dated 1/24/24 at 2:11 p.m. indicated in the early a.m. R1 was making loud noises. R1's nursing progress note dated 1/27/24 at 7:11 a.m. indicated R1's daughter left the facility about around 2:00 a.m. After the daughter left R1 was sitting up on her bed taking to herself and screaming. Her roommate was complaining and requesting something be done. R1 refused to leave the room. Staff was checking on R1 every 30 minutes, she later came out of room at 5:00 a.m. R1's nursing progress note dated 1/29/24 at 1:58 p.m. indicated R1 had elevated anxiety in the early a.m., making loud noises. R1's nursing progress note dated 1/30/24 at 11:41 a.m. indicated in the early a.m. R1 was making loud noises. R1's nursing progress note dated 1/30/24 at 8:50 p.m. indicated R1's family was at the facility until 7:00 p.m. even though family was there R1 was calling out and yelling every once in a while. R1's nursing progress note dated 1/31/24 at 12:31 p.m. indicated R1 was making loud noises early in the morning. R1 had two episodes of yelling and screaming. R1's roommate called several times to complain that R1 was disturbing her sleep. R1's nursing progress note dated 2/1/24 at 12:34 p.m. indicated early in the a.m. R1 was making	2 435		

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 02/23/2024

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
2 435	Continued From page 6	2 435		

loud noises calling out of her room.

R1's nursing progress note dated 2/1/24 at 10:22 p.m. indicated at 3:00 p.m. R1 was yelling. Nurse went in and she was sitting at the edge of her bed and did not want to lay down and said she wanted to go home upstairs and that she was looking for her children or someone to help take her room. Staff assisted her into her wheelchair. Not long after that her roommate called that and stated R1 had wandered into her room, and she was helped to the lobby. While out she was yelling and calling out. After dinner she wheeled herself back to the room and went to the roommate's room and was touching her food and her belongings. Roommate stated that it is so frustrating and depressing for her because she yells out at night, and she cannot sleep, and she roams into her personal space with which she is not comfortable.

R1's nursing progress note dated 2/7/21 at 12:51 p.m. indicated R1 was yelling and calling out early in the a.m.

Upon interview on 2/21/24 at 3:41 p.m. R2 stated her roommate R1 screamed and cried daily. R2 stated most nights she had to call the nurses to either remove R1 from her side of the room or take her away due to the crying and screaming. R2 stated she mentioned the screaming and lack of sleep at her last care conference on 1/26/24 and was told she should see a psychologist to cope. "At 97 years old why should I see therapy for another person screaming?"

Upon interview on 2/21/24 at 3:55 p.m. R2's family member (FM)-A stated the roommates screaming and wandering into R2's room had been happening for over a month. He stated no plan was ever discussed with him for a resolution.

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 02/23/2024

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
2 435	Continued From page 7 Upon interview on 2/21/24 at 4:18 p.m. RN-B stated she worked the p.m. shifts most often and R2 would call almost every shift to have R1 removed her side or the room or complaining of disturbances by R1. RN-B stated the staff did the best they could and would try to remove R1 from the room, but at times she would refuse and become combative with staff. RN-B stated she believed R1's family was offered a room in the memory care department, however they refused. Upon interview on 2/22/24 at 10:34 a.m. social worker (SW)-A stated R2 had mentioned the screaming of her roommate and how it made it difficult for R2 to sleep. SW-A stated she did not do a formal grievance. She stated the RN-A heard from other residents about the disturbances as well and believed RN-A was working on a resolution. SW-A stated R1's family would visit daily to help assist R1 and R1 was offered a room on the memory care unit, however the family refused. Upon interview on 2/22/24 at 11:45 a.m. licensed practical nurse (LPN)-A stated R1 would be screaming loudly between 6:00 and 7:00 a.m. waking R2 up. She stated staff would attempt to get R1 out of her room if R1 would allow. LPN-A was uncertain what the facility was doing about R1's behaviors and disruption of R2. Upon interview on 2/22/24 at 12:32 p.m. RN-A, the nurse manager stated she did not receive any formal complaints from residents on the unit but did overhear conversation between "some" residents about R1' s screaming and wandering RN-A stated she was aware that R2 often called the nurses on duty to remove R1 due to disturbances. RN-A stated she believed SW-A	2 435		

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 02/23/2024

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
2 435	Continued From page 8 was working on a formal grievance as R2 and FM-A reached out often to SW-A. Upon interview on 2/23/24 at 10:15 a.m. the director of nursing (DON) stated he was aware staff had to often redirect R1 due to disturbances and most of R1's disturbances occurred in the p.m. or overnight. The DON was not aware of any formal grievance or any resolutions. Upon interview on 2/23/24 at 10:30 a.m. the Administrator stated the facility had reached out the nurse practitioner and a couple of medications were made for R1. She stated the facility had mentioned the memory care unit the family, but the family declined. The Administrator denied any formal grievance or formal resolution regarding R2's concerns of lack of sleep due to R1. A grievance policy was requested; however, none was received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 435		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		4/8/24

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 02/23/2024

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
2 565	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement identified interventions to prevent alterations in mood and behavior for 1 of 1 resident (R1) reviewed. A video recording identified R1 needing assisting and staff entered the room as R1 was crying. The nursing assistant (NA)-A did not speak with R1, adjusted a blanket, turned off her light and left resident crying. Findings include: R1's care plan dated 1/7/24 indicated R1 had a potential for communication deficits due to ability to understand, ability to be understood, hallucinations or delusions and decision-making ability. R1's goal was to be able to follow instructions. The staff's approach was to break down instructions into simple tasks, avoid lengthy explanations, face R1 when speaking with her. In new situations support and reassure her. Obtain R1's attention before speaking with her. Provide a quiet, non-hurried environment, free of distractions or conversations. Encourage resident to voice feelings and concerns about mood, memory, perceived changes. Do not confront, argue against, or deny R1's hallucinations, explore R1's underlying feelings rather than the content of the hallucination (anxiety or fear). Provide a calm quiet environment. Use calm and positive approach. R1's admission MDS dated 1/12/24 indicated R1 had a BIMs score of 0 indicating severe cognitive	2 565	corrected	

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 02/23/2024

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
2 565	Continued From page 10	2 565		

impairment. R1's potential indicator of psychosis indicated R1 hallucinated. R1's behavior significantly interfered with her cares and was significantly intrusive on the privacy or activity of others. The MDS did not indicate that R1 wandered. R1 required substantial assistance of one staff member with activities of daily and required on supervision or touching assistance with transferring. R1's pertinent diagnoses were heart failure, major depressive disorder, recurrent, severe with psychotic symptoms, age-related cognitive decline, hallucinations, delirium, and delusional disorder.

R1's care plan dated 1/18/24 indicated R1 had a history of trauma. R1's goals were to feel safe and secure in her environments. The staff's approach per family on how to alleviate triggers were to redirect R1 and verbalize she was safe in the facility and to speak calmly with R1. Staff was to be active listeners and reassure R1 of her safety. Staff was to validate R1's feeling and encourage her to vent feelings as needed.

R1's care plan dated 1/28/24 indicated R1 had alteration in mood/behavior related to a diagnosis of psychosis, paranoia, schizophrenia, bipolar and borderline personality. Her symptoms were delusions and hallucinations. R1's goal was to be comfortable in her environment. States she feels safe at the facility and would respond to approaches and have less delusional episodes. The staff's approach was to communicate in her reality, avoid power struggles and all as much control as possible.

Video recording from 2/1/24 at 9:23 p.m. showed NA-A entered R1's room. R1 was seated on the edge of her bed quietly sobbing. R1's wheelchair is positioned directly in front of her. NA-A placed

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 02/23/2024

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
2 565	Continued From page 11	2 565		

her hands on the handles of the wheelchair. NA-A does not say anything to R1. NA approaches R1, tugs on the blanket over R1's legs, turns off the lights, and leaves the room. R1 started screaming loudly as soon as R1 touched the blanket. R1 sat at the edge of her bed crying out for two minutes and forty-three seconds when the video recording ended.

R1's nursing progress note dated 2/1/24 at 10:20 p.m. indicated after dinner R1 wheeled herself back to her room and went to her roommates' room and was helped out of the room as R1 was touching her food and other belongs. There was no documentation in the note about NA-A's interactions with R1 that evening.

Upon interview on 2/21/24 at 9:26 a.m. R1's family member (FM)-B On 2/1/24 she noticed after viewing a video recording the R1 was "neglected" by a nursing assistant. FM-B stated NA-A went into R1's room at 9:23 p.m. p.m. and found R1 seated on the side of her bed crying. FM-B was not certain why NA-A entered the room since R1 could not press her call button. She thought maybe for a safety check, or she heart R1 crying. She stated she then witnessed NA-A "abruptly" moved R1's blanket and shut off her lights leaving R1 in the dark. FM-B stated she could R1 saying on the video, do not turn off the lights and that's when R1 started screaming loudly as NA-A left her in the dark in her room without asking what her needs were.

Upon interview on 2/22/24 at 12:32 p.m. RN-B the nurse manager stated she was not aware that staff left R1 crying in the dark on 2/11/24. She stated staff should have followed the care plan and found out what R1 needed and if they unable to do that address the needed, they should have

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 02/23/2024

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
2 565	Continued From page 12	2 565		

reported any concerns to the nurse.

Upon interview on 2/23/24 at 9:19 a.m. NA-A stated she worked with R1 often. She did not recall an evening where she left R1 crying. She stated she would always ask R1 if she needed to use the restroom, needed water, or was having pain. NA-A stated if she found R1 sitting on the side of her bed she would assist her back in her bed, as R1 tended to slide out of her bed and crawl on the floor.

Upon interview on 2/23/24 at 10:15 a.m. the director of nursing (DON) stated his expectation of the nursing staff was to find out the residents' need was prior to leaving the residents rom. The NA should have contacted the nurse.

A policy regarding the implementation of care planning was requested however none received.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance.

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

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 02/23/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/21/24 - 2/23/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H54399982C (MN100823) The following complaints were reviewed. H54399850C (MN100854/MN100884) with a deficiencies issued at F656 and F689 Deficient practice was identified related to incidental finding at F585 and F609 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 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	F 585		4/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 03/07/2024

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 02/23/2024

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 585	Continued From page 1	F 585		

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 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

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 02/23/2024

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 585	Continued From page 2 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 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	F 585		

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 02/23/2024

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 585	Continued From page 3 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 interview and record review the facility failed to identify, keep resident appraised of ongoing efforts or resolve an ongoing grievance for 1 of 3 residents (R2) reviewed. R2 had a roommate who would cry and scream out at night. In addition, the roommate would wander into R2's side of the room and R2 would have to call the nurses station almost daily to have the roommate removed. Finding Include: R2's nursing progress note dated 1/6/24 at 5:37 a.m. indicated R2 was awake most of the night and concerned about the new roommate. R2 indicated the roommate was disturbing her with noise. She requested the roommate should be moved. R2's nursing progress note dated 1/6/24 at 3:06 p.m. indicated R2 complained of not being to sleep at night due to disturbances by roommate. Family member (FM)-A spoke with staff about the possibility of relocating the roommate due to the resident not being able to sleep. Staff informed FM-A and R2 that frequent checks would be conducted to prevent disturbances and handle the situation accordingly. R2's annual Minimum Data Set (MDS) dated	F 585	Preparation, submission, and implementation of the 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 constitute the facility's allegation of compliance. F585: R2□s grievance is resolved. All residents who had a grievance in the last 60 days will be re-interviewed to verify the resolution. Grievance policy and procedure reviewed and revised as necessary. Nurse managers and Social workers will be re-educated to identify and address grievances raised by residents. Random residents will be interviewed to ensure there are no unresolved concerns will be completed by Nurse Managers and Social workers daily for a week, weekly for a month, and quarterly thereafter.	

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 02/23/2024

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 585	Continued From page 4	F 585		

1/10/24, indicated R2 had a Brief Inventory of Mental Status (BIMs) score of 15 indicating no cognitive impairment. R2 required extensive assistance for activities of daily living. R2's pertinent diagnoses included Multiple Sclerosis, acute respiratory failure, displaced comminuted fracture of shaft of humerus right arm, age related osteoporosis and muscle weakness.

R2's social service progress note dated 1/26/24 indicated R2 expressed difficulty adjusting to her new roommate during the care conference. Social worker (SW)-A offered Associated Clinic of Psychology (ACP) visits for psychosocial support. R2 declined the visits.

R1's nursing progress note dated 1/7/24 at 5:03 a.m. indicated R1 was very confused all night trying to enter other resident's room.

R1's nursing progress note dated 1/11/24 at 10:24 p.m. indicated it was noted that R1 was going into roommates' side of the room (R2) and needed assistance to go back to her room.

R1's admission MDS dated 1/12/24 indicated R1 had a BIMs score of 0 indicating severe cognitive impairment. R1's potential indicator of psychosis indicated R1 hallucinated. R1's behavior significantly interfered with her cares and was significantly intrusive on the privacy or activity of others. The MDS did not indicate that R1 wandered. R1 required substantial assistance of one staff member with activities of daily and required on supervision or touching assistance with transferring. R1's pertinent diagnoses were heart failure, major depressive disorder, recurrent, severe with psychotic symptoms, age-related cognitive decline, hallucinations,

Results will be reported to QAPI committee for further evaluation and recommendation

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 02/23/2024

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 585	Continued From page 5	F 585		

delirium, and delusional disorder.

R1's nursing progress note dated 1/16/24 at 2:12 p.m. indicated R1 was noted to into roommates' room and needed assistance to go back to her own room.

R1's nursing progress note dated 1/18/24 at 7:21 a.m. indicated R1 woke at 4:30 a.m. and roommate called that she is yelling and disturbing. She was brought to the wellness desk.

R1's nursing progress note dated 1/21/24 at 10:53 p.m. indicated R1 kept going into roommates' room and R2 kept calling the nurses statin to have the nurse help get her out.

R1's nursing progress note dated 1/24/24 at 2:44 p.m. indicated in the early a.m. R1 was making loud noises.

R1's nursing progress note dated 1/24/24 at 2:11 p.m. indicated in the early a.m. R1 was making loud noises.

R1's nursing progress note dated 1/27/24 at 7:11 a.m. indicated R1's daughter left the facility about around 2:00 a.m. After the daughter left R1 was sitting up on her bed taking to herself and screaming. Her roommate was complaining and requesting something be done. R1 refused to leave the room. Staff was checking on R1 every 30 minutes, she later came out of room at 5:00 a.m.

R1's nursing progress note dated 1/29/24 at 1:58 p.m. indicated R1 had elevated anxiety in the early a.m., making loud noises.

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 02/23/2024

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 585	Continued From page 6	F 585		

R1's nursing progress note dated 1/30/24 at 11:41 a.m. indicated in the early a.m. R1 was making loud noises.

R1's nursing progress note dated 1/30/24 at 8:50 p.m. indicated R1's family was at the facility until 7:00 p.m. even though family was there R1 was calling out and yelling every once in a while.

R1's nursing progress note dated 1/31/24 at 12:31 p.m. indicated R1 was making loud noises early in the morning. R1 had two episodes of yelling and screaming. R1's roommate called several times to complain that R1 was disturbing her sleep.

R1's nursing progress note dated 2/1/24 at 12:34 p.m. indicated early in the a.m. R1 was making loud noises calling out of her room.

R1's nursing progress note dated 2/1/24 at 10:22 p.m. indicated at 3:00 p.m. R1 was yelling. Nurse went in and she was sitting at the edge of her bed and did not want to lay down and said she wanted to go home upstairs and that she was looking for her children or someone to help take her room. Staff assisted her into her wheelchair. Not long after that her roommate called that and stated R1 had wandered into her room, and she was helped to the lobby. While out she was yelling and calling out. After dinner she wheeled herself back to the room and went to the roommate's room and was touching her food and her belongings. Roommate stated that it is so frustrating and depressing for her because she yells out at night, and she cannot sleep, and she roams into her personal space with which she is not comfortable.

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 02/23/2024

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 585	Continued From page 7	F 585		

R1's nursing progress note dated 2/7/21 at 12:51 p.m. indicated R1 was yelling and calling out early in the a.m.

Upon interview on 2/21/24 at 3:41 p.m. R2 stated her roommate R1 screamed and cried daily. R2 stated most nights she had to call the nurses to either remove R1 from her side of the room or take her away due to the crying and screaming. R2 stated she mentioned the screaming and lack of sleep at her last care conference on 1/26/24 and was told she should see a psychologist to cope. "At 97 years old why should I see therapy for another person screaming?"

Upon interview on 2/21/24 at 3:55 p.m. R2's family member (FM)-A stated the roommates screaming and wandering into R2's room had been happening for over a month. He stated no plan was ever discussed with him for a resolution.

Upon interview on 2/21/24 at 4:18 p.m. RN-B stated she worked the p.m. shifts most often and R2 would call almost every shift to have R1 removed her side or the room or complaining of disturbances by R1. RN-B stated the staff did the best they could and would try to remove R1 from the room, but at times she would refuse and become combative with staff. RN-B stated she believed R1's family was offered a room in the memory care department, however they refused.

Upon interview on 2/22/24 at 10:34 a.m. social worker (SW)-A stated R2 had mentioned the screaming of her roommate and how it made it difficult for R2 to sleep. SW-A stated she did not do a formal grievance. She stated the RN-A heard from other residents about the disturbances as well and believed RN-A was

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 02/23/2024

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 585	Continued From page 8	F 585		

working on a resolution. SW-A stated R1's family would visit daily to help assist R1 and R1 was offered a room on the memory care unit, however the family refused.

Upon interview on 2/22/24 at 11:45 a.m. licensed practical nurse (LPN)-A stated R1 would be screaming loudly between 6:00 and 7:00 a.m. waking R2 up. She stated staff would attempt to get R1 out of her room if R1 would allow. LPN-A was uncertain what the facility was doing about R1's behaviors and disruption of R2.

Upon interview on 2/22/24 at 12:32 p.m. RN-A, the nurse manager stated she did not receive any formal complaints from residents on the unit but did overhear conversation between "some" residents about R1' s screaming and wandering RN-A stated she was aware that R2 often called the nurses on duty to remove R1 due to disturbances. RN-A stated she believed SW-A was working on a formal grievance as R2 and FM-A reached out often to SW-A.

Upon interview on 2/23/24 at 10:15 a.m. the director of nursing (DON) stated he was aware staff had to often redirect R1 due to disturbances and most of R1's disturbances occurred in the p.m. or overnight. The DON was not aware of any formal grievance or any resolutions.

Upon interview on 2/23/24 at 10:30 a.m. the Administrator stated the facility had reached out the nurse practitioner and a couple of medications were made for R1. She stated the facility had mentioned the memory care unit the family, but the family declined. The Administrator denied any formal grievance or formal resolution regarding R2's concerns of lack of sleep due to

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 02/23/2024

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 585	Continued From page 9 R1. A grievance policy was requested; however, none was received.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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 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	F 609	F609:	4/8/24

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 02/23/2024

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 609	Continued From page 10 facility failed to report allegations of abuse to the State agency (SA) for 1 of 3 residents (R2) reviewed who reported allegations of abuse in the facility. R2 and R2's family repeatedly reported allegations of rough treatment and verbal abuse to multiple facility staff over a six-month period. Findings include: R2's nursing progress note dated 8/29/23 indicated R2 reported pain to the left ribcage area below the breast and to her pelvic area. She stated it started after she was put to bed with the mechanical lift. She reported that she had the pain before when she is put to bed but then it goes away soon, but this time it had been constant and not going away. R2's annual Minimum Data Set (MDS) dated 1/10/24, indicated R2 had a Brief Inventory of Mental Status (BIMs) score of 15 indicating no cognitive impairment. R2 required extensive assistance for activities of daily living. R2's pertinent diagnoses included Multiple Sclerosis, acute respiratory failure, displaced comminuted fracture of shaft of humerus right arm, age related osteoporosis and muscle weakness. Upon interview on 2/21/24 at 3:41 p.m. R2 stated the staff "hurts" her when they are doing cares. She stated staff had told her she needs to stop using her light so often. She stated this occurred from the fall of 2023 until about after the new year of 2024. R2 stated it was one female nursing assistant (NA) who told her she needed to stop using the call light all the time. R2 was unable to identify which NA, stating "they don't wear their name tags." R2 stated there was a male NA who was rough with her putting her to bed at night with	F 609	The allegation by R2 has been reported to State Agency. An audit of all residents' progress records will be reviewed for the last 30 days to identify any similar instances of unreported abuse or neglect. Any such instances will be immediately reported to the State Agency. The policy and procedure for Abuse Prevention Investigation and Reporting will be reviewed and revised as necessary. All Licensed staff, nursing assistants, and social workers will receive training on the policy and procedure for Abuse Prevention Investigation and Reporting. Random audits of facility staff will be conducted for any reports of alleged abuse or neglect and will be completed by the Nurse Manager and SW daily for a week, weekly for a month, and quarterly thereafter. Results will be reported to QAPI committee for further evaluation and recommendation.	

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 02/23/2024

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 609 Continued From page 11 F 609

the use of the mechanical lift. She stated she felt abused with the way the NA "forcefully moved my body" and felt "uncared for" when she was told to not use her light so often. R2 only used her call light after the comments when she was soiled with bowel movements. R2 also stated that "most" staff does not knock on her door, introduce themselves or tell her what they are there to do. R2 stated her complaint was voiced to the nurse manager on the unit, the social worker (SW)-A and it was brought up a care conference help in the fall of 2023.

Upon interview on 2/21/24 at 3:55 R2's family member (FM)-A stated he mentioned staff was abusive to R2 at a care conference last fall. FM-A stated the facility was going to investigate the allegations. FM-A stated nothing had changed so he again mentioned the abuse allegations to the social worker (SW)-A on the until and was told he had to write up a complaint. FM-A did file a written complaint. R2's family was looking for a different facility, however FM-A stated, "things have been o.k. for the past month." FM-A stated he did not inform the facility as to why he was looking for a new facility due to fear or retaliation for R2.

Upon interview on 2/21/24 at 4:18 p.m. registered nurse (RN)-B stated R2 used to complain of pain when staff would put her to bed with the mechanical lift, which was a long time ago. RN-B recalled giving her Tylenol for the pain and reminding staff to be gentle with her. RN-B did not report the pain concerns with management.

Upon interview on 2/22/24 at 10:34 a.m. SW-A stated R2's family has had multiple complaints and she does not document all complaints. She

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 02/23/2024

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 609	Continued From page 12	F 609		

stated due to the many issues that R2's family had been helping R2 get her needs met because staff had not been gentle and patient in the past. She stated R2 does not want to "call out" any staff. SW-A stated R2 had been informed when rough care was happening, she was to call staff when it was happening. SW-A stated she had watched R2's cares being completed from behind her curtain, so staff did not know she was observing. SW-A did not find any indications of abuse. The observations occurred "about six weeks ago." SW-A stated she did not report the allegations because she did not find any indications that R2 was being verbally or physically abused during her investigation.

Upon interview on 2/22/24 at 11:45 a.m. licensed practical nurse (LPN)-A stated R2 would often say that staff was "rough" with her. LPN-A stated the NA's had been talked to about rough cares and the facility did follow-up and SW-A observed cares. LPN-A was uncertain whether the allegations were reported to the SA. She believed since cares were being observed and the facility as investigated that the allegations were reported.

Upon interview on 2/22/24 at 12:32 p.m. registered nurse (RN)-A the unit manager stated that during a care conference a few months ago R2 mentioned that she wanted the staff to be gentler and mentioned how young and strong the staff are. RN-A was unaware that the nursing staff was reminding the nursing assistants to be gentle, but she was unaware that R2's cares had been observed. RN-A stated any allegations of abuse need to be reported within two hours to the state agency.

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 02/23/2024

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 609	Continued From page 13 Upon interview on 2/23/24 at 10:15 a.m. the director of nursing (DON) stated he was not aware of any complaints of rough care, verbal abuse or facility-initiated investigation had been completed. The DON stated allegations should have been reported to the SA within two hours. Upon interview on 2/23/24 at 10:20 a.m. the Administrator stated she was not aware of any complaints made by the family written or verbally. She stated if she would have been aware, and the term "rough treatment" was used the allegations would have reported to the SA immediately. A facility policy titled Abuse Prohibition, Investigation, and Reporting revised date 10/24/22 indicated if there is a concern about actual or suspected abuse/neglect/injury of unknown origin/maltreatment a report to the SA will be made immediately but no later than two hours after the allegation are made.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		4/8/24

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 02/23/2024

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 656	Continued From page 14 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement identified interventions to prevent alterations in mood and behavior for 1 of 1 resident (R1) reviewed. A video recording identified R1 needing assisting and staff entered the room as R1 was crying. The nursing	F 656	F656: R1 no longer resides in the facility Nurse Managers conducted reviews of care plans for residents experiencing mood changes and behavioral alterations	

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 02/23/2024

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 656	Continued From page 15 assistant (NA)-A did not speak with R1, adjusted a blanket, turned off her light and left resident crying. Findings include: R1's care plan dated 1/7/24 indicated R1 had a potential for communication deficits due to ability to understand, ability to be understood, hallucinations or delusions and decision-making ability. R1's goal was to be able to follow instructions. The staff's approach was to break down instructions into simple tasks, avoid lengthy explanations, face R1 when speaking with her. In new situations support and reassure her. Obtain R1's attention before speaking with her. Provide a quiet, non-hurried environment, free of distractions or conversations. Encourage resident to voice feelings and concerns about mood, memory, perceived changes. Do not confront, argue against, or deny R1's hallucinations, explore R1's underlying feelings rather than the content of the hallucination (anxiety or fear). Provide a calm quiet environment. Use calm and positive approach. R1's admission MDS dated 1/12/24 indicated R1 had a BIMs score of 0 indicating severe cognitive impairment. R1's potential indicator of psychosis indicated R1 hallucinated. R1's behavior significantly interfered with her cares and was significantly intrusive on the privacy or activity of others. The MDS did not indicate that R1 wandered. R1 required substantial assistance of one staff member with activities of daily and required on supervision or touching assistance with transferring. R1's pertinent diagnoses were heart failure, major depressive disorder, recurrent, severe with psychotic symptoms,	F 656	to ensure appropriate interventions were communicated to staff using resident profiles. Licensed staff and nursing assistants will receive education emphasizing the importance of timely response and communication of care-planned interventions (resident profile) to prevent mood and behavior situations. Resident Profile policy and procedure were reviewed and revised as necessary. Random audits of staff interviews and observations of applying interventions will be conducted by nurse managers or designated personnel daily for a week, weekly for a month, and quarterly thereafter to monitor compliance with care standards. Results will be reported to the QAPI committee for further evaluation and recommendations.	

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 02/23/2024

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 656	Continued From page 16	F 656		

Continued From page 16

age-related cognitive decline, hallucinations, delirium, and delusional disorder.

R1's care plan dated 1/18/24 indicated R1 had a history of trauma. R1's goals were to feel safe and secure in her environments. The staff's approach per family on how to alleviate triggers were to redirect R1 and verbalize she was safe in the facility and to speak calmly with R1. Staff was to be active listeners and reassure R1 of her safety. Staff was to validate R1's feeling and encourage her to vent feelings as needed.

R1's care plan dated 1/28/24 indicated R1 had alteration in mood/behavior related to a diagnosis of psychosis, paranoia, schizophrenia, bipolar and borderline personality. Her symptoms were delusions and hallucinations. R1's goal was to be comfortable in her environment. States she feels safe at the facility and would respond to approaches and have less delusional episodes. The staff's approach was to communicate in her reality, avoid power struggles and all as much control as possible.

Video recording from 2/1/24 at 9:23 p.m. showed NA-A entered R1's room. R1 was seated on the edge of her bed quietly sobbing. R1's wheelchair is positioned directly in front of her. NA-A placed her hands on the handles of the wheelchair. NA-A does not say anything to R1. NA approaches R1, tugs on the blanket over R1's legs, turns off the lights, and leaves the room. R1 started screaming loudly as soon as R1 touched the blanket. R1 sat at the edge of her bed crying out for two minutes and forty-three seconds when the video recording ended.

R1's nursing progress note dated 2/1/24 at 10:20

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 02/23/2024

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 656	Continued From page 17	F 656		

p.m. indicated after dinner R1 wheeled herself back to her room and went to her roommates' room and was helped out of the room as R1 was touching her food and other belongs. There was no documentation in the note about NA-A's interactions with R1 that evening.

Upon interview on 2/21/24 at 9:26 a.m. R1's family member (FM)-B On 2/1/24 she noticed after viewing a video recording the R1 was "neglected" by a nursing assistant. FM-B stated NA-A went into R1's room at 9:23 p.m. p.m. and found R1 seated on the side of her bed crying. FM-B was not certain why NA-A entered the room since R1 could not press her call button. She thought maybe for a safety check, or she heart R1 crying. She stated she then witnessed NA-A "abruptly" moved R1's blanket and shut off her lights leaving R1 in the dark. FM-B stated she could R1 saying on the video, do not turn off the lights and that's when R1 started screaming loudly as NA-A left her in the dark in her room without asking what her needs were.

Upon interview on 2/22/24 at 12:32 p.m. RN-B the nurse manager stated she was not aware that staff left R1 crying in the dark on 2/11/24. She stated staff should have followed the care plan and found out what R1 needed and if they unable to do that address the needed, they should have reported any concerns to the nurse.

Upon interview on 2/23/24 at 9:19 a.m. NA-A stated she worked with R1 often. She did not recall an evening where she left R1 crying. She stated she would always ask R1 if she needed to use the restroom, needed water, or was having pain. NA-A stated if she found R1 sitting on the side of her bed she would assist her back in her

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 02/23/2024

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 656	Continued From page 18 bed, as R1 tended to slide out of her bed and crawl on the floor. Upon interview on 2/23/24 at 10:15 a.m. the director of nursing (DON) stated his expectation of the nursing staff was to find out the residents' need was prior to leaving the residents rom. The NA should have contacted the nurse. A policy regarding the implementation of care planning was requested however none received.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess, evaluate/analysis the fall hazards and risk and implement interventions consistent with the residents needs to reduce further falls for 1 of 3 residents (R1) reviewed for falls. R1 had one fall where no assessments or interventions were completed. R1 had another fall five days later. Finding include: R1's care plan dated 1/7/24 indicated R1 was at risk for falls related osteoporosis, gait/balance problems, visual impairments, hearing	F 689	F689: R1 no longer resides in the facility. Nurse managers reviewed fall risk assessments for all residents who have received falls in the last 60 days to ensure the assessment is completed. Incident report policy and procedure reviewed and revised as necessary. All RNs and LPNs will be educated on identifying, documenting, and responding to falls, including proper fall event reporting procedures. Random audits of fall event reports will be conducted daily for two weeks, weekly for	4/8/24

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 02/23/2024

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 689	Continued From page 19 impairment, elimination needs, impaired cognitive status and pain. R1's goals were to remain free from falls and fall related injuries. The staff's approach was a pharmacy consult per protocol. Promote scheduled rested periods. Reinforcement to request assistance. Safety check on shoes and monitor for foot pain. Monitor for glasses and/or hearing aid. Ensure proper lighting/night lights. Provide non-skid material in wheelchair. When falls occur to investigate the root cause through IDT meeting protocol. When falls occur nursing to monitor using the fall protocol. R1's admission MDS dated 1/12/24 indicated R1 had a BIMs score of 0 indicating severe cognitive impairment. R1's potential indicator of psychosis indicated R1 hallucinated. R1's behavior significantly interfered with her cares and was significantly intrusive on the privacy or activity of others. R1 required substantial assistance of one staff member with activities of daily and required on supervision or touching assistance with transferring. R1's pertinent diagnoses were heart failure, major depressive disorder, recurrent, severe with psychotic symptoms, age-related cognitive decline, hallucinations, delirium, and delusional disorder, osteoporosis, and pain. R1's nursing progress note dated 1/19/24 at 10:26 a.m. indicated R1 was found to have bruising of the left upper arm and left lower arm and right buttock area. R1 was noted by staff to have attempted to crawl out of bed repeated the night before. She has behaviors of crawling on the floor, climbing out of bed, seeking and exit and enter other residents' rooms. No fall event report was completed.	F 689	one month, and quarterly thereafter by nurse managers or designated staff. Results will be reported to the QAPI committee for further evaluation and recommendations.	

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 02/23/2024

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 689	Continued From page 20 An event report dated 2/6/24 at 3:51 p.m. indicated R1's family was self-transferring her and she slid to out of the chair. The following event details were left blank on the event form. 1. Location of the fall 2. Date and time of the fall. 3. What was resident doing just prior to the fall? 4. Was the fall Witnessed? 5. Did the resident exhibit or complain of pain related to the fall. 6. Pain scale of 1-10 7. Did the resident exhibit any non-verbal signs or symptoms of pain. 8. Location of an injury 9. Type of an injury 10. Range of motion 11. Did resident complain of any of the following: Change in vision, dizziness, discomfort/pain, feeling faint, headache, i inability to bear weight, nausea/vomiting, numbness, seizure activity, tinnitus (ringing in ears) tripping, weakness, other or none of the above. 12. Positioning of extremities 13. Did resident response to the following: name, pain, environment, other or unresponsive. 14. Did the resident exhibit any of the following as a change in mental status of new onset: anxiety, agitation, confusion, lethargy, resistiveness, restlessness, sleepiness, slurred speech, other, no changes. 15. Possible contributing factors: anxiety/agitation, cardiac/respiratory disease, dehydration, fever, impaired cognition, impaired vision, infection, neurological disorder, orthopedic condition, recent decline in ADL abilities, recent changes in appetite, recent changes in behavior, recent changes in medications, other or none of the above. 16. Drug review: Did resident use any of the	F 689		

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 02/23/2024

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 689	Continued From page 21 following: analgesics, anticonvulsants, antihypertensive, antipsychotics, anxiolytics, diuretics, narcotics, sleeping medications, other or none of the above. 17. Interventions: adaptive equipment, analgesics, bed alarm, chair/wheelchair arm, cold, direct pressure to wound, direct pressure to wound, elevate edematous/affected extremity, first aid, immobilize/splint area, motion detector, rest, other, none of the above. Under the heading notifications: Attending faxed was answered with no. Physician notified was answered with no. Resident notified was answered with no and care plan reviewed was answered with a no response. Vital signs were taken, and a narrative note indicated to monitor R1 for bruising and skin tear due to unwitnessed fall 2/7/24 - 2/12/24. R1's nursing progress note dated 2/6/24 indicated R1 had an unwitnessed fall. She was an 83-year-old female with COPD. Alert and oriented with confusion. R1 was found on the floor in front of the common area opposite the charge nurse medication cart. Her daughter was self-transferring her. Her daughter stated she tried turning the wheelchair, and the resident slide off the chair to the floor. Vitals signs were stable and no head injury. R1 was stable with family and staff will continue to monitor. R1's nursing progress note dated 2/7/24 - 2/11/24 did not contain any documentation regarding a fall follow-up for R1. R1's event report dated 2/11/24 at 6:55 a.m. indicated R1 was found sitting in front of her bed in her room, no injuries were reported. The date	F 689		

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 02/23/2024

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 689	Continued From page 22	F 689		

and time of the fall was 2/11/24 at 5:50 a.m. Prior to the fall R1 was sitting on her bed. The fall was unwitnessed. R1 did not have any pain. R1 had range of motion (ROM) x4 without pain or limitations. There was no rotation/deformity/shortening of R1's extremities. R1 was able to respond to her name. There were no contributing factors identified from the fall. No adaptive equipment was used at the time of the fall. No interventions were taken immediately. R1's physician and family were notified 2/11/24 at 7:05 a.m. and her care plan was reviewed. R1's vital signs were taken.

Video recording started on 2/11/24 at 4:00 a.m. with R1 laying sideways on her bed. Her bed was pushed up against a wall on one side and the other side was open to the room. Her knees were bent and resting on the floor. Her back was flat on the bed and her head against the wall, she was quietly mumbling and quietly weeping on her bed. At 4:33 a.m. R1 slid from her bed to the floor. She ended up seated on the floor with her back against the bed. The height of the bed enabled her to rest her shoulders against the bed, indicating her bed was not in the lowest position. At 4:54 a.m. R1 attempted to grab her walker that was to the right of her, she was unable to move the walk and started yelling "help me and crying." R1 sat quiet on the floor until rocking her upper torso back and forth with soft mumbling and intermittent whimpering. At 5:09 a.m. she became louder and crying continuously. A few words could be understood, "help me, can't do this anymore, this isn't right." At 5:17 a.m. she R1 forward on her buttock about one foot away from the bed. She attempted to push her unlocked wheelchair. She could still be heard mumbling and weeping intermittently. At 5:33 R1

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 02/23/2024

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 689 Continued From page 23 F 689

scootered herself forward again and could not be visualized on the recording until 5:37 when she pushed the wheelchair again. R1 continued to whimper and mumble words that could not be understand. At 5:51 a.m. NA-A and called out for registered nurse (RN)-D to assist her as R1 was on the floor. NA-A and RN-D used the mechanical lift to place R1 back into bed.

R1's nursing progress note dated 2/11/24 at 2:56 p.m. fall follow-up, R1 was sitting on the floor around her room. R1 was fully awake, oriented self and family. R1's skin was intact. R1's family member (FM)-B was at the facility at 6:00 a.m. and woke resident up. FM-B reported to staff R1 was coughing and needed a chest x-ray. Nursing performed an assessment, lungs were clear no signs of coughing, R1 was on oxygen three liter using a nasal canula. R1 had no wheezing or crackles, no shortness of breath. R1 ate 65% of her breakfast.

R1's nursing progress note dated 2/12/24 at 2:56 a.m. R1 was transferred to the hospital. FM-B reported to nursing staff she wanted 911 called because R1 had fluid in her lungs. She stated she had been requesting and x-ray and never got one. R1's blood pressure was 115/65, pulse was 82, respirations were 18 and her oxygen saturation was 93% on 3 liter of oxygen via nasal canula. A nebulizer treatment was performed, but the ambulance showed-up before the treatment was completed.

R1's hospital record dated 2/12/24 indicated R1 was admitted for hypoxia (low levels of oxygen in the body tissues that can be life threatening). and a closed fracture of one rib of the right side.
R1 was found to have bruising on her right flank,

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 02/23/2024

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 689		F 689		

Continued From page 24
her imaging revealed a fracture in that location, she had a fall at the facility, but the fracture is suspected to be pathological related to her bone cancer. R1 spoke of rough handing in the nursing home.

R1's hospital admission note dated 2/12/24 indicated R1 had atelectasis (collapse of the lung or part of the lung) in the lower lobes of both of her lungs. R1 also had a right chest rib fracture, possibly due to metastatic disease vs. trauma.

R1' hospital discharge note on 2/17/24 at 11:53 p.m. indicated R1 passed away in the hospital.

Upon interview on 2/21/24 at 9:26 a.m. R1's family member (FM)-B stated R1 fell from her wheelchair and the staff did not use a mechanical lift to transfer her back to her wheelchair. Staff placed a gait belt on her and three staff lifted her back to her chair. She stated when R1 was admitted to the hospital on 2/12/24 she was found to have fracture rib. FM-B stated she believed the fractured rib was when staff lifted her with the gait belt following the fall. In addition, FM-B stated when R1 fell on 2/11/24 she was on the floor in her room crying for over an hour. FM-B stated the facility had reported to her that R1 would crawl on the floor and the facility did not consider that a fall. FM-B provided the video tape of R1 seated on the floor on 2/11/24 for one hour and eighteen minutes.

Upon interview on 2/21/24 at 11:25 a.m. registered nurse (RN)-C reported she was the nurse on duty on 2/6/24 when R1 slid out of her chair. She would not recall whether R1 had an anti-skid covering on the chair or not. She stated herself and two nursing assistances used a gait

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 02/23/2024

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 689	Continued From page 25 belt and assisted R1 from the floor back to her wheelchair. She stated she did let the nursing manager know a fall had occurred. She believed she had fully completed the incident form. RN-C stated the nursing staff complete the incident reports and monitor the residents. She was uncertain who identified the root cause of the fall or who updated the care plan, she believed it was the nurse manager. Upon interview on 2/22/24 at 12:32 RN-B the nurse manager stated she was not aware of either one of R1's falls until R1 was admitted to the hospital on 2/12/24. She stated she was not aware the incident report had not been fully filled, as she had not seen it. She stated R1's a root cause and interventions were not put in place for R1's fall on 2/6/24 as she was unaware of the fall, and it was not disused at interdisciplinary team (IDT) meetings. Upon interview on 2/22/24 at 4:09 p.m. RN-D stated she worked on 2/11/24 the night R1 was found on the floor in her room. RN-D stated the staff does rounds every two hours during the night shift. She stated R1 was found on the floor at approximately 5:00 a.m. RN-D stated her, and NA-A used a mechanical lift and placed R1 back in bed. R1 was weeping. She stated R1 stated she slid out of bed. RN-D stated she had checked on R1 at 4:45 a.m. and she was in bed and then at 5:00 a.m. she was found on the floor. RN-D stated 2/11/24 was the first time she had found R1 on the floor and stated if a resident is on the floor, it is a fall. RN-D stated the staff was aware that R1 self-transferred and would staff would provide safety checks on her more often than every two hours.	F 689		

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 02/23/2024

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 689	Continued From page 26 Upon interview on 2/23/24 at 9:19 a.m. nursing assistant (NA)-A stated R1 would yell and scream and was found crawling on her floor at least five to six times when NA-A worked with her, R1 would sit on the edge of bed and slide to the floor. NA-A stated she is not aware when a nurse records a resident being on the floor as a fall. NA-A stated R1 crawled on the floor so often there was talk about getting her recliner to sleep in. R1 stated on the night of 2/11/24 staff were checking in on R1 every half-an-hour due to her anxiety that night. She stated, "there is no way she could been on the floor for over and hour." Upon interview on 2/23/24 at 10:15 a.m. the director of nursing, DON stated if a resident requires more than the standard two-hour safety checks at night, he would except the staff have that on the care plan and provide documentation that the checks are being completed. The DON stated if a resident is on the floor, it is considered fall and an event report should be completed, monitoring should take place, a root cause should be figured out and the report needs to go to IDT to discuss interventions. A facility policy titled Incident Report - Resident revised on 1/12/21 indicated an initial and follow-up physical assessment is done by the nurse. This may include state of consciousness, range of motion, skin conditions and vital signs for 24 hours. Follow-up charting should be done for 72 hours or as condition warrants. A family member should be notified in a timely manner. The nurses note will document the events and follow-up in more detail. The completed event will be closed by the nurse manager.	F 689		