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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1PQR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00916

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245409**
2.STATE VENDOR OR MEDICAID NO.
(L2) **843242200**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLE MANOR NURSING AND REHAB, LLC**
(L4) **1875 19TH STREET NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

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) **01/13/2015**

6. DATE OF SURVEY **02/04/2016** (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)
12/31

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

12.Total Facility Beds **81** (L18)

13.Total Certified Beds **81** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(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 :
Lisa Carey, HFE NE II 02/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/2/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
01/01/1987
(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.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245409

February 12, 2016

Ms. Sheila Nieland-Snyder, Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

Dear Ms. Nieland-Snyder:

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 January 27, 2016 the above facility is certified for:

81 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 81 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 12, 2016

Ms. Sheila Nieland-Snyder, Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

RE: Project Number S5409026 and Complaint numbers H5409031 and H5409032

Dear Ms. Nieland-Snyder:

On December 7, 2015 we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 23, 2015. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on November 13, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on January 7, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 4, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on January 7, 2016. The February 4, 2016 PCR also included an investigation of complaint numbers H5409031 and H5409032, that were found to be unsubstantiated.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 27, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our first PCR, completed on January 7, 2016, as of January 27, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 27, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of January 21, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 13, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective February 13, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective February 13, 2016, is to be rescinded.

In our letter of January 21, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 13, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 27, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245409 (Y1)	A. Building B. Wing (Y2)	2/4/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 01/27/2016	ID Prefix F0322 Reg. # 483.25(g)(2) LSC	Correction Completed 01/27/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 2/12/2016	SIGNATURE OF SURVEYOR 34985	DATE 2/4/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/13/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1PQR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00916

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245409**
2.STATE VENDOR OR MEDICAID NO.
(L2) **843242200**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLE MANOR NURSING AND REHAB, LLC**
(L4) **1875 19TH STREET NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

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) **01/13/2015**

6. DATE OF SURVEY **01/07/2016** (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)
12/31

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

12.Total Facility Beds **81** (L18)

13.Total Certified Beds **81** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(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 :
Lisa Carey, HFE NE II 02/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/29/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
01/01/1987
(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.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

January 21, 2016

Ms. Sheila Nieland-Snyder, Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

RE: Project Number S5409026

Dear Ms. Nieland-Snyder:

On December 7, 2015 and January 20, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 13, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 24, 2015, the Minnesota Department of Public Safety and on January 7, 2016, the Minnesota Department of Health completed revisits to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 23, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on November 13, 2015. The deficiencies not corrected are as follows:

F0315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent Uti, Restore Bladder
F0322 -- S/S: D -- 483.25(g)(2) -- Ng Treatment/services - Restore Eating Skills

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 13, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 13, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 13, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Maple Manor Nursing And Rehab, Llc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 13, 2016. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

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:

Jan.Suzuki@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 Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

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

Failure to submit an acceptable PoC 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 PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 May 13, 2016 (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 a PoC 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
January 20, 2016

Ms. Sheila Nieland-Snyder, Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

RE: Project Number S5409026

Dear Ms. Nieland-Snyder:

On December 7, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 13, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 24, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 23, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on November 13, 2015.

However, compliance with the health deficiencies issued pursuant to the November 13, 2015 standard survey has not yet been verified. The most serious health LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 13, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 13, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 13, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant

training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Maple Manor Nursing And Rehab, Llc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 13, 2016. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

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:

Jan.Suzuki@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 Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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 May 13, 2016 (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 electronic 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	R 01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 An onsite post certification revisit (PCR) was completed on January 5, & 6, 2016. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected and were not corrected at the time of onsite PCR which are located on the CMS2567. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	{F 315}	Preparation and execution of this plan of	1/27/16

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

Electronically Signed | 01/25/2016

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 315}	Continued From page 1 review the facility failed to provide services and treatments for residents with an indwelling urinary catheter to prevent injury and/or develop a urinary tract infection for (R73) observed for catheter care. Findings include: R73's admission record, dated 4/17/13, indicated that the resident had a diagnosis of urinary retention. R73's physician orders, dated 4/30/15, indicated that the resident had been prescribed an indwelling catheter. The physician orders stated to keep the drainage bag below bladder level. R73's care plan, dated 4/27/15, indicated that the resident had urinary incontinence, urinary retention and used an indwelling catheter. It stated that she had a history of urinary tract infections and was at risk for urinary tract infections. It advised to keep the drainage bag below bladder level to prevent reflux (when urine in the clear tubing runs back into the bladder vs. into the urine bag). R73's care area assessment (CAA), dated 3/27/15, indicated that the resident had an indwelling urinary catheter. It stated that she was totally dependent on toilet use. It indicated that R73 had urinary urgency. During an observation on 1/5/16 at 3:59 p.m., nursing assistant (NA)-A & B were in R73's room and transferred the resident from her bed to her wheelchair. The NA's used a hoyer lift (a machine which allows a person to be lifted and transferred with minimum physical effort) for the transfer. At the start of the transfer R73 was lying on her bed.	{F 315}	correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. 1/6/16 R73 Indwelling catheter was assessed for safety and security and prevented from infection. No signs of infection or trauma was found. b. 1/6/16 NA-A was immediately educated on the required technique of how to handle catheter tubing and the collection bag to prevent urine from reentering the bladder which increases the chance of acquiring a urinary tract infection. 2. To prevent any other residents to be affected by the same deficient practice the following action was taken: a. Updated Catheter Care Policy 1/6/16 to include information on handling the catheter bag to avoid potential infection/trauma. b. 1/7/16 Immediate In-service for CNA staff on new policy and procedure on catheter care. Educated staff to keep the catheter tubing and collection drainage bag is to be kept below the bladder level to prevent urine from reentering the bladder which increases the chance of acquiring a urinary tract infection. Staff return demonstrated competency of where to hold drainage bag while safely transferring a resident.	

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{F 315}	Continued From page 2 NA-A took R73's catheter bag which had been hung on the side of the bed to the top of the mattress next to R73. From there the catheter bag was hung onto the Hoyer lift and from this location the urine bag and tubing was higher than R73's bladder level. There was visible urine in the catheter collection bag and in the clear tubing which drained urine from the bladder to the collection bag. After R73 was seated in the wheelchair the catheter tubing and collection bag was lowered to below the bladder level and the collection bag was secured on the wheelchair frame. When interviewed on 1/5/16 at 4:07 p.m., NA-A stated that she had been educated at the facility that the catheter bag was not supposed to rest in a residents lap during transferring. She stated that it was not supposed to be in a resident's lap during transferring because of the potential for the catheter bag would open and it was for sanitary purposes that it should not be put there. Also NA-A was not aware that the catheter tubing and collection bag is to be kept below the bladder level to prevent urine from reentering the bladder which increases the chance of acquiring a urinary tract infection. When interviewed on 1/6/16 at 4:23 p.m. the director of nursing (DON) stated that the catheter bag needed to be lower than the bladder (to prevent potential infection from urine in the bag going back in to the bladder). She stated that she had educated the staff on 12/12/15 during an in-service. She stated that there were multiple occasions of observations of staff when catheter care was performed to ensure proper technique. Review of facility policy titled Catheter Care, issue	{F 315}	c. 1/12/16 In-service for License staff on new policy and procedure on catheter care. Educated staff to keep the catheter tubing and collection drainage bag is to be kept below the bladder level to prevent urine from reentering the bladder which increases the chance of acquiring a urinary tract infection. This also included Recognizing and assessing for complications and their causes and maintaining a record of any catheter-related problems. 3. To be monitored by: a. DON or designee will perform random weekly audits to observe and monitor proper handling technique of catheter tubing and the drainage bag. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. The quality assessment and assurance committee may help the community evaluate existing strategies for identifying and managing incontinence, catheter use and ensure that policies and procedures are consistent with current standards of practice. 4. Completion date: 1/27/2016	

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{F 315}	Continued From page 3 date 8/1/15, did not contain any information on handling the catheter bag to avoid potential infection/trauma.	{F 315}		
{F 322} SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to evaluate hydration status for 2 of 2 residents (R74 & R20) that had feeding tubes reviewed for enteral nutrition. Findings include: R74's quarterly Minimum Data Set (MDS) dated 11/2/15 included diagnoses of heart failure, hypertension, and anemia. The assessment	{F 322}	F322 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by	1/27/16

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{F 322}	Continued From page 4 indicated moderate cognitive impairment with a Brief Interview for Mental Status score of 12. MDS indicated R74 was dependent on staff for eating, had a feeding tube, and received 51% or more of nutrition through the feeding tube and received more than 501 cubic centimeters (cubic centimeters (cc's) or milliliters (ml) are the same unit of measurement and used interchangeably) of water. R74's electronic care plan provided by the facility on 1/6/15 indicated R74 was at risk for nutritional deficit related to stroke, nothing by mouth, dysphagia, and required tube feeding. The care plan directed staff to give enteral feedings as ordered, mix medications with 60 ml of water after crushing then flushing the tubing with 100 ml of water. After the medication is instilled the tube is again flushed with 100 ml of water. The care plan further directed staff to monitor for over hydration and dehydration and to record intake and output each shift including feeding tube intake each shift. The care plan further directed staff to give 120 ml flushes before and after each tube feeding. In addition, the care plan identified R74 to have a risk for fluid imbalance related to history of congestive heart failure. The care plan further directed staff to measure urinary output. R74's physician orders included five cans of Jevity 1.5, administered between 3 feeding times, 120 ml water flush before and after each feeding, 100 ml flush before and after medication administration three times daily, and administer medications in 60 ml of water three times per day. Physician orders also directed staff to record feeding tube intake three times per day as well as urinary Foley catheter output every shift. R74's physician visit note dated 11/16/15 included, "dietary evaluated and gave recommendations for free water to be	{F 322}	the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. 1/7/2016 R74 and R20□s were assessed for proper peg tube management. 2. To prevent any other residents to be affected by the same deficient practice the following action was taken: a. 1/7/2016 DON conducted entire facility check and identified other resident having the potential to be affected by the same deficient practice. 3. To ensure that proper practices continue: a. 1/12/2016 Formal Education reviewed several Policies and Procedures including Flushing Feeding Tubes, Tube Feeding, Administering Medications, Verifying Placement of Feeding Tubes, Peg-tube Care, Hydration/ Prevention and Treatment of Dehydration, Nutritional Alert Program, and Charting and Documentation. Educated staff that a resident who is fed by a Gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Educated staff of requirement to complete consistent daily documentation and evaluation of Inputs and Outputs of residents receiving Peg-Tube cares. Staff will document shift totals of input and output. The night shift nurse will complete daily totals. A weekly progress note will be established to	

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{F 322}	Continued From page 5 administered in the amount of 1300-1400 ml of free water is to be strictly followed, coordinated tube feedings so that it does not interfere with medication passes." R74's progress notes and nursing assessments were reviewed since 12/23/15, the record lacked daily fluid assessments or evaluations to determine if daily intake was meeting recommended fluid requirements to maintain hydration. R74's fluid intake and output was recorded on the treatment administration record (TAR). The January 2016 TAR directed staff to record catheter output; three out of 16 entries were not completed and the TAR did not reflect calculation of 24-hour output totals. The January TAR had three different recording areas related to fluid intake, however lacked 24-hour calculations of daily totals: Intake recording areas on the TAR 1) "Record PEG tube intake each shift. Please record all intake (feeding and H20 [water] three times a day." Five out of fourteen possible entry areas were left blank, one entry reflects a body temperature, and one entry is not legible. 2) "100 cc flush before and after medication administrations three times a day for free water flush." All entries were initialed by the administering nurse one time however, on 1/3/16 and 1/4/16 for both 8:00 a.m. and the 1:00 p.m. administration times the entries were initialed twice. 3) "120 cc flush before feeding Jevity 1.5 (2-2-1) at 175 cc an hour with 120 cc flush after feeding." The TAR reflected nine recorded entries of nurse initials and four entries that indicated the amount flushed with the nurses initials. During an interview on 1/5/16, at 2:22 p.m. trained medication aide (TMA)-A indicated	{F 322}	summarize the total deficit and document hydration status. Any major deficits will be reported to the physician. b. Updated Orders on TAR to document totals of fluid intake and fluid output. 4. To be monitored by: a. DON or designee will be performing weekly audit on the I&O daily documentation on TAR b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. The quality assessment and assurance committee may help the community evaluate existing strategies for identifying and managing appropriate hydration status reviewed for enteral nutrition by ensuring that policies and procedures are consistent with current standards of practice. 5. Completion date: 1/27/16.	

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{F 322}	Continued From page 6	{F 322}		

nursing assistants write down the urine output on a paper collection tool and then they get returned to the nurse and the nurse records the information into the computer or in the treatment book.

During an interview on 1/5/15, at 2:24 p.m. licensed practical nurse (LPN)-A was asked to interpret R74's daily fluid totals off the entries on January's 2016 TAR. LPN-A stated, "I don't know how they are coming up with the totals." LPN-A stated nurses are supposed to be doing fluid balance evaluations every shift.

During an interview on 1/6/15, at 2:32 p.m. registered nurse (RN)-A indicated fluid intake and output was recorded on the TAR. When asked, "How are you determining fluid balance daily?" RN-A stated, "We are recording in the medication administration book." When asked, "How do you know if the resident has had sufficient fluid intake versus output?" RN-A stated, "Well! If we noticed that output equaled more than input we would let the doctor know." When asked, "How do you know if there is a fluid deficit if there are entries missing?" RN-A indicated it was not possible to know if not enough fluid was given or if too much fluid was given each day.

During an interview on 1/6/15, at 7:38 a.m. registered dietician (RD) was asked to review the fluid intake documentation on the TAR and interpret daily total amounts. RD stated, "There are holes in the documentation everywhere and there shouldn't be and the documentation is inconsistent." RD indicated she was not sure what to add up to ascertain daily hydration needs and why some nurses and not others were recording amounts. RD indicated she would not be able to determine if R74 was meeting recommended fluid/water intake amounts. RD stated, "I expect nursing to be assessing

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{F 322}	Continued From page 7	{F 322}		

hydration daily, and nursing should be assessing daily intake needs."
Facility policy and procedure Hydration/Prevention and Treatment of Dehydration dated 8/1/15 included: nursing staff will assess all residents for current hydration risk upon admission and at least quarterly and more often as necessary with hydration risk assessment tool to identify resident at high risk for hydration issues, and nursing will monitor for signs and symptoms of dehydration during daily care. The policy further indicated Nurse's aides will provide and encourage intake of bedside on a daily and routine basis and Intake will be documented in the medical records for those residents whom have individualized interventions for intake and output. The policy further directed staff to develop interventions if signs and symptoms of dehydration were present, and monitor and document fluid intake.
R20's admission record, dated 8/4/15, indicated that the resident had diagnoses of multiple sclerosis, dysphagia (difficulty in swallowing, as a symptom of disease), quadriplegia (paralysis caused by illness or injury resulting in partial or total loss of use of all limbs and torso) and hemiplegia (paralysis of one side of the body) and diabetes.

R20's quarterly Minimum Data Set (MDS) dated 11/2/15 included diagnoses of stroke, quadriplegia, hemiplegia, seizure disorder. The assessment indicated R20 had no short or long term memory problem; R20 had some difficulty in new situations only; had no change in her baseline cognitive status from previous assessments. The MDS, dated 9/7/15, indicated that R20 was dependent on staff for eating, had a feeding tube, and received 51% or more of

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{F 322}	Continued From page 8 nutrition through the feeding tube and received more than 501 cubic centimeters (cc) or milliliters (ml) of water. R20's care plan, dated 12/21/15, indicated that the resident was at risk for deficient fluid volume due to formula tube feedings, the resident was dependent on others for her tube feeding, she was unable to take fluids by mouth from the staff in addition to her diabetes. It stated that the goal would be that R20 would have no signs and symptoms of dehydration, she would have adequate urinary output and moist mucous membranes. To ensure that these goals would be met, the care plan advised nursing staff to administer medications as needed, assess for signs and symptoms of dehydration, measure R20's intake each shift and to administer tube feedings as ordered. The goal for R20 was that she would maintain adequate nutrition. Interventions put in place to reach these goals were for the nursing staff to mix R20's medications with 10-15 ml of water after crushing the medications, then flushing the tubing with 60 ml of water before medication administration; be sure to use 5 ml of water between each medication. After all medications are passed in the tubing, the tube is again flushed with 60 ml of water. R20's physician orders, dated 12/23/15, ordered nursing staff to flush the feeding tube with 150 ml of water prior to the tube feeding and 150 ml of water after the tube feeding. It also ordered to measure intake each shift, three times a day. R20's nutritional risk assessment, dated 8/6/15, identified the resident was at nutritional risk due to her required tube feedings, her inability to	{F 322}		

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(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 322}	Continued From page 9	{F 322}		

communicate her needs and multiple medications. It identified the nutritional goals for R20 being able to tolerate tube feedings without dehydration; the resident would not have any severe weight loss/gain. Interventions recommended on the assessment advised that R20 receive a total of 2034 ml of total water per day from the tube feedings and flushes. It advised staff to monitor weights, hydration status and skin integrity.

Review of R20's nutrition/dietary notes from 12/23/15 through 1/6/16 indicated the water flush orders before and after tube feedings were changed to 150 ml of water to ensure hydration. It stated that R20 continued to receive tube feedings and flush orders. Staff were to monitor intake, weights, hydration per doctors orders.

When interviewed on 1/6/16 at 8:10 a.m., the RD for the facility stated that no one was monitoring the water intake for R20. The RD stated that was a concern as the resident was at risk for dehydration.

R20's treatment administration record (TAR) reviewed from 12/23/15 through 1/6/15, indicated the need to flush the feeding tube with 150 ml of water prior to tube feeding and 150 ml of water after the tube feeding. This was to be done three times a day for fluid maintenance. Review of the records indicated that on 12/25/15 at 1:00 p.m. no staff made an entry of fluids taken. The TAR also instructed nursing staff to measure R20's intake each shift, three times a day. Review of the TAR from 12/23/15 through 1/6/16 indicated that out of 45 shifts the nursing staff failed to record intake a total of 30 times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	R 01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 322}	Continued From page 10 During an observation on 1/6/16 at 8:32 a.m., registered nurse (RN)-B was in R20's room as R20's tube feeding had just ended. RN-B unhooked the feeding tube from R20's tube site. RN-B then did get a cup of water and applied gloves to prepare to administer water via the tube to give to R20. RN-B stated that he was going to give the resident 60 ml of water after the tube feeding. He stated that the current orders were to give 60 ml of water to the resident before and after each tube feeding. RN-B then did administer 60 ml of water to R20. After RN-B completed the procedure, RN-B reiterated that R20 was to receive 60 ml of water before and after tube feedings. When questioned again by this surveyor, RN-B did go check the orders. After RN-B checked the orders he stated that the orders were to give R20 150 ml of free water before and after each tube feeding. After acknowledging this, RN-B did give a total of 150 ml of free water to R20. After RN-B had left the resident's room, he reviewed with this surveyor the treatment administration record (TAR) for the month of January 2016. RN-B acknowledged that there were several missing records where staff were not recording the intake of R20. When interviewed on 1/6/16 at 9:57 a.m., the registered dietician (RD) stated that currently, there was no way to accurately tell R20's intake as the daily intake was missing fluid amounts. When interviewed on 1/6/16 at 10:28 a.m., the facility nurse practitioner (NP)-A stated that the nursing staff should have been recording the intake for R20. She stated that fluid monitoring was important due to the risk for dehydration. She stated that she was concerned that R20 had not been getting enough fluids and that was why the	{F 322}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	R 01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 322}	Continued From page 11 free water intake had recently been increased (before and after tube feedings). Review of the facility policy titled measuring and documenting fluid intake, dated 8/1/15, indicated that an order should be obtained if it was medically indicated for the resident to be on a fluid monitoring schedule. It advised to record the fluid intake as soon as possible after the resident had consumed the fluids. It said to record all fluid intake on the intake and output record. It advised to total the amounts of all liquids the resident consumed at the end of the shift. Review of the facility policy titled hydration/prevention and treatment of dehydration, dated 8/1/15, stated that intake would be documented in the medical records for those residents whom have individualized interventions for intake and output. Aides would report changes to charge nurses. It stated that nursing would monitor and document fluid intake and the dietitian would be kept informed of resident status. Review of the facility policy titled tube feeding: flushing feeding tubes, dated 8/1/15, stated that the tube should be flushed with the prescribed amount of water before and after intermittent feedings. It advised to verify the physician's order for the procedure.	{F 322}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245409 Y1	A. Building B. Wing Y2	1/7/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0160	Correction	ID Prefix F0241	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.10(c)(6)	Completed	Reg. # 483.15(a)	Completed
LSC	12/23/2015	LSC	12/23/2015	LSC	12/23/2015
ID Prefix F0242	Correction	ID Prefix F0247	Correction	ID Prefix F0272	Correction
Reg. # 483.15(b)	Completed	Reg. # 483.15(e)(2)	Completed	Reg. # 483.20(b)(1)	Completed
LSC	12/23/2015	LSC	12/23/2015	LSC	12/23/2015
ID Prefix F0279	Correction	ID Prefix F0280	Correction	ID Prefix F0282	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	12/23/2015	LSC	12/23/2015	LSC	12/23/2015
ID Prefix F0309	Correction	ID Prefix F0312	Correction	ID Prefix F0329	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(l)	Completed
LSC	12/23/2015	LSC	12/23/2015	LSC	12/23/2015
ID Prefix F0428	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.60(c)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	12/23/2015	LSC	12/23/2015	LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	1/21/2016		1/7/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/13/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245409 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/24/2015 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	12/18/2015	LSC K0062	12/18/2015	LSC K0154	12/18/2015
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0155	12/18/2015	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	1/21/2016	34985	12/24/2015
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/10/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

February 16, 2016

Ms. Sheila Nieland-Snyder, Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

Subject: Maple Manor Nursing And Rehab, LLC - IDR
Provider # 245409
Project # S5409026

Dear Ms. Nieland-Snyder:

This is in response to your letter of December 22, 2015, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tags F247, F280 and F441 issued pursuant to the survey event 1PQR11, completed on November 13, 2015.

The information presented with your letter, the CMS 2567 dated November 13, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F247 S/S D 42 CFR § (483.15 (e)(2) A Resident has the right to:
Receive notice before the resident's room or roommate in the facility is changed

Summary of the facility's reason for IDR of this tag.
The facility disputed the findings and indicated the residents (R33 and R77) were notified of the roommate change by the social worker. The social worker had not documented the information. The ADON was interview by the survey team, the facility disputed the findings and indicated the ADON had not completed all of the orientation and was not trained on the room change policy. The DON was not interviewed with regards to the room change policy or asked about R33 and R77.

Summary of findings
The social worker indicated she spoke with R33 and R77 but had not documented in the resident's charts. Both residents indicated they were not informed of the changes. R33 had a roommate change and indicated the social worker did not inform her of the roommate change. R77 had a new roommate and was told of a new roommate at the time the roommate was moving into the room. R77 had a room change and there was no evidence in the medical record that a written notice was provided to R77 prior to the room change. The policy for room changes identifies the social worker will provide a written seven day advance notice to the resident and/or responsible party to sign. The regulation at F247 identifies that a resident has the right to be notified of a roommate change. The residents said they were not informed of the roommate change and there is no documentation in either resident's record that they were informed of the roommate change.

This is a valid deficiency at this tag and at the correct scope and severity of D.

F280 S/S D 42 CFR § (483.10 (d)(3) A Resident has the right to:
Participate in care planning and treatment or changes in care and treatment

Summary of the facility's reason for IDR of this tag.
The facility indicated the tag was cited inappropriately and should have been cited at F279 for failure to develop a comprehensive care plan.

Summary of findings
The resident (R35) had a comprehensive care plan developed with the most current revision date of 6/13/15. The care plan indicated the resident had actual/potential alteration in skin integrity related to impaired mobility and incontinence. Interventions included treatments as ordered, monitor skin with cares and report changes, keep skin clean and dry as able, reposition every two hours and as needed. The care plan was not revised to include a surgical wound on the resident's right lower leg. The care plan was not revised to indicate the resident had dressing changes or that the resident had a wound vacuum. There was also an actual/potential for alteration in elimination related to impaired mobility, incontinence and history of urinary tract infection. Interventions included check and change as needed, assist of one for hygiene, incontinent of bowel and bladder and wore an incontinent brief. The care plan was not revised to indicate how many staff were needed to assist the resident with toileting or how often staff were to check the resident for incontinence.

This is a valid deficiency at this tag and at the correct scope and severity of D.

F441 S/S F 42 CFR § (483.65) Infection Control
The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

Summary of the facility's reason for IDR of this tag.
The ADON is not the infection control coordinator. The infection control coordinator is the DON. ADON was assigned to update the infection log under the DON supervision and guidance. The ADON is reporting directly to the DON and was being coached and being trained for a possible consideration to be the infection control coordinator. The DON was not interviewed by the surveyor with regards to infection control program, the DON was not interviewed regarding the ADON newly hired status. The ADON was recently hired and she was only 3 weeks old as an employee to Maple Manor when the annual survey was conducted. The ADON is still in training. The policy and procedure for infection control was provided and given during the survey.

Summary of findings
During the time of the survey the facility did not provide information to the surveyors to verify there was an infection control program. It was unable to be determined how the facility provided surveillance, documentation, monitoring, data analysis, education, antibiotic review, or reporting communicable diseases. The staff that was interviewed confirmed that she was new to the facility and had recently been asked to work with the infection control program. The DON was asked at the time of the survey for all information on tracking infections and all monthly logs for the facility. September 2015, October 2015 and November 2015 were the only tracking infections and monthly logs provided to the surveyor. The logs identified residents who had an infection however there was no further information on the log to establish if there was any correlation with the infection to any trends or patterns. A policy for infection control was provided with the IDR request

however it was not provided at the time of the survey. The policy that was provided with the IDR request included how to establish infection control for residents who are suspected or confirmed to have communicable diseases/infections that can be transmitted to others. There was no formal infection control program policy or procedure that was provided at the time of the survey or with the IDR process.

This is a valid deficiency at this tag and at the correct scope and severity of F.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Sarah Grebenc

Sarah Grebenc, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Telephone: 651-201-4135 Fax: 651-281-9796

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Gary Nederhoff, Rochester District Office Unit Supervisor

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1PQR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00916

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245409**
2.STATE VENDOR OR MEDICAID NO.
(L2) **843242200**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLE MANOR NURSING AND REHAB, LLC**
(L4) **1875 19TH STREET NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: **2** (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) **01/13/2015**

6. DATE OF SURVEY **11/13/2015** (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)
12/31

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

12.Total Facility Beds **81** (L18)

13.Total Certified Beds **81** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(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 :
Danette Bakken, HFE II 12/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/07/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
01/01/1987
(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.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 3020 0001 8869 0381

December 7, 2015

Ms. Sheila Nieland-Snyder, Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

RE: Project Number S5409026

Dear Ms. Nieland-Snyder:

On November 13, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 December 23, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 23, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC 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 PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 February 13, 2016 (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 May 13, 2016 (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 a PoC 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:

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
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

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
	245409	A. BUILDING _____ B. WING _____	11/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	**1875 19TH STREET NORTHWEST ROCHESTER, MN 55901**

(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 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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		12/23/15

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

Electronically Signed | 12/18/2015

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate liability notices for 1 of 3 residents (R32) reviewed for liability notices. Findings include: R32 was discharged from Medicare services on 6/20/2015, as indicated on a Notice of Medicare Non-Coverage form, signed by R32 on 6/17/15. R32 remained in the facility. There was no evidence in the medical record that R32 received a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form to allow R32 to choose to continue to receive non-covered, skilled services at R32's own cost, and inform R32 of the right to appeal Medicare's decision.	F 156	F156 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. Resident is no longer at Maple Manor. 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. 11/19/2015 In-service for Employee	

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F 156	Continued From page 3 During interview on 11/13/15, business office manager (BOM)-D confirmed R32 had not received a SNFABN form. BOM-D stated R32's last day of therapy was on 6/20/15 and then R32 was private pay. BOM-D stated R32 should have received the SNFABN form. The facility policy Medicare Notice of Denial and Expedited Decision Notice, dated 9/16/10, indicated it is the policy and practice of Maple Manor that all residents covered under Medicare will be given the Medicare denial letter, the expedited decision notice and a verbal explanation of reason for non-coverage and appeal rights.	F 156	Medicare Team on Policies/Procedures in regards to resident Liability notices and appeal rights. b. 12/1/2015 Updated Policy and Procedure for Medicare Notice of Denial and Expedited Decision Notice. c. 12-1-2015 in-service by MDS Consultant reviewed Policy. Provided presentation and education for the Medicare Denial Process. d. 12/1/2015 Updated Notice of Medicare Non-Coverage Form with Instructions. e. 12/1/2015 Updated Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) Form. f. 12/1/2015 Updated Detailed Explanation of Non-Coverage Form. g. 12/1/2015 Updated Part A&B Generic Form. h. 12/1/2015 Updated Denial Letter Notification Tracking Form with instructions for the Notice of Medicare Non-Coverage. i. 12/1/2015 Updated Medicare Non-Coverage Letter for a new admission who does not qualify for Medicare. j. 12/1/2015 Updated Medicare Notice of Denial and Expedited Decision Notice Form with Instructions for the Notice of Medicare Non-Coverage. k. Will Review Policy and Procedure at Resident Council Meeting in January of 2016. 3. To ensure that proper practices continue: a. 12/1/2015 Formal Education was provided for all Medicare team members. 4. To be monitored by:	

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F 156	Continued From page 4	F 156	a. Social Services and/or Business office Manager will review quarterly for 3 months to assure completion as evidenced by QAPI monitoring. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to convey resident funds deposited into trust accounts upon death, for 3 of 4 residents (R1, R42 and R71) who expired and did not have their money returned to their family or personal estate within 30 days. Findings Include: R1 expired on 5/24/15, at which time R1's personal fund account balance was $108.93. The balance was mailed to Olmsted County on 8/19/15. R42 expired on 10/8/15, at which time R42's personal fund account balance was $1,280.74. As of 11/12/15, the funds were still being held by	F 160	F160 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. Funds have been returned to resident. Trust accounts have been closed for Residents R1, R42, and R71. 2. To prevent any other residents that may be affected by the same deficient	12/23/15

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F 160	Continued From page 5 the facility and had not been conveyed to the family or R42's estate. R71 expired on 10/7/15, at which time R71's personal fund account balance was $31.00. As of 11/12/15, the funds were still being held by the facility and had not been conveyed to the family or R71's estate. On 11/12/15 at 12:46 p.m. the business office manager stated, "We had a glitch in there with my staff. Probably a week before I mailed it out [R42's estate check] I discovered it and had to make sure everything was updated in their trust before I could mail it out." The business office manager added she was currently processing the remaining funds for R71 and R42. Facility policy Personal Allowance Account Procedures, dated 6/13/08, reads; "11. Upon the death of a resident, all funds in the resident's account shall be remitted to the resident's legal guardian, conservator, representative payee, or the executor, of the resident's estate within 30 days of the resident's death. This will be done by making out a check drawn from the Personal Allowance Checking Account payable to the estate of the resident."	F 160	practice the following action was taken: a. Personal Funds Allowance Policy has been reviewed by Business Office Manager and Social Services Director. b. Resident Needs Fund Agreement has been reviewed by Business Office Manager and Social Services Director. c. Authorization for Purchase Form/Resident Funds form as been reviewed by Business Office Manager and Social Services Director. 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education was provided for the Business Office Manager and Social Service Director. 4. To be monitored by: a. BOM will monitor quarterly for accuracy and report findings to Qapi committee. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241		12/23/15

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F 241	Continued From page 6 by: Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 5 of 18 residents (R2, R6, R43, R62 and R25) who were observed in the north dining room and not enough staffing to accommodate a pleasant dining experience. Findings Include: LACK OF TIMELINESS OF DINING SERVICE IN THE NORTH DINING ROOM: On 11/9/15 at 4:18 p.m. a steam table filled with food for the evening meal was brought to the north dining room and was plugged into the outlet to keep the food hot. The dietary aide (DA)-A started serving food to residents at 4:25 p.m. R2 was observed on 11/09/2015 at 4:25 p.m. to be sitting in the dining room at the start of the dining observation. R2 was served her meal at 5:39 p.m., one hour and fourteen minutes after the start of the dining service. R6 was wheeled into the dining room on 11/09/15 at 4:34 p.m. and was served her meal at 5:36 p.m., one hour and two minutes after she was brought into the dining room for the evening meal. On 11/09/2015 at 5:02 p.m. two resident observed to be sitting at the same table as R2 and R6 had been served and were eating their meals as R2 & R6 waited for their food and watched the two table mates eat. On 11/09/2015 at 5:42 p.m. DA-A stated this was the second time she has served residents in the north dining room. DA-A stated she looked at the	F 241	F241 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. Facility will promote care for residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality by promoting the resident□s independence and dignity while dining by giving choices and respecting the residents individual preferences on the use of clothing protectors. b. R2, R6, R43, R62, and R25 were interviewed for preferences and Care Clan and Care Guide were updated. c. R2, R6, R43, R62, and R25 will be given a choice and will be asked if they prefer to wear a clothing protector during their meals. d. 11/16/2015 Reviewed and updated Policy and Procedure for Providing Privacy and Dignity for Residents. e. 11/18/2015, 11/19/2015, 11/20/2015, 11/24/2015, 12/10/2015 and 12/16/2015 provided in-service education to all current staff on Policy and Procedure for providing privacy and dignity for Residents.	

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F 241	Continued From page 7 residents name card/diet slip to see what they have ordered. She stated she tried to serve the residents who required assistance with eating first if there was a nursing assistant available to help them eat their meal. She stated she served residents who did not require assistance with eating their meals based on who was in the dining room first. DA-A stated she did not know who R2 and R6 were tonight during the meal service. DA-A stated she asked her boss (the CDM) who the residents were on the two name card/diet slips she had left for residents who had not been served yet. DA-A stated she had the name card/diet slip for R2 and just did not know who she was, and had not served her and stated R6 ' s name card/diet slip was not there for her to use and she did not know who R6 was. DA-A stated was aware R2 and R6 had been in the dining room for quite a while waiting to be served. DA-A stated she had a lot of other residents to serve and she did not know who they were. DA-A stated a staff member came up to her during the dining service and asked when R2 and R6 were going to be served. DA-A stated it usually took her an hour to serve everybody. On 11/09/2015 at 5:52 p.m. the CDM stated a resident should be served their food within five minutes of when they sat down in the dining room. LACK OF GIVING RESIDENCE CHOICE OF WEARING A CLOTHING PROTECTOR: On 11/09/15 at 4:37 p.m. life enrichment assistant (LEA)-A was observed moving from resident to resident applying clothing protectors. LEA-A applied the clothing protector, however, LEA-A did not ask the residents their preference for	F 241	2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. Interviewed each resident to collect preferences in regards to bathing days and times of days. Care plans and care guides for C.N.A. staff have been completed. 3. To ensure that proper practices continue: a12/10/2015 and 12/16/2015 Formal Education was provided for all team members regarding Dignity of appropriate time to serve residents and ask if they desire garment protector at meal times. 4. To be monitored by: a. Culinary Services Director or designee will perform a weekly audit of both dining rooms at a variety of meals for three months. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	

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F 241	Continued From page 8 wearing the clothing protector or explain what she was about to do for the resident, and draped the protectors over their chests and tied them behind their necks for R43, R62, R25, R6. On 11/13/2015 at 1:33 p.m. LEA-A verified she did not ask or explain what she was about to do for the residents R43, R62, R25, R6 when she placed a clothing protector on these residents during the dining observation on 11/9/15. On 11/13/2015 at 1:41 p.m. the life enrichment director (LED)-A stated staff should be asking all residents if they would like a clothing protector and should explain to non-verbal residents what they were about to do before placing a clothing protector. The LED-A stated, "of course it is a dignity issue to place a clothing protector on a resident without asking them, this is their home." The undated dining room procedures included, "It is the policy of Maple Manor to ensure each resident has the opportunity to be seated in the dining room, be served a hot, good tasting meal in a timely manner, and not feel rushed in eating." The Dietary Staff Resident Assistance in the Upper Dining Room dated 9/30/2008 included, "This policy is for the Upper Dining Room only as north unit is run by direct care staff during meal service. Prior to meal service: 3. Dietary staff may assist with apron closure. Ask if they need help and if they want the apron on their lap or around their neck."	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities,	F 242		12/23/15

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F 242	Continued From page 9 schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide choices for bathing and hour of sleep for 1 of 3 residents (R51) reviewed for choices. Findings include: R51's quarterly Minimum Data Set (MDS) dated 9/18/15, indicated R51 was cognitively intact, and required assist of one staff for bathing and dressing. R51's current care plan, indicated R51 self-care deficit related to impaired mobility, assist of one bathing and dressing. During interview on 11/09/15, at 6:15 p.m., R51 stated they have a shower on Thursday and Sunday, and if I do not take a shower on those days I do not get a shower. R51 stated I am too tired on Sundays to take one, because I go out, so I do not get that one. In addition, R51 stated does not choose when to go to bed. R51 stated would like to go to bed at 8:00 p.m., but you cannot get anyone to help. Whenever they are ready is when I go to bed, sometimes 9:00 p.m. One time I got in bed by myself, I was just so tired that night.	F 242	F242 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. Facility will promote care for residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality by promoting the resident□s independence and dignity while providing direct cares by giving choices and respecting the residents individual preferences on bathing and assisting with night time cares. b. Interviewed R51 immediately for her preferences on bathing and waking and sleep hours. Care planned these preferences c. 11/16/2015 Reviewed and updated Policy and Procedure for Providing Privacy and Dignity for Residents.	

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F 242	Continued From page 10 During interview on 11/13/2015, at 9:35 a.m., R51 stated Sunday for bath day was not a good day as busy on Sundays and gets too tired. R51 stated did not want more than two baths a week, but would like to get one of the baths on a different day then Sunday. In addition, R51 said she was not ok with time of going to bed most nights and prefers to go to bed earlier. R51 said that she has waited from 9:00 p.m. to sometimes 10:00 p.m. before being helped to bed. R51 said she has often told nursing assistants she wants to go to bed by 8:00 p.m. Bath list north wing was reviewed and dated 11/2/15 through 11/11/15, indicated R51 was to receive a bath on Sunday and Thursday and please initial when bath is completed. R51's bath was documented as completed on Thursday 11/2/15, however R51's bath on Sunday 11/8/15, lacked documentation of being completed. R51's initial activity assessment dated 3/17/15, identified the facility inquired what time do you like to go to bed, with response of 11:00 p.m. However, this has changed to wanting to go to bed by 8:00 p.m. During interview on 11/13/15, at 11:27 a.m., assistant director of nursing (ADON)-C stated she had not heard from staff R51 requested to be in bed at a certain time and she would expect the nursing assistants to inform her of R51's request to go to bed at a certain time. ADON-C verified R51's care plan failed to include time of when to get up in the morning and time of when to go to bed in the evening. ADON-C stated we usually assign baths two times per week for every resident. I do not know who determines bath days. I expect staff to ask the resident their	F 242	d. 11/17/2015, 11/19/2015, 11/20/2015, 11/23/2015, 12/10/2015 and 12/16/2015 provided In-service Education to all current staff on Policy and Procedure for Providing Privacy and Dignity for Residents. 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. Interviewed each resident to collect preferences on bathing and wake and sleep hours. Care planned preferences. b. Offer bathing days and times per resident desires. c. Offer choice to residents in sleep and wake times. 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education was provided for all nurses including the MDS Coordinator on the Policy and Procedures for Care plans and use the results of the assessments to develop review and revise the resident□s comprehensive plan of care. b. Updated care giver guides to include preferences for bathing, hour of sleep and waking. c. Reviewed and updated Skin Monitoring: Comprehensive CNA Shower Review Form to collect documentation from CNA on resident bathing. d. Updated Community Bathing schedule according to resident preferences. e. Updated bathing binder on each neighborhood.	

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F 242	Continued From page 11 preference, as they should be comfortable with when want to take a bath. If Sunday did not work for R51 would expect it to be changed to a different day R51 would choose. Request for policy regarding resident choices for bathing and bedtime however, not provided.	F 242	4. To be monitored by: a. CNA Supervisor will review bath sheets and address concerns as needed with a licensed nurse daily. Licensed nurse will document as appropriate. DON/ and or Designee will perform a weekly audit of bathing according to preference and schedule for 3 months. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate notice of a room change and/or of a new roommate for 2 of 3 residents (R33 and R77) reviewed for admission, transfer, and discharge. Findings Include: R33 was interviewed on 11/10/15, at 8:36 a.m., R33 stated has had a roommate change, but was not given notice of the change. R77 was interviewed on 11/09/15, at 6:50 p.m., R77 stated has had a room change but was not given notice of the change and has had a roommate change but was told until the roommate moved in.	F 247	F247 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. Documentation for R33 roommate change interviewed and notified. b. R77 is unidentifiable. 2. To prevent any other residents that	12/23/15

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F 247	Continued From page 12 On 11/13/15, at 9:15 a.m., social worker (SW)-A informed R33 had a new roommate on 7/29/15 and on 9/10/15. R77 had a room change on 9/3/15 and a new roommate on 11/2/15. SW-A stated she had informed R33 and R77 of the changes, but had not documented the information. On 11/13/15, at 11:04 a.m., assistant director of nursing (ADON)-C stated she would expect documentation in the residents record regarding change of room and roommate changes. The facility policy Room Changes, dated 7/28/14, indicated social services to talk via phone call or in person with the resident/responsible party regarding any room changes being discussed. Social services is to fill out a written seven day advance notice letter and have the resident/responsible party sign the form. A verbal acceptance is sufficient to proceed with a room change, however the seven day advance notice letter still needs to be mailed to obtain a signature. Social service staff to introduce the potential new roommates and show the resident the new room. Document in social service notes of the new roommate(s) that he/she was told of the change in advance.	F 247	may be affected by the same deficient practice the following action was taken: a. Social Services Director or Designee will approach, educate and document conversations with all residents in regards to roommate changes. 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education was provided for Social Services Director regarding documentation of informed resident roommate changes. 4. To be monitored by: a. Social Services Director will complete monthly random resident chart audits on the documentation of roommate changes for three months. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive	F 272		12/23/15

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F 272	Continued From page 13 assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to comprehensively assess pain for 1 of 1 resident (R106) reviewed for pain and the facility failed to ensure a comprehensive skin assessment included a stage II pressure ulcer for	F 272	F272 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set	

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F 272	Continued From page 14 1 of 3 residents (R3) reviewed for pressure ulcers. Findings include: R106 was interviewed on 11/9/15, at 7:28 p.m., R106 stated he had a lot of discomfort in his esophagus and stomach. R106 rated pain level at an 8 of a pain scale of 1 to 10 with 10 being worst pain ever. R106's admission Minimum Data Set (MDS) dated 8/25/15, indicated diagnosis of cancer, had pain in last five days and R106 was cognitively intact. However, the pain assessment interview for the resident had not been fully completed. R106's pain interview assessment, dated 9/4/15, indicated R106 was able to communicate appropriately, had pain in last five days, frequently and states pain meds help control lower back pain and esophageal burning. On 11/13/15, at 1:50 p.m., registered nurse (RN)-C verified the resident interview for pain had not been completed on the admission Minimum Data Set (MDS) dated 8/25/15 but should have been. On 11/13/15, at 8:22 a.m., assistant director of nursing (ADON)-C verified the resident interview for pain had not been completed and stated the interview should have been completed as the resident was interviewable. The facility policy Pain Management and Assessment, dated 7/28/15, indicated purpose: to develop a standardized method of assessing, monitoring, evaluating and documenting pain in	F 272	forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. R106 was no longer a resident of Maple Manor and no further assessment to be completed. b. R3 is not identified in 2567. Unable to identify resident. 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. Reviewed policy for Pain b. Reviewed policy for the Completion of the Comprehensive Skin Assessments. c. 12/15/2015 Completed Comprehensive Pain Assessments for all residents. d. 12/16/2015 Completed Comprehensive Skin assessments for all residents 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education was provided for all nurses for skin and pain assessment including interventions, pain rating, proper evaluation and documentation. b. 12/10/2015 Formal Education was provided for all staff for proper pain evaluation and interventions. c. Upon admission a comprehensive Pain Assessment is to be completed by the nurse on duty admitting resident. d. Upon admission a comprehensive Skin Assessment is to be completed by	

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F 272	Continued From page 15 both cognitively intact and impaired residents. A comprehensive pain assessment will be completed as part of the initial nursing assessment. R3 was admitted on 8/6/15 according to the admission sheet. The progress notes dated 8/10/15 10:50 p.m. R3's left great toe was red, with no blisters noted. On 8/12/15 2:06 p.m. R3 nurse assessed blisters on left great toe and left second toe. R3's 14-day Assessment MDS, dated 8/20/15, revealed no pressure ulcers present. ARD 8/6/15 through 8/20/15. On 11/13/15 at 10:14 a.m. registered nurse (RN)-C stated "To tell you the the truth I was still learning to do MDS's, I didn't realize that was really a stage II [pressure ulcer]. To me that was intact. I know now that it would be a stage II and it would be on the MDS. This would have been on the admission MDS the ARD was 8/13/15. I would have care planned it, it would have been on the CAA, done a weekly wound assessment, measurement, told the doctor and ensure that it would stay intact." Facility policy regarding the completion of the comprehensive skin assessments was requested but not provided.	F 272	the nurse on duty admitting resident. 4. To be monitored by: a. DON (or designee) will monitor and audit all residents once a month for 3 months to verify that Pain Assessments are being completed upon admission, quarterly, and with a change of condition. b. DON (or designee) will monitor and audit all residents once a month for 3 months to verify that Skin Assessments are being completed upon admission, quarterly, and with a change of condition. c. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		12/23/15

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F 279	Continued From page 16 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R59) who was reviewed for dialysis services and cares and failed to develop a comprehensive care plan that addressed the chronic use of an included indwelling Foley catheter for 1 of 2 residents (R74) who was reviewed for urinary catheter use. Findings include: LACK OF CARE PLAN INTERVENTIONS IN REGARDS TO SPECIFIC CARES FOR RESIDENT RECEIVING DIALYSIS AND SAFETY PRECAUTIONS: R59's undated comprehensive care plan indicated R59 had been admitted on 8/14/15, with diagnoses to include end stage renal disease and received hemodialysis. The care plan lacked	F 279	F279 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: b. 11/16/15 updated care plan for R59 for risk for excess fluid volume due to end stage renal disease on hemodialysis which includes dialysis schedule, direction for care of dialysis, access site, identification of infection symptoms, indication of which medication was held	

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F 279	Continued From page 17 dialysis schedule, direction for care of dialysis access site, identification of infection symptoms, indication of which medication were held on dialysis days, dialysis unit contact phone numbers, and medical emergency information. Review of physician order dated 10/12/15 read "Dialysis cath [catheter] right upper chest-IV [intravenous] access; site care and flushing per facility protocol, keep clean and dry." Review of R59's medical record lacked site care and flushing protocol. On 11/13/15, at 11:34 a.m. during phone interview with Mayo Clinic Dialysis Center registered nurse (RN)-Z it was reported R59 should have been monitored for infection to include redness, and pain at catheter site, fever or chills, and medication. RN-Z stated R59's medical record should have included a memorandum of understanding which had been given to the facility to guide patient care in regards to cares and services for dialysis residents. On 11/13/15, at 12:58 p.m. the director of nursing (DON) verified R59's record lacked the identified components as listed above. The facilities Dialysis Care Policy and Procedure dated 8/1/15 included "2. Risk factors related to potential for bleeding, alteration in fluid volume, potential for infection, alteration in nutrition, alteration in skin integrity, risks for adverse medication effects and psychosocial needs should be identified, assessed, and interventions to manage addressed in the individualized care plan. 8. Emergency protocols should be identified and incorporated into the individual care plan." LAKE OF CARE PLAN INTERVENTIONS FOR CHRONIC USE OF AN INDWELLING URINARY	F 279	on dialysis days, dialysis contact number and medical emergency information. c. 11/16/15 Updated care plan for R74 who has an indwelling catheter due to urinary retention includes catheter care and catheter infection prevention. 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. MDS Coordinator (or designee) will establish a care plan with timetables and resident specific goals and interventions to address the care needs and treatments to the clinical diagnosis and or identified concern for all residents. 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education was provided for all nurses including the MDS Coordinator on the Policy and Procedures for Care plans and use the results of the assessments to develop, review and revise the resident□s comprehensive plan of care. 4. To be monitored by: a. DON (or designee) will complete weekly random residents audits on the interventions updated on the Comprehensive plan of care triggered by the MDS for three months b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	

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F 279	Continued From page 18 CATHETER CARE AND SERVICES AND INTERVENTIONS TO PREVENT URINARY TRACT INFECTIONS: R74 was observed on 11/12/15 at 10:11 a.m. to receive a.m. cares by nursing assistant (NA)-D & trained medication assistant (TMA)-B At the start of the care session, R74's catheter tubing was located underneath the right leg and the tubing was not coiled and anchored to the bed. NA-D took the urine collection bag, removed the tubing from underneath the leg, and placed the collection bag on bed, at the level of the bladder. During the move of the collection bag onto the bed, the urine in the tubing went back up towards the bladder and was no longer visible in the tubing until the collection bag was at the level of the bladder (reflux). TMA-B then lifted the catheter collection bag approximately 12 inches above R74's bladder while pants were donned. Urine in the tubing flowed downward towards the bladder and was no longer visible. TMA-B returned the collection bag to the top of the bed and urine flowed out. The tubing was now almost completely full with urine; no urine was draining into the collection bag. NA-D and TMA-B assisted R74 into a mechanical lift sling to transfer out of bed. They placed urine collection bag on top of R74 with it above the bladder during the entire transfer. R74's care plan which was undated did not reflect daily care and maintenance for an indwelling urinary catheter. R74's electronic care plan included problem statement, "alteration in elimination r/t [related to]: incontinent bowel, indwelling catheter, impaired mobility, risk for UTI [urinary tract infection], hx [history] of UTI, CKD [chronic kidney disease] stage 3 with the goal, will have no complications r/t indwelling catheter through next review." The	F 279		

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F 279	Continued From page 19 care plan identified two interventions pertaining to the care of the indwelling catheter; catheter changes per order and monitor for signs and symptoms of UTI. During an interview on 11/12/15, at 1:26 p.m. licensed practical nurse (LPN)- B was asked what size catheter was used and frequency of changing. LPN-B, did not know and could not find how often the catheter was to be changed or what size catheter should be used. LPN-B stated a visual inspection of the catheter revealed a 14 french with a 10 cc balloon was being used at the time of survey. R74's record or care plan did not reflect prescribed size of catheter, recommended catheter change schedule. A progress note dated 11/4/15 indicated R74 had suprapubic discomfort with no urine output. The note indicated staff performed a bladder scan with results of 330 cc's (cubic centimeters), then irrigated the bladder with no return, then changed the indwelling catheter, collected a urine sample and notified the physician. The record and care plan did not reflect a physician's orders to flush or change the catheter. A physician's note obtained on 11/13/15. The physician's note indicated a service date of 11/9/15 (revised on 11/13/15) and pertained to R74's urinary symptoms on 11/4/15. The note included, "patient has a history of chronic urinary bacteremia." The physician's note explained R74 would not be treated with antibiotics related to history of bacterial resistance, lack of symptoms and potential serious adverse reactions of antibiotics with other medications. The physician directed nursing to monitor for signs and symptoms. The care plan did not reflect the plan of care for the asymptomatic UTI or history of	F 279		

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F 279	Continued From page 20 bacterial resistance. During an interview on 11/12/15, at 1:27 p.m., director of nursing (DON) stated, physician orders for indwelling catheters should include size of catheter and schedule for changing. The DON stated the catheter tubing should go over the leg while in bed and not underneath to prevent pressure areas and kinks in the tubing. DON explained it was not appropriate to put the catheter collection bag on top of the bed or hold it above the bladder at any time, and not placed on top of the resident during transfers. DON verified lack of urinary catheter care plan and stated the care plan should include size of the catheter, schedule for changing, measuring output, and give direction on daily care. A policy for urinary catheter cares was requested and not provided.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280		12/23/15

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	245409	A. BUILDING _____ B. WING _____	11/13/2015

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F 280	Continued From page 21 each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include changes in condition for a surgical wound and toileting for 1 of 1 resident (R35) reviewed for skin condition and activities of daily living. Findings include: R35's admission record, dated 11/12/15, identified diagnoses of planned post procedural wound closure, urgency of urination and dementia. R35's 14 day Minimum Data Set (MDS) dated 10/10/15, identified R35 had surgical wound, surgical wound care, and assist of two for toileting and always incontinent bowel and bladder. R35's care plan, dated revision 6/13/15, indicated actual/potential for alteration in skin integrity related to impaired mobility and incontinence. Interventions of treatments as ordered, monitor skin with cares and report changes, keep skin clean and dry as able, reposition every two hours and as needed. Actual/potential for alteration in elimination related to impaired mobility, incontinence and history of urinary tract infection. Interventions of check and change as needed, assist of one hygiene, incontinent of bowl and bladder, wears incontinent brief. However, R35's care plan failed to include R35 had a surgical wound, which included	F 280	F280 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. Care plan updated for a surgical wound and toileting for R35 b. Care plan updated for R36 including diseases of the lips and right finger infection, monitoring for changes and symptoms of infections. 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. MDS Coordinator (or designee) will establish a care plan with timetables and resident specific goals and interventions to address the care needs and treatments to the clinical diagnosis and or identified concern for all residents. 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education was provided for all nurses including the MDS Coordinator on the Policy and Procedures	

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F 280	Continued From page 22 interventions for assessing and monitoring for changes, including signs and symptoms of infection and how often staff should check and change R35 for incontinence and interventions for sometimes aware of need to toilet. On 11/13/15, at 11:23 a.m., assistant director of nursing (ADON)-C verified R35's care plan failed to include surgical wound interventions and stated the surgical wound should be identified on the care plan. ADON-C verified R35's care plan failed to include how often R35 should be checked and changed. ADON-C sated she would expect R35's care plan to include direction for the NA's on how often R35 was to be check and changed, as some residents have frequency and should be checked every two to three hours. ADON-C stated if a resident was able to sit on the toilet, she would expect offer to toilet would be care planned. R36's admission record, dated 11/12/15, identified diagnoses of dementia, tinea unguium and diseases of lips. R36's 14 day Minimum Data Set (MDS) dated 10/05/15, identified application of ointments/medications other than feet. R36's care plan, dated revision 7/27/15, indicated actual/potential for alteration in skin integrity related to impaired mobility and incontinence. Interventions of treatments as ordered, monitor skin with cares and report changes, keep skin clean and dry as able, incontinence care after each incontinent episode, assist of one for bed mobility and pressure reduction mattress to the bed and pressure reduction cushion to the chair. However, R36's care plan failed to include diseases of lips and right ring finger infection,	F 280	for Care plans and use the results of the assessments to develop, review and revise the resident□s comprehensive plan of care. b. Stop and watch form will be utilized as an internal document to address concerns or a change of status. Forms can be submitted to DON, ADON, MDS Nurse, or Social Services Manager. Manager will revise care plan 4. To be monitored by: a. DON will complete weekly random residents audits on the interventions updated on the Comprehensive plan of care triggered by the MDS for three months. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	

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F 280	Continued From page 23 which included interventions for assessing and monitoring for changes, including signs and symptoms of infection. On 11/13/15, at 8:24 a.m., RN-C verified R36's care plan failed to include disease of lips and right ring finger infection, which included specifics for the areas. On 11/13/15, at 11:20 a.m., ADON-C verified R36's care plan failed to include disease of lips and right ring finger infection and stated she would expect everything to be included on the care plan. A facility policy related to Care Planning was requested but not provided.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow each residents comprehensive care plan in regards to transfer a resident for 1 of 1 resident (R35), provide pain services for 1 of 1 resident (R106), secure placement of a catheter bag during a transfer for 1 of 2 residents (R20), provide oral care for 1 of 1 resident (R74), failed to flush feeding tube for 1 of 1 resident (R74), lacked monitoring and document skin integrity changes for 2 of 2	F 282	F282 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following	12/23/15

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F 282	Continued From page 24 residents (R74, R84), and failed to monitor and document effectiveness of as needed pain medications, attempt and document non-pharmacological interventions before pain medication was given, report weight increases, monitor physician ordered intake for 1 of 1 resident (R84). Findings include: LACK OF ASSESSED TRANSFER NEEDS PROVIDED: R35's care plan, dated revision 6/13/15, indicated self-care deficit related to impaired mobility, weakness and blindness with intervention of assist of two with mechanical lift for transfer. The unit four care guide dated 11/12/15, indicated R35 transfers with assist of two using a mechanical lift. During observation on 11/12/15, at 9:55 a.m., nursing assistant (NA)-D entered R35's room and asked R35 if R35 needed to use the bathroom and R35 replied yes. NA-D then assisted R35 into the bathroom, instructed R35 to hang onto the grab bars and assisted R35 to stand and turn to sit down onto the toilet. During interview on 11/12/15, at 9:55 a.m., NA-D verified had transferred R35 by using the grab bars to stand, with assist of one. NA-D verified the care guide dated 11/12/15, directed R35 for transfers required assist of two and a mechanical lift. On 11/13/15, at 11:23 a.m., assistant director of nursing (ADON)-C stated she would expect staff to follow the care plan for transfers.	F 282	immediate action concerning the deficiency identified on the CMS-2567: a. 12/8/2015 R74 was reassessed for oral care, tube flush feedings, skin, pain, weight and record input and output by daily log. Care Plan and Care Guides updated. b. 12/8/2015 R106 discharged and unable to reassess for pain. c. 12/8/2015 R20 Indwelling catheter was re-assessed and care plan and Care Guide was updated. d. 12/8/2015 R35 was reassessed for safe transfers and Care Plan and Care Guide was updated. e. 12/8/2015 R84 Reassessed skin, pain, weight and record input and output by daily log. 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. 12/10/2015 conducted an entire facility check and identified other residents having the potential to be affected by the same deficient practice. b. 12/10/2015 DON (or designee) revised and updated Care Guides for all Residents 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education was provided for all staff including nurses and C.N.A□s on Comprehensive Care Plan Policy, revised Care Guides, ensure resident plan of care is being followed with regards to safe transfer, pain medication, indwelling catheter care, oral care, intake and output and pain management. b. Administrator and DON (or designee)	

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F 282	Continued From page 25 LACK OF TIMELY PAIN MEDICATION: R106's care plan dated revision 9/8/15, received Hospice services related to terminal diagnosis, debility, physical decline, weight loss. Resident will be made comfortable physically and spiritually and maintain dignity daily with the assistance of Hospice services through next review. Interventions of: administer medications as ordered, follow Hospice care plan along with facility care plan, notify Hospice if changes in condition, notify Hospice if increased signs or symptoms of dyspnea, anxiety and/or pain is not controlled. R106's Hospice plan of care dated 8/18/15, indicated patient is to experience safe and timely reduction of pain for as long as it persists, to a level of comfort that is acceptable to the patient. Interventions of: assess pain using a pain scale, evaluate effectiveness of interventions related to comfort, consider alternative medication, teach and titrate medication regimen to relieve distressing symptoms, medicate prior to activity/cares causing discomfort, teach regarding pain management and resources available: Dilaudid scheduled twice daily in facility and teach pharmacological and non-pharmacological means to provide comfort. During interview on 11/9/15, at 7:28 p.m. R106 stated I have been in pain since last night, a lot of discomfort through esophagus and through stomach. I am waiting for a medication dilaudid. Last dose was yesterday (11/8/15) when I requested it. During interview on 11/10/2015, at 3:34 p.m., Hospice registered nurse (RN)-F and Hospice	F 282	perform daily walk through of facility to monitor and correct identified patterns/trends of noncompliance. 4. To be monitored by: a. DON (or designee) will complete bi-weekly audits for 3 months to confirm that the care plan is being followed with resident transfer s and cares. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	

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registered nurse (RN)-G stated the facility called on 11/9/15 between 9:00 and 9:30 a.m. to reorder the dilaudid medication. We sent request to the physician and signed order at 1:30 p.m. Hospice provider stated the facility can directly order the medication from the pharmacy and if the pharmacy is unable to fill the script we would want to know immediately before the patient runs out of medication. The facility should have reordered medication two days prior to running out or if only 20 ml's left they should be calling.

During interview on 11/12/2015, at 1:22 p.m., registered nurse (RN)-A verified had worked on 11/9/15 day shift. RN-A verified had not given R106 any dilaudid medication for the entire day shift on 11/9/15 and no other narcotic medication was provided and the resident complained of pain not being controlled until the Dilaudid medication was received on 11/9/15 in late p.m. shift.

During interview on 11/13/2015, at 11:08 a.m., assistant director of nursing (ADON)-C stated the residents (R106) care plan should be followed.
LACK OF SECURING CATHETER AND LOCATING BELOW BLADDER LEVEL TO PREVENT URINARY INFECTIONS AND FROM HAVING CATHETER FROM BEING PULLED OUT OF BLADDER:

R20 was observed on 11/12/2015 at 9:03 a.m. in her room. Nursing assistants (NA)-B and (NA)-C were observed to transfer R20 with the Hoyer lift. The catheter bag was placed on R20's lap during the transfer from the shower chair to the bed. NA-B and NA-C dressed R20 while she was in the bed and then transferred R20 from the bed to her wheelchair using the Hoyer lift. During the second transfer the catheter bag was again

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F 282	Continued From page 27 placed on R20's lap during the transfer. However, when the urine bag was placed on R20's lap it was located above the bladder level which allowed urine in the tubing to run back into the bladder. R20's care guide updated 11/13/15, instructed staff, "Has a Foley catheter-directed use leg strap secured to patient leg so the Foley does not tug; keep drainage bag below bladder level. Please unhook cath [catheter] bag from wheelchair prior to any transfers!" R20's care plan dated 8/4/2015 identified R20 had an indwelling catheter related to neurogenic bladder and history of urinary tract infection (UTI). The care plan directed staff to use a leg strap secured to patient leg so the Foley does not tug; keep drainage bag below bladder level to prevent reflux, maintain a closed drainage system. The care plan directed staff to monitor/document/report s/sx (signs and symptoms) of UTI; fever, abd (abdominal) pain, mental status changes, weakness, functional decline, nausea, vomiting, dark cloudy urine, foul smelling urine, retention (new), blood in urine, pus in urine. On 11/13/2015 at 12:28 p.m. registered nurse (RN)-B stated when staff transferred R20 with the Hoyer lift, staff should secure the catheter bag to the side of the sling next to the leg where the catheter was connected. RN-B stated some staff put the catheter bag on the residents lap, but I guess that is not safe, because it might fall off the lap and tug it. RN-B stated R20's spouse shared with her in the past that R20's catheter was pulled out during a transfer. R74 oral care and feeding tube flushes	F 282		

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R74's fourteen day Minimum Data set (MDS) dated 10/19/15 included diagnoses of anemia, congestive heart failure, hypertension, and peripheral arterial disease. The MDS identified R74 had moderately impaired cognition with a Brief Interview for Mental Status Score of 12. The assessment indicated R74 was dependent on staff for activities of daily living, had a feeding tube for all nutrition, and had an indwelling urinary catheter.

The care plan identified conflicting instructions for medication administration through the feeding tube. The care plan directed staff to, "Mix medications with 10-15 milliliters (ml) of water after crushing then flushing the tubing with 30 ml of water. After the medication is instilled the tube is again flushed with 30 ml of water." The care plan then instructed staff to request an order from physician to flush with 60 ml of water before and after medications and 5 ml of water between medications (order obtained on 10/21/15 after dietician's recommendations). The care plan directed staff to perform oral care in the morning and evening as tolerated.

During an observation on 11/10/15, 9:29 a.m. R74's mouth appeared very dry with white thick stringy debris stuck to the left side of his mouth between his lips; the stringy debris stayed intact while R74 talked. White dry skin flakes speckled his red shirt. R74 was asked how his mouth feels, R74 responded, "same as usual very dry." R74 stated he had not had oral care performed yet that morning.

During an observation on 11/10/15, at 2:47 p.m., R74's oral cavity and lips appeared very dry; no moisture apparent. R74 stated mouth was still dry and felt thirsty.

During an observation of medication

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administration on 11/12/2015, at 9:09 a.m. R74 still connected to the feeding pump. LPN-A washed hands and donned gloves. LPN-A disconnected the feeding pump and infused 60 ml of tap water into the tube without checking placement or residual. LPN-A drew up, infused the first medication, and followed it with a 5 ml water flush. LPN-A repeated the process for the second and third medications however did not flush between the fourth and fifth medications and did not flush between the 5th and the 6th medications.

During an observation on 11/12/2015, at 9:56 a.m. R74 laid on his back in bed. R74's mouth continued to appear dry and the tip of the tongue showed a white patch approximately 1 centimeter in diameter. R74 stated his mouth was dry and no one had come in to clean out his mouth. At 10:11 a.m. nursing assistant (NA)-D and trained medication assistant (TMA)-B entered the room to perform morning cares. After R74 was dressed and transferred to the wheelchair, NA-D asked if R74 was thirsty, R74 responded "yes" and NA-D was going to give him a drink, however TMA-D stated R74 was nothing by mouth. NA-D then grabbed a packed of lemon glycerin swabs from the bedside nightstand. NA-D was asked if R74 had a physician's order, NA-D responded "no" and then threw the swabs away. Staff did not offer any other kind of oral care.

During an observation on 11/12/15, at 11:25 a.m. LPN-A indicated R74 had an appointment at 11:45 a.m. and instruction was to give a can of nutrition prior to leaving. As LPN-A infused the 60 ml water flush, R74 displayed facial grimace. LPN-A stopped flushing after 30 ml and stated the flush was stopped because R74 displayed discomfort.

During an observation and interview with director

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F 282	Continued From page 30 of nursing (DON) and LPN-A on 11/12/15, 11:43 a.m., DON looked in R74's mouth to view the white spot on tip of tongue. DON stated, "I don't know what that is." LPN-A indicated not being aware of the white spot. DON stated oral care should be done every shift, not just for R74 but for everybody. DON stated staff should be using a moist green lollipop swab to clean mouth and provide moisture. DON explained lemon glycerin swabs should not be used without a physician's order and depending on the resident should not be used at all related to inhibits saliva production. LPN-A stated R74 had problems managing saturated lollipops and liked the lemon glycerin swabs (R74's problems managing lollipops was not located in the record). R74 urinary catheter R74's electronic care plan included problem statement, "alteration in elimination r/t [related to]: incontinent bowel, indwelling catheter, impaired mobility, risk for UTI [urinary tract infection], hx [history] of UTI, CKD [chronic kidney disease] stage 3 with the goal, "will have no complications r/t indwelling catheter through next review." The care plan identified two interventions pertaining to the care of the indwelling catheter; catheter changes per order and monitor for signs and symptoms of UTI. A progress note dated 11/4/15 indicated R74 had suprapubic discomfort with no urine output. The note indicated staff performed a bladder scan with results of 330 cc's (cubic centimeters), then irrigated the bladder with no return, then changed the indwelling catheter, collected a urine sample and notified the physician. The documentation indicated, "his urine is cloudy odorous, blood tinged and noted small blood clots." The record	F 282		

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F 282	Continued From page 31 did not reflect a physician's orders to flush or change the catheter. The record did not reflect, ongoing monitoring of the symptoms or a treatment plan. A physician's note obtained on 11/13/15. The physician's note indicated a service date of 11/9/15 (revised on 11/13/15) and pertained to R74's urinary symptoms on 11/4/15. The note included, "patient has a history of chronic urinary bacteremia.", and "Results of microbiology shows two bacteria: Escherichia coli and pseudomonas Aeruginosa both >100,000 CFU." The physician's note explained R74 would not be treated with antibiotics related to history of bacterial resistance, lack of symptoms and potential serious adverse reactions of antibiotics with other medications. The physician directed nursing to monitor for signs and symptoms. During an interview on 11/13/15, at 8:52 a.m. licensed practical nurse (LPN)-A was asked why the physician's note dated 11/9/15 was not in the medical record. LPN-A indicated an unawareness; however, explained nurses on the floor were responsible for ensuring any follow up necessary. LPN-A verified the lack of monitoring for signs and symptoms of a UTI and was not aware R74 had a positive urinalysis on 11/4/15 or the physician's plan to monitor, and did not know why the physician's visit note had not been in the chart. LPN-A stated monitoring for signs and symptoms of a UTI should be documented and done every shift. During an interview on 11/12/15, at 1:26 p.m. LPN- B was asked what size catheter was used and frequency of changing. LPN-B, did not know and could not find how often the catheter was to be changed or what size catheter should be used. LPN-B stated a visual inspection of the catheter revealed a 14 french with a 10 cc balloon was	F 282		

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F 282	Continued From page 32 being used at the time of survey. During an interview on 11/12/15, at 1:27 p.m., assistant director of nursing (ADON) stated, physician orders for indwelling catheters should include size of catheter and schedule for changing. ADON stated when staff provide catheter care; staff are to clean the catheter first with a separate washcloth and then the perineum is cleaned. The ADON stated the catheter tubing should go over the leg while in bed and not underneath to prevent pressure areas and kinks in the tubing. ADON explained it was not appropriate to put the catheter collection bag on top of the bed or hold it above the bladder at any time, and not placed on top of the resident during transfers. ADON verified lack of urinary catheter care plan and stated the care plan should include size of the catheter, schedule for changing, measuring output, and give direction on daily care. The ADON then explained nurses need to document every shift output, urine integrity, and care performed. The facility used two brands of indwelling catheter collections bags, both bags equipped with anti-reflux valves at the drain point. The facility used two brands of indwelling catheters; both brands were not equipped with anti-reflux valves that would prevent the urine from going back into the bladder. R74 skin During an observation on 11/10/15 at 9:35 a.m., R74's bilateral arms showed multiple nickel and dimed size bruises with one bruise slightly larger than the size of a thumb. R74's right arm showed 2 nickel sized dark purple bruises by the elbow, mid forearm showed a quarter size dark purple bruise, and the wrist area showed a half dollar sized dark purple bruise. R74's left arm showed	F 282		

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3 nickel sized dark purple bruises on the forearm.
During an observation at 2:47 p.m. licensed practical nurse (LPN)-D noted to be in the room providing feeding tube care. The record did not indicate identification of the bilateral upper extremity bruising after.
During an observation and interview on 11/12/15, at 9:17 a.m., LPN-A verified the presence of bruising. LPN-A stated, R74 always had bruises. Stated the left forearm bruise has always been there and indicated they had been there for months. LPN-A stated when new bruises are identified; they are documented and then watched for a while. LPN-A stated, "I'm the one that usually looks at them, so I look at them Monday through Friday." LPN-A indicated the lack of monitoring for the bruises on R74 related to the bruises being old and explained if the bruises had been new then we progress it. The record did not reflect the identification of the bruising or a plan for ongoing monitoring after LPN-A had observed the bruises.
During an observation and interview on 11/12/2015, at 10:11 a.m., trained medication assistant (TMA)-B was questioned about the bruises. TMA-B stated, "They look like they are a couple of day old on the ones on the right arm have been there for three or four days."
R74's fourteen day Minimum Data set (MDS) dated 10/19/15 included diagnoses of anemia, congestive heart failure, hypertension, and peripheral arterial disease. The MDS identified R74 had moderately impaired cognition with a Brief Interview for Mental Status Score of 12. The assessment indicated R74 was dependent on staff for activities of daily living. The MDS identified R74 had unilateral upper and lower extremity limited range of motion.
R74's electronic care plan provided by the facility

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F 282	Continued From page 34 on 11/12/15 alerted staff of a potential for impaired skin integrity and directed staff to monitor skin with cares and report changes. During an interview on 11/13/2015, at 10:28 AM Maria ADON stated NA's should check skin when providing care and nurses should do a thorough skin evaluation at least weekly. If staff identify a bruise, nurses fill out a report, and an investigation initiated to determine what caused the bruise if the origin is unknown. ADON indicated the expectation is daily bruise monitoring until it resolves and reported to the doctor if it worsens. R84 skin integrity R84's five day Minimum Data Set (MDS) dated 8/26/15 indicated no The MDS did not identify other skin alterations during the assessment period other than skin ulcers. R84's physician orders provided by the facility on 11/9/15 included Coumadin (blood thinning medication) 4 milligrams (mg) daily. R84's care plan dated 9/9/15 indicated "actual/potential for alteration in skin integrity r/t [related to]: unstageable pressure ulcers both heels, poor skin turgor, excoriation of coccyx and right hip, impaired mobility, and incontinent bowel and bladder" and "takes anticoagulation medication r/t atrial fibrillation." The care plan directed staff to monitor skin with cares and report changes, and monitor, document, report excessive bruising, skin tears or cuts with excessive bleeding. During an observation on 11/9/15, at 6:36 p.m. R84's right upper arm showed four small dimed sized dark purple bruises just above the elbow. R84 stated he thought bruises came from laying on the arm while sleeping. R84 stated he easily	F 282		

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bruises related to Coumadin (blood thinner) use. It was not evident in the record the facility had identified the bruises on the right arm.
During an observation on 11/10/15, at 8:33 a.m. bruising on right upper arm slightly faded in comparison to 11/9/15 and R84 now had bilateral lower extremity generalized scabbed scratch mark like abrasions varying in length and width mainly on the shins. Lower extremities also showed large amounts of edema (swelling related to fluid). Abdomen also showed multipole small-scabbed abrasions and was distended. R84 indicated he was itchy. On 11/10/15 did not reflect identification of the impaired skin integrity areas.
During an observation on 11/12/15, at 9:44 a.m. nursing assistant (NA)-E provided perineum hygiene after an incontinent episode. R84's buttocks showed excoriated red scratch marks. NA-E remarked the area "looked a lot better." The abrasions had not changed since last observation. On 11/12/15, the record did not reflect documentation of the impaired skin integrity areas.
On 11/13/15, at 10:14 a.m. the right arm showed one unresolved purple bruise above the elbow that had decreased in size by half, however four new bruises had developed on the right forearm near tattoo, and a quarter sized bruise over the right carotid area of the neck. The bruises were a lighter purple, oblong shaped, approximately the size of a quarter, with pinpoint-scabbed areas near the bruises. R84 was not aware if scratching caused the bruises or the scabbed areas. On 11/13/15, the record did not reflect documentation of the impaired skin integrity areas until the areas were brought to LPN-A's attention. R84's Body Audit Form dated 11/7/15 included, "dry feet, several scabs but no new skin issues."

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F 282	Continued From page 36 The form did not identify location of scabs. Body Audit Form dated 11/10/15 completed during evening shift indicated staff performed a bed bath related to R84 refusal of shower; the form did not identify the bruising on the right arm or the abrasions on the lower extremity. Progress note dated 11/13/15 read, "Bruising noted to resident RFA [right forearm] and upper arm. RFA measures- 6 areas each 1.5 x 0.5 centimeters (cm). Upper right are 1 area 1 x 0.4 cm." The note indicated the NP stated, "that is what the Sarna cream is for." During an interview on 11/13/15, at 10:14 a.m. LPN-A indicated unawareness of bruising above the elbow and an unawareness of the bruises on the forearm near the tattoo. LPN-A indicated an incident report would be filled out and the nurse practitioner (NP) would be notified. At approximately 10:45 a.m. LPN-A reported the NP had been aware of the bruises during visit on 11/10/15 and the reason for the Sarna cream order. During an interview on 11/13/2015, at 10:28 AM Maria ADON stated NA's should check skin when providing care and nurses should do a thorough skin evaluation at least weekly. If a bruise is found, a report is filled out and an investigation is done to determine what caused the bruise if the origin is unknown. ADON indicated the expectation is daily bruise monitoring until it resolves and reported to the doctor if it worsens. R84 pain medication R84's five day Minimum Data Set (MDS) dated 8/26/15 indicated no cognitive impairment with a Brief Interview for Mental Status score of 13. The MDS also indicated R84 received as needed pain medication, did not receive non-pharmacological interventions to relieve pain, and staff identified	F 282		

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F 282	Continued From page 37 R84 did not have pain or possible pain during the assessment period. R84's physician orders provided by the facility on 11/9/15 included Oxycodone 5mg by mouth every four hours as needed for pain with an order date of 9/22/15. R84's care plan included, "Actual/Potential for alteration in comfort r/t [related to]: pressure areas, right hip pain post fall prior to admission, HX [history] migraines, impaired mobility." The care plan instructed staff to monitor and document effectiveness of medications, monitor for non-verbal signs and symptoms of pain. The care plan directed staff to "Offer non-pharmacological interventions before administering medications: backrub, food, soft music, repositioning, diversion, ect. Monitor and document effectiveness." R84's record did not reflect consistent documentation of evaluation of effectiveness after administration and did not reflect non-pharmacological interventions attempted or used. R84's treatment administration record (TAR) for October 2015 indicated administration of as needed Oxycodone seven times. The documentation included the nurse's initials who administered the medication on all recorded doses. On 10/5/15 and 10/12/15 the documentation also indicated a "0 (zero)". The documentation did not indicate what the "zero" pertained too. Doses on 10/2/15, 10/17/15, and 10/18/15 included the times of administration (other doses did not include times of administration). The October TAR did not reflect any further information pertaining to the administered doses. R84's TAR for November 2015 indicated administration of as needed Oxycodone six	F 282		

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times. The dose administered on 11/6 had the initials of the nurse, administration time, and pain rating of seven (on a 0-10 scale). Dose administered on 11/7 indicated administration time and nurse's initials. The second dose administered on 11/9 indicated administration time and nurse's initials. Doses administered on 11/8, 11/9, and 11/10 included nurse's initials, time of administration, location of pain, rating of pain, and effectiveness.
During an interview on 11/13/15, at 9:42 a.m. licensed practical nurse (LPN)-A verified the lack of documentation on the TARs. LPN-A indicated documentation should have reflected administration time, location, severity, and effectiveness. LPN-A stated R84 historically refused non-pharmacological interventions. Documentation does not reflect offered interventions or refusals.
During an interview on 11/13/15, at 10:28 a.m., ADON indicated she expects nurses to assess the pain fully and document; location, use the pain scale, take vital signs and mental status, duration of pain, aggravating factors, and attempt non-pharmacological measures first unless the pain is extreme. ADON explained the nurse's should also document any refusals of non-pharmacological measures.

R84 fluid balance
R84's care plan included the problem statement revised on 9/23/15 of potential risk for decline in nutritional status related to fluid restriction, edema in all four extremities, abnormal labs, vascular ulcer, and severe weight loss related to paracentesis. The goal included, "will not have sign severe weight loss/gain and will show no signs or symptoms of dehydration." Prior to

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F 282	Continued From page 39 11/13/15 the care plan directed staff to provide diet as ordered, monitor intake, weights, and wound healing, and to notify physician as needed. It was not evident the facility had recorded outputs. Food and fluid intake records from 10/26/15 through 11/12/15 were obtained from the dietary department. The records revealed no recorded entries for any meals for that period. R84's weight on 11/5/15 was 210.8 pounds. On 11/6 the record indicated a weight gain of 9.2 pounds (lb) or 220.0 lb (5% weight increase in one day); the weight was recorded twice. Documentation does not reflect the physician was notified of the 2-3 lb in one day or the weight gain or 5 lb increase over baseline weight. On 11/11 recorded weight was 220.8 lb. It was not evident the facility had identified the increase in weight demonstrated by the lack of assessment to identify possible cause of weight gain for possible needed treatment. During an interview on 11/12/15, at 1:12 p.m. certified dietary manager (CDM) explained because R84 ate meals in his room nursing was responsible for recording the fluid intake. During an interview on 11/13/15, at 9:42 a.m. LPN-A was asked, "How is fluid intake and output documented?" LPN-A- explained intakes are tracked by the dietary staff, the dietary department communicates with nursing for the amounts allotted between departments. LPN-A stated for hypo/hypervolemia/dehydration/swelling and documents findings in a progress note. LPN-A indicated evaluation of fluid balance consisted of obtaining daily weights. LPN-A verified complete lack of documentation of evaluations pertaining to fluid balance. LPN-A explained 24 hour output totals were not collected or recorded because it would be difficult related to R84 not consistently using the urinal, and the	F 282		

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F 282	Continued From page 40 urinary incontinence. LPN-A indicated there was not a way to measure the amount of urine in a depend. During an interview on 11/13/15, at 10:28 a.m. ADON explained accurate intake and output meant everything is measured and recorded even if the resident is incontinent. ADON stated she expected staff to follow the care plan and expected nurses to keep track of the intake and output as ordered. Facility policy and procedure Hydration/prevention and Treatment of Dehydration dated 8/1/15 included, "Nursing staff will assess all residents for current hydration risk upon admission and at least quarterly, and more often as necessary with Hydration Risk Assessment tool to identify resident at high risk for hydration issues.", and "Nursing will monitor for signs and symptoms of dehydration during daily care.", and "Intake will be documented in the medical records for those residents who have individualized interventions for I and O, aides will report changes in fluid or food intake to charge nurse.", and "Nursing will monitor and document fluid intake and the dietician will be kept informed of status. Interdisciplinary team will update care plan and document resident response to interventions until team agrees that fluid intake and relating factor are resolved."	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		12/23/15

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F 309	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care and services to meet the needs of the resident for 1 of 1 resident (R106) reviewed for pain; failed to monitor and evaluate risk factors for 1 of 1 resident (R59) with end stage renal failure; failed to identify and monitor bruising for (R74 and R84) reviewed for skin conditions and failed to monitor and evaluate fluid balance for 1 of 1 resident (R84) reviewed for skin conditions. Findings include: LACK OF SECURING PAIN MEDICATION TO TREAT MODERATE TO SEVERE PAIN TIMELY: R106 had pain managed with scheduled and as needed dilaudid. However, when the facility failed to reorder the dilaudid in a timely manner, the resident experienced pain. R106 experienced ongoing pain from 11/8/15 early morning until receipt of a new supply of the dilaudid on 11/9/15 at 7:30 p.m. The facility had not contacted hospice to notify them of the lack of pain medication, nor had they attempted to reach the resident's physician to discuss potential use of an alternate pain medication until the dilaudid supply could be replenished. R106 was observed during a medication pass on 11/9/15, at 7:03 p.m., to receive medications from licensed practical nurse (LPN)-C. LPN-C stated R106 was in pain but stated she was waiting for the pharmacy to deliver a resupply of the resident's pain medication (dilaudid- an analgesic	F 309	F309 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. R59 discharged. Unable to monitor, assess and update care plan for risk factors and interventions for end stage renal failure/dialysis in regards to safety and care services. b. R106 discharged. Unable to reassess for pain c. R84 I and O are being completed (tube feeding) d. R74 and R84 completed skin assessment and weekly skin monitoring 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. Complete Pain assessment for all residents, review and modify care plan as needed. b. Complete Comprehensive Skin assessments for all residents, review and modify care plan as needed. Nursing team will assess and document on skin issue minimum of once weekly using the	

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F 309	Continued From page 42 opioid medication used for moderate pain). At 7:16 p.m. LPN-C told the surveyor she was going to give R106 Tylenol for pain because the pain medication had not come in yet from the pharmacy. LPN-C was observed to take Tylenol to R106 and upon entering R106's room, R106 asked if the pain medication had been received yet. LPN-C stated "no, but I have your Tylenol." R106 asked if the stronger pain medication would be in soon. LPN-C stated to R106, "yes and I will get it to you as soon as it is here." R106 was heard to state "good, I cannot go through another night of pain." During interview on 11/9/15, at 7:28 p.m. R106 stated, "I have been in pain since last night and it hasn't gotten any better." R106 described the pain as a discomfort through the esophagus and stomach and stated, "I am waiting for a medication, dilaudid. My last dose was yesterday when I requested it." On 11/09/2015, 7:34 p.m., LPN- C stated R106's dilaudid had just come from the pharmacy. LPN-C stated, "when I came on shift I was informed the medication had been reordered." LPN-C stated, "[R106] receives dilaudid scheduled twice daily and as needed." LPN-C was then observed to administer dilaudid to R106. LPN-C verified R106 had not received the dilaudid as scheduled at 8 a.m. on 11/8/15 or 8 a.m. 11/9/15. Review of R106's MAR verified the medication had not been administered for the 8 a.m. dose on 11/8/15 and 11/9/15. During interview on 11/09/2015 7:48 p.m., R106 stated Tylenol does not really help and when queried regarding pain level on a scale of 0 to 10, 10 being the most severe level, R106 stated pain	F 309	Skin Monitoring Comprehensive CAN Shower Review Form. c. Place Nursing orders in TAR to complete documentation for skin issues. D/C order when skin issue is healed/resolved. d. Establish a Skin/Weight Committee that will meet once/month to discuss current skin issues and monitoring cross referencing weights. e. ADON or designee will have oversite of pain management program which will include non-pharmalogical interventions and pain medication effectiveness. f. Nursing team will complete I&O charting for residents who receive tube feedings and do not receive their nutrition in the dining room. 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education was provided for all staff including nurses and C.N.A□s on providing necessary services to each resident to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care. Reviewed Comprehensive Care Plan Policy, and ensured resident plan of care is being followed with regards to safe pain medication and management, intake and output documentation and skin monitoring and documentation. b. Administrator and DON (or designee) perform daily walk through of facility to monitor and correct identified patterns/trends of noncompliance. 4. To be monitored by: a. DON (or designee) will complete	

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F 309	Continued From page 43 level was an "8" since yesterday when they ran out of the pain medication dilaudid. On 11/10/2015, at 8:22 a.m., R106 stated I feel a lot better, back still hurts little. They got the medication last night, once the medication kicked in I felt better. During interview on 11/12/2015, at 7:43 a.m., R106 stated Tylenol does not seem to do anything for pain relief however, the dilaudid does. R106 told the nurse that he wanted something stronger for pain than the Tylenol but nothing was provided. On asking R106 why there was no dilaudid available he said that they ran out of it yesterday. When asked if this has happened before R106 said it had not. R106 stated what happened was the pharmacy needed a renewal prescription and I told them [the facility staff] the pharmacy needed to get on top of that soon as I need the dilaudid for pain control. R106 stated he feels ok today, the dilaudid medication helps with my back pain, which varies. R106's admission Minimum Data Set (MDS) dated 8/25/15, identified diagnosis of cancer, R106 was cognitively intact and had pain in the last five days. R106's physician order dated 11/6/15, identified Dilaudid-5 1 mg (milligrams)/ml (milliliter) liquid 3 ml two times a day and every one hour as needed and Tylenol 500 mg two tablets three times a day. On 11/12/15, orders to discontinue the scheduled Tylenol and change to Tylenol 1000 mg every four hours as needed for pain, do not exceed 4 grams/day from all sources and increase the Hydromorphone HCl (Dilaudid-5) liquid to 4 ml two times a day and every one hour as needed	F 309	bi-weekly audits for 3 months to confirm that staff is in compliance for providing Quality Cares to residents focusing on correct skin monitoring and documentation and proper pain management. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	

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F 309	Continued From page 44 for pain. R106's pain assessment dated 9/4/15, indicated R106 was able to communicate appropriately, had pain in last five days, frequently and states pain medications help control lower back pain and esophageal burning. R106's care plan dated revision 9/8/15, indicated on Hospice services related to terminal diagnosis, debility, physical decline. Resident will be made comfortable physically and spiritually and maintain dignity daily with the assistance of Hospice services through next review. Interventions of: administer medications as ordered, follow Hospice care plan along with facility care plan, notify Hospice if changes in condition, notify Hospice if increased signs or symptoms of dyspnea, anxiety and/or pain is not controlled. R106's Hospice plan of care dated 8/18/15, indicated patient is to experience safe and timely reduction of pain for as long as it persists, to a level of comfort that is acceptable to the patient. Interventions of: assess pain using a pain scale, evaluate effectiveness of interventions related to comfort, consider alternative medication, teach and titrate medication regimen to relieve distressing symptoms, medicate prior to activity/cares causing discomfort, teach regarding pain management and resources available: Dilaudid scheduled twice daily in facility and teach pharmacological and non-pharmacological means to provide comfort. R106's Treatment Administration record (TAR) dated 11/2105, identified the following: Dilaudid solution 1 mg/ml - give 3 ml by mouth	F 309		

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F 309	Continued From page 45	F 309		

two times a day for pain with times of administration for 8:00 a.m. and 8:00 p.m. It was also noted that 11/8/15 and 11/9/15 a.m. dose of dilaudid doses read "OUT." There was no as needed doses of dilaudid given from 11/8/15 and 11/9/15 until 7:30 p.m. when she received the scheduled dilaudid dose.

Review of the facility narcotic medication book/individual narcotic record identified on 11/8/15 at 6:00 a.m. amount remaining 1 ml and at 8:00 a.m. amount remaining 0 ml's. On 11/9/15, Dilaudid-5 200 ml's was received at 7:30 p.m.

Review of Maple Manor Emergency Med Kit List, undated, included the following list for analgesics: Morphine solution, Morphine suppositories, Morphine injection, Oxycodone and Tramadol.

R106's clinical document copy Hospice nursing home visit, dated 11/06/15, identified pain scale four out of ten (using a 1 of 10 pain scale with 10 being the worst pain) with the resident's goal of having a one pain tolerance. Location of pain: epigastric area/middle back area. Duration: intermittent. Quality: achy, dull. Contributing factors: "mornings are always the worst." Relieving factors: diversion, medications, relaxation, and rest. "I've been waking up with a lot of back pain." R106 is taking liquid Dilaudid 3 ml usually three times per day. R106 rates pain at a "4" when it is at its worst and currently rates it at "2" resting in bed. R106 states the Dilaudid had been helpful to relieve the pain. Impression/plan: R106 is requesting Tylenol in addition to the liquid Dilaudid. R106 is offering new complaints of pain in the middle part of back today and continues to have pain in the epigastric area also.

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F 309	Continued From page 46 R106's clinical document copy Hospice nursing home visit, dated 11/10/15, identified pain scale five out of ten, resident goal of one. Location of pain: mid to lower back. Duration: intermittent. Quality: achy, dull, sharp. Relieving factors: medication, repositioning, rest. R106 is taking Dilaudid 3 ml two to four times per day and scheduled dose of 1 gm Tylenol three times per day. R106 states, "The Tylenol doesn't seem to do much." When asked if the liquid Dilaudid is helpful to relieve pain R106 states, "It doesn't do the whole trick, but it does help." Impression/plan: R106 offers complaints of more discomfort in mid back, pain level "5" today. "It's achy, like it is just hard to find a position that is comfortable." R106 is getting fair relief of discomfort with current pain medications. Will review for follow up. During interview on 11/9/15, at 7:54 p.m., the pharmacy provider stated R106's dilaudid medication was ordered today (11/9/15) at 3:00 p.m. and prior to today the medication was last ordered on 11/6/15. During interview on 11/10/2015, at 3:34 p.m., Hospice registered nurse (RN)-F and Hospice RN-G stated the facility called on 11/9/15 between 9:00 and 9:30 a.m. to reorder the dilaudid medication. We sent request to the physician and signed order at 1:30 p.m. RN-F & G stated the facility can directly order the medication from the pharmacy and if the pharmacy is unable to fill the script we would want to know immediately before the patient runs out of the dilaudid. They also said that the facility should reorder pain medications at least two days prior to running out or if only 20 milliliters left they should be calling to reorder.	F 309		

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F 309	Continued From page 47 During interview on 11/12/2015, at 1:22 p.m., RN-A verified had worked on 11/9/15 day shift. RN-A verified there was no dilaudid medication available for R106 for the day shift on 11//15. RN-A stated was told by overnight staff R106 was out of dilaudid medication and they had ordered it. I checked the medication cart and medication room for more of the dilaudid, but did not find any. The emergency kit had no dilaudid either. When it was time to follow up on the medication, the pharmacy had not delivered the medication. RN-B who was working on the East wing told me to call hospice. RN-B did call hospice of R106 being out of dilaudid. RN-B followed up with me and told me the medication would be delivered. RN-A said she had administered Tylenol for pain at 1:00 p.m. RN-A then stated she had not called the physician for orders to have dilaudid delivered for R106. During interview on 11/12/2015, at 2:38 p.m., RN-D verified she had worked Sunday evening shift on 11/8/15 and there was no dilaudid medication available to give to R106. RN-D stated she did not contact the physician or Hospice regarding being out of the dilaudid medication, just gave Tylenol for pain control. On asking RN-D about pain control with the use of Tylenol to relieve pain RN-D said she had not assessed pain level as this is not her routine practice. During interview on 11/13/15, at 10:01 a.m., medical director (MD)-E stated he would have expected the facility to contact him before the dilaudid ran out so the resident does not go without pain medication even if it a Sunday. MD-E said R106 needs the dilaudid to control pain from	F 309		

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F 309	Continued From page 48 having end stage esophageal cancer. During interview on 11/13/2015, at 11:08 a.m., assistant director of nursing (ADON) stated she would expect staff to document pain rating when giving as needed pain medication. Also she was aware that R106 was out of dilaudid on 11/9/15 but not 11/8/15. ADON said as soon as she was informed of no dilaudid for R106 she called the pharmacy in mid afternoon. ADON stated she would expect staff to have reorder the dilaudid before the medication runs out for R106. ADON stated she would expect staff to follow up with the pharmacy for timely delivery of the dilaudid and if unable to get the medication timely then call the nurse practitioner or physician for orders for different pain medication to use for pain management until the medication comes from the pharmacy. The facility policy Administering Medications, dated 8/1/15, indicated the director of nursing services is responsible for the supervision and direction of all personnel with medication administration duties and functions. Medications should be administered within one hour of the prescribed time. The facility policy Ordering Medications, dated 8/1/15, indicated refills/reorders 3. Refills/reorders should be submitted within three days prior to exhausting the supply of medication to allow ample time for delivery. The facility policy Change in Condition, dated 8/1/15, indicated 1. The physician will be notified when there has been a change that is sudden in onset, a change that is marked difference in usual sign/symptoms and /or the signs/symptoms are unrelieved by measures already prescribed: 2. Specific information that requires prompt	F 309		

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F 309	Continued From page 49 notification include, but is not limited to: C. Uncontrolled pain. LACK OF DIALYSIS INTERVENTIONS IN REGARDS TO CARE AND SERVICES TO PROMOTE SAFETY: R59's undated comprehensive care plan indicated R59 had been admitted on 8/14/15, with diagnoses to include end stage renal disease and received hemodialysis. The care plan lacked dialysis schedule, direction for care of dialysis access site, identification of infection symptoms, indication of which medication were held on dialysis days, dialysis unit contact phone numbers, and medical emergency information nor was this information provided when requested. Review of physician order dated 10/12/15 read "Dialysis cath [sic] right upper chest-IV access; site care and flushing per facility protocol, keep clean and dry." Review of R59's medical record lacked site care and flushing protocol. The facilities Dialysis Care Policy and Procedure dated 8/1/15 included "2. Risk factors related to potential for bleeding, alteration in fluid volume, potential for infection, alteration in nutrition, alteration in skin integrity, risks for adverse medication effects and psychosocial needs should be identified, assessed, and interventions to manage addressed in the individualized care plan. 8. Emergency protocols should be identified and incorporated into the individual care plan." On 11/13/15, at 11:34 a.m. during phone interview with Mayo Clinic Dialysis Center registered nurse (RN)-Z it was reported R59 should have been monitored for infection to include redness, and pain at catheter site, fever or chills, and	F 309		

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F 309	Continued From page 50 medication. The RN-Z stated R59's medical record should have included a memorandum of understanding which had been given to the facility to guide patient care. On 11/13/15, at 12:58 p.m. the director of nursing (DON) verified R59's record lacked care plan interventions for dialysis services. LACK OF MONITORING BRUISING AND SKIN IMPAIRMENT TO DETERMINE CAUSE, INTERVENTIONS AND PROMOTE HEALING: R74 was observed on observation on 11/10/15 at 9:35 a.m., R74's bilateral arms showed multiple nickel and dimmed size bruises with one bruise slightly larger than the size of a thumb. R74's right arm showed 2 nickel sized dark purple bruises by the elbow, mid forearm showed a quarter size dark purple bruise, and the wrist area showed a half dollar sized dark purple bruise. R74's left arm showed 3 nickel sized dark purple bruises on the forearm. During an observation and interview on 11/12/15, at 9:17 a.m., LPN-A verified the presence of bruising on R74's arms. LPN-A stated, R74 always had bruises. Stated the left forearm bruise has always been there and indicated they had been there for months. LPN-A stated when new bruises are identified; they are documented and then watched for a while. LPN-A stated, "I'm the one that usually looks at them, so I look at them Monday through Friday." LPN-A indicated the lack of monitoring for the bruises on R74 related to the bruises being old and explained if the bruises had been new then we progress it. R74's record was reviewed and lacked consistent monitoring of bruising was located nor provided when requested by staff. During an observation and interview on 11/12/2015, at 10:11 a.m., trained medication	F 309		

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F 309	Continued From page 51 assistant (TMA)-B was questioned about the bruises on R74. TMA-B stated, "They look like they are a couple of day old on the ones on the right arm have been there for three or four days." R74's fourteen day Minimum Data set (MDS) dated 10/19/15 included diagnoses of anemia, congestive heart failure, hypertension, and peripheral arterial disease. The MDS identified R74 had moderately impaired cognition with a Brief Interview for Mental Status Score of 12. The assessment indicated R74 was dependent on staff for activities of daily living. The MDS identified R74 had unilateral upper and lower extremity limited range of motion. R74's electronic care plan provided by the facility on 11/12/15 alerted staff of a potential for impaired skin integrity and directed staff to monitor skin with cares and report changes. During an interview on 11/13/2015, at 10:28 a.m. the assistant director of nursing (ADON) stated nursing assistants (NAs) should check skin when providing care and report to nurses if found. ADON said the nurses should do a thorough skin evaluation at least weekly. If staff identify a bruise, nurses fill out a report, and an investigation initiated to determine what caused the bruise if the origin is unknown. ADON indicated the expectation is daily bruise monitoring until it resolves and reported to the doctor if it worsens. R84 was observed on 11/9/15, at 6:36 p.m. R84's right upper arm showed four small dimmed sized dark purple bruises just above the elbow. R84 stated he thought these bruises came from laying on the arm while sleeping. R84 stated he easily bruises related to Coumadin (blood thinner) use. The staff were asked for monitoring of these bruises and none was provided nor was	F 309		

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F 309	Continued From page 52 information found in the records. During an observation on 11/10/15, at 8:33 a.m. bruising on right upper arm slightly faded in comparison to 11/9/15 and R84 now had bilateral lower extremity generalized scabbed scratch mark like abrasions varying in length and width mainly on the shins. Lower extremities also showed large amounts of edema (swelling related to fluid). Abdomen also showed multipole small-scabbed abrasions and was distended. R84 indicated he was itchy. Again there was no documentation of skin impairment located in record nor was any provided when requested from staff. During an observation on 11/12/15, at 9:44 a.m. nursing assistant (NA)-E provided perineum hygiene after an incontinent episode. R84's buttocks showed excoriated red scratch marks. NA-E remarked the area "looked a lot better" compared to previous observations. Even though the escoreated skin was present prior to 11/12/15 at 9:44 a.m. there was no identification, assessment and ongoing monitoring completed by staff, nor was any provided when requested of staff. On 11/13/15, at 10:14 a.m. R84's right arm showed one unresolved purple bruise above the elbow that had decreased in size by half, however four new bruises had developed on the right forearm near a tattoo, and a quarter sized bruise over the right carotid area of the neck. he bruises were a lighter purple, oblong shaped, approximately the size of a quarter, with pinpoint-scabbed areas near the bruises. R84 was not aware if scratching caused the bruises or the scabbed areas. On 11/13/15, the record did not have documentation of the impaired skin integrity until the areas were brought to LPN-A attention.	F 309		

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F 309	Continued From page 53 R84 was admitted to the facility on 8/21/15 with diagnoses that included chronic foot ulcers, diabetes II with neuropathy, abdominal pain, peripheral vascular disease, and chronic kidney disease stage III, acute on chronic congestive heart failure, and atrial fibrillation according to the facility admission report. Hospital discharge summary dated 9/22/15 included diagnosis of suspected cardiac cirrhosis with massive ascites. R84's five day Minimum Data Set (MDS) dated 8/26/15 indicated no cognitive impairment with a Brief Interview for Mental Status score of 13 and required extensive assist of one staff to complete activities of daily living. The MDS did not identify the diagnosis of atrial fibrillation, however indicated had received an anticoagulant medication. The MDS did not identify other skin alterations during the assessment period other than skin ulcers. R84's physician orders provided by the facility on 11/9/15 included Coumadin (blood thinning medication) 4 milligrams (mg) daily. Written physicians orders dated 11/10/15 included decrease Benadryl to 25 mg twice per day as needed for itching and Sarna lotion (anti itch lotion) twice per day. R84's care plan dated 9/9/15 indicated, "actual/potential for alteration in skin integrity r/t [related to]: unstageable pressure ulcers both heels, poor skin turgor, excoriation of coccyx and right hip, impaired mobility, and incontinent bowel and bladder" and "takes anticoagulation medication r/t atrial fibrillation." The care plan directed staff to monitor skin with cares and report changes, and monitor, document, report excessive bruising, skin tears or cuts with excessive bleeding. R84's Body Audit Form dated 11/7/15 included, "dry feet, several scabs but no new skin issues."	F 309		

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	245409	A. BUILDING _____ B. WING _____	11/13/2015

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MAPLE MANOR NURSING AND REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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F 309	Continued From page 54 The form did not identify location of scabs. Body Audit Form dated 11/10/15 completed during evening shift indicated staff performed a bed bath related to R84 refusal of shower; the form did not identify the bruising on the right arm or the abrasions on the lower extremity. Progress note dated 11/13/15 read, "Bruising noted to resident RFA [right forearm] and upper arm. RFA measures- 6 areas each 1.5 x 0.5 centimeters (cm). Upper right are 1 area 1 x 0.4 cm." The note indicated the nurse practitioner (NP)-A stated, "that is what the Sarna cream is for." During an interview on 11/13/15, at 10:14 a.m. Licensed practical nurse (LPN)-E indicated unawareness of bruising above the elbow and an unawareness of the bruises on the forearm near the tattoo. LPN-E indicated an incident report would be filled out and the nurse practitioner (NP) would be notified. At 10:45 a.m. LPN-E reported the NP had been aware of the bruises during visit on 11/10/15 and the reason for the Sarna cream order. During an interview on 11/13/2015, at 10:28 a.m. ADON stated NA's should check skin when providing care and nurses should do a thorough skin evaluation at least weekly. If a bruise is found, a report is filled out and an investigation is done to determine what caused the bruise if the origin is unknown. ADON indicated the expectation is daily bruise monitoring until it resolves and reported to the doctor if it worsens. LACK OF ONGOING MONITORING OF FLUID RETENTION, ACCURATE INTAKE AND OUTPUT, REPORTING WEIGHT GAIN ACCORDING TO PHYSICIAN ORDERS: R84 was observed on 11/10/15, at 8:33 a.m. R84 was lying in bed with abdomen and lower extremities exposed. Abdomen was very	F 309		

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edematous and both legs were edematous. Baseline and ongoing measurements of swelling in abdomen and legs were not evident in the record.
R84 was admitted to the facility on 8/21/15 with diagnoses that included chronic foot ulcers, diabetes II with neuropathy, abdominal pain, peripheral vascular disease, and chronic kidney disease stage III, acute on chronic congestive heart failure, and atrial fibrillation according to the facility admission report.
R84's five day Minimum Data Set (MDS) dated 8/26/15 indicated no cognitive impairment with a Brief Interview for Mental Status score of 13 and required extensive assist of one staff to complete activities of daily living. The MDS included diagnoses of hypertension and hyperkalemia (high potassium). The MDS did not identify the diagnosis of atrial fibrillation, however indicated R84 received an anticoagulant medication and diuretic medication use.
R84 was hospitalized on 9/16/15 and was admitted to the home on 9/22/15. The discharge summary indicated the reason for hospitalization was acute-on-chronic systolic and diastolic congestive heart failure due to ischemic cardiomyopathy and suspected cardiac cirrhosis with massive ascites (the accumulation of fluid in the peritoneal cavity, causing abdominal swelling). During the hospital course a paracentesis was performed to remove abdominal fluid; resulting in 7.5 liters of fluid removal. The discharge summary also included the instructions to report signs or symptoms to primary care provider urgently if; weight increase of 2-3 pounds in one day or increase of 5 pounds over baseline weight and an increase in swelling or bloating. Record review did not indicate implementation of a plan of care that reflected

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monitoring for swelling and bloating, reporting weight changes, and monitoring for changes to prevent repeat acute exacerbations of congestive heart failure that required hospitalization. Facility documentation does not reflect monitoring of edema or swelling nor was any provided when requested of staff.
R84's weight on 11/5/15 was 210.8 pounds. On 11/6 the record indicated a weight gain of 9.2 pounds (lb) or 220 lb (5% weight increase in one day); the weight was recorded twice.
Documentation does not reflect the physician was notified of the 9.2 lb in one day or the weight gain or 5 lb increase over baseline weight as ordered by the physician on 9/22/15. On 11/11/15 recorded weight was 220.8 lb. Again the physician had not been contacted with increased weight.
Written physician orders on a facility Consultation form (communication form used for outside medical appointments for new physician's orders) not dated but was provided by the facility on 10/16/15 included, "minimum fluid intake of 1 liter per day to minimize risk of pre-renal injury. Start Uloric 40 mg daily for hyperuremia, Please monitor accurate intake and output. Daily weights if possible. Low sodium diet recommended."
R84's electronic physician orders provided by the facility on 11/9/15, medication and treatment administration records (MAR/TAR) for October and November 2015 did not reflect implementation of the 1.0 liter per day fluid restriction instead it indicated a fluid restriction of 2.0 liters of fluid per day divided by nursing and dietary. October and November 2015 MARs and TARs did not reflect the order to record accurate intake and output and none was provided when requested.
It was not evident the facility had recorded

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F 309	Continued From page 57 outputs. Food and fluid intake records from 10/26/15 through 11/12/15 were obtained from the dietary department. The records revealed no recorded entries for any meals for that period. The record did not show intake monitoring or daily evaluation of hydration monitoring for appropriate fluid balance in the presence of diuretic use, 1 liter fluid restriction, renal failure, and recent history of acute congestive heart failure requiring hospitalization. Physician visit note date on 10/16/15 re-iterated the consultation orders given on 10/16/15 which included the order to decrease the Lasix to 140 mg every a.m. and continue 120 mg every p.m. Physician orders and the October and Novembers 2015 MARs did not reflect this order change. Physician visit note date on 10/20/15 indicated, "per review of medical administration record, patient has been continued on Lasix 180 mg every a.m. and 120 mg every." R84's care plan included the problem statement revised on 9/23/15 of potential risk for decline in nutritional status related to fluid restriction, edema in all four extremities, abnormal labs, vascular ulcer, and severe weight loss related to paracentesis. The goal included, "will not have sign severe weight loss/gain and will show no signs or symptoms of dehydration." Prior to 11/13/15 the care plan directed staff to provide diet as ordered, monitor intake, weights, and wound healing, and to notify physician as needed. During an interview on 11/12/15, at 1:12 p.m. certified dietary manager (CDM) explained because R84 ate meals in his room nursing was responsible for recording the fluid intake. During an interview on 11/13/15, at 9:42 a.m. LPN-A was asked, "How is the ascites being monitored?" LPN-A explained "We have been eyeballing if he has been filling up with fluid. He is	F 309		

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F 309	Continued From page 58 very non-compliant." LPN-A stated abdominal girth had not and was not being measured. Nursing progress notes did not reflect refusals of adhering to fluid restrictions. Physician's note from a visit on 10/20/16 included, "He states he is compliant with salt and fluid restrictions." In response to the question, "How is fluid intake and output documented?" LPN-A explained dietary staff track intakes, the dietary department communicates with nursing for the amounts allotted between departments. LPN-A stated for hypo/hypervolemia/dehydration/swelling and documents findings in a progress note. LPN-A indicated evaluation of fluid balance consisted of obtaining daily weights. LPN-A verified complete lack of documentation of evaluations pertaining to fluid balance. LPN-A explained 24 hour output totals were not collected or recorded because it would be difficult related to R84 not consistently using the urinal, and the urinary incontinence. LPN-A indicated there was not a way to measure the amount of urine in a depend. During an interview on 11/13/15, at 10:28 a.m. ADON explained accurate intake and output meant everything is measured and recorded even if the resident is incontinent. ADON explained the amount of urine in the depend could be measured by weighing and estimating. ADON stated she expected staff to follow the care plan and expected nurses to keep track of the intake and output as ordered, measure abdominal girth on a daily basis, and document findings. Facility policy and procedure Measuring and Documenting Fluid Output dated 8/1/15 did not include a procedure for measuring output in the presence of urinary incontinence. Facility policy and procedure Hydration/prevention and Treatment of Dehydration dated 8/1/15 included, "Nursing staff will assess all residents	F 309		

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F 309	Continued From page 59 for current hydration risk upon admission and at least quarterly, and more often as necessary with Hydration Risk Assessment tool to identify resident at high risk for hydration issues.", and "Nursing will monitor for signs and symptoms of dehydration during daily care.", and "Intake will be documented in the medical records for those residents who have individualized interventions for I and O, aides will report changes in fluid or food intake to charge nurse.", and "Nursing will monitor and document fluid intake and the dietician will be kept informed of status. Interdisciplinary team will update care plan and document resident response to interventions until team agrees that fluid intake and relating factor are resolved."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide oral care for 1 of 1 resident (R74) who was dependent on staff for oral care. Findings include R74's fourteen day Minimum Data set (MDS) dated 10/19/15 included diagnoses of anemia, congestive heart failure, hypertension, and	F 312	F312 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following	12/23/15

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F 312	Continued From page 60 peripheral arterial disease. The MDS identified R74 had moderately impaired cognition with a Brief Interview for Mental Status Score of 12. The assessment indicated R74 was dependent on staff for activities of daily living, had a feeding tube for all nutrition. R74's comprehensive care plan directed staff to perform oral care in the morning and evening as tolerated also included R74 had a feeding tube for all liquid/food intake. During an observation on 11/10/15, 9:29 a.m. R74's mouth appeared very dry with white thick stringy debris stuck to the left side of his mouth between his lips; the stringy debris stayed intact while R74 talked. White dry skin flakes speckled his red shirt. R74 was asked how his mouth feels, R74 responded, "Same as usual very dry." R74 stated he had not had oral care performed yet that morning. During an observation on 11/10/15, at 2:47 p.m., R74's oral cavity and lips appeared very dry; no moisture apparent. R74 stated mouth was still dry and felt thirsty. During an observation on 11/12/2015, at 9:56 a.m. R74 laid on his back in bed. R74's mouth continued to appear dry and the tip of the tongue showed a white patch approximately 1 centimeter in diameter. R74 stated his mouth was dry and no one had come in to clean out his mouth. At 10:11 a.m. nursing assistant (NA)-D and trained medication assistant (TMA)-B entered the room to perform morning cares. After R74 was dressed and transferred to the wheelchair, NA-D asked if R74 was thirsty, R74 responded "yes" and NA-D was going to give him a drink, however TMA-D stated R74 was nothing by mouth. NA-D then grabbed a packed of lemon glycerin swabs from the bedside nightstand. NA-D was asked if R74 had a physician's order, NA-D responded	F 312	immediate action concerning the deficiency identified on the CMS-2567: a. 12/16/2015 R74 was assessed for oral cares, care plan and care guide updated to provide dependent oral cares routinely. 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. Complete Oral assessments for all residents, referred to dentist and review and modify care plan and care guide as needed. 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education was provided for all staff including nurses and C.N.A□s that each resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Services to maintain oral hygiene may include brushing the teeth, cleaning dentures, cleaning the mouth and tongue either by assisting the resident with a mouth wash or by manual cleaning with gauze sponge and or an application of medication as prescribed. 4. To be monitored by: a. As determined by DON weekly Audit will be performed on two staff per week for three months observing that services were provided according to care plan to maintain oral hygiene. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team.	

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F 312	Continued From page 61 "no" and then threw the swabs away. Staff did not offer any other kind of oral care. During an observation and interview with director of nursing (DON) and LPN-A on 11/12/15, 11:43 a.m., DON looked in R74's mouth to view the white spot on tip of tongue. DON stated, "I don't know what that is." LPN-A indicated not being aware of the white spot. DON stated oral care should be done every shift, not just for R74 but for everybody. DON stated staff should be using a moist green lollipop swab to clean mouth and provide moisture. DON explained lemon glycerin swabs should not be used without a physician's order and depending on the resident should not be used at all related to inhibits saliva production. Facility policy and procedure Mouth/Oral Care dated 7/28/15 described the purpose of the policy as, "to keep the resident's lips and oral tissues moist, cleanse and freshen the resident's mouth, and prevent infections of the mouth." The policy instructed how to perform oral care using a moistened applicator with water.	F 312	5. Completion date: 12/23/2015	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315		12/23/15

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F 315	Continued From page 62 by: Based on observation, interview and document review, the facility failed to provide indwelling urine catheter use services/cares to prevent trauma to urinary system and prevent a urinary tract infection/s from developing for 2 of 2 residents (R20 and R74) who used a Foley catheter. Finding Include: R20's family member (FM)-A was interviewed on 11/12/15 at 1:06 p.m. FM-A shared last Friday night on 11-6-15, FM-A stepped out of the room when staff assisted R20 to bed and after her cares were completed one of the nursing assistants told him R20's catheter fell out (actually the catheter had been pulled out of bladder which was held in place with a balloon filled with water during staff transfer of R20). FM-A stated the next night, two different staff members were transferring R20 from the wheelchair to the bed and FM-A stated he stopped the staff during the transfer as the catheter bag was still attached underneath the wheelchair and the tubing was stretching and started to pull tight as staff started to transfer R20 with the Hoyer lift from her wheelchair to the bed. FM-A stated the nursing assistants told him the night before that also happened during a transfer with R20. FM-A showed writer a picture he had taken of the catheter bag filled with red urine. The red urine was indication of bladder trauma from being pulled on and this trauma increases the chance of having a urinary tract infection as well as being painful for the resident. R20 had a sign tapped to the wall above her bed and on her closet door that included, "please	F 315	F315 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. R20 Indwelling catheter was assessed for safety and security and prevented from infection. b. R74 was assessed for infection. No infection found. 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. 11/18/2015 Immediate In-service for nursing staff on policy and procedure on catheter care and catheter insertions proper catheter bag handling by ensuring that the catheter bag is not tugged when the resident is being moved. Do not put catheter bag on the resident□s lap when moving. Make sure it is off the bed frame when transferring the resident. b. 11/18/2015 DON conducted entire facility check and identified other resident having the potential to be affected by the same deficient practice. c. 12/10/2015 Established a Policy and Procedure for Safe Transfer with Catheter 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education	

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F 315	Continued From page 63 make sure to unhook catheter bag from wheelchair or bed during transfers, to avoid cath [catheter] being pulled out of res [resident]." R20 had an incident report dated 11/8/15 that included, "during resident change, aides found that the catheter was out of resident in brief with balloon still intact." There facility did not have an incident report for R20 from 11/6/15 incident. In-service education related to R20's catheter being pulled out during a transfer included, "Catheter bag handling- Ensure that the catheter bag is not tugged when the resident is being moved. Do not put the catheter bag on the resident's lap when moving. Make sure it's off the bedframe when transferring the resident." R20's care guide updated 11/13/15, instructed staff R20, "Has a Foley catheter-directed use leg strap secured to patient leg so the Foley does not tug; keep drainage bag below bladder level. Please unhook cath [catheter] bag from wheelchair prior to any transfers!" R20's care plan dated 8/4/2015 identified R20 had an indwelling catheter related to neurogenic bladder and history of urinary tract infection (UTI). The care plan directed staff to use a leg strap secured to patient leg so the Foley does not tug; keep drainage bag below bladder level to prevent reflux, maintain a closed drainage system. The care plan directed staff to monitor/document/report s/sx [signs and symptoms] of UTI; fever, abd [abdominal] pain, mental status changes, weakness, functional decline, nausea, vomiting, dark cloudy urine, foul smelling urine, retention (new), blood in urine, pus in urine.	F 315	reviewing all Policies and Procedures regarding Catheters including safe transfer. Education and review of care practices related to catheterization was provided for all nursing and C.N.A staff for to ensure each resident with a catheter receives the appropriate care and services to prevent infections to the extent possible. This also included Recognizing and assessing for complications and their causes and maintaining a record of any catheter-related problems. 4. To be monitored by: a. DON or designee will perform a monthly audit monitoring for infections related to catheter care. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. The quality assessment and assurance committee may help the community evaluate existing strategies for identifying and managing incontinence, catheter use and ensure that policies and procedures are consistent with current standards of practice. 5. Completion date: 12/23/2015 F322 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the	

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F 315	Continued From page 64 R20's certified nurse practitioner visit noted dated 11/10/15 included, "...History of present illness. Nursing noted that indwelling urinary catheter was found in bed with balloon intact. The catheter has had to be replaced twice during transfer. There was some minor bleeding noted. The nursing staff inserted another urinary catheter with larger balloon and have been monitoring." R20's progress note dated 11/8/15 included, "Resident had trauma to cath [catheter] insertion site from pulling it out with inflating the balloon on 11/06/15. This resulted to some bleeding as seen in cath [catheter] collection bag after new cath [catheter] was put in on the 11/06/15. Today resident's cath [catheter] was changed after was found by aid during the process of changing the resident in the diaper with the balloon still inflated ..." R20's progress note dated 11/8/15 included, "Resident's cath [catheter] bag was red (Urine and blood) but the cath [catheter] was intact. Resident husband complained of staff not being careful [sic] when doing transfer. The husband requested a note to be placed near the head of bed to avoid the same incident to happen again." R20's progress noted dated 11/7/15 included, "Resident continues to have bllod [sic] in cath [catheter] due to trauma from yesterday during transfers as report by other nurse. Cath [catheter] is paten at this time with some clots noted. Resident denies any pain. Will continue to monitor resident." R20's progress note dated 11/7/15 included, "Upon assessment of res [resident] urine by-pass, it was noted that the catheter with	F 315	deficiency identified on the CMS-2567: a. 11/28/2015 R74 was assessed for peg tube management 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. 11/18/2015 DON conducted entire facility check and identified other resident having the potential to be affected by the same deficient practice. 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education reviewing all Policies and Procedures regarding a Gastrostomy tube including current clinical standards of practice and services that must be provided to prevent complications to the extent possible including washing hands, cleaning tube, and checking placement before infusing fluid to the Peg tube. After feeding care provided proper disconnecting and closing of the insertion site. 4. To be monitored by: a. DON or designee will complete a bi-weekly audit for three months and observe nursing staff demonstrate proper technique of a tube feeding following policy and procedure and the clinical standards of care. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	

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	245409	A. BUILDING _____ B. WING _____	11/13/2015

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inflected [sic] balloon was out and pull ups tinged with blood. CNA [certified nursing assistant] [nursing assistant] said, she found catheter like that when res pull ups was being changed. It is suspected that this may have happened during transfer."

R20 was observed on 11/12/2015 at 9:03 a.m. in her room. Nursing assistants (NA)-B and (NA)-C were observed to transfer R20 with the Hoyer lift. The catheter bag was placed on R20's lap during the transfer from the shower chair to the bed (this allowed the catheter bag/tubing to be above the bladder and allow urine to run back into the bladder). NA-B and NA-C dressed R20 while she was in the bed and then transferred R20 from the bed to her wheelchair using the Hoyer lift. During the second transfer the catheter bag was again placed on R20's lap during the transfer.

On 11/12/2015 at 7:58 a.m. licensed practical nurse (LPN)-B stated she heard R20's catheter was pulled out during a transfer once, but stated she was not here when it happened.

On 11/12/2015 at 2:30 p.m. the director of nursing (DON) stated he was unaware of the incident when R20's catheter was pulled out during a transfer and stated no education to staff had been completed as he was unaware of the incident.

On 11/12/2015 at 3:03 p.m. the licensed social worker (LSW)-A stated she was made aware of the incident yesterday by the assistant director of nursing (ADON) as she had talked to R20's spouse regarding this concern and started to do some investigation. LSW-A stated R20's spouse also discussed his concerns with the catheter being pulled out during a transfer at the care

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F 315	Continued From page 66 conference today. On 11/13/2015 at 9:20 a.m. the ADON stated R20's spouse told her about the incident regarding R20's catheter being pulled out during a transfer, but could not remember when she was told. The ADON stated she followed up on the catheter being clear for three days, documented this in the progress notes, informed the nurse practitioner, stated she talked about this with R20's spouse and this is why we hung the signs in her room. The ADON stated she started ongoing education with staff. The in-service education sheet did not include the dates staff were trained and the ADON could not recall when she started the training. The ADON stated she interviewed staff regarding the incident on 11/8/15. The ADON stated she did not document the interviews or any of her investigation regarding this incident. The ADON stated she had no documentation of her conversations with the R20's spouse regarding this incident. The ADON stated she was unaware of the incident that occurred on 11/6/15 and stated this has not been investigated by the facility. The ADON stated a staff member told her on 11/8/15 they found the catheter out. The ADON stated the spouse told her it was pulled out during a transfer. The ADON stated the catheter should not be placed in the residents lap during a transfer as the catheter bag has to always be down from the bladder. The ADON stated staff should hold the catheter bag down or hook it the resident below the bladder, to prevent backflow into the bladder during a transfer. On 11/13/2015 at 10:23 a.m. NA-B stated she was educated on 11/12/15 and NA-C stated she was educated on 11/13/15 on transferring	F 315		

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residents with a catheter bag. NA-B and NA-C stated when they transferred R20 with the Hoyer lift they placed the catheter bag on R20's lap and both stated they were unaware they should not be doing this and stated they would check with nursing on how to transfer R20 with her catheter bag.

On 11/13/2015 at 12:28 p.m. registered nurse (RN)-B stated when staff transferred R20 with the Hoyer lift, staff should secure the catheter bag to the side of the sling next to the leg where the catheter was connected. RN-B stated some staff put the catheter bag on the residents lap, but I guess that is not safe, because it might fall off the lap and tug it. RN-B stated R20's spouse shared with her the catheter was pulled out during a transfer.

The catheter polices provided by the facility did not include safe transferring techniques of residents with a catheter.
R74 was observed on 11/12/15 at 10:11 a.m. with nursing assistant (NA)-D and trained medication aide (TMA)-B were providing morning cares. At the start of the care session, R74's catheter tubing was underneath the right leg and the tubing was not coiled and anchored to the bed. NA-D and TMA-B unfastened the incontinent brief and pulled the front down to reveal small amount of soft stool. NA-D drained the urine collection bag according to protocol; the bag contained 400 cubic centimeters (cc) of dark yellow urine. NA-D then took the collection bag, removed the tubing from underneath the leg, and placed the collection bag on bed, at the level of the bladder. During the move of the collection bag onto the bed, the urine in the tubing went back up towards the bladder and was no longer visible in the

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tubing until the collection bag was at the level of the bladder. NA-D with gloves on took a washcloth with soap and washed left groin area then with the same stool soiled washcloth cleansed the catheter. The catheter collection bag was still on the bed and more urine was in the tubing and continued to reflux back and forth in and out of the bladder. After perineum care was completed, TMA-B lifted the catheter collection bag approximately 12 inches above R74 while pants donned. Urine in the tubing flowed downward towards the bladder and no longer visible. TMA-B returned the collection bag to the top of the bed and urine flowed out. The tubing was now almost completely full with urine; no urine was draining into the collection bag. NA's assisted R74 into a mechanical lift sling to transfer out of bed. NA's placed urine collection bag on top of R74 during the entire transfer. The urine in the tubing again refluxed (reflux is a backward flow of the contents and here it is urine) during the transfer.

Physician visit note dated 8/28/15 indicated R74 had a neurogenic bladder that required an indwelling Foley catheter with a medical history of urinary retention after multiple strokes exacerbated by obstructive uropathy and multiple prior lumbar laminectomies.
R74's fourteen day Minimum Data Set (MDS) dated 10/19/15 indicated moderate cognitive impairment with a Brief Interview for Mental Status score of 12 and was dependent on staff for activities of daily living with use of mechanical lift for transfers. The MDS identified R74 required an indwelling catheter and was always incontinent of bowel. The MDS included problem of urinary retention and kidney failure, however did not identify the diagnosis of neurogenic bladder,

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obstruction, or stroke.
R74's electronic care plan included problem statement, "alteration in elimination r/t [related to]: incontinent bowel, indwelling catheter, impaired mobility, risk for UTI [urinary tract infection], hx [history] of UTI, CKD [chronic kidney disease] stage 3 with the goal, "will have no complications r/t indwelling catheter through next review." The care plan identified two interventions pertaining to the care of the indwelling catheter; catheter changes per order and monitor for signs and symptoms of UTI.
R74's record lacked consistent documentation of catheter care, monitoring for placement, and monitoring for signs/symptoms of a UTI.
A urinalysis on 10/2/15 revealed the presence of a urinary tract infection with the infective organism indicated as Enterococcus Faecalis. The associated culture and sensitivity report results revealed the bacterium was susceptible to Penicillin- 1 microgram per milliliter (mcg/ml), Nitrofurantoin <=32 mcg/ml, Levofloxacin <=1 mcg/ml, Vancomycin <=2 mcg/ml, and Gent Synergy <=500 mcg/ml. A hand written note on the lab result indicated, " he is on Augmentin [antibiotic] so it's fine." According to physician's orders, Augmentin was prescribed for aspiration pneumonia.
A progress note dated 11/4/15 indicated R74 had suprapubic discomfort with no urine output. The note indicated staff performed a bladder scan with results of 330 cc's (cubic centimeters), then irrigated the bladder with no return, then changed the indwelling catheter, collected a urine sample and notified the physician. The documentation indicated, "his urine is cloudy odorous, blood tinged and noted small blood clots." The record did not reflect a physician's orders to flush or change the catheter. The record did not reflect,

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ongoing monitoring of the symptoms or a treatment plan.
A physician's note obtained on 11/13/15. The physician's note indicated a service date of 11/9/15 (revised on 11/13/15) and pertained to R74's urinary symptoms. The note included, "patient has a history of chronic urinary bacteremia.", and "Results of microbiology shows two bacteria: Escherichia coli and pseudomonas Aeruginosa both >100,000 CFU." The physician's note explained R74 would not be treated with antibiotics related to history of bacterial resistance, lack of symptoms and potential serious adverse reactions of antibiotics with other medications. The physician directed nursing to monitor for signs and symptoms. During an interview on 11/13/15, at 8:52 a.m. licensed practical nurse (LPN)-A was asked why the physician's note dated 11/9/15 was not in the medical record. LPN-A indicated an unawareness; however, explained nurses on the floor were responsible for ensuring any follow up necessary. LPN-A verified the lack of monitoring for signs and symptoms of a UTI and was not aware R74 had a positive urinalysis on 11/4/15 or the physician's plan to monitor, and did not know why the physician's visit note had not been in the chart. LPN-A stated monitoring for signs and symptoms of a UTI should be documented and done every shift.
During an interview on 11/12/15, at 1:26 p.m. LPN- B was asked what size catheter was used and frequency of changing. LPN-B, did not know and could not find how often the catheter was to be changed or what size catheter should be used. LPN-B stated a visual inspection of the catheter revealed a 14 french with a 10 cc balloon was being used at the time of survey.
During an interview on 11/12/15, at 1:27 p.m.,

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F 315	Continued From page 71 assistant director of nursing (ADON) stated, physician orders for indwelling catheters should include size of catheter and schedule for changing. ADON stated when staff provide catheter care; staff are to clean the catheter first with a separate washcloth and then the perineum is cleaned. The ADON stated the catheter tubing should go over the leg while in bed and not underneath to prevent pressure areas and kinks in the tubing. ADON explained it was not appropriate to put the catheter collection bag on top of the bed or hold it above the bladder at any time, and not placed on top of the resident during transfers. ADON verified lack of urinary catheter care plan and stated the care plan should include size of the catheter, schedule for changing, measuring output, and give direction on daily care. The ADON then explained nurses need to document every shift output, urine integrity, and care performed. The facility used two brands of indwelling catheter collections bags, both bags equipped with anti-reflux valves at the drain point. The facility used two brands of indwelling catheters; both brands were not equipped with anti-reflux valves that would prevent the urine from going back into the bladder. Facility policy and procedure for care of an indwelling catheter was asked for and not received. A facility policy Foley Catheter Insertion dated 8/1/15 instructed staff to verify the physician's order. Facility policy and procedure Measuring and Documenting Fluid Output dated 8/1/15 instructed staff to record and document character of output.	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS	F 322		12/23/15

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F 322	Continued From page 72 Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow physician's orders, and provide cares and services a for percutaneous endoscopic gastrostomy (PEG) tube management for 1 of 1 resident (R74) who utilized a PEG tube for all fluid/food. Findings include R74 was observed on 11/10/15, at 2:47 p.m., R74 sat in his wheelchair while the tube feeding was being administered. Licensed practical nurse (LPN)-D was in the room with R74's neighbor when the tube feeding finished. LPN-D walked over to the feeding pump without washing hands,	F 322	F322 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. 11/28/2015 R74 was assessed for peg tube management 2. To prevent any other residents that	

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F 322	Continued From page 73 removed the flush syringe from storage bag, and walked to the bathroom and filled syringe with 60 milliliters (ml) of tap water. LPN-D without washing hands and without gloving disconnected the feeding pump and draped the line over the feeding pump pole where it was left to dangle without being capped. LPN-D then infused the 60 ml of water into the feeding tube without washing hands and without donning gloves. LPN-D then repeated the process to infuse another 60 ml. The PEG tube was not secured into place and the insertion site was light pink with brown-crusted debris around the tube. During an observation on 11/12/2015, at 8:44 a.m., R74's feeding finished infusing, assistant director of nursing (ADON) walked into the room and turned off the pump without disconnecting the pump from R74, ADON then walked back out of the room. At 8:46 a.m. LPN-A indicated R74 had already been given his morning 120 ml free water flush, and would not be given another 120 ml free water flush. LPN-A indicated she would give R74 his medication and finish the feeding after she gave another resident their medication. During an observation of medication administration on 11/12/2015, at 9:09 a.m. R74 still connected to the feeding pump. LPN-A washed hands and donned gloves. LPN-A disconnected the feeding pump and infused 60 ml of tap water into the tube without checking placement or residual. LPN-A drew up, infused the first medication, and followed it with a 5 ml water flush. LPN-A repeated the process for the second and third medications however did not flush between the fourth and fifth medications and did not flush between the 5th and the 6th medications. During an observation on 11/12/15, at 11:25 a.m. LPN-A indicated R74 had an appointment at	F 322	may be affected by the same deficient practice the following action was taken: a. 11/18/2015 DON conducted entire facility check and identified other resident having the potential to be affected by the same deficient practice. 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education reviewing all Policies and Procedures regarding a Gastrostomy tube including current clinical standards of practice and services that must be provided to prevent complications to the extent possible including washing hands, cleaning tube, and checking placement before infusing fluid to the Peg tube. After feeding care provided proper disconnecting and closing of the insertion site. 4. To be monitored by: a. DON or designee will complete a bi-weekly audit for three months and observe nursing staff demonstrate proper technique of a tube feeding following policy and procedure and the clinical standards of care. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	

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F 322	Continued From page 74 11:45 a.m. and instruction was to give a can of nutrition prior to leaving. LPN-A donned gloves and removed the cap from the feeding line, the end of the feeding line rubbed up against the feeding pump and was not cleaned prior to connecting to R74's PEG tube. As LPN-A infused the 60 ml water flush, R74 displayed facial grimace. LPN-A stopped flushing after 30 ml and stated the flush was stopped because R74 displayed discomfort. LPN-A did not check placement or check for residual prior to flushing and infusing the feeding formula. LPN-A stated, flushes are cooler water as opposed to medications, which are dissolved in warm water. During an observation with ADON on 11/12/15 at 2:34 p.m. ADON, stated R74 was demonstrating signs of dehydration because skin was dry and tenting. R74's fourteen day Minimum Data set (MDS) dated 10/19/15 included diagnoses of anemia, congestive heart failure, hypertension, and peripheral arterial disease. The MDS identified R74 had moderately impaired cognition with a Brief Interview for Mental Status Score of 12. The assessment indicated R74 was dependent on staff for activities of daily living, had a feeding tube for all nutrition, and had an indwelling urinary catheter. The care plan identified conflicting instructions for medication administration through the feeding tube. The care plan directed staff to, "Mix medications with 10-15 milliliters (ml) of water after crushing then flushing the tubing with 30 ml of water. After the medication is instilled the tube is again flushed with 30 ml of water." The care plan then instructed staff to request an order from physician to flush with 60 ml of water before and after medications and 5 ml of water between medications (order obtained on 10/21/15 after	F 322		

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F 322	Continued From page 75	F 322		

dietician's recommendations). The care plan directed staff to perform oral care in the morning and evening as tolerated.
R74's current electronic orders and care plan were inconsistent with verbal orders and written physician consultation orders from outside appointments.
A verbal order obtained on 9/1/15 and signed by the physician on 9/1/15 included, "please provide resident with two moist swabs every morning to clean his mouth. Mouth care three times daily." Current electronic physician's orders did not reflect the oral care orders and was inconsistent with care plan, however, had been in the physicians orders until 10/5/15. The record did not reflect why the prescribed oral care was removed and a physician's order to discontinue the oral care was not evident in the record.
Physician orders written on a facility Consultation form not dated but noted by the facility on 10/6/15 included "120 ml water flush before and after each feed plus other water flushes with medications. Goal fluid 2000-2500 ml. 1185 ml formula, 720 ml water flushes, another 100-500 ml." Because of the transcription error, a fluid deficit of 360 ml occurred daily since the order date. Daily fluid intake monitoring and daily evaluations to ensure meeting recommended fluid intake was not evident in the medical record.
The Consultation form also included orders to, "Please turn PEG tube once a day in a complete circle, and Secure tube with either Flexi-Track and/or Sepronet size 11." Electronic physician orders or the care plan did not reflect transcription of turning or securing the PEG tube.
R74's current (at the time of survey) electronic physician's orders also included, Jevity 1.5 (enteral nutrition) 5 cans per day and Scopolamine patch change every three days to

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F 322	Continued From page 76 help manage secretions. A consult appointment note dated 9/30/15 from Home enteral Nutrition-Nutrition included, "Water flushes: varies with RN [registered nurse] staff, wife states some pay more attention to his hydration and give adequate flushes." The note indicated the estimated fluid needs were 2100 ml per day. It was not evident in the record the facility had followed up with the noted concern. A progress note authored by the facility's dietician dated 10/21/15 indicated hospitalization occurred 10/2/15 through 10/5 related to aspiration pneumonia and included, "Resident is NPO [nothing by mouth] with enteral feeding of Jevity 1.5 1200 ml with 120 ml water before and after each feeding. Will request med flush order of 60 cc water before and after meds with 5 cc water between meds." The progress note indicated total water from formula and flush equaled 1940 ml every day. The note reported no documented problems with feeding tolerance and daily fluid requirements assessed as 2190 ml per day. The note identified, "Resident is at risk for dehydration, over hydration, nausea, vomiting, diarrhea, elevated temp, aspiration pneumonia. Staff to monitor tolerance, weights, hydration, per policy/MD order; notify CDM [certified dietary manager], RD [registered dietician] as needed." A progress note authored by the CDM on 11/9/15 included, "R74 will continue to maintain adequate hydration and nutrition to meet his body's requirement by feeding tube and will [sic] no complications." A corresponding evaluation of daily fluid intake was not evident in the record. During an interview on 11/12/15, at 1:26 p.m. In response to the question, How are staff ensuring R74 is getting the recommended daily intake of fluids?, ADON stated, "Daily fluid monitoring is not being done right now to evaluate for	F 322		

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F 322	Continued From page 77	F 322		

dehydration, but it will be now." ADON indicated nurses monitor for dehydration by assessing body temperature and oral cavity. ADON stated she expected nurses to where gloves when working with feeding tubes and the feeding bag tube should always be capped when not in use. ADON stated tepid water is supposed to be used for flushes. ADON verified the care plan for the feeding tube was incomplete and updated the care plan and electronic physician's orders during the interview to include the ordered oral care, instruction for tube maintenance, and revised the free water to reflect the physician's order.

Facility policy and procedure Tube Feeding: Administering medications dated 8/1/15 included the directions to staff to: perform hand hygiene and apply gloves, instill air while auscultating the abdomen and verify placement by checking residual gastric contents, do not use cold water, administer medications separately with 5-10 ml flush in-between medications unless contraindicated, and flush tubing with room temperature or warm water.

Facility policy and procedure Verifying Placement of Feeding Tubes dated 8/1/15 indicated the purpose of the policy was to ensure proper placement of the feeding tube to prevent aspiration during feedings. The policy directed staff to listen to the abdomen while infusing air to ensure a whooshing noise was heard that verifies placement. The policy also directed staff to aspirate gastric contents.

Facility policy and procedure Hydration/Prevention and Treatment of Dehydration dated 8/1/15 included: nursing staff will assess all residents for current hydration risk upon admission and at least quarterly and more often as necessary with hydration risk assessment tool to identify resident at high risk

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F 322	Continued From page 78 for hydration issues, and nursing will monitor for signs and symptoms of dehydration during daily care. The policy further indicated Nurse's aides will provide and encourage intake of bedside on a daily and routine basis and Intake will be documented in the medical records for those residents whom have individualized interventions for intake and output. The policy further directed staff to develop interventions if signs and symptoms of dehydration were present, and monitor and document fluid intake. Facility policy and procedure Mouth/Oral Care dated 7/28/15 described the purpose of the policy as, "to keep the resident's lips and oral tissues moist, cleanse and freshen the resident's mouth, and prevent infections of the mouth." The policy instructed how to perform oral care using a moistened applicator with water.	F 322		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		12/23/15

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F 329	Continued From page 79 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure sleep assessments were completed for 3 of 5 residents (R51, R28, and R84); failed to ensure gradual dose reduction (GDR) for 1 of 5 residents (R51) and failed to assess pain medication for efficacy and attempt non-pharmalogical interventions prior to the administration of medications for 1 of 5 residents (R84) reviewed for unnecessary medications. Findings include: LACK OF SLEEP ASSESSMENT TO WARRANT USE OF HYPNOTIC ALSO A GRADUAL DOSE REDUCTION ATTEMPTED TWICE IN THE FIRST YEAR OR A PHYSICIAN'S JUSTIFICATION AS TO WHY IT IS CONTRAINDICATED: R51's quarterly Minimum Data Set (MDS) dated 9/18/15, identified admit date of diagnosis of anxiety, cognitively intact. No behaviors or moods, no trouble falling asleep or staying asleep and had received antianxiety and antidepressant medications. R51's physician orders dated 10/20/15, identified orders for Trazodone (antidepressant) 25 mg (milligrams) at bedtime for insomnia and Ativan	F 329	F329 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. 11/23/2015 Education provided to consultant pharmacy on Ftag 329 by DON. b. 11/25/2015 Pharmacist Consultant reviewed medications of R51, R28 and R84 and completed a Medication Regimen Review Report that included documentation for unnecessary medications. c. 11/25/2015 Gradual Dose Reduction (GDR) completed by Pharmacy Consultant for R51. d. 12/02/2015 MARs updated with nursing order to monitor/document adverse side effects for R51, R28 and R84.	

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F 329	Continued From page 80 (antianxiety) 0.5 mg two times a day for anxiety disorder. Review of R106's medication administration record, dated 11/15, revealed R106 was receiving the medications as ordered. R106's Daily Behavior Observation Sheets dated 11/15, 10/15 and 9/2015 identified target behaviors of refusal of cares, repetitive verbal, sleepiness at night and no documented episodes of behaviors. R106's consultant pharmacist medication regimen review, identified Trazodone 25 mg at bedtime, start date of 3/18/15 and Ativan 0.5 mg twice daily, start date of 4/14/15. Recommendation for GDR of Trazodone dated 7/16/15, with physician response of doing well at this time, do not want to interrupt rehabilitation due to inability to sleep, will evaluate at recertification date. Recommendation on 9/18/15 for GDR Ativan. However, R51's record failed to include documentation of physician justification as to why it was contraindicated for gradual dose reductions for the Trazodone and the Ativan at this time. Also R51's medical record lacked documentation of a comprehensive sleep assessment. During interview on 11/13/15 at 9:04 a.m., registered nurse (RN)-C verified R51's record failed to include a sleep assessment. RN-C confirmed there were no gradual dose reductions attempted for the Trazodone and Ativan. During interview on 11/13/15 at 9:04 a.m., social worker (SW)-A verified R51 had no documented target behaviors for the months of 9/15, 10/15, 11/15. SW-A verified there were no gradual dose	F 329	e. 12/10/2015 Sleep log initiated for R51, R28 and R84. Insomnia assessment to be completed upon completion of sleep log. f. 12/15/2015 R51 was assessed for pain medication for efficiency. 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. 11/23/2015-11/25/2015 Pharmacy Consultant reviewed all residents medications and completed a GDR as necessary and submitted a Medication Regimen Review Report. b. 12/02/2015 MAR updated with nursing order to monitor/document adverse side effects for any resident that is using a Hypnotic. c. 12/10/2015 Sleep log initiated. Insomnia Assessment to be completed upon completion of sleep log. d. 12/15/15 all residents were assessed for pain for efficiency. 3. To ensure that proper practices continue: a. 12/10/2015 Formal Education was provided for all nurses for sleep assessment, pain assessment including non pharmalogical interventions, monitoring and documentation. b. 12/10/2015 Formal Education was provided for all C.N.A staff for sleep monitoring, non-pharmalogical interventions for pain and documentation. c. The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist. The pharmacist consultant will report any irregularities regarding a residents use of a Hypnotic	

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F 329	Continued From page 81 reductions attempted for the Trazodone and Ativan. During interview on 11/13/15 at 11:36 a.m., assistant director of nursing (ADON)-C stated if no behaviors and no problems with sleep, she would expect the nurse to make the nurse practitioner aware, and a dose reduction be done. ADON-C stated sleep assessments were not being done. LACK OF SLEEP ASSESSMENT AND ONGOING MONITORING OF SLEEP MEDICATION FOR EFFECTIVENESS: R28's physician visit note dated 9/10/15, indicated diagnoses to include dementia with behavioral dyscontrol. The note directed Melatonin 5 milligram (mg) by mouth at bedtime. Review of the November 2015 medication administration record (MAR) indicated Melatonin 5 mg had been given at bedtime for behaviors and not sleeping at night. An annual Minimum Data Set (MDS) dated 6/23/15, identified R28 had severe cognitive impairment and had no trouble falling or staying asleep. Review of Consultant Pharmacy medication regime review sheet for review performed on 8/24/15 indicated Melatonin had been increased from 3 mg to 5 mg on 7/16/15. Review of the medical record revealed lack of ongoing sleep monitoring and an initial comprehensive sleep assessment to warrant the use of a hypnotic for sleep. During interview on 11/13/15, at 12:58 p.m. the director of nursing (DON) verified R28 had received Melatonin for sleep, and further verified	F 329	to the attending physician and the DON and these reports will be acted upon. d. Established a psychotropic Committee to meet monthly for ongoing review of psych drugs. During Psychotropic monitoring meetings IDT reviews a schedule of those residents that are due for a GDR, reviews resident□s targeted behaviors and evidence based data through staff documentation and Pharmacist will bring any suggestions for GDR□s to team per CMS guidelines. The Consultant Pharmacist then will complete GDR forms with information on targeted behaviors exhibited for provider to review. Following psychotropic drug monitoring meetings, ADON or designee will complete progress note indicating targeted behaviors, stating if targeted behaviors have increased or decreased over the last month, and indicating if the resident remains baseline. e. Sleep logs will be initiated for all new admissions and upon request for a Hypnotic. Insomnia Assessments will be completed following the completion of the sleep log. 4. To be monitored by: a. SW or designee will complete audits on each resident□s chart monthly by manually looking at each resident□s physician orders to verify each psychotropic drug is on the GDR schedule every month for the next 3 months. b. DON (or designee) will monitor and audit all residents once a month for 3 months to verify that Hypnotic and pain assessment, monitoring and documentation is being completed.	

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F 329	Continued From page 82 sleep monitoring and assessment had not been completed. The DON reported residents that receive sleep medication should have been monitored and have had a sleep assessment completed. Surveyor had requested from facility a policy for sleep, none had been provided. R84 was admitted to the facility on 8/21/15 with diagnoses that included chronic foot ulcers, migraine headaches, diabetes II with neuropathy and abdominal pain. R84's five day Minimum Data Set (MDS) dated 8/26/15 indicated no cognitive impairment with a Brief Interview for Mental Status score of 13. The MDS indicated R84 had impaired sleep integrity. The MDS also indicated R84 received as needed pain medication, did not receive non-pharmacological interventions to relieve pain, and staff identified R84 did not have pain or possible pain during the assessment period. R84's physician orders provided by the facility on 11/9/15 included Melatonin 3 milligrams (mg) by mouth at bedtime for insomnia with an order date of 9/25/15 and Oxycodone 5 mg by mouth every four hours as needed for pain with an order date of 9/22/15. A comprehensive sleep assessment prior to the initiation of a sleep medication and before the dose was increased, was not evident in the medical record. In addition, it was not evident sleep monitoring had been completed prior to the initiation, prior to the increase in dose, and ongoing monitoring to justify the ongoing use of the sleep medication. R84's medication administration record (MAR) from September 2015 reflected an order for Melatonin 2 mg at bedtime with a start date of 9/11/15. According to the physician orders	F 329	c. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	

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F 329	Continued From page 83 melatonin increased from 2 mg to 3 mg at bedtime on 9/25/15. During an interview on 11/13/15, at 9:40 a.m. the director of nursing stated "I'm a 100% sure we do not have a sleep assessment but we do sleep monitoring." During an interview on 11/13/15, at 10:28 a.m. the assistant director of nursing (ADON) indicated the facility did not perform sleep monitoring on a routine basis. ADON indicated the facility did not perform sleep assessments however, they should be performed prior to the start of hypnotic medications and include: eating habits, activities of daily living, normal bed times, toileting times, sleep hygiene routines, and other predisposing factors that might interrupt sleep. ADON referenced the care plan and stated non-pharmacological interventions for sleep should have been included in the care plan. LACK OF PAIN CONTROL: R84's care plan included, "Actual/Potential for alteration in comfort r/t: pressure areas, right hip pain post fall prior to admission, HX [history] migraines, impaired mobility." The care plan instructed staff to monitor and document effectiveness, monitor for non-verbal signs and symptoms of pain. The care plan directed staff to offer non-pharmacological interventions before administering pain medications and then to monitor and document effectiveness of the interventions. R84's record did not reflect consistent documentation of an evaluation (i.e. location, severity/intensity, duration, causal factors) of pain, non-pharmacological interventions attempted or used, or efficacy of the pain medication. R84's treatment administration record (TAR) for October 2015 indicated administration of as	F 329		

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F 329	Continued From page 84 needed Oxycodone seven times. The documentation included the nurse's initials who administered the medication on all recorded doses. On 10/5/15 and 10/12/15 the documentation also indicated a "0 [zero]." The documentation did not indicate what the zero pertained too. Doses on 10/2/15, 10/17/15, and 10/18/15 included the times of administration (other doses did not include times of administration). The October 2015 TAR did not reflect any further information pertaining to the administered doses. R84's TAR for November 2015 indicated administration of as needed Oxycodone six times. The dose administered on 11/6/15 had the initials of the nurse, administration time, and pain rating of seven (on a 0-10 scale). Dose administered on 11/7 indicated administration time and nurse's initials. The second dose administered on 11/9 indicated administration time and nurse's initials. Doses administered on 11/8, 11/9, and 11/10 included nurse's initials, time of administration, for shoulder pain, rating of pain, and effectiveness. During an interview on 11/13/15, at 9:42 a.m. licensed practical nurse (LPN)-A verified the lack of documentation on the TARs. LPN-A indicated documentation should have reflected administration time, location, severity, and effectiveness. LPN-A stated R84 historically refused non-pharmacological interventions. Documentation does not reflect offered interventions or refusals. During an interview on 11/13/15, at 10:28 a.m., ADON indicated she expects nurses to assess the pain fully and document; location, use the pain scale, take vital signs and mental status, duration of pain, aggravating factors, and attempt non-pharmacological measures first unless the	F 329		

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F 329	Continued From page 85 pain is extreme. ADON explained the nurse's should also document any refusals of non-pharmacological measures. Facility policy and procedure Administering Medications dated 8/1/15 did not include procedures for administration and documentation requirements for an as needed medication (except instruction to notify physician for repeat ongoing use). The document did not address the use of hypnotic medications.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the consulting pharmacist identified, reported and physician/director of nursing acted upon these irregularites for 1 of 1 resident (R28) who had a pharmacist recommendation to monitor hypnotic medication use. Findings include: R28's physician visit note dated 9/10/15, indicated	F 428	F428 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the	12/23/15

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F 428	Continued From page 86 diagnoses to include dementia with behavioral dyscontrol. The note directed Melatonin 5 milligram (mg) by mouth at bedtime. Review of the medical record revealed lack of documentation of sleep monitoring and a comprehensive sleep assessment completed. A review of the consulting pharmacist's medication regime review recommendation dated 7/15/15, read, "Ensure hypnotic monitoring" and further read "Will f/u [follow up] next month to ensure hypnotic monitoring is in place." Review of R28's record revealed there was no documented response from the facility regarding the recommendation by the consulting pharmacist dated 7/15/15. During interview on 11/13/15, at 12:58 p.m. the director of nursing (DON) verified R28 had received Melatonin for sleep, and further verified sleep monitoring and assessment had not been completed. Surveyor had requested from facility a policy for pharmacy recommendation however none had been provided.	F 428	deficiency identified on the CMS-2567: a. 11/23/2015 Education provided to consultant pharmacy on Ftag 428 by DON. b. 11/25/2015 Pharmacist Consultant reviewed medications of R28 and submitted GDR and Medication Regimen Review for Melatonin. c. 12/02/2015 MAR updated with nursing order to monitor/document adverse side effects. d. 12/10/2015 Sleep log initiated. Insomnia assessment to be completed upon completion of sleep log. 2. To prevent any other residents that may be the same deficient practice the following action was taken: a. 11/23/2015-11/25/2015 Pharmacy Consultant reviewed all residents medications and submitted a Medication Regimen Review for all Hypnotics. b. 12/02/2015 MAR updated with nursing order to monitor/document adverse side effects for any resident that is using a Hypnotic. c. 12/10/2015 Sleep log initiated. Insomnia Assessment to be completed upon completion of sleep log. 3. System put into place to correct the deficient practice includes: a. 12/10/2015 Formal Education was provided for all nurses for sleep assessment, monitoring and documentation. b. 12/10/2015 Formal Education was provided for all C.N.A staff for sleep monitoring documentation. c. The drug regimen of each resident will be reviewed at least once a month by	

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F 428	Continued From page 87	F 428	a licensed pharmacist. The pharmacist consultant will report any irregularities regarding a residents□ use of a Hypnotic to the attending physician and the DON and these reports will be acted upon. d. Sleep logs will be initiated for all new admissions and upon request for a Hypnotic. Insomnia Assessments will be completed following the completion of the sleep log. 4. To be monitored by: a. DON (or designee) will monitor and audit all residents once a month for 3 months to verify that Hypnotic assessment, monitoring and documentation is being completed. b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		12/23/15

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	245409	A. BUILDING _____ B. WING _____	11/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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F 441	Continued From page 88 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review, the facility failed to ensure an infection control program was in place and actively being used to prevent the spread of infection. this affected all 59 residents, staff and visitors to the home. Findings include Facility infection control monthly tracking logs were requested and provided by the director of nursing (DON) on 11/9/15, however monthly logs were only available for September, October and November 2015. The logs only identified the resident who had the infection and type of	F 441	F441 Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. Reviewed Policy and procedure for Infection control. b. Establish an Infection Control	

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F 441	Continued From page 89 infection; no other information was present on the logs. The facility was asked to run a medication report for antibiotics to compare to the monthly tracking logs. The report was provided on 11/12/15. The monthly tracking logs did not accurately reflect the resident's who had been prescribed a course antibiotics during the months of September, October and November 2015. The September 2015 tracking log identified two residents and the type of infection. The infection identified for both residents was urinary tract infection. The antibiotic listing report identified the residents listed on the log and identified two residents received antibiotics for reasons not indicated on the report and three residents were treated with antibiotics for urinary tract infections. The October 2015 tracking log identified two residents and the type of infection. The first resident identified had Methicillin-resistant Staphylococcus aureus (MRSA) and pneumonia. The second resident identified had cellulitis. The antibiotic listing report included the residents listed on the log and identified four residents treated with antibiotics for prophylactic purposes, two residents were prescribed antibiotics for reasons not indicated on the report, two residents that were treated with antibiotics for aspiration pneumonia, four residents were treated with antibiotics for pneumonia, and two residents were treated for urinary tract infections. The November 2015 tracking log identified one resident; infection indicated was urinary tract. The antibiotic listing report included the resident listed on the log and identified two additional residents who were treated with antibiotics for urinary tract infection (UTI) prophylaxis.	F 441	Program that investigates, controls, and prevents infections within the facility, decides what procedures should be applied to an individual resident and maintains a record of incidents and corrective actions related to infections. 2. To prevent any other residents that may be affected by the same deficient practice the following action was taken: a. ADON will document a monthly infection log and cross reference to the pharmacy antibiotic log. b. Infection Control Monthly review and action plan will be reported c. Incidence of Infection by wing report will be utilized. d. Establish a monthly Resident Specific Infection Tracking Chart to detect patterns of infections 3. System put into place to correct the deficient practice includes: a. 12/10/2015 Formal Education was provided for all nurses to complete infection assessment, monitoring and documentation. b. 12/10/2015 Formal Education was provided for all staff on the Policy and Procedures of Infection Control. c. Create an Infection Control Monthly review and action plan 4. To be monitored by: a. DON (or designee) will create a monthly Resident Specific Infection Tracking Chart b. Initial compliance for adherence to this plan will be the responsibility of the QAPI Team. 5. Completion date: 12/23/2015	

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F 441	Continued From page 90 During an interview on 11/13/15, at 1:23 p.m., the infection control coordinator assistant director of nursing (ADON) stated being a new employee and had recently been assigned to infection control. ADON explained no previous experience with overseeing infection control. ADON verified tracking and trending infections was not being done and an infection control program was not in place. An infection control program policy/procedure was asked for and not received.	F 441		

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	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/10/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC 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. UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Maple Manor Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: . Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/18/2015

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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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Maple Manor Nursing Home is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction, with a partial basement. In 1974, addition was constructed and was determined to be of Type II(111) construction, with a full basement.

Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 81 beds and had a

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K 000	Continued From page 2 census of 59 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 51 residents. Findings include: On facility tour between 9:00 AM and 11:00 AM on 11/10/2015, the review of the fire drill documentation for the past 12 months (October 2014 to October 2015) revealed that the evening shift fire drills for 2015 2nd quarter and 3rd quarter were missed. The night shift fire drill for	K 050	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. K154 1. The facility has taken the following immediate action concerning the deficiency identified on the CMS-2567: a. Review of documentation of Fire Drill Policy and Policy review by Maintenance team. b. Telssystem updated to auto announce fire drill time frames as reminder for	12/18/15

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K 050	Continued From page 3 the 2015 1st quarter was also missed. This deficient practice was confirmed by the Facility Maintenance Director (WK) at the time of discovery.	K 050	Safety lead. c. Night shift fire drill completed on 12-7-2015. d. Administrator/and or designee will review monitor completion of fire drills. Auditing for completeness each quarter.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 LSC (00) section 19.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 59 residents. Findings include: On facility tour between 9:00 AM and 11:00 AM on 11/10/2015, 1. A review of documentation and interview with the Maintenance Supervisor, revealed the facility failed to provide documentation of the quarterly fire sprinkler flow tests inspections required by NFPA 13(99) and NFPA 25(98).	K 062	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. K155 2. Policy in place a. 12/1/2015 policy updated and reviewed regarding fire watch plan. b. 12/10/15 Formal Education was provided for Safety Department Director regarding policy. Policy to be reviewed during safety committee meeting January 2016 c. Sprinkler system has been tested quarterly. To be monitored by: Safety Director/Safety committee	12/18/15

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K 062	Continued From page 4	K 062	3. Completion date: 12/10/2015	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:00 AM and 11:00 AM on 11/10/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (WK) at the time of discovery.	K 154	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. K155 2. Policy was in place at time of inspection. Unfortunately, Maintenance Director was new to positon and assumed policy was not in place. Prepared and readiness plan is put into place: a. 12/1/2015 policy updated and reviewed regarding fire watch plan. b. 12/10/15 Formal Education was provided for Safety Department Director regarding policy. Policy to be reviewed during safety committee meeting January 2016 To be monitored by: Safety	12/18/15

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K 154	Continued From page 5	K 154	Director/Safety committee 3. Completion date: 12/10/2015	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:00 AM and 11:00 AM on 11/10/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (WK) at the time of discovery.	K 155	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. K155 2. Policy was in place at time of inspection. Unfortunately, Maintenance Director was new to positon and assumed policy was not in place. Prepared and readiness plan is put into place: a. 12/1/2015 policy updated and reviewed regarding fire watch plan. b. 12/10/15 Formal Education was provided for Safety Department Director regarding policy. Policy to be reviewed during safety committee meeting January 2016 To be monitored by: Safety	12/18/15

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K 155	Continued From page 6	K 155	Director/Safety committee 3. Completion date: 12/10/2015	