DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2021

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

RE: CCN: 245439
Cycle Start Date: December 10, 2020

Dear Administrator:

On January 28, 2021, we notified you a remedy was imposed. On February 3, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 16, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 10, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 28, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 10, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 16, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Electronically delivered

January 28, 2021

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

RE: CCN: 245439
Cycle Start Date: December 10, 2020

Dear Administrator:

On December 29, 2020, we informed you that we may impose enforcement remedies.

On January 11, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 10, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 10, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 10, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of

payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by March 10, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Catholic Eldercare On Main will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 10, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 10, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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 01/11/2021

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 1/11/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5439060C (MN00068888), H5439061C (MN00068792) with deficiencies cited at F600 and F609. 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. 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.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		2/16/21

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

Electronically Signed | 02/04/2021

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

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F 600	Continued From page 1 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to prevent incidences of resident to resident sexual abuse for 2 of 3 residents (R2 and R3) reviewed for abuse. Findings include: R1's quarterly MDS, dated 9/30/20, identified R1 had moderately impaired cognition and diagnoses including Alzheimer's disease, and dementia. The MDS further indicated R1 walked independently on the unit. R1's care plan last updated 1/11/21, indicated R1 had been identified as having socially inappropriate disruptive behavioral symptoms including wandering into others' rooms and sexual inappropriateness. The care plan identified interventions including "one on one supervision when out of room to prevent him from entering other resident rooms or approaching others in a sexual nature", stop sign across doorway at all times to help identify if he left his room, remove resident from other resident's rooms and unsafe situations, document and report inappropriate behaviors, and multiple suggested methods of redirection. R3's quarterly Minimum Data Set (MDS), dated	F 600	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. F600 It is the practice of Catholic Eldercare to protect its residents from sexual abuse. R1 was discharged from Catholic Eldercare on 1/19/2021. R2 and R3 have shown no signs of distress or incident recall since the described events. Follow up with R2 and R3 for signs of trauma related to the situation is being done weekly until determined to no longer be necessary. Staff will receive education on abuse and neglect. Abuse prohibition policies will be reviewed and updated as needed. Nursing management will review Incident reports for January 2021 for resident to resident interactions that may	

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F 600	Continued From page 2 12/1/20, identified R3 had severely impaired cognition and diagnoses including Alzheimer's disease, and anxiety. The MDS further indicated R3 walked unassisted on the unit. A progress note dated 1/5/21, at 2:20 p.m. indicated R1 was seen at the large dining room entrance about 2:00 p.m., standing in front of a female resident. R1 was blocking her escape and he had both of his hands on her breasts. R1 was told the behavior was not allowed and redirected away from the female resident. A progress note dated 1/5/21, at 3:42 p.m. indicated R3 was blocked by another resident who had both hands on R3's breasts. The progress note further indicated staff was able to redirect the residents and remove R3 from the situation. When interviewed on 1/11/21, at 1:22 p.m., licensed practical nurse (LPN)-B stated she stepped out from the nurses station to check R1's whereabouts, and could see R1's back with R3 trying to get past him. LPN-B stated R1 had both of his hands on R3's breast area. LPN-B further stated she was able to redirect R1 and told R1 that his behavior was not allowed. R3 was seated at the nurses station for safety and her behavior returned to baseline. LPN-B stated she notified registered nurse (RN)-A immediately. When interviewed on 1/11/21, at 2:18 p.m., RN-A stated an incident of sexual abuse with R3 happened on 1/5/21, towards the end of the day shift, around 2:00 p.m. RN-A stated LPN-B reported to her and RN-A immediately reported the incident to the administrator and director of nursing (DON). R1 was placed on 30 minute	F 600	potentially have the same deficient practice. Random audits of the memory care unit will be done by Nurse Management to observe for resident to resident interactions, and staff interventions of those interactions, five times a week for one month, then three times a week until compliance is achieved. Nurse Management will monitor and review information and forward results to the QAPI committee for further review and recommendations	

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F 600	Continued From page 3	F 600		

checks and increased monitoring when out of his room.

R2's admission MDS, dated 11/10/20, identified R2 had severely impaired cognition and diagnoses including Alzheimer's disease, dementia, and delusional disorder. The MDS further indicated R2 walked independently on the unit.

A progress note dated 1/07/21, at 4:26 p.m. indicated R2 was laying on the bed face up with R1 sitting on her bed with his hand in her pants at about 3:15 p.m. The progress note further indicated R2 did not resist or appear to be in any distress, and R1 was redirected out of R2's room.

When interviewed 1/11/21, at 3:47 p.m., LPN-A stated she went onto the floor after shift report and during her rounds, saw R1 in R2's room with his hands in R2's pants. LPN-A stated R2 was very relaxed and she didn't want to be interrupted. LPN-A further stated R2 refused to be assessed initally, but when reapproached for incontinence cares, was assessed and no physical harm or damage was noted. LPN-A further stated R2's behaviors have not changed since the incident with R1.

When interviewed on 1/11/21, at 2:18 p.m., RN-A stated she was notified by the social worker (SW)-A that R1 was found in R2's room with his hands down her pants. RN-A notified the administrator and DON immediately. RN-A further stated there was no sign of injury to R2 and her behavior remains at baseline. RN-A further stated R1 was placed on 1:1 monitoring and as of the date of this investigation, remained on 1:1

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F 600	Continued From page 4 monitoring when out of his room. When interviewed on 1/11/21, at 3:55 p.m., the DON stated it would be her expectation that residents would remain free of abuse. A facility policy on "Abuse Prohibition, Investigation, and Reporting," revised 11/17/20, indicated it is policy to provide a setting in which each resident shall be free from physical, verbal, sexual, emotional, neglect or mental abuse and financial exploitation, by staff, family, visitor or another resident.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other 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.	F 609		2/16/21

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F 609	Continued From page 5 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential sexual abuse were reported to the State agency (SA) within two hours for 1 of 3 residents (R2) reviewed for sexual abuse. Findings include: R1's quarterly Minimum Data Set (MDS), dated 9/30/20, identified R1 had moderately impaired cognition and diagnoses including Alzheimer's disease, and dementia. The MDS further indicated R1 walked independently on the unit. R2's admission MDS, dated 11/10/20, identified R2 had severely impaired cognition and diagnoses including Alzheimer's disease, dementia, and delusional disorder. The MDS further indicated R2 walked independently on the unit. When interviewed on 1/11/21, at 3:47 p.m., licensed practical nurse (LPN)-A stated she came on after shift report and went on rounds and saw R1 in R2's room with his hands in R2's pants. When interviewed on 1/11/21, at 2:18 p.m., Registered Nurse (RN)-A indicated she learned about the sexual abuse incident involving R1 and R2 on 1/7/21, from the social worker (SW)-A at	F 609	F609 It is the practice of Catholic Eldercare to follow policies and procedures on reporting abuse. All staff will receive education on abuse and neglect including timely reporting. Social Service, Nursing Management, and Administrator will be re-educated on timelines for making reports. Abuse prohibition policies will be reviewed and updated if necessary. Facility incident reports from January 2021 will be reviewed for the potential to be affected by the same deficient practice. Random audits of facilty events to identify late reporting of abuse will be done by Nurse Management five times a week for one month, then three times a week until compliance is achieved.Nurse Management will monitor and review information and forward results to the QAPI committee for further review and recommendations	

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F 609	Continued From page 6	F 609		

about 3:30 p.m. and notified the administrator and director of nursing (DON) immediately.

A submitted SA Nursing Home Incident Reporting - Incident Report Summary, dated 1/7/21, identified an allegation of, "Sexual Abuse," was submitted indicating R1 was discovered in R2's room with his hands in her pants. The report listed a date and time of the incident as, 1/07/21, at 3:15 p.m. The report indicated the incident was reported to the SA 1/07/21, at 6:08 p.m. (2 hours and 53 minutes after the incident). There was no provided evidence the allegation of sexual abuse had been reported to the SA within two hours, as required.

When interviewed on 1/11/21, at 3:08 p.m., the DON confirmed the incident of sexual abuse reported 1/7/21 exceeded the required two hour SA reporting timeframe. The DON stated, "We missed the cutoff on that. It should've been reported within the 2 hour timeframe as an incident of abuse."

A facility policy on "Abuse Prohibition, Investigation, and Reporting," revised 11/17/20, indicated any incident involving a resident that contains sexual overtones, whether intentional or not should be reported as abuse. The policy further indicated an incident would be reported to the state agency immediately but not later than two hours after the allegation is made, if the events that caused the allegation involved abuse or resulted in serious bodily injury.

Electronically delivered
January 28, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: JENH11

Dear Administrator:

The above facility was surveyed on January 11, 2021 through January 11, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00984	A. BUILDING: _____ B. WING _____	C 01/11/2021

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 *****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 1/11/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	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.	

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

Electronically Signed | 02/04/21

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5439060C (MN00068888), H5439061C (MN00068792) with a licensing order issued at S1995 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting	21995		2/16/21

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21995	Continued From page 2 internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential sexual abuse were reported to the State agency (SA) within two hours for 1 of 3 residents (R2) reviewed for sexual abuse. Findings include: R1's quarterly Minimum Data Set (MDS), dated 9/30/20, identified R1 had moderately impaired cognition and diagnoses including Alzheimer's disease, and dementia. The MDS further indicated R1 walked independently on the unit. R2's admission MDS, dated 11/10/20, identified R2 had severely impaired cognition and diagnoses including Alzheimer's disease, dementia, and delusional disorder. The MDS further indicated R2 walked independently on the unit. When interviewed on 1/11/21, at 3:47 p.m., licensed practical nurse (LPN)-A stated she came on after shift report and went on rounds and saw R1 in R2's room with his hands in R2's pants. When interviewed on 1/11/21, at 2:18 p.m., Registered Nurse (RN)-A indicated she learned about the sexual abuse incident involving R1 and R2 on 1/7/21, from the social worker (SW)-A at about 3:30 p.m. and notified the administrator and director of nursing (DON) immediately. A submitted SA Nursing Home Incident Reporting	21995	corrected	

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21995	Continued From page 3	21995		

- Incident Report Summary, dated 1/7/21, identified an allegation of, "Sexual Abuse," was submitted indicating R1 was discovered in R2's room with his hands in her pants. The report listed a date and time of the incident as, 1/07/21, at 3:15 p.m. The report indicated the incident was reported to the SA 1/07/21, at 6:08 p.m. (2 hours and 53 minutes after the incident). There was no provided evidence the allegation of sexual abuse had been reported to the SA within two hours, as required.

When interviewed on 1/11/21, at 3:08 p.m., the DON confirmed the incident of sexual abuse reported 1/7/21 exceeded the required two hour SA reporting timeframe. The DON stated, "We missed the cutoff on that. It should've been reported within the 2 hour timeframe as an incident of abuse."

A facility policy on "Abuse Prohibition, Investigation, and Reporting," revised 11/17/20, indicated any incident involving a resident that contains sexual overtones, whether intentional or not should be reported as abuse. The policy further indicated an incident would be reported to the state agency immediately but not later than two hours after the allegation is made, if the events that caused the allegation involved abuse or resulted in serious bodily injury.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures for reporting incident of abuse. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly reported to the DON, administrator and State Agency. The quality assurance committee could monitor these

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21995	Continued From page 4 measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21995		