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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 1NZI
Facility ID: 00226

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245462**

2.STATE VENDOR OR MEDICAID NO.
(L2) **731342000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MARANATHA CARE CENTER**
(L4) **5409 69TH AVENUE NORTH**
(L5) **BROOKLYN CENTER, MN** (L6) **55429**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/21/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **97** (L18)

13.Total Certified Beds **97** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | **97** | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 06/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 08/23/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**04/01/1987**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**06/28/2017**
(L33)

DETERMINATION APPROVAL

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

CMS Certification Number (CCN): 245462

June 26, 2017

Ms. Anne O'Connor, Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN  55429

Dear Ms. O'Connor:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 7, 2017 the above facility is recommended for:

97 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 97 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697
cc: Licensing and Certification File

*An equal opportunity employer.*

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

Electronically delivered
June 26, 2017

Ms. Anne O'Connor, Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

RE: Project Number S5462031

Dear Ms. O'Connor:

On May 15, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 28, 2017. This survey found the most serious deficiencies 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) whereby corrections were required.

On June 21, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 28, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 7, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 28, 2017, effective June 7, 2017 and therefore remedies outlined in our letter to you dated May 15, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

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(L5) **BROOKLYN CENTER, MN** (L6) **55429**

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| | |
|---|---|
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| **3. Termination** | **4. CHOW** |
| **5. Validation** | **6. Complaint** |
| **7. On-Site Visit** | **9. Other** |

**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/28/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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| **02 SNF/NF/Dual** | **06 PRTF** | **10 NF** | **14 CORF** | |
| **03 SNF/NF/Distinct** | **07 X-Ray** | **11 ICF/IID** | **15 ASC** | |
| **04 SNF** | **08 OPT/SP** | **12 RHC** | **16 HOSPICE** | |

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

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A. In Compliance With Program Requirements Compliance Based On:

___1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NE II 05/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/27/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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3. Both of the Above :

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(L24)

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(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
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29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 15, 2017

Ms. Anne O'Connor, Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

RE: Project Number S5462031

Dear Ms. O'Connor:

On April 28, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

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:

**Maria King, RN, APM**
**Licensing and Certification Program**
**Health Regulation Division**
**Minnesota Department of Health**
**Mankato Plaza**
**12 Civic Center Plaza, Suite #2105**
**Mankato, Minnesota 56001-7789**
**Email: maria.king@state.mn.us**
**Phone: (507) 344-2716**
**Fax: (507) 344-2723**

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 7, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 July 28, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 October 28, 2017 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012

Fax: (651) 215-0525

Please contact me if you have questions related to this eNotice.

Sincerely,

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

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MARANATHA CARE CENTER** | **5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429** |

| (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<br><br>On April 24 through April 27, 2017, a 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.<br><br>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.<br><br>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 176 SS=D | 483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications (SAM) was safe for 2 of 2 residents (R31, R136) observed to self-administer a nebulizer (neb-broken into a mist and inhaled through a mask) treatment during a random observation. | F 176 | The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also noted to be construed as an admission against interest of the Facility, | 6/7/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 05/24/2017

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 |
|---|---|---|---|
| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MARANATHA CARE CENTER** | **5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429** |

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|---|---|---|---|---|
| F 176 | Continued From page 1<br>Findings include:<br><br>R31 was observed to be receiving a neb on 4/24/17, at 4:22 p.m. and there was no staff present in the room. A review of the SAM assessment (requested and partially provided) dated, 1/27/17, indicated R31 was not capable of administering the medications by themselves.<br><br>On 4/24/17, at 4:34 p.m. RN-H entered room with surveyor, and stopped the nebulized medication, RN-H stated "the nebulized medication was started for him at 4:19 p.m., so it's not self-administered." RN-H was aware R31's SAM said he was not safe to self-administer medications. RN-H further stated R31 had at times removed his neb mask (no longer receiving the medication) and that was why she checked on him frequently.<br><br>R31's Physician Order dated 5/15/15, included Albuterol Sulfate (dilates the airways in the lungs) nebulization Solutions 2.5 mg / 3 ml (2.5 milligrams of liquid Albuterol in 3 milliliters of normal saline twice a day for wheezing).<br><br>R31's care plan dated 6/3/15, indicated impaired cognitive function, and thought process related to dementia and Alzheimer's disease; and directed staff to administer medications as ordered. An additional care plan dated 11/18/15, directed "I am not able to self-administer my own medication."<br><br>An electronic Medication Administration Record (MAR) dated 7/29/15, directed albuterol sulfate nebulization Solution 2.5 mg inhale orally via nebulizer two times a day for chronic obstructive pulmonary disease. | F 176 | its Administrator, or any employees, agents, or other individuals who draft or may discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency.<br><br>Residents (R31) and (R136) were reviewed for ability to self administer nebulizers and care plans revised in regard to self administration of nebulizer treatments.<br><br>All residents receiving nebulizer treatments were reviewed and care plans updated to current support needs. All residents who currently self administer medication are being reviewed for level of assistance related to self administration of medication and treatments and their care plans updated. All residents will continue to be assessed per the RAI schedule and with any change of condition for self administration of medications.<br><br>Education regarding the assessment and care planning process for self administration of medication was started on 5/18/17 and is ongoing. The policy and procedure regarding self administration of medication was reviewed and is current. Staff are instructed on the importance of assessing self-administration of medication and treatments in the care | |

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| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|

F 176

Continued From page 2

On 4/24/17, at 5:04 p.m. RN-I stated she had gotten the nurse practitioner to order it would be okay to leave R31 alone after the nebulizer was set up, RN-I verified the SAM assessment stated R31 would not be safe to self-administer medications. RN-I further verified R31 would sometimes take off the neb when the staff left the room.

R136 was observed to be receiving a neb on 4/26/17, at 10:06 a.m. and there was no staff present in the room. R136 was seated in a wheelchair with a nebulizer mask applied to the face. The neb machine was turned on and running; the medication in the chamber affixed to the mask and resident had leaned forward and both eyes were closed. At the time of the observation, licensed practical nurse (LPN)-A was observed standing outside room. At 10:09 a.m. LPN-A was approached and asked if she had medications left to give. LPN-A carried the laptop computer and went to the other medication cart located in the middle of hallway of the unit as the nebulizer ran.

R136's care plan dated 3/21/17, indicated "I am not able to self-administer my own medication." The care plan directed staff to assess resident for self-administration of medication per policy and to administer his medication per orders.

R136's Physician Order dated 4/7/17, indicated an order for "DuoNeb Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 application inhale orally two times a day for wheezing."

On 4/26/17, at 10:26 a.m. LPN-A verified the

F 176

plan and following the plan of care.

Random audits on 10% of residents will be completed weekly for one month and monthly thereafter by the Clinical Coordinators or designee to ensure compliance. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as needed.

The Clinical Administrator will be responsible for ongoing compliance. The completion date for certification purposes will be 6/7/17.

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|---|---|---|---|
| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 176 | Continued From page 3<br>nebulizer was still running 20 minutes later. When asked if resident had an order to SAM, LPN-A stated, "No, we usually put it and leave him. He is not able to take it off."<br><br>On 4/26/17, at 10:33 a.m. LPN-A reviewed the orders and verified R136 did not have order to SAM stated would be getting an order.<br><br>On 4/27/17, at 11:46 a.m. the director of nursing stated she would expect all residents to have an order to self-administer medications and be assessed and the nurse was supposed to stay with resident during the nebulizer.<br><br>The facility Self Administration of Medication Policy modified November 2016, directed "1. A Self Administration of Medication Assessment as part of the Comprehensive Data Collection will be completed on all residents upon admission, annually and with significant change in condition and at any time a resident is requesting to administer any medication without the direct supervision of a nurse. 2. After the assessment is completed, the interdisciplinary team reviews the assessment to determine that the practice of self-administration is clinically appropriate..." | F 176 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan. | F 279 | | 6/7/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 279 | Continued From page 4 | F 279 | | |

483.21
(b) Comprehensive Care Plans

(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 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.

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|---|---|---|---|
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|---|---|---|---|---|
| F 279 | Continued From page 5<br>(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.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to develop a care plan for 1 of 5 residents (R97) who used Trazodone (anti-depressant used for sleep) reviewed for unnecessary medications.<br><br>Findings include:<br><br>On 4/27/17, at 8:11 a.m. R96 was observed sitting in wheelchair watching television. When approached and asked how he was doing, R96 stated, "feeling very good." When asked about his sleeping habits R97 stated, "I don't know, sometimes I can't sleep all night and sometimes it's good but its okay. I just wait, wait, wait, sometimes time to go" R97 made snoring noise. When asked if he knew his medication R97 stated "I don't know for sure." When asked if he had pain R97 stated "nope never."<br><br>R97's communication Care Area Assessment (CAA) dated 7/5/16, identified resident was on an antidepressant however CAA did not specify what antidepressant R97 received. In addition, the entire CAA's that had triggered non identified R97 using Trazodone for trouble sleeping. R97's care | F 279 | Resident (R97) was reviewed for appropriate use and diagnosis for antidepressant medication. The care plan for depression and sleep was reviewed and updated to include appropriate interventions for depression and sleep. Nurse Practitioner was updated and saw resident on 5/3/17. Nurse Practitioner noted appropriate clinical indication for antidepressant use in progress notes for 5/3/17 visit.<br><br>All residents currently receiving an antidepressant are being reviewed and care plans updated related to depression and sleep to ensure that appropriate diagnoses are in place for antidepressant use and for effective interventions. All residents will continue to be assessed per the RAI schedule and with any change of condition. The pharmacist consultant will review all resident records monthly for appropriate use of antidepressant medications and recommendations reviewed by the physician and nursing staff. All residents with change in mood | |

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|---|---|---|---|
| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 279 | Continued From page 6<br>plan dated 7/5/16, identified R97 used an anti-depressant for depression. The care plan directed staff to monitor side effects and effectiveness, administer medications as ordered and staff was to observe to update physician of ongoing sign and symptoms as needed for depression. The care plan did not address R97 was on Trazadone for trouble sleeping (insomnia), use of non-pharmalogical interventions, how the staff was to monitor for adverse side effects, and efficacy of the medication used for insomnia.<br><br>The April 2017, Electronic Medication Administration Record (EMAR) revealed R97 continued to receive Trazodone 50 mg every bedtime even though the physician had signed an order on 3/2/17, to reduce it to 25 mg. R97's diagnoses included major depressive disorder, dementia, attention concentration deficit and Alzheimer's disease obtained from the April 2017, Medication Administration Record (MAR).<br><br>On 4/27/17, at 12:36 p.m. when asked about R97's mood nursing assistant (NA)-C stated "he's in a good mood when I work with him."<br><br>Licensed practical nurse (LPN)-C was interviewed on 4/27/17, at 12:43 p.m. when asked how long she had known R97 she stated, "Since he came." When asked what the resident was like LPN-C stated, "Usually he's really calm, likes to read, to be in his own space. Most of the time he is smiley. When offered drinks he likes that. Sometimes he is in a bad mood, just like us. He's calm and smiley." When asked about R97's behavior she stated "I have not seen him with bad behavior. | F 279 | and/or sleep are reviewed at interdisciplinary team meetings.<br><br>Education regarding the use of antidepressants and unnecessary drugs, including the care planning process, was started on 5/18/17 and is ongoing. The policy and procedure regarding care planning and unnecessary drugs was reviewed and is current. Staff were instructed on the importance of assessing depression and sleep in the care plan.<br><br>Random audits of 10% of residents on antipsychotic medications will be completed weekly for one month and monthly thereafter by the Clinical Coordinators or designee to ensure compliance. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as needed.<br><br>The Clinical Administrator will be responsible for ongoing compliance. The completion date for certification purposes will be 6/7/17. | |

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|---|---|---|---|---|
| F 279 | Continued From page 7 | F 279 | | |

On 4/27/17, at 1:53 p.m. during a telephone interview with the MDS RN, when asked what psychotropic drugs R97 was receiving on admission she stated R97 was on Celexa 20 mg for depression and Trazodone 50 mg for insomnia. When asked if Trazodone should have been addressed on the care plan MDS RN state "yes, Trazodone should be on there for sleep, insomnia."

On 4/27/17, 3:07 p.m. the director of nursing (DON) stated Trazodone should have been on the assessment dated 6/29/16. When asked if Trazodone was supposed to be addressed in the care plan, DON stated "This should be in the care plan."

The Presbyterian Homes & Services Psychoactive Medication and Unnecessary Medication Use Policy dated November 2016, indicated "When a change in dosage occurs documentation in the medical record will include rationale for the need for changes in dosage or type of medication" and "A review of medication will be completed with Psychoactive Drug Assessment." In addition, the policy directed "All residents receiving medication for the use to promote sleep will be monitored for their hours of sleep daily. The care plan will reflect non-pharmacological interventions to promote sleep individualized to the resident."

The undated Presbyterian Homes & Services Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care Planning and Submission policy "The facility is responsible for addressing all needs and strengths of residents in the care plan regardless of whether the issue is included in the MDS or CAA's."

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|---|---|---|---|
| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 329 SS=D | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS | F 329 | | 6/7/17 |

483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

483.45(e) Psychotropic Drugs.
Based on a comprehensive assessment of a resident, the facility must ensure that--

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 329 | Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate hypnotic monitoring was being completed, pharmacy recommendations were carried out, and provider orders were followed for dose reduction for 1 of 5 residents (R97) reviewed for unnecessary medication. In addition, an antidepressant was started without clinical indication.<br><br>Findings include:<br><br>On 4/27/17, at 8:11 a.m. R96 was observed sitting in wheelchair watching television. When approached and asked how he was doing, R96 stated, "feeling very good." When asked about his sleeping habits R97 stated, "I don't know, sometimes I can't sleep all night and sometimes it's good but its okay. I just wait, wait, wait, sometimes time to go" R97 made snoring noise. When asked if he knew his medication R97 stated "I don't know for sure." When asked if he had pain R97 stated "nope never."<br><br>R97's communication Care Area Assessment (CAA) dated 7/5/16, identified resident was on an antidepressant however CAA did not specify what antidepressant R97 received. In addition, the entire CAA's that had triggered non identified R97 using Trazodone for trouble sleeping. R97's care plan dated 7/5/16, identified R97 used an anti-depressant for depression. The care plan directed staff to monitor side effects and effectiveness, administer medications as ordered and staff was to observe to update physician of ongoing signs and symptoms as needed for depression. However, the care plan did not | F 329 | Resident (R97)'s antidepressant medications were reviewed for clinical indications for use of an antidepressant medication. Zoloft was reviewed by Nurse Practitioner for clinical indication as documented in a progress note on 5/3/17. The care plan for depression and sleep was reviewed and updated to include appropriate interventions for depression and sleep.<br><br>All residents currently receiving an antidepressant are being reviewed and care plans updated related to depression and sleep to ensure that appropriate diagnoses are in place for antidepressant use and for effective interventions. All residents will continue to be assessed per the RAI schedule and with any change of condition. The pharmacist consultant will review all resident records monthly for appropriate use of antidepressant medications and recommendations reviewed by the physician and nursing staff. All residents with change in mood and/or sleep are reviewed at interdisciplinary team meetings.<br><br>Education regarding the use of antidepressants and unnecessary drugs, including the care planning process, was started on 5/18/17 and is ongoing. The policy and procedure regarding care planning and unnecessary drugs was reviewed and is current. Staff were instructed on the importance of assessing depression and sleep in the care plan. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 329 | Continued From page 10 | F 329 | | |

address resident was on Trazadone for trouble sleeping (insomnia), lacked evidence of any non-pharmacological interventions for sleep, lacked side effect monitoring for any adverse effect.

Review of the Interdisciplinary Progress Notes from 1/1/17 through 4/23/17, it was revealed there was no documentation by any of the staff of R97 showing any signs and symptoms of depression or sleeplessness.

The Consultant Pharmacist Communication to Physician report dated 1/31/17, indicated "This resident's drug regimen includes Trazodone 50 mg qhs (hour of sleep). When reading the nursing notes, it doesn't appear the resident has been experiencing insomnia. Would it be possible to try a small dose decrease in Trazodone?" The physician wrote an order on 3/2/17, underneath the report to "decrease Trazodone 25 mg Q [every] HS [bedtime]." The report was not noted by facility staff that it had been reviewed and transcribed.

Review of geriatrics nurse practitioner Progress Notes for 2/2/17, 2/16/17, and 3/26/17, noted the resident had been weaned off of Celexa for possible interaction between Celexa (an antidepressant) and Seroquel (an antipsychotic), however, the notes lacked evidence of an indication for starting the Zoloft.

Review of the monthly consultant pharmacist regimen review documentation revealed the consultant pharmacist had done a review on 3/13/17, and 4/17/17, which were both after the physician order to change Trazodone from 50 mg to 25 mg.

Random audits of 10% of residents on antipsychotic medications will be completed weekly for one month and monthly thereafter by the Clinical Coordinators or designee to ensure compliance. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as needed.

The Clinical Administrator will be responsible for ongoing compliance. The completion date for certification purposes will be 6/7/17.

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|---|---|---|---|
| | 245462 | A. BUILDING ______<br>B. WING ______ | 04/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **MARANATHA CARE CENTER** | **5409 69TH AVENUE NORTH**<br>**BROOKLYN CENTER, MN 55429** |

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|---|---|---|---|---|
| F 329 | Continued From page 11 | F 329 | | |

The April 2017, Electronic Medication Administration Record (EMAR) revealed R97 continued to receive Trazodone 50 mg every bedtime even though the physician had signed an order on 3/2/17 to reduce it to 25 mg. R97's diagnoses included encephalopathy, major depressive disorder, dementia without behavioral disturbance, attention concentration deficit and Alzheimer's disease obtained from the April 2017, Medication Administration Record (MAR).

A Physician Order dated 4/20/17, revealed R97 had been started on Zoloft 25 mg by mouth at bedtime for depression and Celexa had been discontinued however, there was no clear indication why the medication had been started even though R97's depression showed a score of zero on the quarterly Minimum Data Set (MDS) dated 3/29/17. R97's Order Summary Report dated 4/27/16, revealed R97 had following orders:
-Trazadone 50 milligram (mg) by mouth at bedtime for trouble sleeping.
-Zoloft 25 mg by mouth at bedtime for depression.

On 4/27/17, at 12:36 p.m. when asked about R97's mood nursing assistant (NA)-C stated "he's in a good mood when I work with him."

Licensed practical nurse (LPN)-C was interviewed on 4/27/17, at 12:43 p.m. when asked how long she had known R97 she stated, "Since he came." When asked what the resident was like LPN-C stated, "Usually he's really calm, likes to read, to be in his own space. Most of the time he is smiley. When offered drinks he likes that. Sometimes he is in a bad mood, just like us. He's calm and smiley." When asked about R97's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

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| F 329 | Continued From page 12 | F 329 | | |

behavior she stated "I have not seen him with bad behavior.

On 4/27/17, at 1:53 p.m. during a telephone interview with the MDS registered nurse (RN), when asked what psychotropic drugs R97 was receiving on admission she stated R97 was on Celexa 20 mg for depression and Trazodone 50 mg for insomnia. When asked if Trazodone should have been addressed on the care plan MDS RN stated "Yes, Trazodone should be on there for sleep, insomnia."

On 4/27/17, 3:07 p.m. the director of nursing (DON) stated Trazodone should have been on the assessment dated 6/29/16. When asked if Trazodone was supposed to be addressed in the care plan, DON stated "This should be in the care plan." When asked what the clinical indication for starting Zoloft on 4/20/17, after Celexa was discontinued, DON stated she did not know and would find out the clinical indications. When asked about who processed new orders DON stated "New orders need to be processed by who ever received the document." DON verified R97 continued getting Trazodone 50 mg since 3/2/17, as noted in the EMAR.

The Presbyterian Homes & Services Psychoactive Medication and Unnecessary Medication Use Policy dated November 2016, indicated "When a change in dosage occurs documentation in the medical record will include rationale for the need for changes in dosage or type of medication" and "A review of medication will be completed with Psychoactive Drug Assessment." In addition, the policy directed "All residents receiving medication for the use to promote sleep will be monitored for their hours of

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|---|---|---|---|---|
| F 329 | Continued From page 13<br>sleep daily. The care plan will reflect non-pharmacological interventions to promote sleep individualized to the resident."<br><br>The undated Presbyterian Homes & Services Resident Assessment Instrument (RAI) Process: MDS 3.0, Care Area Assessments, Care Planning and Submission policy indicated "The facility is responsible for addressing all needs and strengths of residents in the care plan regardless of whether the issue is included in the MDS or CAA's." | F 329 | | |
| F 371 SS=E | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, | F 371 | | 6/7/17 |

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|---|---|---|---|---|
| F 371 | Continued From page 14<br>handling, and consumption.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure safe and sanitary conditions for kitchen equipment that has direct contact with food during preparation. This had the potential to affect 92 of 93 residents residing in the facility who received meals prepared in the kitchen.<br><br>Findings include:<br><br>On 4/26/17, at 10:07 a.m. a kitchen tour was conducted with the culinary director (CD) and Cook (C)-A. The following sanitation concerns were observed:<br><br>- Grated grill approximately three feet by three feet had a heavy buildup of blackened/charred food matter on all linear surfaces of the grill grates. Flat horizontal areas adjacent to both sides and the back of the grated grill were observed to have a thin layer of brown/blackened matter present. The vertical splash guards,approximately three inches high on both sides and the back of the grated grill contained a buildup of tan/brown grease streaks.<br><br>- Flat top griddle to the left of the grated grill was observed to have a brown/black greasy substance around the entire perimeter of the unit. The vertical backsplash, approximately three inches high on the sides and back of the unit had a buildup of tan/brown greasy substance.<br><br>During interview on 4/26/17, at 10:27 a.m. C-A stated she brushes the grated grill if it's used, but the "brush doesn't reach everything." C-A stated | F 371 | The grated grill and the flat top griddle were cleaned and sanitized on 4/26/17.<br><br>Education regarding cleaning and sanitizing of equipment was started on 5/18/17 and is ongoing. The policy and procedure regarding sanitation of equipment was reviewed and is current. Staff were instructed on the importance of documenting completion of sanitation procedures.<br><br>Kitchen equipment sanitation will be audited daily through 6/7/17 by the Nutrition and Culinary Director or designee to ensure compliance. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as needed.<br><br>The Campus Administrator will be responsible for ongoing compliance. The completion date for certification purposes will be 6/7/17. | |

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|---|---|---|---|---|
| F 371 | Continued From page 15<br>the flat grill was used to cook eggs, but had not been used "for awhile." When the greasy buildup of matter around the perimeter of the flat grill was scraped with a knife, the CD verified the areas were not clean, stating "deep cleaning was supposed to be done weekly."<br><br>A review of the Weekly Cleaning Schedules from 1/17/17 through 4/23/17, indicated that both the grill and oven were to be cleaned weekly, however records indicated that cleaning occurred only monthly on 1/11/17, 2/20/17, 3/19/17 and 4/6/17.<br><br>A review of the undated facility policy "Grill - Gas" indicated the sanitation of equipment was to occur after each use. The policy indicated the grill was to be scraped to loosen burned on particles, clean surface with grill stone and degreaser, and clean back and side guards with soap and water. | F 371 | | |
| F 428 SS=D | 483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>c) Drug Regimen Review<br><br>(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br><br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic. | F 428 | | 6/7/17 |

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|---|---|---|---|---|
| F 428 | Continued From page 16<br><br>(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br><br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br><br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br><br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure a pharmacy recommendation with a provider order to reduce Trazodone (an anti-depressant used for sleep) | F 428 | Resident (R97)'s medication for sleep and depression was changed to reflect new orders given by the Nurse Practitioner as recommended by the | |

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|---|---|---|---|---|
| F 428 | Continued From page 17 was acted upon for 1 of 5 residents (R97). In addition failed to ensure the consultant pharmacist identified lack of or documentation of physician justification for re-starting Zoloft (anti-depressant) for 1 of 5 residents (R97) reviewed for unnecessary medications.<br><br>Findings include:<br><br>On 4/27/17, at 8:11 a.m. R96 was observed sitting in wheelchair watching television. When approached and asked how he was doing, R96 stated, "feeling very good." When asked about his sleeping habits R97 stated, "I don't know, sometimes I can't sleep all night and sometimes it's good but its okay. I just wait, wait, wait, sometimes time to go" R97 made snoring noise. When asked if he knew his medication R97 stated "I don't know for sure." When asked if he had pain R97 stated "nope never."<br><br>R97's communication Care Area Assessment (CAA) dated 7/5/16, identified resident was on an antidepressant however CAA did not specify what antidepressant R97 received. In addition, the entire CAA's that had triggered non identified R97 using Trazodone for trouble sleeping. R97's care plan dated 7/5/16, identified R97 used an anti-depressant for depression. The care plan directed staff to monitor side effects and effectiveness, administer medications as ordered and staff was to observe to update physician of ongoing signs and symptoms as needed for depression.<br><br>Review of the Interdisciplinary Progress Notes from 1/1/17 through 4/23/17, it was revealed there was no documentation by any of the staff of R97 showing any signs and symptoms of | F 428 | Consultant Pharmacist. The EMAR was updated to reflect the changes. The resident assessment for psychotropic medication and care plan were reviewed and are current.<br><br>All residents are reviewed monthly by the pharmacist consultant for appropriate use of medication and results are communicated to nursing and physician. Education regarding medication order processing was started on 5/18/17 and is ongoing. The policy and procedure regarding medication order processing and consultant pharmacy reviews were reviewed and are current. Clinical Coordinators or designee will complete order reviews of all residents receiving psychotropic medications in partnership with the pharmacist consultant.<br><br>Random audits on 10% of residents will be completed weekly for one month and monthly thereafter by the Clinical Coordinators or designee to ensure compliance. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as needed.<br><br>The Clinical Administrator will be responsible for ongoing compliance. The completion date for certification purposes will be 6/7/17. | |

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|---|---|---|---|---|
| F 428 | Continued From page 18<br>depression or sleeplessness.<br><br>The Consultant Pharmacist Communication to Physician report dated 1/31/17, indicated "This resident's drug regimen includes Trazodone 50 mg qhs (hour of sleep). When reading the nursing notes, it doesn't appear the resident has been experiencing insomnia. Would it be possible to try a small dose decrease in Trazodone?" The physician wrote an order on 3/2/17, underneath the report to "decrease Trazodone 25 mg Q HS." The report was not noted by facility staff that it had been reviewed and transcribed.<br><br>Review of geriatrics nurse practitioner Progress Notes for 2/2/17, 2/16/17, and 3/26/17, noted the resident had been weaned off of Celexa for possible interaction between Celexa (an antidepressant) and Seroquel (an antipsychotic), however, the notes lacked evidence of an indication for starting the Zoloft.<br><br>Review of the monthly consultant pharmacist regimen review documentation revealed the consultant pharmacist had done a review on 3/13/17, and 4/17/17, which were both after the physician order to change Trazodone from 50 mg to 25 mg.<br><br>The April 2017, Electronic Medication Administration Record (EMAR) revealed R97 continued to receive Trazodone 50 mg every bedtime even though the physician had signed an order on 3/2/17 to reduce it to 25 mg. R97's diagnoses included encephalopathy, major depressive disorder, dementia without behavioral disturbance, attention concentration deficit and Alzheimer's disease obtained from the April 2017, Medication Administration Record (MAR). | F 428 | | |

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|---|---|---|---|---|
| F 428 | Continued From page 19 | F 428 | | |

A Physician Order dated 4/20/17, revealed R97 had been started on Zoloft 25 mg by mouth at bedtime for depression and Celexa had been discontinued however, there was no clear indication why the medication had been started even though R97's depression showed a score of zero on the quarterly Minimum Data Set (MDS) dated 3/29/17. R97's Order Summary Report dated 4/27/16, revealed R97 had following orders:
-Trazadone 50 milligram (mg) by mouth at bedtime for trouble sleeping.
-Zoloft 25 mg by mouth at bedtime for depression.

On 4/27/17, at 12:36 p.m. when asked about R97's mood nursing assistant (NA)-C stated "he's in a good mood when I work with him."

Licensed practical nurse (LPN)-C was interviewed on 4/27/17, at 12:43 p.m. when asked how long she had known R97 she stated, "Since he came." When asked what the resident was like LPN-C stated, "Usually he's really calm, likes to read, to be in his own space. Most of the time he is smiley. When offered drinks he likes that. Sometimes he is in a bad mood, just like us. He's calm and smiley." When asked about R97's behavior she stated "I have not seen him with bad behavior.

On 4/27/17, at 2:40 p.m. during telephone interview with the consultant pharmacist (CP), when asked if the order to decrease the Trazodone to 25 mg from 50 mg was completed CP stated he reviewed his own notes and he could not remember if he talked to someone. CP stated that "he couldn't remember why he didn't address it. He didn't know what happened."

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|---|---|---|---|---|
| F 428 | Continued From page 20 | F 428 | | |

On 4/27/17, 3:07 p.m. the director of nursing (DON) stated Trazodone should have been on the assessment dated 6/29/16. When asked if Trazodone was supposed to be addressed in the care plan, DON stated "This should be in the care plan." When asked what the clinical indication for starting Zoloft on 4/20/17 after Celexa was discontinued, DON stated she did not know and would find out the clinical indications. When asked about who processed new orders DON stated that "new orders need to be processed by who ever received the document." DON verified R97 continued getting Trazodone 50 mg since 3/2/17, as noted in the EMAR.

The facility Monthly Medication Review from Merwin LTC Pharmacy dated 12/7/16, directed "The consultant pharmacist identifies potential irregularities by reviewing a variety of sources in the medical record including-Medication Administration Records (MARs); prescribers' orders; progress notes of prescribers, nurses, and /or consultants; Care Plan; Resident Assessment Instrument (RAI); laboratory and diagnostic test results; and behavior/mood and sleep monitoring information."

The Presbyterian Homes & Services Psychoactive Medication and Unnecessary Medication Use Policy dated November 2016, indicated "When a change in dosage occurs documentation in the medical record will include rationale for the need for changes in dosage or type of medication" and "A review of medication will be completed with Psychoactive Drug Assessment." In addition, the policy directed "All residents receiving medication for the use to promote sleep will be monitored for their hours of

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| F 428 | Continued From page 21<br>sleep daily. The care plan will reflect non-pharmacological interventions to promote sleep individualized to the resident." | F 428 | | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; | F 441 | | 6/7/17 |

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|---|---|---|---|---|
| F 441 | Continued From page 22<br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure gloving and hand hygiene were completed for 1 of 1 resident (R1) observed for a dressing change to the nephrostomy stoma site reviewed for activities of daily living. In addition, the facility failed to ensure gloving and hand hygiene for tube feeding care | F 441 | Resident (R1) and resident (R21) were assessed for signs or symptoms of infection and none were noted. Staff directly involved in providing the care to resident (R1) and resident (R21) were immediately re-educated on infection control practices. | |

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| F 441 | Continued From page 23<br>and pericare for 1 of 1 resident (R21).<br><br>Findings include:<br><br>Stoma/Wound care:<br>R1's care plan dated 3/20/17, indicated resident had a high risk for infections related to history of infections and identified resident had a nephrostomy tube. The care plan directed staff to perform the treatment to the nephrostomy site per medical doctor's orders.<br><br>R1's diagnoses included disorders of bladder, dementia, heart disease with heart failure, diabetes mellitus with diabetic neuropathy, aphasia, hemiplegia and hemiparesis obtained from the Medication Administration Record (MAR) dated April 2017.<br><br>On 4/26/17, at 7:35 a.m. nursing assistant (NA)-A was providing peri-care and applied resident clean incontinent pad, removed the gloves and used hand sanitizer to cleanse his hands. NA-A then called for licensed practical nurse (LPN)-B to come to room. LPN-A came to room and stated, "Do you want me to change the dressing?" LPN-B then washed her hands at the time brought all the supplies to the bedside stand, applied a clean pair of gloves, approached the resident, then was observed attempt to remove the adhesive part of the cloth tape, then removed the soiled gauze around the nephrostomy dressing, removed the gloves with dressing which was observed with dried crusty drainage tossed in trash. LPN-B then re-applied another pair of gloves, used wound cleanser to clean the area, removed gloves, applied another pair still she had not washed and/or cleansed her hands opened a package of gauze, applied the clean dressing around the | F 441 | Education regarding proper hand washing and glove use for infection control was started on 5/18/17 and is ongoing. The policy and procedure regarding hand washing and glove use for infection control was reviewed and is current.<br><br>All staff are educated on infection control practices, including glove use and hand washing, upon hire, annually, and as needed.<br><br>Random audits on resident care and infection control practices will be completed weekly for one month and monthly thereafter by the Clinical Coordinators or designee to ensure compliance. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as necessary.<br><br>The Clinical Administrator will be responsible for ongoing compliance. The completion date for certification purposes will be 6/7/17. | |

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|---|---|---|---|
| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARANATHA CARE CENTER | 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 |

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| F 441 | Continued From page 24 | F 441 | | |

Continued From page 24

stoma, secured with tape, removed gloves and then dated the dressing then re-applied another pair of gloves and assisted NA-A to adjust R1's clothing and then applied the lift sheet under R1 and transferred R1 to the wheelchair.

On 4/26/17, at 8:06 a.m. LPN-B acknowledged she had removed the gloves after removing the soiled dressing and she had not cleansed the hands. LPN-B verified she had cleaned around the stoma applied a clean gauze with the same gloves. She stated she was supposed to remove the gloves and cleanse with hand sanitizer or wash hands in between "that is what we are supposed to do."

R21 was admitted to the facility on 9/24/16, with admission diagnoses of multiple sclerosis (disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body), dementia, dysphagia (difficulty swallowing), and had a tube feeding per the Admission Face Sheet.

The care plan dated 2/6/17, indicated R21 had a tube feeding for weight loss and poor nutritional intake, spitting out of food and fluids, dependent on staff for tube feeding (percutaneous gastrostomy tube (PEG), a feeding tube inserted through the abdomen, into the stomach for tube feeding) and care. R21 had bowel and bladder incontinence, dependent on staff for all cares. R21 had a self-care deficit and required assist of one staff for personal hygiene.

The undated nursing assistant care sheet, directed staff to check and change every three hours while awake and every four hours during the night.

On 4/25/17, at 9:34 a.m. during a medication

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|---|---|---|---|
| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 441 | Continued From page 25 observation, registered nurse (RN-B) was observed provide peg dressing change and wound care for R21. RN-B applied gloves and removed the soiled g-tube dressing. She then cleansed g-tube site with a wet gauze with normal saline. RN-B then dipped long Q-tip into the Hydrogen Peroxide and cleansed the g-tube site using three separate Q-tips. RN-B place two pieces of split gauze over site and secured it with dated paper tape. At 9:39 a.m. RN-B removed and applied new gloves to provide R21's oral cares without washing hands. RN-B brushed resident's teeth, and gave R21 water to gargle and R21 spit it to an emesis basin. RN-B used a pink disposable toothette to finish cleaning R21's teeth, sprayed mouth with Biotene (a medication used for dry mouth syndrome) and asked R21 to gargle with water and spit it out. RN-B then removed gloves and was never observed to wash her hands. At 9:44 a.m. RN-B walked out of the room to get a new box of gloves. When RN-B came back she applied a clean pair of gloves then took off the blue boot and sock off the left leg. RN-B proceeded to clean the wound on the left heel with moistened gauze with normal saline and then sprayed gauze with wound cleaner and cleaned the wound. RN-B then applied Medihoney (a medication used to speed wound healing) using a Q-tip on the base of the left heel wound and then covered the wound with Allevyn (a dressing that maintains moisture and will not stick) wound dressing. At 9:50 a.m. RN-B still wearing the same gloves dipped her hand into the Aquaphor ointment (a medication used for dry cracked skin) and applied it to R21's toes. She then applied the socks and blue boot on and removed gloves. At 9:52 a.m. RN-B applied another pair of gloves without washing her hands and wiped g-tube line with alcohol prep. RN-B | F 441 | | |

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| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

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| F 441 | Continued From page 26<br>then removed gloves and returned wound supplies back to closet and left the room without washing her hands.<br><br>On 4/25/17, at 9:58 a.m. RN-B was interviewed and when asked if she washed her hands during medication administration, oral cares, g-tube cares and wound care for R21, RN-B stated she used hand sanitizer before preparing the medications and washed her hands in the bathroom when getting the resident's toothbrush and water and when she stepped out of the room when she got the box of gloves which two surveyor never observed. RN-B verified she should have washed her hands during all the cares and should have removed dirty gloves, washed hands and applied a clean pair each time with all the cares observed.<br><br>The facility Dressing Change, Clean policy created 12/14, directed staff to "7. Remove soiled dressing and discard in plastic bag, wash hands. 8. Remove gloves and discard in plastic bag wash hands. 9. Put on second pair of disposable gloves. 10. Pour prescribed solution onto gauze to be used for cleaning, if required. 11. Cleanse wound with prescribed solution. 12. Apply prescribed medications if ordered. 13. Apply dressings and secure. 14. Remove gloves and discard with all unused supplies in plastic bag, wash hands.<br><br>Peri-care:<br>On 4/26/17, at 7:50 a.m. nursing assistant (NA)-B was providing morning cares for R21. NA-B had donned gloves, changed the soiled incontinence product (stool and continuous urine leakage), provided peri-care, removed his soiled gloves and washed his hands. NA-B put on new gloves, | F 441 | | |

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| | 245462 | A. BUILDING ______ B. WING ______ | 04/28/2017 |

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| --- | --- | --- | --- | --- |
| F 441 | Continued From page 27<br>finished putting on the fresh incontinence product and removed the soiled sheets that also had stool and urine on them. Without changing gloves or performing hand hygiene, NA-B then brushed R21's hair, and prepared R21's toothbrush, handed it to her, then took it back and continued to brush her teeth with the same soiled gloves on. NA-B then wiped R21's mouth with the same gloves on. With the same pair of gloves on NA-B then straightened the room, moved R21's water glass on the table. NA-B then moved the bedside table near the end of the bed (out of reach of R21), removed the soiled gloves and took trash and soiled linen to the dirty utility room.<br><br>On 4/26/17, at 8:09 a.m. NA-B was interviewed and stated he thought he had removed his gloves after removing the soiled sheets. NA-B stated that was his usual habit and he really did not recall changing his gloves after that, but felt he would have changed the gloves by habit. On 4/27/17, at 2:30 p.m. NA-B stated, "I would have expected to perform hand hygiene and change the gloves after removing the soiled linen." | F 441 | | |

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

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|---|---|---|---|
| | 245462 | A. BUILDING 02 - **MAIN BULIDING**<br>B. WING ______ | **04/27/2017** |

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| **MARANATHA CARE CENTER** | **5409 69TH AVENUE NORTH**<br>**BROOKLYN CENTER, MN 55429** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 27, 2017. At the time of this survey, Maranatha Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.<br><br>Maranatha Care Center is Building 2 is a 3-story building with no basement that was built tin 2013 and was determined to be of Type II (222) construction. The facility is fully protected throughout by and automatic fire sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The building is attached to the Kitchen and Chapel 03 building which is of non-conforming construction and separated by a 2-hour fire wall.<br><br>The facility has a capacity of 97 beds and had a census of 93 at time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is MET. | K 000 | | |

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

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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|---|---|---|---|
| | 245462 | A. BUILDING 03 - **KITCHEN AND CHAPEL**<br>B. WING ______ | **04/27/2017** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 27, 2017. At the time of this survey, Maranatha Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.<br><br>Maranatha Care Center Building 3 is a 1-story building with no basement that was built in 2013 and was determined to be of Type V (111) construction. Building 3 houses the kitchen and chapel. The facility is fully protected throughout with an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to the Main Building 02 building which is of non-conforming construction and separated by a 2-hour fire wall.<br><br>The facility has a capacity of 97 beds and had a census of 93 at time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is MET. | K 000 | | |

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

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