



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 26, 2020

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

RE: CCN: 245439
Cycle Start Date: February 6, 2020

Dear Administrator:

On February 6, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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" tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 6, 2020 (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 6, 2020 (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

Catholic Eldercare On Main

February 26, 2020

Page 4

specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Douglas Larson", with a long horizontal flourish extending to the right.

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 03/10/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2020
NAME OF PROVIDER OR SUPPLIER CATHOLIC ELDERCARE ON MAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 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 From 2/4/20 to 2/6/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was found to be substantiated with tags: H5439044C. Deficiency issued at F689 The following complaint was found to be SUBSTANTIATED with NO deficiencies cited due to actions implemented by the facility prior to survey. H5439045C The following complaints were found to be unsubstantiated: H5439048C. H5439047C. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	F 000			
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	F 689		3/6/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/06/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2020
NAME OF PROVIDER OR SUPPLIER CATHOLIC ELDERCARE ON MAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 1 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall interventions were consistently implemented for 1 of 4 residents (R5) reviewed for falls.</p> <p>Findings include:</p> <p>R5's significant change Minimum Data Set (MDS) assessment dated 12/24/19, identified R5 had moderate cognitive impairment and diagnoses which included dementia and anxiety. The MDS indicated R5 required extensive staff assistance for activities of daily living (ADL's).</p> <p>R5's falls Care Area Assessment (CAA) dated 12/25/19, identified R5 was at risk for falls related to impaired balance, self-transfers, confusion, multiple falls, activity intolerance, shortness of breath, impaired vision, behaviors and incontinence and directed staff to encourage R5 to use call light for toileting and mobility needs.</p> <p>R5's falls Care Plan edited 1/31/20, identified R5 was at risk for falls and directed staff to use walker or wheelchair (w/c), to put a transfer-belt on for all transfers and ambulation, grab bar to bed, safety check for shoes, investigate root cause when fall occurred and nursing to monitor.</p> <p>An Incident Report dated 1/29/20, indicated R5 was found sitting on the floor in front of her bed, indicating R5 had rolled out of her bed. The Incident Report follow-up indicated a low bed was intimated 1/28/20.</p> <p>R5 was observed on 2/4/20, at 12:21 p.m. and</p>	F 689	<p>F 689</p> <p>It is the policy of Catholic Eldercare to maintain the safety of residents and to have individual plans of care in place to prevent falls.</p> <p>The care plan of R5 was updated to clearly state that a transfer belt was to be applied before going into the bathroom and that her bed was to be in low position whenever she was in it.</p> <p>Nursing management reviewed all care plans and beds of residents who had orders for low beds. Care plans have been updated as necessary. completed as of 3/6/20</p> <p>Transfer belt and fall prevention policies have been reviewed, and updates were made as needed.</p> <p>NA-A received counsel on the use of transfer belts and low beds on 2/7/20. Charge nurses monitored her cares, and as of 3/6/20, no new concerns were observed.</p> <p>Education on transfer belts and low beds as part of training for all NARs that was complete as of 3/6/20.</p> <p>Charge Nurses are responsible for ensuring that when there is an order for a low bed, it is in the appropriate position.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2020
NAME OF PROVIDER OR SUPPLIER CATHOLIC ELDERCARE ON MAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 2</p> <p>stated to nursing assistant (NA)-A "I need to go to the bathroom." NA-A was observed to assist R5 into the bathroom wheeling R5 in the w/c up to the toilet grab bar next to the toilet. R5 immediately stood up and held onto the grab bar without a transfer belt and/or the w/c brakes locked. R5 appeared unsteady and shaky while she stood and held onto the grab bar. NA-A removed R5's clothing and guided R5 to sit onto the toilet.</p> <p>NA-A was interviewed on 2/4/20, at 12:24 p.m. and verified R5 was impulsive and had transferred without waiting for a transfer belt or the w/c brakes locked. NA-A explained they normally used a transfer belt and locked the w/c brakes, however hadn't been able to because of R5 being impulsive and standing up too quickly. NA-A stated R5 could have fallen due to her unsteadiness as she stood next to the toilet. NA-A also stated R5 required guided assistance to the toilet right away to prevent falls.</p> <p>R5 was interviewed on 2/4/20, at 12:33 p.m. and did not recall having fallen while at the facility.</p> <p>R5 was observed on 2/6/20, at 12:17 p.m. lying in bed eyes with her eyes closed. R5's bed was not in the low position, the mattress was noted to be two to three feet off of the ground, and R5's w/c was next to her bed without the brakes locked.</p> <p>Registered nurse (RN)-A was interviewed on 2/6/20, at 12:33 p.m. and verified R5 was supposed to have the bed in a low position so when R5 was in bed due to her fall risk.</p> <p>NA-B was interviewed on 2/6/20, at 12:42 p.m. and confirmed R5 was lying in bed and the bed</p>	F 689	<p>Nursing management will randomly audit the position of low beds and report concerns to the QA committee.</p> <p>Charge Nurses are responsible for the monitoring of appropriate transfer belt use. Nursing management randomly audits transfer belt use and will report noted concerns to the QA committee for further follow up and recommendations</p>		

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

PRINTED: 03/10/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2020
NAME OF PROVIDER OR SUPPLIER CATHOLIC ELDERCARE ON MAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 3</p> <p>was positioned two to three feet off of the ground at knee level, not having been lowered to the lowest position. NA-B stated R5's bed was to remain at knee level so R5 could get in and out of bed easily.</p> <p>The director of nursing was interviewed on 2/6/20, at 1:38 p.m. and stated it was her expectation fall interventions would be consistently implemented staff should "always" follow the resident's care plan.</p> <p>The facility's Fall Risk Assessment Policy revised 9/20/19, indicated individualized care plans would be developed for residents who were identified as high risk for falls. The policy indicated the fall prevention plan would be documented in the resident's care plan and communicated to staff.</p> <p>The facility's Transfer Belt Policy reviewed 8/16/19, indicated transfer belts were to be used by all personnel when assisting residents with transfers.</p>	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 26, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: 9R7F11

Dear Administrator:

The above facility was surveyed on February 4, 2020 through February 6, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

**Sarah Grebenc, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697**

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

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

Please feel free to call me with any questions.

Sincerely,



Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Catholic Eldercare On Main

February 26, 2020

Page 3

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00984	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2020
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CATHOLIC ELDERCARE ON MAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 2/4/20 to 2/6/20, a survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.</p>	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
03/06/20

Minnesota Department of Health

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 02/06/2020
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CATHOLIC ELDERCARE ON MAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 1</p> <p>The following complaint was found to be substantiated with tags: H5439044C. Deficiency issued at F689</p> <p>The following complaint was found to be SUBSTANTIATED with NO deficiencies cited due to actions implemented by the facility prior to survey. H5439045C</p> <p>The following complaints were found to be unsubstantiated: H5439048C. H5439047C.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.</p>	2 000		
2 830	<p>MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General</p> <p>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out</p>	2 830		3/6/20

Minnesota Department of Health

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 02/06/2020
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CATHOLIC ELDERCARE ON MAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 830	<p>Continued From page 2</p> <p>of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall interventions were consistently implemented for 1 of 4 residents (R5) reviewed for falls.</p> <p>Findings include:</p> <p>R5's significant change Minimum Data Set (MDS) assessment dated 12/24/19, identified R5 had moderate cognitive impairment and diagnoses which included dementia and anxiety. The MDS indicated R5 required extensive staff assistance for activities of daily living (ADL's).</p> <p>R5's falls Care Area Assessment (CAA) dated 12/25/19, identified R5 was at risk for falls related to impaired balance, self-transfers, confusion, multiple falls, activity intolerance, shortness of breath, impaired vision, behaviors and incontinence and directed staff to encourage R5 to use call light for toileting and mobility needs.</p> <p>R5's falls Care Plan edited 1/31/20, identified R5 was at risk for falls and directed staff to use walker or wheelchair (w/c), to put a transfer-belt on for all transfers and ambulation, grab bar to bed, safety check for shoes, investigate root cause when fall occurred and nursing to monitor.</p> <p>An Incident Report dated 1/29/20, indicated R5</p>	2 830	n/a	

Minnesota Department of Health

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 02/06/2020
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CATHOLIC ELDERCARE ON MAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 830	<p>Continued From page 3</p> <p>was found sitting on the floor in front of her bed, indicating R5 had rolled out of her bed. The Incident Report follow-up indicated a low bed was intimated 1/28/20.</p> <p>R5 was observed on 2/4/20, at 12:21 p.m. and stated to nursing assistant (NA)-A "I need to go to the bathroom." NA-A was observed to assist R5 into the bathroom wheeling R5 in the w/c up to the toilet grab bar next to the toilet. R5 immediately stood up and held onto the grab bar without a transfer belt and/or the w/c brakes locked. R5 appeared unsteady and shaky while she stood and held onto the grab bar. NA-A removed R5's clothing and guided R5 to sit onto the toilet.</p> <p>NA-A was interviewed on 2/4/20, at 12:24 p.m. and verified R5 was impulsive and had transferred without waiting for a transfer belt or the w/c brakes locked. NA-A explained they normally used a transfer belt and locked the w/c brakes, however hadn't been able to because of R5 being impulsive and standing up too quickly. NA-A stated R5 could have fallen due to her unsteadiness as she stood next to the toilet. NA-A also stated R5 required guided assistance to the toilet right away to prevent falls.</p> <p>R5 was interviewed on 2/4/20, at 12:33 p.m. and did not recall having fallen while at the facility.</p> <p>R5 was observed on 2/6/20, at 12:17 p.m. lying in bed eyes with her eyes closed. R5's bed was not in the low position, the mattress was noted to be two to three feet off of the ground, and R5's w/c was next to her bed without the brakes locked.</p> <p>Registered nurse (RN)-A was interviewed on 2/6/20, at 12:33 p.m. and verified R5 was</p>	2 830		

Minnesota Department of Health

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 02/06/2020
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CATHOLIC ELDERCARE ON MAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 830	<p>Continued From page 4</p> <p>supposed to have the bed in a low position so when R5 was in bed due to her fall risk.</p> <p>NA-B was interviewed on 2/6/20, at 12:42 p.m. and confirmed R5 was lying in bed and the bed was positioned two to three feet off of the ground at knee level, not having been lowered to the lowest position. NA-B stated R5's bed was to remain at knee level so R5 could get in and out of bed easily.</p> <p>The director of nursing was interviewed on 2/6/20, at 1:38 p.m. and stated it was her expectation fall interventions would be consistently implemented staff should "always" follow the resident's care plan.</p> <p>The facility's Fall Risk Assessment Policy revised 9/20/19, indicated individualized care plans would be developed for residents who were identified as high risk for falls. The policy indicated the fall prevention plan would be documented in the resident's care plan and communicated to staff.</p> <p>The facility's Transfer Belt Policy reviewed 8/16/19, indicated transfer belts were to be used by all personnel when assisting residents with transfers.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review, revise policies and procedures regarding comprehensive assessment and interventions related to falls. Facility staff could be educated on these policies and procedures. The administrator, DON or designee could develop a monitoring system to ensure ongoing compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty One</p>	2 830		

Minnesota Department of Health

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 02/06/2020
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CATHOLIC ELDERCARE ON MAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 830	Continued From page 5 (21) days.	2 830		