DEPARTMENT OF HEALTI	I AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAL	ID SERVICES
					AND TRANSMITTAL FE SURVEY AGENCY		3QEK
1. MEDICARE/MEDICAID PROVIDE (L1) 245409 2.STATE VENDOR OR MEDICAID N (L2) 843242200	R NO.	3. NAME AND AL (L3) MAPLE MA (L4) 1875 19TH S (L5) ROCHESTE	DDRESS OF FAC ANOR NURSI STREET NOR	CILITY NG AND R	REHAB, LLC	Fac 4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	ility ID: 00916 <u>7</u> (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF ((L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	OVIDER/SUPPLIER CATEGO ital 05 HHA		<u>02</u> (L7) 13 PTIP 22 CLIA	 7. On-Site Visit 8. Full Survey After Comparison 	9. Other omplaint
6. DATE OF SURVEY 04/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	7/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF 0 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 09/30	DATE: (L35)
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	81 (L18) 81 (L17)	Complianc 1. A B. Not in Con		gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	6. Scope of Servic 7. Medical Direct	ces Limit or
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
81 (L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Kyla Einertson, HFE	NE II	0	04/29/2015	(L19) k	Kamala Fiske-Downing, H	Enforcement Speciali	<u>st</u> 05/12/2015 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RF	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY	
 DETERMINATION OF ELIGIBIL 1. Facility is Eligible to P 2. Facility is not Eligible 			IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (He :	CFA-1513)
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION:	(L3	0)
OF PARTICIPATION 01/01/1987	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure		ARY et Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		et Agreement
25. LTC EXTENSION DATE: (L27)	A. Suspension	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	nn <u>OTHER</u> 07-Provider S 00-Active	Status Change
		1	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APPI	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245409

May 5, 2015

Mr. Patrick Blum, Administrator Maple Manor Nursing And Rehab, LLC 1875 19th Street Northwest Rochester, Minnesota 55901

Dear Mr. Blum:

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 April 17, 2015 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,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered April 29, 2015

Mr. Patrick Blum, Administrator Maple Manor Nursing And Rehab, LLC 1875 19th Street Northwest Rochester, Minnesota 55901

RE: Project Number S5409025

Dear Mr. Blum:

On March 30, 2015, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 4, 2015. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on January 30, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 20, 2015. The most serious deficiencies at the time of the revisit 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.

On April 27, 2015, 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 March 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 20, 2015, as of April 17, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 17, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of March 30, 2015. 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 April 30, 2015, 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 April 30, 2015, is to be rescinded. They will also notify the State

Maple Manor Nursing And Rehab, LLC April 29, 2015 Page 2

Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 30, 2015, is to be rescinded.

In our letter of March 30, 2015, 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 April 30, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 17, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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,

Kumalu Fiske Downing

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

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245409	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/27/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
M	APLE MANOR NURSING AND REHA	B, LLC	1875 19TH STREET NORTHWE ROCHESTER, MN 55901	EST

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).

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item		(Y5)	Date
	F0282 483.20(k)(3)(ii)	Correction Completed 04/17/2015		F0312 483.25(a)(3)	Correction Completed 04/17/2015	Reg. #	F0315 483.25(d)		Correction Completed 04/17/2015
ID Prefix Reg. #		Correction Completed 04/17/2015	ID Prefix Reg. #		Correction Completed 04/17/2015	ID Prefix Reg. #	F0329 483.25(I)		Correction Completed 04/17/2015
	F0431 483.60(b), (d), (e)	Correction Completed 04/17/2015	ID Prefix Reg. # LSC	F0441 483.65	Correction Completed 04/17/2015	Reg. #			Correction Completed
Reg. #						– (: 		
Reg. #			Reg. #						
Reviewed B	By Revi	ewed By	Date:	Signature	of Surveyor:			Date:	
State Agen	-	/kfd	04/29/2015	5		31221		04/22	7/2015
Reviewed E CMS RO	3y Revi	ewed By	Date:	Signature	of Surveyor:			Date:	
Followup t	o Survey Complete 1/30/2015				V Uncorrected Defined Defined Deficiencies (CM			YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

April 29, 2015

Mr. Patrick Blum, Administrator Maple Manor Nursing And Rehab, LLC 1875 19th Street Northwest Rochester, Minnesota 55901

RE: Project Number S5409025

Dear Mr. Blum:

On April 27, 2015, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on April 27, 2015, imposed a daily fine in the amount of \$2600.00.

On April 27, 2015, an acknowledgement was electronically received by the Department stating that the violations had been corrected. A reinspection was held on April 27, 2015 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is \$2600.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$417.60, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$3017.60 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Maple Manor Nursing And Rehab, LLC April 29, 2015 Page 2

Sincerely,

Kumalu Piske Downing

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

cc: Program Assurance Unit Penalty Assessment Deposit Staff

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00916	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/27/2015
Name	e of Facility		Street Address, City, State, Zip Code	
MA	APLE MANOR NURSING AND REHA	B, LLC	1875 19TH STREET NORTHWE ROCHESTER, MN 55901	EST

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5)) Date	(Y4) Item		(Y5) Date (Y4) Item	(Y5)	Date
	MN Rule 4658.0405 Sul			MN Rule 4658.040			MN Rule 4658.0520	
LSC		-	LSC			LSC		
ID Prefix Reg. # LSC	20895 MN Rule 4658.0525 Sul	Correction Completed 04/17/2015 bp.	ID Prefix Reg. # LSC	20910 MN Rule 4658.052	Correction Completed 04/17/2015 5 Subp.	ID Prefix Reg. # LSC	MN Rule 4658.0525	Correction Completed 04/17/2015 Subp.
ID Prefix Reg. # LSC	21375 MN Rule 4658.0800 Sul		ID Prefix Reg. # LSC	21535 MN Rule4658.1315				
ID Prefix Reg. # LSC			Reg. #			Reg. #		
ID Prefix Reg. # LSC		Correction Completed	Reg. #			Reg. #		
Reviewed E State Agen	cy GPN/kfc	1	Date: 04/29/201		312	221		27/2015
Reviewed E CMS RO	By Reviewed	І Ву	Date:	Signature o	f Surveyor:		Date	
	o Survey Completed or 1/30/2015 M: REVISIT REPORT (5				Incorrected Deficion Deficiencies (CMS			

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDI	CAID SERVICES
					AND TRANSMITTAL		ID: 3QEK
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY		Facility ID: 00916
1. MEDICARE/MEDICAID PROVIDER (L1) 245409	R NO.	3. NAME AND AI (L3) MAPLE MA	NOR NURSI	NG AND R	EHAB, LLC	4. TYPE OF ACTION 1. Initial	ON: 7 (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO (L2) 843242200	Э.	(L4) 1875 19TH S (L5) ROCHESTE		RTHWEST	(L6) 55901	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Afte	9. Other er Complaint
6. DATE OF SURVEY 03/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END 09/30	ING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirer	nents:
To (b):			equirements		2. Technical Personnel		
12. Total Facility Beds	81 (L18)		e Based On: cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	 7. Medical D NF) 8. Patient Roo 9. Beds/Roor 	om Size
13.Total Certified Beds	81 (L17)	X B. Not in Con Requirement	npliance with Pro ents and/or Appl		* Code: B	(L12)	u
14. LTC CERTIFIED BED BREAKDOW	٧N	1			15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
81 (L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	(APPROVAL	Date:
<u>Kyla Einertson, HFE N</u>	JE II	04/29	/2015	(L19) K	amala Fiske-Downing, I	Enforcement Spec	<u>ialist</u> 05/11/2015 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	COFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Pa			IPLIANCE WIT ITS ACT:	H CIVIL	 Statement of Fina Ownership/Contre Both of the Above 	ol Interest Disclosure Stm	
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION 01/01/1987	BEGINNINC	6 DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		<u>NTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		ler Status Change
(L27)	B. Rescind St	spension Date:	(L44)			00-Active	3
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

March 30, 2015

Mr. Patrick Blum, Administrator Maple Manor Nursing And Rehab, LLC 1875 19th Street Northwest Rochester, Minnesota 55901

RE: Project Number S5409025

Dear Mr. Blum:

On February 13, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 30, 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 March 20, 2015, the Minnesota Department of Health 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 January 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 11, 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 January 30, 2015. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0312 -- S/S: D -- 483.25(a)(3) -- Adl Care Provided For Dependent Residents F0315 -- S/S: D -- 483.25(d) -- No Catheter, Prevent Uti, Restore Bladder F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs F0431 -- S/S: E -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals F0441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found 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.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective April 4, 2015. (42 CFR 488.422)

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 April 30, 2015. (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 April 30, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 30, 2015. 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 Program or Competency Evaluation Programs for two years effective April 30, 2015. 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 determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

> Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 gary.nederhoff@state.mn.us Telephone: (507) 206-2731 Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 July 30, 2015 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumalu Piske Downing

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245409	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/20/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
M	APLE MANOR NURSING AND REHA	B, LLC	1875 19TH STREET NORTHWE ROCHESTER, MN 55901	EST

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).

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
ID Prefix	F0156	C	orrection ompleted 3/11/2015	ID Prefix	F0176		Correction Completed 03/11/2015		ID Prefix	F0225		Correction Completed 03/11/2015
Reg. # LSC	483.10(b)(5) - (10), 483.10	(k	Reg. # LSC	483.10(n)		-		Reg. # LSC	483.13(c)(1)(ii)-(iii), ((c)(2) -
ID Prefix Reg. # LSC	F0226 483.13(c)	C	orrection ompleted 3/11/2015	ID Prefix Reg. # LSC	F0241 483.15(a)		Correction Completed 03/11/2015		ID Prefix Reg. # LSC	F0246 483.15(e)(1)	Correction Completed 03/11/2015
	F0278 483.20(g) - (i)	C	orrection ompleted 3/11/2015	ID Prefix Reg. # LSC	F0279 483.20(d), 4	183.20(k)(1)	Correction Completed 03/11/2015		ID Prefix Reg. # LSC	F0280 483.20(d)(3	3), 483.10	Correction Completed 03/11/2015 (k)(2)
ID Prefix Reg. # LSC	F0309 483.25	С	orrection ompleted 3/11/2015	ID Prefix Reg. # LSC	F0322 483.25(g)(2)	Correction Completed 03/11/2015		ID Prefix Reg. # LSC	F0325 483.25(i)		Correction Completed 03/11/2015
ID Prefix Reg. # LSC	F0334 483.25(n)	C	orrection ompleted 3/11/2015	ID Prefix Reg. # LSC	F0353 483.30(a)		Correction Completed 03/11/2015		ID Prefix Reg. # LSC	F0369 483.35(g)		Correction Completed 03/11/2015
Reviewed I State Agen	cy GI	viewed E PN/kfd viewed E	-	Date: 03/30/20	15	ature of Su	15	425			Date: 0 Date:	3/20/2015
Reviewed I CMS RO	By Re	viewed E	y	Date:	Sign							

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245409	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/20/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
M	APLE MANOR NURSING AND REHA	B, LLC	1875 19TH STREET NORTHWE ROCHESTER, MN 55901	EST

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).

(Y4) Item		(Y5)	Date	(Y4) Item	(Y5) [Date	(Y4)	ltem		(Y5)	Date
ID Prefix			Correction Completed 03/11/2015	ID Prefix		Co	orrection ompleted / 11/2015		ID Prefix			Correction Completed 03/11/2015
	483.35(i)			Reg. # LSC	483.35(h)	;			Reg. # LSC	483.60(c)		
LSC				LSC					L30			_
			Correction									
ID Prefix	F0466		Completed 03/11/2015									
	483.70(h)(1)		-									
LSC				_								
Reviewed	Ву	Reviewed	Ву	Date:	Signature of	Survey	yor:				Date:	
State Agen	су											
Reviewed	Ву	Reviewed	Ву	Date:	Signature of	Survey	yor:				Date:	
CMS RO												
Followup	to Survey Con	-	1:		Check for any Ur Uncorrected D	orrec	cted Defici	ienci S-256	es. Was a	Summary of the Facility?		
	1/30/	2015		1	Unconcelled D	Choice		J-2J(the racinty?	YES	NO

		AND HUMAN SERVICES		FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		D. 0938-0391 TE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:			MPLETED
		245409	B. WING _		R 3/ 20/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	20/2013
	ANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 COMMENT	rs	{F 000	D}	
	completed on Marc certification tags tha found on the CMS2 that were not found	ification revisit (PCR) was h 18, 19 & 20, 2015. The at were corrected can be 567B. Also there are tag/s corrected and/or new tags time of onsite PCR which are 52567.			
	signature is not req				
{F 282} SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility will be conducted to untial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	{F 28;	2}	4/17/15
	must be provided b	led or arranged by the facility y qualified persons in Ich resident's written plan of			
	by: Based on interview facility failed to ens	NT is not met as evidenced and document review, the ure the plan of care was esidents (R38, R32) reviewed entions.		Tag F282 Services by Qualified Person/Per Care Plan Maple Manor Nursing & Rehab, LLC develops an interdisciplinary plan of care for each resident based on a	
LABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed

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.

03/31/2015

PRINTED: 05/12/2015

	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
				G		3
		245409	B. WING			20/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
MAPLE N	MANOR NURSING AN	ND REHAB, LLC		1875 19TH STREET NORTHWES ROCHESTER, MN 55901	Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
{F 282}	Continued From pa	age 1	{F 282	2}		
	LACK of OBTAININ	NG WEEKLY WEIGHTS:		comprehensive assessm resident s needs and pro-		
	orders to check we	ders dated 3/19/15, revealed ights Monday, Wednesday,		nursing staff are made av resident s plan of care a	ware of each Ind services are	
	and Friday.			routinely provided that me standards and supports t	he highest	
	3/19/15, revealed a	of resident care plan dated a care plan problem of diet, i intervention to weigh Monday,		practicable level of function well-being. The procedures for comm		
	Wednesday, and F			residents' care needs to t staff were reviewed and f	he direct care	
	dated 3/11/15 to 3/	of facility treatment sheets 18/15, revealed check weights		appropriate. During a ma meeting, the nursing staf	ndatory training f were instructed	
	treatment sheet re	ay, and Friday. However, the vealed no weights were		that the resident care pla followed and that job perf expectations include beir	ormance	
	identified out of 4 t	of facility resident vitals/weights		following the care plan. In reference to personal of	-	
	monitoring reveale	d from 3/11/15 to 3/18/15, no ified out of 4 times possible.		the residents: The direct been instructed to refer to	care staff have	
	According to the sa	ame monitoring, most recent /15 and was checked on		assistance care guides for meeting the residents	or direction on	
	2/25/15.			assistance with personal needs. The nursing assis	tants were	
	of nursing stated th	n 3/20/15, at 8:10 a.m., director ne weights for R38 had been :05 a.m., director of nursing		reminded to pay particula cleaning eyeglasses, rem	noval of facial	
	stated R38 's weig	hts were changed by the nurse)/15, to check weights per		hair, and cleaning/cutting grooming needs of reside were reviewed. Auditing b	ent number 32	
	routine. Director o was to check weig	f nursing stated facility routine hts weekly. Director of nursing		will be monitored to ident grooming needs.	ify any additional	
	Wednesday, and F	to check weights Monday, Friday, according to the Id care plan. Director of		Residents number 38 and been discharged from the In reference to obtaining	e facility.	
	nursing verified we	ights were not checked cian orders, treatment sheet, or		licensed and certified nur been instructed to refer to	sing staff have	
	resident care plan.			orders and unit assistance direction on the frequence weights. The importance	e care guides for y of resident s	

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If continuation sheet Page 2 of 30

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	СОМ	E SURVEY PLETED	
		245409	B. WING _			R 03/20/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2			
MAPLE N	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWE ROCHESTER, MN 55901	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
{F 282}	OUTPUT RECORE R38 had a physicia revealed orders to a and as needed and The order was date Document review of 3/19/15, revealed a elimination. Approx ostomy output ever Document review of dated 3/11/15 to 3/1 to empty colostomy and document output treatment sheets for colostomy output w possible shifts. Doc movement charting 3/18/15, revealed b (colostomy) was do possible shifts. During interview on nursing verified color recorded each shift the facility bowel m assistant document (colostomy) and tree document colostomy of document colostomy of	DED: n orders dated 3/19/15, empty colostomy every shift document output every shift. dot 1/9/15. of resident care plan dated a care plan problem of altered aches included to record y shift. of facility treatment sheets 18/15, revealed staff directed y every shift and as needed out. Document review of or 3/11/15 to 3/18/15, revealed ras documented 12 out of 24 cument review of facility bowel (colostomy) for 3/11/15 to powel movement output bound and the sheets were nursing tation of bowel movements eatment sheets were nursing tation of bowel movements eatment sheet was nurse olostomy output. Director of expected nursing assistants to uput to the nurse and nurse to ny output on the treatment hursing verified the facility nonitoring of R38 ' s colostomy	{F 282	2} weights as instructed or was reinforced with the assistants. The need to weights, monitor weight report weight changes a directs were reviewed w nurses. In reference to monitorin output and weights for re nursing staff have been need to follow the physic monitoring output and w who require monitoring and physician order will be tr changes to weight and of facility s monitoring and procedures were discus staff instruction/education Compliance with care pl assistance with personal weights, reporting of we monitoring output, will b Director of Nursing/design random observation and one month. Compliance at the next Quality Asset Assurance Committee m Completion Date: April	certified nursing assure timely changes, and is the physician ith the licensed ng colostomy esidents: The instructed on the cian s orders for reights. Residents and output by racked for putput. The d documentation sed as part of the on process. ans addressing l cares, obtaining ight changes, e monitored by the gnee through d record review for will be reviewed ssment and neeting.		
	Document review of	f facility Care Plan policy					

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245409	B. WING _		R 03/20/2015	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ND REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
{F 282}	reviewed dated 2/2 the care plan was, multi-disciplinary, o which provides a w needs of each resis LACK OF NAIL AN R32's facility admis diagnoses that incl dementia with Lew generalized muscle R32's quarterly Mir 1/9/15 indicated wa impaired with diagr required extensive living that included dressing and hygie R32's current care facility on 3/18/15 a indicated R32 was of daily living howe when, how, and by assistance would b indicated the R32 o directed staff to re- time to provide neo During an observat R32 had very long contracture caused indentations on the was not cleanly sha above the upper lip stated he liked to b During an interview nursing assistant (If fingernails and had a shave and finger declined. NA-A exp became agitated w	2015, indicated the purpose of "To provide a comprehensive plan of care porking tool that addresses the dent." D FACIAL HAIR GROOMING: asion record indicated R32 had uded but was not limited to y bodies, diabetes, and e weakness. nimum Data Set (MDS) dated as moderately cognitively noses of dementia, and assist with activities of daily eating, toileting, transfers, ne. plan was provided by the and reviewed. The care plan extensive assist with activities ver, lacked direction to staff whom grooming and hygiene be provided. The care plan also could be resistive to cares and approach R32 at a different essary care. tion on 3/18/15 at 11:55 a.m., soiled fingernails. Left hand d finger nails to leave e palm of the hand. R32 also aven; had long facial hair o and on chin and neck. R32	{F 28	2}		

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		AND HUMAN SERVICES		F	TED: 05/12/2015 ORM APPROVED NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3	B) DATE SURVEY COMPLETED
		245409	B. WING		R 03/20/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/20/2010
MAPLE	MANOR NURSING AN	ID REHAB, LLC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
{F 282} {F 312} SS=D	R32 continued to h facial hair. R32 ' s nursing note 3/18/15; notes did r refused cares or fu made to provide hy A facility policy on p assistance was not 483.25(a)(3) ADL C DEPENDENT RES A resident who is u daily living receives	ion on 3/19/15, at 8:51 a.m. ave long soiled nails and had es were reviewed from not indicate resident had rther attempts or offers were giene assistance. providing grooming/hygiene provided. CARE PROVIDED FOR	{F 282 {F 312		4/17/15
	by: Based on observative review, the facility f grooming needs for had soiled fingerna Findings included: R32's facility admiss diagnoses that included ementia with Lewy generalized muscle R32's quarterly Min 1/9/15 indicated was impaired with diagn required extensive	imum Data Set (MDS) dated is moderately cognitively ioses of dementia, and assist with activities of daily eating, toileting, transfers,		Tag F312 ADL Care for Dependent Residents Maple Manor Nursing & Rehab, LLC ensures that all residents who are una to carry out activities of daily living rec the necessary services to maintain go nutrition, grooming, and personal and hygiene. Resident 32 identified as needing assistance with personal care is curre receiving assistance according to the individualized plan of care. Nursing st are auditing residents for grooming ne and nail care. During the next CNA/Nurses meeting	eive od oral ntly taff eeds

Facility ID: 00916

						0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED R	
		245409	B. WING		03/	20/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ND REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 312}	R32's current care facility on 3/18/15 a indicated R32 was of daily living howe when, how, and by assistance would b indicated the R32 of directed staff to re- time to provide neo During an observa R32 had very long contracture caused indentations on the was not cleanly sha above the upper lip stated he liked to b During an interview nursing assistant (fingernails and had a shave and finger declined. NA-A exp became agitated w NA-A stated if a res would be notified. During an observa R32 continued to h facial hair. R32 's nursing not 3/18/15; notes did refused cares or fu made to provide hy A facility policy on p assistance was not	plan was provided by the and reviewed. The care plan extensive assist with activities ever, lacked direction to staff whom grooming and hygiene be provided. The care plan also could be resistive to cares and approach R32 at a different cessary care. tion on 3/18/15 at 11:55 a.m., soiled fingernails. Left hand d finger nails to leave e palm of the hand. R32 also aven; had long facial hair o and on chin and neck. R32 be shaved daily. v on 3/18/15, at 4:11 p.m., NA)-A verified R32 ' s long d facial hair. NA-A offered R32 nail care however, R32 blained R32 sometimes vith cares and would refuse. sident refused cares a nurse tion on 3/19/15, at 8:51 a.m. have long soiled nails and had res were reviewed from not indicate resident had orther attempts or offers were vgiene assistance. providing grooming/hygiene t provided.	{F 312}	will be in-serviced on the policy & procedures for meeting the resid needs based on the individualized plan. The Director of Nursing/designee perform random audits will be corfor one month to ensure that pershygiene and eating needs are be for those residents requiring assis and are addressed on the care pl Completion Date: April 17, 2015	d care will nducted onal ing met stance	4/17/15

Facility ID: 00916

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		AND HUMAN SERVICES & MEDICAID SERVICES	1		OMB NO.	APPROVE 0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245409	B. WING			7
	PROVIDER OR SUPPLIER	243403	D. Mild	STREET ADDRESS, CITY, STATE, ZIP CO		20/2015
	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
{F 315}	Continued From page 6 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:			5}		
	review, the facility fa comprehensive blac assessment of risks infections (UTIs) wa residents (R23 & R urinary tract infection follow physician or catheterizations and and assess urine or in the sample with s catheterizations. Findings Include: R23's nursing notes record (TAR) were 3/11/15-3/19/15. Nu indwelling catheter and symptoms of in catheter and urine, care had been prov administration recor output had been recor	dder assessment and an s for developing urinary tract as completed for 2 of 3 70) reviewed with recurrent ons and the facility failed to lers for intermittent d failed to monitor, evaluate, utput for 1 of 1 residents (R70) scheduled physician ordered s and treatment administration reviewed from ursing notes did not indicate was being monitored for signs fection, integrity of indwelling and if general maintenance ided. The treatment rd had two different areas that corded; the entries of output d were incomplete. The TAR Is on all daily entries recorded;		Tag F315 Urinary Incontinence Maple Manor Nursing & Reha ensures that a resident does indwelling catheter placed un resident s clinical condition of that catheterization is necess a resident who is incontinent receives appropriate treatmen services to prevent urinary tra and to restore as much norm function as possible. Residen without a catheter receive app care and services to prevent extent possible. According to the updated faci bladder assessment is compl each resident on admission, of with a change of condition, an needed. Residents with risk furinary tract infections will had documented in the progress of the plan of care. According to facility policy, the physician/nurse practitioner is	not have an less the demonstrates ary; and that of bladder nt and act infections al bladder ts with or propriate infections to lity policy, a eted for quarterly, nd as actors for ve this notes and in	

Facility ID: 00916

	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II 7	TIPLE CONSTRUCTION		0938-039	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED	
			A. BOILDI		F	3	
		245409	B. WING			03/20/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1875 19TH STREET NORTHWEST			
MAPLE	MANOR NURSING AN	ID REHAB, LLC		ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
{F 315}	Continued From pa	ige 7	{F 31	5)			
	R23's quarterly Min 3/20/15 indicated n Brief Interview for M 13, was dependent living (ADLs) of bec and personal hygie included but was no hypertension, diabe an indwelling urinar disease index repo diagnoses of neuro R23's current care 3/19/15 included th indwelling catheter monitor for signs ar (included decrease indwelling catheter, collection bag every placement of draina drainage system, a R23's current physi facility included a 2 measure output every every month on the R23's physician or catheter size, reten cleaning maintenar checking catheter p failed to address ris use of indwelling Fo	imum Data Set (MDS) dated o cognitive impairment with a Mental Status (BIMS) score of on staff for activities of daily d mobility, eating, toilet use, ne, had diagnoses that ot limited to heart failure, etes, hemiplegia, and required ry catheter (the facilities rt indicated R23 had		 when a resident is exhibiting symptoms. The nursing staff urinary tract symptoms, notifiphysician/nurse practitioner, medical/nursing interventions on the effectiveness of the treatments/interventions is de According to facility policy, w resident requires intermittent catheterization or has an inducatheter, the output is docum medical record. Indwelling cathung/placed below the level of and off of the floor with the tu arranged to avoid kinking or catheter bags are placed in a cover. A bladder scan is pert to/after an in and out catheter perameters ordered by the physician/nurse practitioner. of the scan and the output ar documented in the medical record. At the mandatory meetings, the assistants will be reinstructed placement of the urine collect covering the bags to maintain dignity, and documenting out licensed nurses will be instrut facility s policy and procedu 	document cation of the and any s. Follow up ocumented. hen a in and out welling hented in the theters are of the bladder bing pulling. All a pouch formed prior rization with The results e ecord. When eterized, the medical the nursing d on tion bags, n resident put. The cted on the		

Facility ID: 00916

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	COF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPI I			0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
						F	3
		245409	B. WING _			03/2	20/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC		-	375 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE
{F 315}		tenance) should be in the care	{F 31	5}	effectiveness of nursing/medical		
	 plan. RN-A stated bladder assessments were performed quarterly. During an interview on 3/19/15, at 9:50 a.m., RN-B explained catheter care entailed nurses changing the catheter once per month and aides emptied and measured the urine. RN-B further 				interventions, following the physiciar orders for intermittent catheterization intervals, and notifying the physician large residual amounts.	n	
	explained aide staff was a concern with During an interview RN-C explained ca collection bag once collection bag with applied, and new ca	f would alert nurses if there			Resident number 23 The resident bladder function (has indwelling suprapubic catheter due to a neurog bladder) was reassessed by a regist nurse including an assessment of th resident s risk of urinary tract infect The care plan has been reviewed ar revised accordingly.	genic tered ne tions.	
	During an interview nursing assistant (N entailed; cleaning th	e per week, but I ' m not sure." on 3/19/15, at 9:58 a.m., NA)-B explained catheter care he collection bag with vinegar be with every incontinent			Resident number 70 was discharged the facility on March 23, 2015. The Director of Nursing/designee wi		
	bowel episode. In re often do you check patency?" NA-B sta checked at the beg with each incontine During an interview director of nursing (monitoring should h TAR, and the aides	nd cleaning the tube with every incontinent owel episode. In response to the question, "How ften do you check the tubing for kinks to ensure atency?" NA-B stated the catheter bag was hecked at the beginning and end of the shift and vith each incontinent episode. During an interview on 3/19/15, at 10:30 a.m. irector of nursing (DON) stated output nonitoring should have been recorded on the AR, and the aides should be providing cleaning			perform random audits through observation and record review for or month to ensure catheterization pro- is followed, that residents with symp of urinary tract infection have approp documentation and follow up, and the bladder assessments are completed scheduled.	ne tocol otoms priate nat	
	familiar with routine patency. Facility policy, phys did not instruct staf with vinegar, if it sh should be cleaned should be changed According to the Ce	DN explained she was not e checking catheter tubing for ician orders, and the care plan f to clean the collection bag ould be cleaned, how often it or how often the collection bag enters for Disease Control and article in regards to Guideline			Completion Date: April 17, 2015		

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		AND HUMAN SERVICES				FORM	D: 05/12/2015 MAPPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY MPLETED
		245409	B. WING			03/20/2015	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COE	-	
MAPLE	MANOR NURSING AN	ID REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 315}	infections 2009." F catheter and collect routine hygiene is a meatal surface durf showering). Routine antimicrobial solution is not recommende R70's quarterly Min 2-10-15 revealed R indicating intact coor assistance to meet required limited assist was intermittently of R70's record review bowel and bladder comprehensive UT R70 had a current I R70's current care 3/19/15 indicated F and gave staff direct plan indicated resid deficit and directed in a shift. Care plar diagnosis of hypert hyperplasia (enlarg and required interm directed staff to per catheterization as of include the physician's included diagnoses Lewy bodies, hyper the bladder making	atheter-associated urinary tract Recommends, "Keep the ting tube free from kinking, appropriate (cleansing of the ing daily bathing or e installation of antiseptic or ons into urinary drainage bags ed." himum Data Set (MDS) dated 70 had a BIMS score of 13 gnition, required extensive personal hygiene needs, sist to meet toileting needs and cauterized. W lacked a comprehensive assessment and a I risk assessment even though history of UTIs. plan provided by the facility on 870 occasionally refused cares ction to chart refusals. Care lent was at risk for fluid volume staff to report no urine output n also indicated R70's onic bladder, benign prostatic led prostate) with obstruction, nittent catheterization and	{F 3	15}			

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		AND HUMAN SERVICES			FORM): 05/12/2015 APPROVED). 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT COM	TE SURVEY MPLETED
		245409	B. WING			R / 20/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 315}	prostatic hyperplasi enlargement of the difficult to pass urin Signed physician's included in and out (Cath) every four ho cath for retention/di and "ok to bladder s cath if scanned am centimeters (cc). R70's treatment addi indicated scheduled a.m., 5:00 a.m., 9 a 9:00 p.m. However, cath was completed The Maple Manor E 2015 indicated I and amount of outputs r catheterization. How scan was not comp The bladder scan s 3-11-15 to 3-17-15 cathed a total of 31 There were 12 time procedure resulted and 8 times collecti above. At no point of to 3-17-15 document and O cathed every orders or a reason completed.	ia (BPH which is an prostate) making it more ne. orders dated 12/19/14 (I and O) catheterization ours scheduled, may I and O iscomfort as needed (PRN) scan prior to I and O and hold ount is less than 200 cubic ministration record (TAR) d I and O cath times were 1:00 a.m., 1:00 p.m., 5:00 p.m., and , the documentation to indicate	{F 315	5}		

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245409	B. WING	G		R	
	PROVIDER OR SUPPLIER	243409		STREET ADDRESS, CITY, STATE, ZIP COI		8/20/2015	
	MANOR NURSING AN	ID REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
{F 315}	cups [480 cc] of uri On 3/18/15 at 3:33 verified R70's TAR cath times were 1:0 p.m., 5:00 p.m., an documentation to in completed was ince expected the staff the know, if R70 was rest order if R70 was rest DON stated the facility short order if R70 was rest DON stated it looke catheterized every be a more approprind DON stated there we nurses ' progress to being catheterized comprehensive boar and the risk for UT completed for R70 comprehensive ass complete summary reviewing the record the resident and the why the resident was stated she just made completed and did see if they were co she delegated these coordinator to com should have made complete the comp Bowel and bladder stated parameters	can hold 1.5 [360 cc] to 2		}			

Facility ID: 00916

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CO	MPLETED
		245409	B. WING _		03	R 8/ 20/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ID REHAB, LLC				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
{F 315}		-	{F 315	5}		
		er did not have parameters of lent for high urine output.				
	On 3/19/15 at 8:56 a.m. the DON stated nobody should be cathed for 1000 cc or more at a time and stated she has heard the comment a couple					
	times form the nurs could not pull that r	ses they were not aware they nuch urine at a time. The DON				
	appropriate cathete looking look at doin	to be assessed for er use and stated we should be ig something different for R70				
	cannot keep up wit schedule, the facilit	much urine and the staff h the every four hour y needs to look at this and I				
	assessment. The D	rd to the provider for OON stated pulling 1000 cc of aff could cause hypotension,				
	bladder spasms an be that full. The DC	d stated his bladder should not DN stated staff is not assessing being pulled and reporting				
	practitioner (CNP)-, per his physician or	p.m. the certified nurse A stated staff need to cath R70 rder and stated if R70 refused eed to report it to the charge				
	nurse and educate refusals. CNP-A sta a problem for R70	the resident and family on the ated she was unaware this was and stated if he refused to be ving this high of urine output				
	the facility needed to catheter for this res 1300 cc of urine wa	sident. CNP-A stated pulling off as a huge amount and stated ential for harm to the resident.				
	CNP-A stated she e refused to be cathe staff was pulling off	expected to be notified if R70 ed three times in a row or if the over 750 cc three times in a would need to be addressed.				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
						7
		245409	B. WING	 	03/2	20/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE N	MANOR NURSING AN	D REHAB, LLC		875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 315}	urine outputs. On 3/19/15 at 3:09 (LPN)-A stated R70 shift. LPN-A stated depending him on v and documented th (Maple Manor Blade stated R70 would o scanned and just w stated he documen book and the nurse the book is she war LPN-A stated he wor (communication to the nurse practition below 200 cc. LPN- turn in a report on F the CNP didn't have he would notify the anything under 200 reported any high u On 3/20/15 at 9:42 (LPN)-B stated she a day on her shift. L times R70 was cath time and three time at one time between nurse practitioner s the high urine output The facility did not h catheterization.	p.m. licensed practical nurse was cathed two times on his he bladder scanned R70 what his urine outputs were e urine output on the sheet der Scan Sheet). LPN-A ften refuse to be bladder anted to be cathed. LPN-A ted R70's urine output in the practitioner could look at it in need to see R70's outputs. build fill out an SBAR the provider of a concern) for er when R70 had urine output A stated we are not going to R70's urine outputs weekly as a time for that. LPN-A verified CNP of low urine output cc but stated he has never rine outputs to the CNP. a.m. licensed practical nurse usually tried to cath R70 twice .PN-B stated there were five hed for over 1000 cc at one s R70 was cathed for 1000 cc n 3-11-15 and 3-17-15 and the hould have been informed of it.	{F 3			4/17/15
SS=D	IN KANGE OF MU	HUN				

Facility ID: 00916

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PRINTED: 05/12/2015

STATEMEN	F OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		245409	B. WING	····	R 03/20/2015
NAME OF	PROVIDER OR SUPPLIER	240400		STREET ADDRESS, CITY, STATE, ZIP CO	
MAPLE	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETIO
{F 318}	Based on the comp resident, the facility with a limited range appropriate treatme range of motion and decrease in range of	orehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further of motion.	{F 318	3}	
	by: Based on observative review, the facility frand risks of continu- services for 1 of 3 m ROM services. Findings included: R32's facility admiss diagnoses that inclu- dementia with Lewy side), diabetes, and weakness. R32's quarterly Min 1/9/15 indicated wai impaired and requir activities of daily live toileting, transfers, R32 's current care facility on 3/18/15 a indicated R32 was of daily living, had to degenerative joint of had a right hand coo during the night; R3 required a mechani- plan identified R32 included intervention	NT is not met as evidenced ion, interview, and document ailed to assess the benefits ing ROM (range of motion) esidents (R32) reviewed for sion record indicated R32 had uded but was not limited to v bodies, hemiplegia (right d generalized muscle imum Data Set (MDS) dated s moderately cognitively red extensive assist with ing that included eating, dressing and hygiene. e plan was provided by the nd reviewed. The care plan extensive assist with activities he potential for pain related to lisease and limited mobility, ntracture and utilized a splint 62 did not ambulate, and cal lift for transfers. The care had resistive behaviors that ns to prevent or minimize e plan also indicated R32 had		Tag F318 Range of Motion R32 was evaluated by therap set-up for active/ passive RO as tolerated. Other residents benefit from a range of motio will be assessed for referral in interdisciplinary care conferent schedule. In addition to when positioning and appropriate m assessment, therapies are ever range of motion programs to enhance residents well-bein residents transition from activi interventions, staff will be trail ongoing maintenance. Nursing management or desires ponsible for monitoring by monthly audits. Completion Plan Date: April	M program who may n program n the nce elchair nechanical lift valuating for maintain or ng. As ve PT and OT ned for gnee will be random

Facility ID: 00916

		AND HUMAN SERVICES				FORM	05/12/2015 APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	COM	E SURVEY PLETED
		245409	B. WING _				R 20/2015
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	•	
MAPLE	MANOR NURSING AN	ID REHAB, LLC			19TH STREET NORTHWEST HESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 318}	indicated on the MI facility 's disease in R32 's care plan al and exercise progra discontinued. The or refuses and become (even when he has maintenance caress resident and staff in plan did not indicate exercise program w The only document displayed disruptive program was enter 5/2/14; the note real extremity] exercise dailysupine exerci Resident refuses, b kicking, biting, etc.) A referral to physical comprehensive ass appropriateness of place and/or an ass ongoing treatment or slow decline of n medical record. The indicated the physic consulted ROM pro- been discontinued. not be found in the family members we risk/benefits for cor ROM/exercise prog During an interview physical therapist a had not received ph services for ROM s	osis of Parkinson 's was not DS, physician 's orders, or the ndex report for this resident. Iso revealed a range of motion am had been in place and was care plan read, "Resident res abusive when attempted agreed to ROM) to perform with this resident puts the n harm 's way." The care e a date when ROM or vas discontinued. ration that indicated R32 e behaviors or refusal of ROM ed into a nursing note on ad, "Seated bilateral L.E. [lower s, 5 reps [repetitions] ises 10 x [times] daily. becomes agitated (hitting, continue to encourage. al therapy (PT) or a sessment to determine the program that had been in sessment to determine and or interventions to prevent nobility was not found in the ere was no documentation that cian had been notified or ogram/exercise program had Furthermore, evidence could medical record resident and ere given education of ntinuing or discontinuing	{F 31	8}			

Facility ID: 00916

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		AND HUMAN SERVICES				FORM	: 05/12/2015 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	CON	E SURVEY IPLETED R
		245409	B. WING	i			n 20/2015
NAME OF I	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MAPLE I	MANOR NURSING AN	ID REHAB, LLC			1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{F 318}	During an interview doctor of physical the resident displayed he difficulties with reside ROM/exercises we determine if the bell discomfort, if the ex- correctly, if the time refusals or behavior should just not be con- attempting to detern refusing or displayin look at the reason where accommodate the re- department should physical therapy de status of the ROM s a collaborative effi During an interview director of nursing one nursing note in refusal by R32 to p- program. DON state than likely disconting reevaluating what the the program were to been completed to and if the resident re physical therapy." According to the far 3/11/15 it read, "of benefit from range assessed for referred	ROM services in the last year. on 3/19/15, at 1:34 p.m. herapy (DPT)-A explained if a behaviors or nursing had dents performing would look at the program to haviors were a result of cercises were being performed of day was a factor for rs. DPT-A stated the program discontinued without mine why the resident is ng behaviors. "We want to why and what is going on ptions." DPT-A stated evised and designed to resident and the nursing communicate with the partment with concerns and programs. DPT-A stated, " It ' fort." on 3/19/15, at 2:00 p.m. (DON) stated there was only the medical record regarding articipate in ROM/exercise ed, "the program was more nued without determining or he cause of behaviors during the physician should have attempt root cause analysis needed to be referred to cility's plan of correction dated of motion programs will be al in the interdisciplinary care le. The facility is in the process	{F 3	18			

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		AND HUMAN SERVICES			FORM	: 05/12/2015 APPROVED . 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	CON	E SURVEY IPLETED	
	245409		B. WING			R 03/20/2015	
NAME OF F	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
	IANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIZ TAG) BE	(X5) COMPLETION DATE	
{F 318} {F 323} SS=D	be responsible for r audits" The facility provider ROM programs we completed was per 3/11/15 and 3/18/19 had not been perfo The facility provider however, the guide need for ROM serv assessment or eva when to make outs occupational therap programs would be monitor and track p resident who would 483.25(h) FREE OF HAZARDS/SUPER The facility must er environment remain as is possible; and	IDEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) d From page 17 {F 318} nursing management or designee will nsible for monitoring by random monthly {F 318} ty provided a random audit to ensure grams were being addressed and d was performed by the facility between nd 3/18/15; an audit pertaining to R32 een performed. ty provided a range of motion guideline the guideline did not include: how the ROM services would be identified, when ent or evaluation would be conducted, make outside referrals to physical or onal therapy, under what circumstances is would be discontinued, and how to ind track progress or decline of the who would receive ROM services. Si SUPERVISION/DEVICES {F 323} ty must ensure that the resident ent remains as free of accident hazards sible; and each resident receives r supervision and assistance devices to {F 323}		4/17/15			
	by: Based on interview facility failed to ens assessment for 2 o reviewed in the san Findings included: R58 sustained an u	NT is not met as evidenced v and document review, the ure a comprehensive fall f 3 residents (R58, R43) nple for falls. unwitnessed fall on 3/15/15 ergency room visit to rule out		Tag F323 Accidents Maple Manor Nursing & Rehab, LL provides an environment as free o accident hazards as is possible an	f		

Facility ID: 00916

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		PLETED
		245409	B. WING			R 20/2015
NAME OF	PROVIDER OR SUPPLIER	240400		STREET ADDRESS, CITY, STATE, ZIP CODE		20/2015
	MANOR NURSING AN	D REHAB. LLC		1875 19TH STREET NORTHWEST		
				ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
{F 323}	Continued From pa	ae 18	{F 32	3}		
. ,	hip and/or pelvic fra assess/evaluate the and determine and place to prevent or	acture. The facility failed to e fall for root cause analysis put ongoing interventions in minimize risk for further falls. ecord indicated R58 was	[1 02.	resident has adequate supervis assistance devices to prevent a accidents. A comprehensive fall risk asses	voidable	
	admitted to the faci diagnoses that inclu dementia, depressi stroke.	lity on 11/6/13 and had uded but were not limited to ve disorder, and history of imum Data Set (MDS) dated		completed on all residents on a with a change of condition, and needed. The care plan identified factors and interventions that a to prevent avoidable falls. If a r	dmission, as es risk re initiated	
	3/20/15 indicated so with a Brief Intervie score of 2, displaye behaviors 1-3 days assist of two staff m	evere cognitive impairment w for Mental Status (BIMS) d physical, verbal, and other per week, required extensive nembers for bed mobility, personal hygiene, and		does have a fall, incidents are r IDT meetings. Referrals are ma interventions are initiated as ap The plan of care is reviewed an accordingly.	eviewed in ide and propriate.	
	required extensive ambulation. The MI not steady and only assistance with tran when standing, and	assist of one staff for DS further indicated R58 was able to stabilize with staff nsfers, walking, turning around I moving from a seated ng position. The MDS also		Fall assessments for resident 5 were completed and referrals n policy and procedure for accide was reviewed. At the Nurses meetings on Apri 2015 the staff was in-serviced a	nade. The nts/falls I 2nd & 3rd	
	revealed the reside of bowel and bladd the last assessmen receiving therapies	nt was frequently incontinent er, had sustained 2 falls since it period, and was not or nursing restorative		re-educated on the policy and p for fall risk assessments and in implementation.	rocedure tervention	
	facility indicated R5 antidepressant med	care plan provided by the 8 was at risk for falls related dication. The care plan the following interventions to		The Director of Nursing and/or will monitor for compliance for t weeks.	he next 4	
	prevent or minimized care plan was revised chair to prevent slipp plan updated to toiled (later revised on 12 hours while awake, and nights to toilet a	e the risk for falls; on 11/10 /14 ed to add Dycem in wheel oping out, on 12/1/14 toileting et every one hour while awake /17/14 to prompt every 2 evening to toilet at 10:00 p.m. at 6:00 a.m., on 1/7/15 care include a perimeter mattress		Completion Date: April 17, 201	,	

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		B. WING			R / 20/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03	20/2013
	MANOR NURSING AN	ND REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
{F 323}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 to define the edge of the bed. The care plan did not reflect revision or review after R58's last fall on 3/15/15. R58's most current physician's orders obtained from the facility on 3/19/15 included Imdur (cardiac medication) 30 milligrams (mg) once a day, Zoloft (anti-depressant) 25 mg once per day before bed, and Metoprolol (blood pressure medication) 12.5 mg twice per day. R58's last fall risk assessment was completed on 2/11/15 and indicated high risk for falls. The summary note read, "29 fall risk scorealert with confusion. Staff anticipates needs, multiple falls secondary to unassisted self- transfer. Due to cognition. Redirection is poorly to not retained." R58's fall incident report dated 3/15/15 indicated R58 was found on the floor at 7:15 p.m. shortly after family had left. The incident report indicated the fall was unavoidable do to "informed decisions not to follow safety recommendations, impulsive, poor judgement, agitated, and physically abusive." The report also indicated the R58 was alert to person, forgetful, and confused. However, the BIMS score was a 2 taken at the time of the quarterly MDS on March 20, 2015 indication marked confusion. A facility policy events/accidents/incidents last reviewed in February 2015 read, "The unit manager/licensed nurse are responsible for reviewing the occurrence for risk factors and the initiation of appropriate interventions, beginning the follow up investigation as appropriate for each		(F 32	23}		
	the follow up inves resident involved sustained an injury have a full set of vi incident and every observe resident c habits that could be					

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		0938-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .			IPLETED
		245409	B. WING				R 20/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE MANOR NURSING AND REHAB, LLC					875 19TH STREET NORTHWEST COCHESTER, MN 55901		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
{F 323}	Continued From pa	ge 20	{F 3	23}			
		nt's care plan should be					
		d with information pertinent to interventions, fall risk					
		reviewed." The policy also form an investigation as well					
	as implementing im	mediate interventions.					
{F 329} SS=D	483.25(I) DRUG REGIMEN IS FREE FROM		{F 3:	29}			4/17/15
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above.					
	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	chensive assessment of a must ensure that residents antipsychotic drugs are not inless antipsychotic drug ry to treat a specific condition documented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	by:	NT is not met as evidenced ion, interview and document			Tag F329		

PRINTED: 05/12/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/12/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		245409	B. WING	ì		03/20/2015	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE N	MANOR NURSING AN	D REHAB, LLC			875 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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 329}	Continued From pa	-	{F 3	29}			
	effects monitoring v side effects for the medications for 1 o received Seroquel a Findings Include: R68 received an an (Seroquel) and was side effects. R68's Medication A for 3/1/15 through 3 including psychosis anxiety state and un indicated R68 was evening; Remeron bedtime. R68's MAR or treat	f 5 residents (R68) who an antipsychotic medication. htipsychotic medication a not monitored for possible dministration Record (MAR) 3/31/15, listed R68's diagnoses , dementia, depression, rinary retention. The MAR also on Seroquel 12.5 mg every (antidepressant) 15 mg at ment sheet for 3/1/15 through ude monitoring for side effects			Unnecessary Drugs Maple Manor Nursing & Rehab, LL assures that each resident s drug is free from unnecessary drugs. The resident s drug regime is reviewed staff, physician and consultant phat to assure that medications are not excessive doses, for excessive dur without adequate monitoring, without adequate indications, or in the press of adverse consequences. The medication review includes monito unnecessary duplicate therapy. The policies related to completion of Abnormal Involuntary Movement S assess (AIMS) for adverse effects antipsychotic medications. AIMS assessments will continue to be do monthly for three months and then six months.	regime d by the rmacist used in ration, but sence ring for of the cale to of	
	risk for falls related use. Interventions in orders. However, si medications in relat and were not specif monitored. R68's care plan dat symptoms of "some about [R68] and is o included "nurse to a ordered and monito care plan did not given the second care plan did not given the second sec	d 1/27/14 indicated R68 was at to psychotropic medication nclude giving medications per de effects of psychotropic tion to falls were not identified fically planned to be ed 4/24/14, identified behavior e paranoia of people talking easily angered." Approaches administer medications as or possible side effects." The ve directions on monitoring rget behavior and it did not			During the consultant pharmacist monthly medication audits and the quarterly care planning process, th resident s medications will continue reviewed to assure that the resider receiving the lowest effective medi- dose with appropriate indications a monitoring. Other residents who ar prescribed antipsychotic medication be observed for targeted behaviors physical side effects and reviewed quarterly as well. Resident number 68 The AIMS assessment was completed Febru	e ue to be nt is cation .nd re ns will s and	

Facility ID: 00916

If continuation sheet Page 22 of 30

STATEMENT	OF DEFICIENCIES DF CORRECTION	KANNERS KANNERS		IPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED R 03/20/2015		
		245409	B. WING _					
	PROVIDER OR SUPPLIER	ID REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE		
{F 329}	identify specific sid medications to be r On 3/19/15 at 10:5- (LPN)-C stated he behaviors for the us effects. LPN-C veri administration reco monitoring of possi Seroquel. On 3/19/15 at 11:49 (DON) stated her e effects staff was to in the specific resid should be monitore in the care plan for R68 received an ar (Seroquel) and was side effects. The facility's Antips dated 3/2015 read, and report any of th Attending Physicia hypotension; c. Lig e. Blurred vision; f. retention; h. Increa (atropine psychosis Akathisia [Akathisia characterized by in inability to sit or stat is a movement disc contractions of you result in twisting an Tremor [A tremor is rhythmic, muscle c involving oscillation	e effects of psychotropic	{F 32\$	 2015; no adverse reactions psychotropic medication we The care plan was updated target behaviors justifying u and to reflect monitoring for The nursing staff will contin document observed target I monitor for any physical sid The Director of Nurses/des Consultant Pharmacist will monitor for compliance with side effect monitoring, behadocumentation, and duplicat therapy during the routine or reviews and more often if in Completion date: April 17, 2 	ere observed. to identify the lse of Seroquel r side effects. ue to behaviors and e effects. ignee and the continue to a antipsychotic avior related ate drug juarterly record ndicated.			

If continuation sheet Page 23 of 30

	-	AND HUMAN SERVICES				FORM	APPROVED	
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIP			IB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		245409	B. WING			R 03/20/2015		
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		20/2010	
				1	1875 19TH STREET NORTHWEST			
MAPLE MANOR NURSING AND REHAB, LLC				F	ROCHESTER, MN 55901			
(X4) ID		TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	~	CROSS-REFERENCED TO THE APPROPI		DATE	
					DEFICIENCY)			
{F 329}	Continued From pa	ao 22	رت مر ا	וחר				
(1 020)		bodily movement. One of the	{F 32	29}				
		ovement disorders,						
	hypokinesia is char	acterized by a partial or						
		uscle movement]; n. Akinesia a/ (a?ki-ne´zhah) absence,						
		control of voluntary muscle						
	movements.]; or tar	dive dyskinesia [Tardive						
		tly irreversible neurological ary movements caused by						
		tipsychotic or neuroleptic						
	drugs.]"							
{F 431}	483.60(b), (d), (e) [{F 43	31}			4/17/15	
SS=E	LABEL/STORE DR	UGS & BIOLOGICALS						
		nploy or obtain the services of						
		ist who establishes a system t and disposition of all						
		sufficient detail to enable an						
	accurate reconciliat	ion; and determines that drug						
		r and that an account of all						
	reconciled arugs is i	maintained and periodically						
		als used in the facility must be						
		ce with currently accepted les, and include the						
	appropriate access							
		e expiration date when						
	applicable.							
		State and Federal laws, the						
		Il drugs and biologicals in						
		nts under proper temperature t only authorized personnel to						
	have access to the							
	The facility must me	wide concretely leaded						
		ovide separately locked, I compartments for storage of						

If continuation sheet Page 24 of 30

PRINTED: 05/12/2015

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION		. 0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			IPLETED	
						R	
		245409	B. WING			03/20/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 1875 19TH STREET NORTH			
MAPLE MANOR NURSING AND REHAB, LLC				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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE	
{F 431} Continued From page 24 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single uni package drug distribution systems in which the quantity stored is minimal and a missing dose be readily detected.		ed in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the inimal and a missing dose can	{F 43	31}			
	by: Based on observat review, the facility fa and discard medical potential to affect th use the medications Findings included: The facilities plan of indicated all medical check for outdated and biologicals and was held that instru- trained medication processing disconti medications and bio insulin vials. However storage concerns we During medication so medication room real a.m. an open vial of with no open date at was observed in the (RN)-B. RN-B verifition on the vial and indice open date located of	ologicals and dating open ver, outdated medications and		and biologicals are re according to accepte The policies for stora were reviewed and for medication storage a for outdated and disc	fanor Nursing & s for 1) safe and safe handling a) of all medications and 3) a system of hat enables periodic on and accounting of tions. The facility authorized under o administer ed and expired drugs outinely discarded ed practice standards. Age of medications ound appropriate. All areas were checked continued ogicals. On a routine ned medication aid		

Facility ID: 00916

If continuation sheet Page 25 of 30

re survey Mpleted R / 20/2015
/20/2015
(X5) COMPLETIO DATE
nc r g

If continuation sheet Page 26 of 30

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 05/12/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT CON	E SURVEY
		245409	B. WING		R 03/20/2015	
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE MANOR NURSING AND REHAB, LLC				875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 431} {F 441} SS=F	potency and inaccu The Latanoprost pa bottle is opened for temperature up 25 for 6 weeks." The facility policy m reviewed February kept on hand after t No food items can refrigerator On a will check both the r carts for expired me dispose per disposa on hand for residen medications not ser of discharge shall b stock and either loc immediately destroy address when to da use of multi-dose vi opening other than 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and o to help prevent the of disease and infect (a) Infection Contro The facility must es Program under whit (1) Investigates, con in the facility; (2) Decides what pr should be applied to	rate test results." rate test results." rate test results." rate test results." rate test results." reckage insert read, "once use, it may be stored at room C [Celsius] (77 F [Fahrenheit]) redication storage policy last 2015, read, "drugs shall not be the expiration date on the label n be stored in the medication weekly basis the night nurse refrigerator and medication edications, remove them and al policyand all medications ts who expire and those nt home with residents at time e immediately withdrawn from ked away separately or yed" The policy did not the when opened especially for als that have expiration after insulin. I CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control	{F 431}			4/17/15

Facility ID: 00916

If continuation sheet Page 27 of 30

		I AND HUMAN SERVICES				APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
		245409	B. WING _			н 20/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1875 19TH STREET NORTHWEST		
MAPLE	MANOR NURSING AN	ND REHAB, LLC		ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
{F 441}	actions related to in (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will the (3) The facility must hands after each d hand washing is in professional practice (c) Linens Personnel must ha	nfections. ead of Infection tion Control Program resident needs isolation to of infection, the facility must t. st prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. st require staff to wash their lirect resident contact for which dicated by accepted	F 44	11}		
	by: Based on observa review, the facility f program to identify included trends and educate staff on pe (PPE) and isolation necessary by the C (CDC). Findings included: During an interview director of nursing not an infection con started. The DON a	NT is not met as evidenced tion, interview, and document failed to develop a surveillance resident infections that d analysis of data and failed to ersonal protective equipment n precautions for R63 if Centers for Disease Control w on 3/19/15, at 3:11 p.m. the (DON) confirmed there was ntrol log for March 2015 also confirmed tracking or ns had not been completed so		Tag F441 Infection Control Maple Manor Nursing & F established and maintains control program designed safe, sanitary, and comfor environment and to preve development of disease a The infection control prog investigates, controls, and infections in the facility 2) appropriate procedures, if	s an infection I to provide a rtable and the and infection. ram 1) d prevents determines the	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		COMPLETED R 03/20/2015	
		245409	B. WING _				
NAME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP			
MAPLE I	MANOR NURSING AN	D 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLETIO DATE	
{F 441}	 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 far for March. The DON reported since 3/11/15 there had been two cases of infections one of them was R63 who had an open hand wound infection. DON stated she thought bacterium causing infection in the hand wound was methicillin resistant staphylococcus aureus (MRSA) and R63 was on isolation precautions. R63's hospital dismissal summary dated 3/13/15 read, " Intraoperative culture data in the past revealed MRSA, and from March 11, 2015, the culture grew staphylococcus aureus and pseudomonas. Infectious disease services at hospital recommended initiation of a two week course of daily Cefepime and Vancomycin (both intravenous (IV) antibiotics). R63's care plan did not address the peripherally inserted central catheter (PICC) which was inserted at the hospital and left in when arrived at the facility to be used for antibiotic therapy or the antibiotic use for the hand infection. The PICC should have care plan directions to protect the site, signs and symptoms of infection, and daily monitoring for patency. During an observation on 3/19/15, at 3:55 p.m. licensed practical nurse (LPN)-C had just completed a dressing change to R63' s hand. LPN-C had gloves on and had not worn a gown even though there were large amounts of bright red bloody drainage from the wound cleansing and dressing were seen on the side of the clear 		{F 44 ⁻	 implemented (such as isol resident with an infectious maintains a record of incid infections and tracks any a actions taken related to inf The facility has comprehener control policies and proceed been reviewed and revised closely reflect the current separatice and the state/fede. The policies address the se investigation of infections are comprehensive records of infections. The revised poly procedures will provide ad guidance to the nursing state and reporting symptoms or infections and documentiner related symptoms. Comprehensive tracking learning have been updated to created for trending and analysis or infection control status and appropriate interventions to other control status and control status and appropriate interventions to other control status and c	disease and 3) lences of alternative fection control. nsive infection dures that have d to more standards of eral regulations. surveillance and and resident licies and ditional aff for identifying f possible g/tracking		
	garbage bag. During an interview stated he had two o wound, but could no R63 stated he had antibiotics. R67 als arm. During an interview	on 3/19/15, at 4:00 p.m. R63 different infections in his ot recall the name of them. 2 different kinds of IV so had a PICC on the right on 3/19/15, at 4:01 p.m., as not aware of what infection		and staff. Personal protect will be provided and direct contact charge nurse for in precautions. Compliance with facility por regulatory requirements w by the Director of Nurses/of through record review and infection control logs and r	ions posted to nformation on plicies and ill be monitored designee audits of the		

Facility ID: 00916

TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATI COM	0938-039 E SURVEY PLETED			
		245409	B. WING _			R 03/20/2015			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		00/20/2010			
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE			
{F 441}	causing bacterium stated R63 was no " how do you know know what the bac LPN-C stated, he u gloves and a mask sure who determine residents with activ During an interview registered nurse (F and was not aware prescribed. RN-B s isolation precaution residents could cor explained the nurse	was in R63 's wound. LPN-C t on isolation. To the question, which PPE to use if you don 't teria were causing infection? " used contact isolation and wore . LPN-C indicated he was not ed isolation precautions for	{F 441	 months and randomly thereat results of the infection control and investigation activities ar monthly as part of the continuin improvement program. Compreviewed during the May quat Assessment and Assurance of meeting and ongoing. Completion date: April 17, 20 	I surveillance e reviewed lous quality bliance will be rterly Quality Committee				

Facility ID: 00916

If continuation sheet Page 30 of 30

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245409	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01		(Y3) Date of Revisit 3/21/2015				
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).

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 03/11/2015	ID Prefix		Correction Completed 03/11/2015	ID Prefix			Correction Completed 03/11/2015
-	NFPA 101		-	NFPA 101		Ū	NFPA 101		
LSC	K0062		LSC	K0144		LSC	K0147		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
	-								
LSC			LSC			LSC			
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix			Correction Completed
Reg. #			Reg. #			Reg. #			
			LSC			LSC			
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix			Correction Completed
Reg. # LSC			Reg. #			Reg. #			
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix			Correction Completed
Reg. # LSC			Reg. # LSC			Reg. # LSC			
Reviewed E	By Revi	ewed By	Date:	Signature	of Surveyor:			Date:	
State Agen	cy PS/	/kfd	04/29/20	15	25822				03/21/2015
Reviewed E CMS RO	3y Revi	ewed By	Date:	Signature	of Surveyor:			Date:	
Followup t	o Survey Complet 1/26/2015				/ Uncorrected Defic d Deficiencies (CM			YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on April 29, 2015.

Mr. Karl Swedberg, Administrator Maple Manor Nursing And Rehab, LLC 1875 19th Street Northwest Rochester, Minnesota 55901

Re: Project # S5409025

Dear Mr. Swedberg:

On March 20, 2015, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 30, 2015 with orders received by you on February 13, 2015.

State licensing orders issued pursuant to the last survey completed on January 30, 2015 and found corrected at the time of this March 20, 2015 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on January 30, 2015, found not corrected at the time of this March 20, 2015 revisit and subject to penalty assessment are as follows:

20560 S/S:	MN Rule 4658.0405 Subp. 2 Comprehensive Plan Of Care; Contents 300.00
	MN Rule 4658.0405 Subp. 3 Comprehensive Plan Of Care; Use 300.00
	MN Rule 4658.0520 Subp. 1 Adequate And Proper Nursing Care; General 350.00
	MN Rule 4658.0525 Subp. 2.B Rehab - Range Of Motion 350.00
	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence 350.00
	MN Rule 4658.0525 Subp. 6 B Rehab - Adls 350.00
	MN Rule 4658.0800 Subp. 1 Infection Control; Program 300.00
21535 S/S:	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General 300.00

The details of the violations noted at the time of this revisit completed on March 20, 2015 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Maple Manor Nursing And Rehab, Llc March 30, 2015 Page 2

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$2600.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to:

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

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Maple Manor Nursing And Rehab, Llc March 30, 2015 Page 3

Sincerely,

Kumala Piske Downing

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

cc: Licensing and Certification File Gary Nederhoff, Rochester District Office Survey and Review Unit Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00916	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/20/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
M	APLE MANOR NURSING AND REHA	B, LLC	1875 19TH STREET NORTHWE ROCHESTER, MN 55901	EST

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y	5) Date	(Y4) Item	(Y	5) Date	(Y4) Item	(Y5)) Date
ID Prefix Beg. #	_20570 MN Rule 4658.0405 S	Correction Completed 03/11/2015	ID Prefix	_20800 MN Rule 4658.0510 S	Correction Completed 03/11/2015	ID Prefix Beg. #	_20930 MN Rule 4658.05	Correction Completed 03/11/2015
						U U		-
ID Prefix		Correction Completed 03/11/2015	ID Prefix Reg. #		Correction Completed 03/11/2015 ubp.	ID Prefix Reg. #	_21530 MN Rule 4658.13	Correction Completed 03/11/2015 10 A.B.C
ID Prefix Reg. # LSC	21550 MN Rule 4658.1325 S		ID Prefix Reg. # LSC	21565 MN Rule 4658.1325 S	Correction Completed 03/11/2015 ubp.	Reg. #	21800 MN St. Statute14	Correction Completed 03/11/2015 4.651 Sub
ID Prefix Reg. # LSC	21805 MN St. Statute 144.65	Correction Completed 03/11/2015	ID Prefix Reg. # LSC	21980 MN St. Statute 626.55	Correction Completed 03/11/2015 57 Sul	ID Prefix Reg. # LSC		
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			ID Prefix Reg. # LSC		
Reviewed E State Agend Reviewed E CMS RO	cy GPN	/kfd	Date: 03/30/20 Date:	Signature of S 015 Signature of S	1	5425		nte: 03/20/2015 nte:
Followup t	o Survey Completed of 1/30/2015 M: REVISIT REPORT			Check for any Unc Uncorrected De Page 1 of 1			Ales Fasilia.0	ES NO

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00916	B. WING		F 03/2	₹ 0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN		H STREET N TER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	March, 18, 19 & 20 it was determined of had not been corre- will remain in effect next onsite visit. Al reviewed for possib	rS: visit was completed on , 2015. During this onsite visit one or more licensing order cted. This uncorrected order/s and will be reviewed at the so uncorrected order/s will be ble penalty assessment/s.				
	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

03/31/15

6899

If continuation sheet 1 of 31

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00916	B. WING			R 20/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
MAPLE	MANOR NURSING AN		H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{2 560}	 Plan of Care; Contents comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The con assessment. The con must include the ind required by Minnes subdivision 14, para This MN Requirement by: This uncorrected or will be reviewed at evidenced by: Based on observative review, the facility fit to address a history and Vancomycin-re prevent the spread resident (R38) who Findings include: R38 had a history of plan interventions to and other residents R38 's diagnosis in VRE according to fa sheet dated 1/9/15. C. difficile infection life-threatening. Syn watery diarrhea, thr 	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, <i>y</i> chosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b). ent is not met as evidenced rder/s will remain in effect and the next onsite visit. As on, interview and document ailed to develop interventions <i>y</i> of Clostridium difficile (C-diff) sistant enterococcus (VRE) to of these infections for 1 of 1 had chronic C-Diff and VRE.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00916	B. WING			R 20/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MAPLE I	MANOR NURSING AN		H STREET NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{2 560}	Continued From pa	ige 2	{2 560}			
	dated 1/5/15; revea incontinence and co directed staff to ass ostomy care and to shift. Document re plan dated 3/19/15 related to C-Diff an Document review of dated 3/11/15 to 3/7 have colostomy our staff each shift and of facility bowel mo bowel movements measured each shi colostomy and assi had potential to exp resident to C-diff an During interview on of nursing verified to care plan to address Director of nursing lack of care plan in the initial survey and develop care plan of diagnosis. Document review of reviewed dated 2/2 the care plan was, multi-disciplinary, c which provides a w needs of each reside	a 3/20/15, at 8:10 a.m., director he facility had not developed a s history of C-diff and VRE. verified she was aware the terventions was identified in d stated she would not directions for a history of of facility Care Plan policy 015, indicated the purpose of " To provide a omprehensive plan of care orking tool that addresses the				

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		00916	B. WING			R 20/2015
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
	MANOR NURSING AN		TH STREET NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
{2 565}	Continued From pa	ige 3	{2 565}			
{2 565}	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	{2 565}			
		omprehensive plan of care I personnel involved in the t.				
	by: This uncorrected or will be reviewed at evidenced by: Based on interview facility failed to ens	ent is not met as evidenced rder/s will remain in effect and the next onsite visit. As and document review, the ure the plan of care was residents (R38, R32) reviewed entions.				
	Findings include:					
	LACK of OBTAININ	IG WEEKLY WEIGHTS:				
		ders dated 3/19/15, revealed ights Monday, Wednesday,				
	3/19/15, revealed a	of resident care plan dated care plan problem of diet, intervention to weigh Monday riday.	,			
	dated 3/11/15 to 3/ Monday, Wednesd	of facility treatment sheets 18/15, revealed check weights ay, and Friday. However, the vealed no weights were mes possible.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING.			D
		00916	B. WING			R 20/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLE DATE
{2 565}	Continued From pa	age 4	{2 565}			
	monitoring reveale weights were ident According to the sa weight prior to 3/11 2/25/15. During interview or of nursing stated th discontinued. At 9 stated R38 ' s weig practitioner on 3/10 routine. Director o was to check weigh verified staff were to Wednesday, and F treatment sheet an nursing verified we	of facility resident vitals/weights d from 3/11/15 to 3/18/15, no ified out of 4 times possible. ame monitoring, most recent /15 and was checked on no 3/20/15, at 8:10 a.m., director ne weights for R38 had been :05 a.m., director of nursing ths were changed by the nurse 0/15, to check weights per f nursing stated facility routine hts weekly. Director of nursing to check weights Monday, friday, according to the id care plan. Director of ights were not checked cian orders, treatment sheet, or	e e			
	LACK OF CONSIS OUTPUT RECORI	TENT COLOSTOMY DED:				
	revealed orders to	an orders dated 3/19/15, empty colostomy every shift d document output every shift. ed 1/9/15.				
	3/19/15, revealed a	of resident care plan dated a care plan problem of altered aches included to record ry shift.				
	dated 3/11/15 to 3/ to empty colostomy and document output treatment sheets for	of facility treatment sheets 18/15, revealed staff directed y every shift and as needed out. Document review of or 3/11/15 to 3/18/15, revealed was documented 12 out of 24				

STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00916	B. WING			R 20/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN	1875 19Т	H STREET NO	DRTHWEST		
		ROCHES	STER, MN 559	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
{2 565}	Continued From pa	ige 5	{2 565}			
	movement charting 3/18/15, revealed b	cument review of facility bowel (colostomy) for 3/11/15 to lowel movement output ocumented 17 out of 24				
	nursing verified col- recorded each shift the facility bowel m assistant documen (colostomy) and tree documentation of c nursing stated she report colostomy of document colostom sheet. Director of r	a 3/20/15, 8:10 a.m., director of ostomy output was not a. Director of nursing stated ovement sheets were nursing tation of bowel movements eatment sheet was nurse olostomy output. Director of expected nursing assistants to utput to the nurse and nurse to by output on the treatment nursing verified the facility nonitoring of R38 's colostomy				
	reviewed dated 2/2 the care plan was, multi-disciplinary, c which provides a w needs of each resid LACK OF NAIL AN R32's facility admis diagnoses that include dementia with Lewy generalized muscle R32's quarterly Min 1/9/15 indicated was impaired with diagn required extensive	omprehensive plan of care orking tool that addresses the dent. " D FACIAL HAIR GROOMING: sion record indicated R32 had uded but was not limited to y bodies, diabetes, and weakness. imum Data Set (MDS) dated as moderately cognitively noses of dementia, and assist with activities of daily eating, toileting, transfers, ne.				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COM	FLETED
		00916	B. WING			R 20/2015
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
	MANOR NURSING AN	ID ВЕНАВ Ц.С. 1875 19T	H STREET NO	ORTHWEST		
		ROCHES	TER, MN 5590	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
{2 565}	Continued From pa	ige 6	{2 565}			
{2 830}	when, how, and by assistance would b indicated the R32 of directed staff to re- time to provide neo During an observat R32 had very long contracture caused indentations on the was not cleanly sha above the upper lip stated he liked to b During an interview nursing assistant (N fingernails and had a shave and fingern declined. NA-A exp became agitated w NA-A stated if a rest would be notified. During an observat R32 continued to h facial hair. R32 ' s nursing not 3/18/15; notes did n refused cares or fu made to provide hy A facility policy on p assistance was not Also uncorrected o possible penalty as MN Rule 4658.0520 Proper Nursing Care	ion on 3/18/15 at 11:55 a.m., soiled fingernails. Left hand l finger nails to leave palm of the hand. R32 also aven; had long facial hair and on chin and neck. R32 e shaved daily. on 3/18/15, at 4:11 p.m., NA)-A verified R32 ' s long facial hair. NA-A offered R32 hail care however, R32 lained R32 sometimes ith cares and would refuse. sident refused cares a nurse ion on 3/19/15, at 8:51 a.m. ave long soiled nails and had es were reviewed from not indicate resident had rther attempts or offers were giene assistance. provided. refer/s will be reviewed for sessment/s. 0 Subp. 1 Adequate and re; General general. A resident must e and treatment, personal and	{2 830}			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			R
		00916	B. WING			20/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
MAPLE I	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
{2 830}	Continued From pa	age 7	{2 830}			
	the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	nd preferences as identified in e resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				
	by: This licensing orde Based on observat review, the facility f grooming needs fo	ent is not met as evidenced r was not corrected due to: ion, interview and record failed to meet the assessed r 1 of 3 residents (R32) who ils and long facial hairs.				
	diagnoses that includementia with Lewy generalized muscle R32's quarterly Mir 1/9/15 indicated was impaired with diagr required extensive living that included dressing and hygie R32's current care facility on 3/18/15 a indicated R32 was of daily living howe when, how, and by assistance would b indicated the R32 of	nimum Data Set (MDS) dated as moderately cognitively noses of dementia, and assist with activities of daily eating, toileting, transfers,				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			R
		00916	B. WING			n 20/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MAPLE I	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
{2 830}	Continued From pa	ige 8	{2 830}			
{2 895}	R32 had very long contracture caused indentations on the was not cleanly sha above the upper lip stated he liked to b During an interview nursing assistant (If fingernails and had a shave and fingern declined. NA-A exp became agitated w NA-A stated if a res would be notified. During an observat R32 continued to h facial hair. R32's nursing note notes did not indica or further attempts hygiene assistance A facility policy on p assistance was not Also uncorrected o possible penalty as MN Rule 4658.052 Motion	tion on 3/18/15 at 11:55 a.m., soiled fingernails. Left hand I finger nails to leave palm of the hand. R32 also aven; had long facial hair and on chin and neck. R32 e shaved daily. on 3/18/15, at 4:11 p.m., NA)-A verified R32 ' s long facial hair. NA-A offered R32 hail care however, R32 lained R32 sometimes ith cares and would refuse. sident refused cares a nurse tion on 3/19/15, at 8:51 a.m. ave long soiled nails and had s were reviewed from 3/18/15; ate resident had refused cares or offers were made to provide the provided. rder/s will be reviewed for	{2 895}			
	that is directed tow through positioning implemented and n comprehensive res of nursing services	ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the pursing care plan which				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00916	B. WING	B. WING		R 20/2015
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		1875 191	TH STREET NO	DRTHWEST		
MAPLE	MANOR NURSING AN	ID REHAB, LLC ROCHES	STER, MN 559	01		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO		COMPLET DATE
IAG			IAG	DEFICIENC		
{2 895}	Continued From pa	age 9	{2 895}			
[2 000]		ige o	[2 000]			
	provides that:					
	P. a regident wit	th a limited range of motion				
		te treatment and services to				
		notion and to prevent further				
	decrease in range					
	Ũ					
		ent is not met as evidenced				
	by:	where wet composed due to				
	This licensing orde	r was not corrected due to:				
	Based on observat	ion, interview, and document				
		ailed to assess the benefits				
		uing ROM (range of motion)				
		residents (R32) reviewed for				
	ROM services.					
	Findings included:	sion record indicated D20 had				
		ssion record indicated R32 had uded but was not limited to				
		y bodies, hemiplegia (right				
		d generalized muscle				
	weakness.	3 • • • • • • • • • •				
		nimum Data Set (MDS) dated				
		as moderately cognitively				
		red extensive assist with				
		ing that included eating, dressing and hygiene.				
		e plan was provided by the				
		and reviewed. The care plan				
		extensive assist with activities				
	of daily living, had t	he potential for pain related to				
		disease and limited mobility,				
		ontracture and utilized a splint				
		32 did not ambulate, and				
		ical lift for transfers. The care had resistive behaviors that				
		ons to prevent or minimize				
		re plan also indicated R32 had				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00916	B. WING	B. WING		R 20/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		1875 10	TH STREET NO			
MAPLE	MANOR NURSING AN	ND REHAB, LLC ROCHES	STER, MN 559	01		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	HE APPROPRIATE	COMPLET DATE
				DEFICIENC	Y)	
{2 895}	Continued From pa	age 10	{2 895}			
	medications. Diagr	osis of Parkinson 's was not				
		DS, physician ' s orders, or the	•			
		ndex report for this resident.				
		lso revealed a range of motion	1			
		am had been in place and was				
		care plan read, "Resident				
		nes abusive when attempted				
		agreed to ROM) to perform				
		with this resident puts the				
		n harm ' s way. " The care				
		e a date when ROM or				
	exercise program v					
		tation that indicated R32				
		e behaviors or refusal of ROM				
		red into a nursing note on				
		ad, "Seated bilateral L.E. [lowe	r			
		s, 5 reps [repetitions]	•			
		ises 10 x [times] daily.				
		becomes agitated (hitting,				
) continue to encourage.				
		al therapy (PT) or a				
		sessment to determine				
		the program that had been in				
		sessment to determine				
			+			
		and or interventions to prevent nobility was not found in the	·			
		ere was no documentation that	.+			
		cian had been notified or				
		ogram/exercise program had Furthermore, evidence could				
		medical record resident and				
		ere given education of				
		5				
	ROM/exercise prog	ntinuing or discontinuing				
		v on 3/19/15, at 1:29 p.m.				
		assistant (PTA)-A stated R32				
		hysical or occupational	.			
		services in the last year nor did	1			
		erral to evaluate for ROM services in the last year				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00916	B. WING	B. WING		R 03/20/2015	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S				
		1875 191	TH STREET NO				
MAPLE	MANOR NURSING AN	ID REHAR ITC	STER, MN 559				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
{2 895}	Continued From pa	age 11	{2 895}				
	determine if the be discomfort, if the ex- correctly, if the time refusals or behavior should just not be or attempting to deter refusing or displayi look at the reason and exhaust all o programs can be re accommodate the department should physical therapy de status of the ROM s a collaborative ef During an interview director of nursing one nursing note in	e would look at the program to haviors were a result of xercises were being performed e of day was a factor for ors. DPT-A stated the program discontinued without mine why the resident is ng behaviors. "We want to why and what is going on ptions." DPT-A stated evised and designed to resident and the nursing communicate with the epartment with concerns and programs. DPT-A stated, "It '					
	program. DON stat than likely discontin reevaluating what t the program were.	ted, "the program was more nued without determining or he cause of behaviors during the physician should have d an assessment should have					
	and if the resident physical therapy."	attempt root cause analysis needed to be referred to cility's plan of correction dated					
	3/11/15 it read, "c benefit from range assessed for referr	other residents who would of motion programs will be al in the interdisciplinary care ile. The facility is in the process					
	of developing a res programnursing r						

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _		R	
		00916	B. WING			R 20/2015
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
{2 895}	Continued From pa	age 12	{2 895}			
{2 910}	ROM programs we completed was per 3/11/15 and 3/18/19 had not been perfo The facility provide however, the guide need for ROM serv assessment or eva when to make outs occupational therap programs would be monitor and track p resident who would Also uncorrected o possible penalty as MN Rule 4658.052 Incontinence Subp. 5. Incontine have a continuous management to red unnecessary use o comprehensive res home must ensure A. a resident wi receives appropriat prevent urinary trad	d a range of motion guideline eline did not include: how the rices would be identified, when fluation would be conducted, side referrals to physical or by, under what circumstances e discontinued, and how to brogress or decline of the d receive ROM services. rder/s will be reviewed for sessment/s. 5 Subp. 5 A.B Rehab - nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the sident assessment, a nursing	{2 910}			

Minneso	ta Department of He	alth			FORM	IAPPROVEI
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00916	B. WING	B. WING		R 20/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
		1875 19T	H STREET N	ORTHWEST		
MAPLE	MANOR NURSING AN	ID REHAB, LLC ROCHES	TER, MN 559	901		
(X4) ID			ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLETE DATE
				DEFICIENCY	Y)	
{2 910}	Continued From pa	ige 13	{2 910}			
	This MN Requirem	This MN Requirement is not met as evidenced				
	by:					
		r was not corrected due to:				
		ion, interview and document				
	review, the facility f	alled to ensure a dder assessment and an				
		s for developing urinary tract				
		as completed for 2 of 3				
		70) reviewed with recurrent				
		ons and the facility failed to				
	follow physician or					
		d failed to monitor, evaluate,				
		utput for 1 of 1 residents (R70) scheduled physician ordered				
	catheterizations.	scheddied physician ordered				
	Findings Include:					
	R23's nursing notes	s and treatment administration				
	record (TAR) were					
		ursing notes did not indicate				
		was being monitored for signs				
		nfection, integrity of indwelling and if general maintenance				
		rided. The treatment				
		rd had two different areas that				
		corded; the entries of output				
		d were incomplete. The TAR				
		Is on all daily entries recorded				
	24 hour totals were					
		imum Data Set (MDS) dated o cognitive impairment with a				
		Iental Status (BIMS) score of				
		on staff for activities of daily				
	•	d mobility, eating, toilet use,				
	and personal hygie	ne, had diagnoses that				
		ot limited to heart failure,				
		etes, hemiplegia, and required				
	an indwelling urinar epartment of Health	ry catheter (the facilities				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		DENTITION TON NOMBER.	A. BUILDING: _	A. BUILDING:		
		00916	B. WING			R 20/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
{2 910}	Continued From pa	age 14	{2 910}			
	diagnoses of neuror R23's current care 3/19/15 included the indwelling catheter monitor for signs and (included decrease indwelling catheter collection bag ever placement of draina drainage system, a R23's current physi- facility included a 2 measure output ever every month on the R23's physician or catheter size, reten cleaning maintenar checking catheter p failed to address ris use of indwelling Fe interventions to min R23's medical reco indwelling catheter During an interview registered nurse (Fe catheter care (clear instructions would I notes would address catheter was paten (cleaning and main plan. RN-A stated to performed quarterly During an interview RN-B explained ca changing the cather emptied and mease	plan provided by the facility on the direction to care for that included but not limited to and symptoms of infection and urine output) related to and check and empty urine y shift, apply leg strap, age bag, maintain a closed and change catheter per policy. ician's orders provided by the liter fluid restriction and ery shift, and change catheter a 14th of every month. ders and care plan lacked attion balloon size, frequency of batency integrity. The care plan sk for infection associated with oley catheter with associated mimize risk for infection. assessment. asse				
	was a concern with	f would alert nurses if there the catheter. on 3/19/15, at 9:53 a.m.,				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00916	B. WING	B. WING		R 20/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ID REHABILIC	H STREET NO STER, MN 559			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
{2 910}	Continued From pa	age 15	{2 910}			
	collection bag once collection bag with applied, and new c month. RN-C state collection bag once During an interview nursing assistant (I entailed; cleaning t and cleaning the tu bowel episode. In r often do you check patency?" NA-B sta checked at the beg with each incontine During an interview director of nursing monitoring should I TAR, and the aides of catheter. The DC familiar with routine patency. Facility policy, phys did not instruct staf with vinegar, if it sh should be cleaned should be changed According to the Ce Prevention (CDC) a for prevention of ca infections 2009." F catheter and collec routine hygiene is a meatal surface dur showering). Routin antimicrobial solutio is not recommende R70's quarterly Mir 2-10-15 revealed F	y on 3/19/15, at 10:30 a.m. (DON) stated output have been recorded on the should be providing cleaning DN explained she was not e checking catheter tubing for sician orders, and the care plan f to clean the collection bag hould be cleaned, how often it or how often the collection bag hould be cleaned, how often it or how often the collection bag hatticle in regards to Guideline atticle in regards to Guideline atheter-associated urinary tract Recommends, "Keep the ting tube free from kinking, appropriate (cleansing of the ing daily bathing or e installation of antiseptic or ons into urinary drainage bags				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		00916	B. WING		03/2	20/2015
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST H STREET NC			
	MANOR NURSING AN		TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{2 910}	Continued From pa	ge 16	{2 910}			
		personal hygiene needs, ist to meet toileting needs and auterized.				
	bowel and bladder a	l risk assessment even though				
	3/19/15 indicated R and gave staff direct plan indicated resid deficit and directed in a shift. Care plan diagnosis of hyperto hyperplasia (enlarge and required interm directed staff to per catheterization as o	plan provided by the facility on 70 occasionally refused cares etion to chart refusals. Care ent was at risk for fluid volume staff to report no urine output also indicated R70's onic bladder, benign prostatic ed prostate) with obstruction, ittent catheterization and form intermittent rdered. The care plan did not ans order to bladder scan if				
	included diagnoses Lewy bodies, hyper the bladder making complete urinating a prostatic hyperplasi	prostate) making it more				
	included in and out (Cath) every four he cath for retention/di and "ok to bladder s	orders dated 12/19/14 (I and O) catheterization burs scheduled, may I and O scomfort as needed (PRN) scan prior to I and O and hold bunt is less than 200 cubic				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
00916		B. WING			R 20/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
MAPLE	MANOR NURSING AN		H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
{2 910}	Continued From pa	ge 17	{2 910}			
	indicated scheduled a.m., 5:00 a.m., 9 a 9:00 p.m. However cath was completed The Maple Manor E 2015 indicated I an amount of outputs in catheterization. How scan was not comp The bladder scan s 3-11-15 to 3-17-15 cathed a total of 31 There were 12 time procedure resulted and 8 times collection above. At no point of to 3-17-15 docume and O cathed every	ministration record (TAR) d I and O cath times were 1:00 u.m., 1:00 p.m., 5:00 p.m., and , the documentation to indicate d was inconsistent. Bladder Scan Sheets for March d O catheterization times and resulting from urinary wever, the use of the bladder deted prior to any I & O done. heet documentation from reflected R70 had I and O times out of 42 opportunities. es urine obtained from cathing in amounts 500 cc and above on amounts were 1000 cc and during the review from 3-11-15 ntation reflected R70 was I / four hours per physician's why R70 refused to have it				
	Institute of health (I December 2013) it	icle published by the National NIH Publication No. 14-3195 read, "A normal bladder acts can hold 1.5 [360 cc] to 2 ne."				
	verified R70's TAR cath times were 1:0 p.m., 5:00 p.m., and documentation to in completed was inco expected the staff t know, if R70 was re stated the facility sh	p.m. the director of nursing indicated scheduled I and O 00 a.m., 5:00 a.m., 9 a.m., 1:00 d 9:00 p.m. and verified the indicate catheterization was onsistent. The DON stated she o let the nurse practitioner efusing to be cathed and nould look at adjusting the fusing the be cathed. The				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00916	B. WING			20/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MAPLE	MANOR NURSING AN		TH STREET NO STER, MN 5590			
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIC FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD				ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
{2 910}	Continued From pa	ige 18	{2 910}			
	catheterized every be a more appropri DON stated there we nurses' progress of to being catheterized comprehensive bow and the risk for UTI completed for R70 comprehensive ass comprehensive ass complete summary reviewing the record the resident and the why the resident was stated she just made completed and did see if they were cond she delegated thes coordinator to complete the complete she delegated thes coordinator to complete the complete she delegated thes coordinator to complete the complete she delegated thes coordinator to complete the complete the complete should have made complete the complete the complete the complete the complete stated parameters were not to cath R7 than 200 cc per the the physicians order when to notify reside On 3/19/15 at 8:56 should be cathed for and stated she has times form the nurs could not pull that r stated R70 needed appropriate catheter looking look at doing	ed like R70 was being 8 hours and maybe that would ate order for resident. The vas no documentation in the notes to say R70 was refusing ed. The DON stated the wel and bladder assessment assessments that were on 2-20-15 were not sessments. The DON stated a sessment would provide a of a resident so a person d would have a clear picture o eir need for catheterization and as at risk for UTIs. The DON de sure the assessments were not review the assessments to mprehensive. The DON stated e assessments to MDS plete, but then stated she sure she understood how to rehensive assessments for and at risk for UTI. The DON in place for catheterization 70 if the bladder scan was less e physician order and verified er did not have parameters of lent for high urine output. a.m. the DON stated nobody or 1000 cc or more at a time heard the comment a couple set hey were not aware they nuch urine at a time. The DON to be assessed for er use and stated we should be ag something different for R70 much urine and the staff h the every four hour				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED	
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		00916	B. WING			R 03/20/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
	MANOR NURSING AN		H STREET NO				
		ROCHES	TER, MN 559	01			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{2 910}	Continued From pa	ige 19	{2 910}				
	assessment. The D urine at one time st bladder spasms an be that full. The DC the amount of urine concerns to the pro On 3/19/15 at 2:41 practitioner (CNP)-, per his physician or to be cathed they n nurse and educate refusals. CNP-A sta a problem for R70 a cathed and was ha the facility needed to catheter for this res 1300 cc of urine wa there would be pote CNP-A stated she e refused to be cather staff was pulling off row and stated this CNP-A stated the p parameters of when urine outputs. On 3/19/15 at 3:09 (LPN)-A stated R70 shift. LPN-A stated depending him on w and documented th (Maple Manor Blad stated R70 would o scanned and just w stated he document	rd to the provider for DON stated pulling 1000 cc of aff could cause hypotension, d stated his bladder should no DN stated staff is not assessing being pulled and reporting ovider for R70. p.m. the certified nurse A stated staff need to cath R70 rder and stated if R70 refused eed to report it to the charge the resident and family on the ated she was unaware this was and stated if he refused to be ving this high of urine output to look at placing a Foley sident. CNP-A stated pulling off as a huge amount and stated ential for harm to the resident. expected to be notified if R70 ed three times in a row or if the over 750 cc three times in a would need to be addressed. ohysician's order should have n to notify the provider of high p.m. licensed practical nurse 0 was cathed two times on his he bladder scanned R70 what his urine outputs were he urine output on the sheet der Scan Sheet). LPN-A ften refuse to be bladder vanted to be cathed. LPN-A ted R70's urine output in the e practitioner could look at it in					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		BERTH TOXITOT TOMBER.	A. BUILDING: _	· · · · · · · · · · · · · · · · · · ·		
		00916	B. WING		R 03/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 5590			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
{2 910}	Continued From pa	age 20	{2 910}			
	the nurse practition below 200 cc. LPN turn in a report on I the CNP didn't have he would notify the anything under 200 reported any high u On 3/20/15 at 9:42 (LPN)-B stated she a day on her shift. I times R70 was cath times R70 was cath time and three time at one time betwee nurse practitioner s the high urine outp The facility did not catheterization.	have a policy for in and out rder/s will be reviewed for	9			
{2 920}	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	{2 920}			
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by:	ent is not met as evidenced r was not corrected due to:				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:				
		00916	B. WING			R 20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	MANOR NURSING AN	1875 191	TH STREET NO	DRTHWEST			
		ROCHES	STER, MN 559	01			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO		COMPLET DATE	
				DEFICIENC	CY)		
{2 920}	Continued From pa	age 21	{2 920}				
	Based on observat	ion, interview, and document					
		failed to assess the benefits					
		uing ROM (range of motion)					
		residents (R32) reviewed for					
	ROM services.						
	Findings included:						
		ssion record indicated R32 had					
		uded but was not limited to					
		y bodies, hemiplegia (right d generalized muscle					
	weakness.	d generalized muscle					
		nimum Data Set (MDS) dated					
		as moderately cognitively					
		red extensive assist with					
		ving that included eating,					
		dressing and hygiene.					
		e plan was provided by the					
		and reviewed. The care plan extensive assist with activities					
		the potential for pain related to					
	,	disease and limited mobility,					
		ontracture and utilized a splint					
		32 did not ambulate, and					
		ical lift for transfers. The care					
		had resistive behaviors that					
		ons to prevent or minimize					
		re plan also indicated R32 had					
		had been treated with hosis of Parkinson 's was not					
	0	DS, physician 's orders, or the					
		ndex report for this resident.					
		lso revealed a range of motion					
		am had been in place and was					
	discontinued. The	care plan read, "Resident					
		nes abusive when attempted					
		agreed to ROM) to perform					
		with this resident puts the					
		n harm 's way. " The care					
		e a date when ROM or					
	exercise program v	was discontinued.					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED R
		00916	B. WING		03/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	ANOR NURSING AN	1875 19Т	H STREET NO	DRTHWEST		
		ROCHES	TER, MN 559	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
{2 920}	Continued From pa	ige 22	{2 920}			
	displayed disruptive program was enter 5/2/14; the note real extremity] exercises dailysupine exercises appropriateness of place and/or an ass ongoing treatment a or slow decline of m medical record. The indicated the physic consulted ROM pro- been discontinued. not be found in the family members we risk/benefits for cor ROM/exercise prog During an interview physical therapist a had not received ph services for ROM s nursing make a refe appropriateness of During an interview doctor of physical the	on 3/19/15, at 1:29 p.m. assistant (PTA)-A stated R32 hysical or occupational ervices in the last year nor did erral to evaluate for ROM services in the last year. on 3/19/15, at 1:34 p.m. herapy (DPT)-A explained if a behaviors or nursing had				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING			R 03/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
		1875 197	H STREET NO				
MAPLE	MANOR NURSING AN	ND REHAB, LLC ROCHES	TER, MN 559	01			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T		COMPLET DATE	
				DEFICIENC	Y)		
{2 920}	Continued From pa	age 23	{2 920}				
	look at the reason	why and what is going on					
		options." DPT-A stated					
		evised and designed to					
		resident and the nursing					
		communicate with the					
	physical therapy de	epartment with concerns and					
		programs. DPT-A stated, " It '					
	s a collaborative ef						
		v on 3/19/15, at 2:00 p.m.					
		(DON) stated there was only					
		the medical record regarding					
		articipate in ROM/exercise					
		ted, "the program was more					
		nued without determining or					
		the cause of behaviors during					
		the physician should have					
		d an assessment should have					
		attempt root cause analysis needed to be referred to					
		needed to be referred to					
	physical therapy."	cility's plan of correction dated					
		other residents who would					
		of motion programs will be					
		al in the interdisciplinary care					
		ile. The facility is in the process					
	of developing a res						
		management or designee will					
		monitoring by random monthly					
	audits"						
		d a random audit to ensure					
		ere being addressed and					
		formed by the facility between					
	3/11/15 and 3/18/1	5; an audit pertaining to R32					
	had not been perfo	ormed.					
		d a range of motion guideline					
		eline did not include: how the					
		vices would be identified, when					
		aluation would be conducted,					
		side referrals to physical or					
	a a a un ati a a al tha ra	py, under what circumstances				1	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IAPLE I	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
{2 920}	monitor and track p resident who would	e discontinued, and how to progress or decline of the I receive ROM services. rder/s will be reviewed for	{2 920}			
{21375}	Program Subpart 1. Infection home must establis	0 Subp. 1 Infection Control; on control program. A nursing sh and maintain an infection signed to provide a safe and nt.	{21375}			
	by: This licensing order This uncorrected or will be reviewed at Based on observati review, the facility f program to identify included trends and educate staff on pe (PPE) and isolation the Centers for Dis Findings included: During an interview director of nursing of not an infection cor started. The DON a trending of infection far for March. The I there had been two them was R67 who	ent is not met as evidenced r was not corrected due to: rder/s will remain in effect and the next onsite visit. ion, interview, and document ailed to develop a surveillance resident infections that d analysis of data and failed to precautions if necessary by ease Control (CDC). r on 3/19/15, at 3:11 p.m. the (DON) confirmed there was notrol log for March 2015 also confirmed tracking or ns had not been completed so DON reported since 3/11/15 o cases of infections one of had an open hand wound ed she thought bacterium				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COM	FLETED
		00916	B. WING		R 03/20/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		1875 191	TH STREET NO	DRTHWEST		
IAPLE	MANOR NURSING AN	ND REHAB, LLC ROCHES	STER, MN 559	01		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLE DATE
				DEFICIENC	Y)	
21375}	Continued From pa	age 25	{21375}			
	methicillin resistan	t staphylococcus aureus				
		vas on isolation precautions.				
		missal summary dated 3/13/15	5			
		ive culture data in the past				
		nd from March 11, 2015, the				
		ylococcus aureus and				
		ectious disease services at				
	•	nded initiation of a two week				
		epime and Vancomycin (both				
	intravenous (IV) ar	lid not address the peripherally				
		theter (PICC) which was				
		pital and left in when arrived at				
		ed for antibiotic therapy or the				
		he hand infection. The PICC				
	should have care p	plan directions to protect the				
		nptoms of infection, and daily				
	monitoring for pate					
		tion on 3/19/15, at 3:55 p.m.				
		hurse (LPN)-C had just				
		ing change to R67 's hand. on and had not worn a gown				
		were large amounts of bright				
		e from the wound cleansing				
		seen on the side of the clear				
	garbage bag.					
		v on 3/19/15, at 4:00 p.m. R67				
		different infections in his				
		not recall the name of them.				
		2 different kinds of IV				
		so had a PICC on the right				
	arm.	v on 3/19/15, at 4:01 p.m.,				
		vas not aware of what infection				
		was in R67 's wound. LPN-C				
	5	t on isolation. To the question,				
		which PPE to use if you don '	t			
		teria were causing infection? "				
		used contact isolation and wore				
		LPN-C indicated he was not				

If continuation sheet 26 of 31

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00916	B. WING			R 03/20/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
		1875 19	TH STREET NO				
	MANOR NURSING AN	ND REHAB, LLC ROCHES	STER, MN 559	01			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLET DATE	
				DEFICIENC	Y)		
{21375}	Continued From pa	age 26	{21375}				
	sure who determin	ed isolation precautions for					
	residents with activ						
		v on 3/20/15, at 8:23 a.m.					
		RN)-B stated R67 had MRSA					
		what antibiotics were					
		stated R67 had been on					
		ns and was not aware when					
		me off of isolation. RN-B					
		e that did the admission of the					
		isolation precautions in place	if				
	they were needed.						
		v on 3/20/15, at 8:26 a.m.					
	RN-C stated, "I am	not sure what [R67] is being					
		was on isolation when he					
		e hospital." RN-C reported					
		hen changing the dressing.					
		ed the facility policy was to					
		recautions after 7 days of bein	g				
	treated with an ant						
		v on 3/20/15, at 9:38 a.m.					
		signed to infection control					
		he bacterium that caused the					
		hand had been MRSA. LPN-D					
		been put in charge of the					
		ogram, however did not have					
		ucation, or training to oversee of program. LPN-D stated her					
		ection control was limited to ording of information only.					
		eillance for infection control las					
		ary 2015 read, "Maple Manor					
		o, LLC. Closely monitors all					
		bit signs/symptoms of infection	n				
		urveillance and sues a	'				
		l of collecting, consolidating,					
		discern the frequency and					
		en illness and/or even, followed	 				
		of that information to those	•				
	sy sommanioanon		1			1	
	who can assist with	n outcome improvement.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURV COMPLETED R	
		00916	B. WING			R 20/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	MANOR NURSING AN		H STREET NC STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
[21375]	Continued From pa	age 27	{21375}			
	or have the potentia policy also read, " determines whethe protective equipme residents are monit and for the present	tify infections that are causing al to cause an outbreak. " The The surveillance processes or the facilityuses personal ont when indicated. " and " All tored for the risk of infection ce of actual infections." rder/s will be reviewed for sessment/s.				
{21535}	MN Rule4658.1315 Drug Usage; Gene	Subp.1 ABCD Unnecessary ral	{21535}			
	must be free from t unnecessary drug i A. in excessive therapy; B. for excessive D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finance This standard is inter available through th	quate indications for its use; or ince of adverse consequences dose should be reduced or lrug regimen review required in e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for acilities, published by the lith and Human Services, corporated by reference. It is he Minitex interlibrary loan tte Law Library. It is not				
	This MN Requirem	ent is not met as evidenced				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			R
		00916	B. WING		03/20/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ID REHAB. LLC	TH STREET NO STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
{21535}	Continued From pa	age 28	{21535}			
	by: This licensing orde	r was not corrected due to:				
	review, the facility of effects monitoring v side effects for the medications for 1 of	ion, interview and document did not ensure adequate side was completed to determine use of psychotropic of 5 residents (R68) who an antipsychotic medication.				
	Findings Include:					
		ntipsychotic medication s not monitored for possible				
	for 3/1/15 through 3 including psychosis anxiety state and u indicated R68 was	administration Record (MAR) 3/31/15, listed R68's diagnoses s, dementia, depression, rinary retention. The MAR also on Seroquel 12.5 mg every (antidepressant) 15 mg at				
		tment sheet for 3/1/15 through ude monitoring for side effects eroquel.				
	risk for falls related use. Interventions i orders. However, s medications in rela	d 1/27/14 indicated R68 was a to psychotropic medication nclude giving medications per ide effects of psychotropic tion to falls were not identified fically planned to be				
	symptoms of "some about [R68] and is	ted 4/24/14, identified behavio e paranoia of people talking easily angered." Approaches administer medications as	r			

DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SE	RVICES	
					AND TRANSMITTAL	ID: 3QEK		
MEDICARE/MEDICAID PROVIDER (L1) 245409 2.STATE VENDOR OR MEDICAID NO (L2) 843242200	R NO.	3. NAME AND AI (L3) MAPLE MA (L4) 1875 19TH S (L5) ROCHESTE	DDRESS OF FAC NOR NURSI STREET NOR	CILITY NG AND R	,	3. Termination 4. CH	_8) ertification OW	
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		<u>02</u> (L7) 13 PTIP 22 CLIA	5. Validation 6. Con 7. On-Site Visit 9. Oth 8. Full Survey After Complaint	er		
6. DATE OF SURVEY 01/30 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	0/2015 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IIE 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: 09/30	(L35)	
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 	81 (L18)81 (L17)	Complianc 1. A X B. Not in Con	nce With equirements e Based On: cceptable POC	gram	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	The Following Requirements: 6. Scope of Services Limit 7. Medical Director (F) 8. Patient Room Size 9. Beds/Room (L12)	it	
14. LTC CERTIFIED BED BREAKDOW	VN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
81 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
<u>Marietta Lee, HFE NE</u>	II	0	2/25/2015	(L19) K	(L20) Kamala Fiske-Downing, Enforcement Specialist 03/12/2015			
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY		
 DETERMINATION OF ELIGIBILI 1. Facility is Eligible to Pa 2. Facility is not Eligible 			IPLIANCE WITI ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-15) : :	13)	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	(L30)		
OF PARTICIPATION 01/01/1987	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Healt	h/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	· · · · · · · · · · · · · · · · · · ·	ement	
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminatic 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status C 00-Active	hange	
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL	<u></u> .	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered February 13, 2015

Mr. Patrick Blum, Administrator Maple Manor Nursing And Rehab, Llc 1875 19th Street Northwest Rochester, Minnesota 55901

RE: Project Number S5409025

Dear Mr. Blum:

On January 30, 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>Electronic 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

<u>Informal Dispute Resolution</u> - 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 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 March 11, 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 March 11, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable. Maple Manor Nursing And Rehab, Llc February 13, 2015 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 30, 2015 (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

Maple Manor Nursing And Rehab, Llc February 13, 2015 Page 5

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 April 30, 2015 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205 Fax: (651) 215-0525 Maple Manor Nursing And Rehab, Llc February 13, 2015 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

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

Enclosure

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NC	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245409	B. WING	·····	01	/30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00		
F 156 SS=E	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substat regulations has been your verification. 483.10(b)(5) - (10), RIGHTS, RULES, S The facility must inf	of correction (POC) will serve of compliance upon the obtance. Because you are your signature is not required of first page of the CMS-2567 nic submission of the POC will cion of compliance. acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with 483.10(b)(1) NOTICE OF SERVICES, CHARGES form the resident both orally anguage that the resident	F 15	56		3/11/15
	understands of his regulations governi responsibilities duri facility must also pr notice (if any) of the §1919(e)(6) of the A made prior to or up resident's stay. Re any amendments to writing. The facility must inf entitled to Medicaid of admission to the	or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the e State developed under Act. Such notification must be on admission and during the ceipt of such information, and o it, must be acknowledged in form each resident who is benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the				
	items and services facility services und which the resident	that are included in nursing ler the State plan and for may not be charged; those vices that the facility offers				
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					02/23/2015

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.

PRINTED: 02/25/2015

		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING	i		01/;	30/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 156	and for which the re- the amount of charge inform each resider the items and servic (i)(A) and (B) of this The facility must inf at the time of admiss the resident's stay, facility and of charge including any charge under Medicare or I The facility must fur legal rights which in A description of the funds, under parage A description of the for establishing elige the right to request 1924(c) which dete non-exempt resour- institutionalization a spouse an equitable cannot be consider- toward the cost of t medical care in his down to Medicaid e A posting of names numbers of all perti groups such as the agency, the State lii ombudsman progra advocacy network, unit; and a stateme	esident may be charged, and ges for those services; and nt when changes are made to ces specified in paragraphs (5) s section. form each resident before, or ssion, and periodically during of services available in the ges for those services, ges for services not covered by the facility's per diem rate. rnish a written description of neludes: manner of protecting personal raph (c) of this section; requirements and procedures piblity for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment he institutionalized spouse's or her process of spending		156			

If continuation sheet Page 2 of 133

		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			X3) DATE	E SURVEY PLETED
		245409	B. WING			01/3	80/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE N	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 156	agency concerning misappropriation of facility, and non-cor directives requirem The facility must inf name, specialty, an physician responsite The facility must pro- written information, applicants for admis- information about h Medicare and Medi	resident abuse, neglect, and resident property in the npliance with the advance	F 1	56			
	by: Based on interview facility failed to prov Nursing Facility Adv (SNFABN) or a unif skilled nursing facili Medicare Part A ski provide appropriate residents (R28, R6 liability notices; and notice prior to disch for 2 of 5 residents liability notices. Findings include:	NT is not met as evidenced y and document review, the vide the required Skilled yanced Beneficiary Notice orm denial letter to be used by ities upon termination of all lled services; and failed to liability notices for 4 of 5 16, R77 & R88) reviewed for failed to provide two day harge from Medicare services (R77, R88) reviewed for			Tag F156 Medicare Notices Plan of Correction Maple Manor Nursing and Rehab, LL routinely informs the resident both or and in writing in a language that the resident understands of his/her rights all rules and regulations governing resident conduct and responsibilities during their stay in the facility. Such notification is made prior to or upon admission and during the resident s Receipt of such information and any amendments to it are acknowledged writing. The goal of Maple Manor Nursing an Rehab., LLC is to assure that each	rally s and s stay. in	

Facility ID: 00916

If continuation sheet Page 3 of 133

PRINTED: 02/25/2015

TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED	
		245409	B. WING	-		01/30/2015		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	50/2015	
MAPLE	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 156	R77 and R88 receive Notice of Noncover provided was not for Also no residents in to have their bill sul Document review of Notice of Noncover (03/08)) used by the read, " Option 1. I above. You may as want Medicare bille payment, which is a Summary Notice (M Medicare doesn't p payment, but I can following the directi does pay, you will re you, less co-pays of this option, the facil Medicare made a d any payments mad Document review of Medicaid Services a Noncoverage, form facilities (SNF) mus- items/services exper- Medicare Part B on During interview on business office ass and R88 had receive were discharged fro- remained in the fac-	ved Advance Beneficiary age. However, the form or skilled nursing facility use. In the sample selected option 1 omitted to Medicare for review. If the Advance Beneficiary age (Form CMS-R-131 e facility, options selection want the (D) Services listed sk to be paid now, but I also d for an official decision on sent to me on a Medicare <i>ISN</i>). I understand that if ay, I am responsible for appeal to Medicare by ons on the MSN. If Medicare efund any payments I made to r deductibles." According to lity would bill residents until lecision and then would refund e by the resident. If Centers for Medicare and Advance Beneficiary Notice of CMS-R-131, " Skilled nursing st use the ABN for ected to be denied under ly." 1/28/15, at 2:00 p.m., istant (BOA)-A verified R77 ved Medicare Part A services, om Medicare Part A, and illity. BOA-A verified the ry Notice of Noncoverage was eneficiary Notice of	F 1	56	resident knows his/her rights and responsibilities and that the facility communicates this information in a for all residents not just residents identified as: 28, 66, 77, 88. The fa notifies the resident/family/represe before Medicare benefits are disco and provides the resident/family/representative with notice of their rights of appeal. The regulations and a facility policies/procedures addressing res notification non-coverage of Medic benefits were reviewed and in-serv with responsible staff on 2/9/2015 a 2/11/2015. The Office Manager and/or design be responsible for monitoring comp Resident records will be audited fo months to verify completion of requ Medicare notification compliance. Completion date:3/11/2015	acility ntative ntinued a sident are riced and ee will bliance. r two		

If continuation sheet Page 4 of 133

	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	. 				0938-0391
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION		E SURVEY PLETED
		245409	B. WING			01/:	30/2015
NAME OF	PROVIDER OR SUPPLIER			ç	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				-	1875 19TH STREET NORTHWEST		
	MANOR NURSING AN	D RENAD, LLC		I	ROCHESTER, MN 55901		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE
F 156	Cartinued From pa	4			<u></u>		
E 100		-	FI	50			
		Continued From page 4 ACK OF SKILLED NURSING FACILITY DVANCED BENEFICIARY NOTICE: R28 was discharged from Medicare Part A ervices on 12/5/14, according to R28's Notice of Medicare Non-Coverage, a Medicare liability otice. R28 remained in the facility. The facility ailed to provide Skilled Nursing Facility Advance Beneficiary Notice, a Medicare liability notice that vould allow R28 the choice to submit the facility ill to Medicare for review. During interview on /28/15, at 2:00 p.m., BOA-A verified R28 did not					
	Medicare Non-Cove	erage, a Medicare liability					
	bill to Medicare for	review. During interview on					
		sing Advanced Beneficiary					
		denial letter to inform of non-covered services and of					
		he denial to Medicare.					
		d from Medicare Part A					
		, according to R66 's Notice					
		a Medicare liability notice. R66 ility. Document review of the					
		Non-Coverage, revealed a					
	telephone voice me	essage was left and the notice					
		2/14. The notice lacked					
		or representative. There was					
		w-up contact. The facility illed Nursing Facility Advance					
		a Medicare liability notice that					
		e choice to submit the facility					
		review. During interview on					
		n., BOA-A verified R66 did not					
		sing Advanced Beneficiary denial letter to inform of					
		non-covered services and of					
		he denial to Medicare. BA-A					
	verified lack of sign	ature, no further					
		act, and R66 did not receive					
		anced Beneficiary Notice or a r to inform of potential liability					

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PRINTED: 02/25/2015

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING _			01/;	30/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC			375 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	for non-covered set appeal the denial to LACKED 2 DAY NO DISCHARGE FROM R77 was discharge services on 9/19/14 Medicare Non-Cove notice, which was s 9/22/14, 4 days afte R77 remained in th evidence of when th notified of non-cove coverage ending. F Advanced Beneficia representative on 9 services ended. D 2:00 p.m., BOA-A v that the facility had days prior to dischar R88 was discharge services on 9/29/14 Medicare Non-Cove notice, which was s 10/2/14, 4 days afte R88 remained in th evidence of when th notified of non-cove coverage ending. F Advanced Beneficia representative on 1 services ended. D 2:00 p.m., BOA-A v that the facility had	rvices and of his right to Medicare.	F 1	56			

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		& MEDICAID SERVICES	(X2) MI II TI	DME	3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG	COMPLETED
		245409	B. WING _		01/30/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MAPLE I	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 156	During interview on verified R28, R66, I Medicare Part A se Medicare Part A, ar BOA-A verified the resident or represe	1/28/15, at 2:00 p.m., BOA-A R77, and R88 had received rvices, were discharged from nd remained in the facility. facility lacked evidence of ntative notification. BOA-A d not have a written policy or	F 15	56	
F 176 SS=D	DRUGS IF DEEME An individual reside the interdisciplinary	NT SELF-ADMINISTER D SAFE ent may self-administer drugs if team, as defined by as determined that this	F 17	6	3/11/15
	by: Based on observative review, the facility for (R96) was assessed to self-administer model Findings include: R96 was observed was observed to early interviewed and shore related to her gastriand diabetes. On the indicated that she model indicated that she model was stable. R96 's admission Model 12/9/14 indic of mental status (Bi possible 15 points of	NT is not met as evidenced tion, interview and record ailed to ensure 1 of 1 resident d and provided the opportunity nedications. on 1/25/15 at 12:00 p.m. R96 at regular meals and was e knew foods allowed to eat ic by-pass, kidney transplant, 1/30/15 at 9:15 a.m. R96 nanaged her diabetes ome and that the blood sugar Minimum Data Set (MDS) ated R96 had a brief interview IMS) score of 14 out of a or was cognitively intact. The at R96 had no functional range		Tag F176 Self-Administration of Medication Plan of Correction Maple Manor Nursing & Rehab, LLC respects the right of residents to self-administer their own medications residents who request to self-administ medications will be assessed to assu that it is safe to do so. A Physician is order will be obtained and plan of card be updated. The appropriateness of self-administr of drugs will be reviewed quarterly, wi change of condition, and as needed ensure continued safety. The policy and procedure regarding self-administration of medications wa reviewed and revised. Resident number 96 has been assess	ter re e will ration th to

Facility ID: 00916

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	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION		. 0938-039 E SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G		E SURVEY IPLETED	
		245409	B. WING			/30/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI			
MAPLE I	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWES ROCHESTER, MN 55901	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 176	Continued From pa	ige 7	F 176	6			
	Continued From page 7 of motion limitation of shoulders, arms, wrists, or hands. The nurse practitioner (NP)-A was interviewed on 1/30/15 at 10:20 a.m. NP-A stated that R96 would like to manage and determine the amount of insulin she needed. NP-A stated R96 was told hat nursing did not have a lock box so she could not keep her insulin supplies in her room for self-use. The case manager registered nurse (RN)-A stated that nursing was asked by NP-A to allow R96 to tell staff how much insulin she needed, but because nurses could not take orders from esidents, it was not allowed. RN-A stated he did not follow through with an assessment to determine R96 's ability safely gives herself insulin and takes blood sugars.			by the NP and it was determined that shi is safe to self-administer her own medications. An order for self-administration has been obtained. At the next Nurses meeting education staff will be in-serviced regarding the Policy and Procedure for self-administration of medication. The Director of Nursing/designee will monitor compliance with self-administration of medication throug observation and record review. Completion Date: March 11, 2015			
	the administration of at home she gave I pen. She stated th the amount of insul would give her own	30/15 R96 was asked about of her insulin. R96 stated that her own insulin using an insulin at here the nurse would dial in in to be given and that she insulin injection. R96 stated to be totally independent in in.					
	medication was pro	self-administration of wided upon request.					
F 225 SS=D	1/30/15 at 10:45 a.	(c)(2) - (4)	F 225	5		3/11/15	

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		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY
		245409	PREFIX TAG COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 225 (e		30/2015		
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>	l	5	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2010
	MANOR NURSING AN			1	1875 19TH STREET NORTHWEST		
		U RENAD, LLC			ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF) BE	(X5) COMPLETION DATE
F 225	Continued From pa	-	F 2	225	;		
	been found guilty of mistreating resident had a finding enterer registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit						
	involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce The facility must ha violations are thorou	ave evidence that all alleged ughly investigated, and must					
	The results of all inv to the administrator representative and with State law (inclu certification agency incident, and if the a	vestigations must be reported					

Facility ID: 00916

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PRINTED: 02/25/2015

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		0938-039 SURVEY	
ND PLAN C	F CORRECTION	DENTIFICATION NUMBER:				COM	PLETED	
		245409	B. WING			01/3	80/2015	
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
	ANOR NURSING AN	D REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	Continued From pa	-	F 2	25				
	by:	NT is not met as evidenced						
	facility failed to inve	and document review, the stigate and immediately report ng money and physical abuse			Tag F225 Report/Investigate Allegations			
	to the administrator	and designated state agency (R70 & R29) reviewed for			Maple Manor Nursing & Rehab, LL requires that all alleged resident mistreatment, neglect, or abuse, in			
	Findings included:	imum Data Set (MDS) dated			injuries of unknown source, and misappropriation of resident proper 1) reported immediately to the	Ũ		
	11/20/14 indicated impairment with a E	R70, had moderate cognitive Brief Interview for Mental			administrator and other appropriate officials and 2) thoroughly investigation	ated in		
	extensive assist for	e of eleven, and required activities of daily living of ransfers, and hygiene.			a timely manner with the investigat results reported to the administrativ and state officials as required. If the	/e staff		
	During an interview stated approximate his drawer about 3	on 1/26/15, at 1:00 p.m. R70 ly \$30.00 went missing out of months ago. R70 stated he v at bingo. R70 stated he had			alleged violation is verified, approp corrective action is taken. The facil intervenes to prevent further poten abuse while the investigation is in	riate ity		
	not kept money in r missing and had m	oom since the \$30.00 was ade it a habit to deposit bingo			process.			
	stated staff was not R70 did recall he ha administrator about				Maple Manor Nursing & Rehab, LL not knowingly employ individuals w have been found guilty of abusing, neglecting, or mistreating residents	ho		
	licensed social work R70 had reported n and stated she had	ker (SW)-A was notified the nissing money to this surveyor not been aware money had			knowledge of actions against an employee which would indicate unf for service as a nursing assistant o other resident care positions are	r in		
	R70 had never repo she was aware of.	70's drawer. SW-A stated orted anything missing that			investigated and reported to the Sta nurse aid registry or licensing author	orities.		
	SW-A stated R70's informed of the mis	on 1/29/15, at 8:12 a.m. family member was just sing money but has not			The facility s vulnerable policies, A Incident Reporting and Resident At Prevention Plan, were reviewed an	ouse d found		
	not reported the mi	call. Also SW-A said she had ssing money to the designated being informed of it yesterday			appropriate. The policy language c reflects that the appropriate regulatory/government agencies ar	-		

Facility ID: 00916

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE		(3) DATE	0938-039 SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:				COMF	PLETED
		245409	B. WING _			01/3	80/2015
NAME OF I	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC		375 19TH STREET NORTHWEST OCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 225 Continued From page 10 a.m. R29 made an allegation of abuse but it was not immediately reported to the administrator or to		F 22	25	immediately notified (as soon as poss upon the becoming aware of the concerns) of alleged violations involvi	ring		
	indicated an allegat to R29 on 12/5/15.	nce form completed by SW-A tion of physical abuse occurred Nursing assistant (NA)-M had			resident mistreatment, neglect, abuse misappropriation of resident property. During the planned mandatory meetir staff will be instructed on 1) the facility	r. ng,	
	reported the incident to the nurse however allegation was not immediately reported to administrator nor to the designated state ag (Office of Health Compliance-OHFC). A letter was provided in regards to the alleg	mmediately reported to the the designated state agency ompliance-OHFC).			zero tolerance policy for abuse/neglect/misappropriation of property 2) the residents rights to be	e	
	of abuse for R29. T who was accused b face during cares.	he letter was written by NA-M by R29 to have hit her in the NA-A wrote, "The second one	regards to the allegation tter was written by NA-M 9 to have hit her in the wrote, "The second one free from abuse 3) the definition of vulnerable adult 4) who is a manda reporter of actual or suspected res abuse/neglect/misappropriation of	ed ent			
	[R29] pillow and I h change a different p accidentally hit her	gument] was I was fixing her old her head up and when I pillow and move my hand I on her cheek. I apologized to			property 5) the types of incidents that must be reported to the common entr point and/or the Minnesota Departme Health 6) timely reporting of incidents	ry ent of	
	wasn't I did it on pu turn me in." The let reported the incider	vas an accident she say it rpose and she was going to ter went on to explain NA-M nt to the licensed practical			the procedures for communicating/documenting resident concerns/incidents and 8) internal reporting of vulnerable adult issues	nt	
	SW-A confirmed the	on 1/29/15, at 3:47 p.m. e incident was not immediately ated by LPN-F Facility policy			especially those related to missing property. The staff are reeducated on vulnerable adult issues at least every twelve months and vulnerable adult		
	on 2/6/2013 read, " notify the administra	cident Reporting last revised Facility staff are required to ator immediately of any cidents and the federal			reporting/investigation is addressed a part of the new employee orientation process.		
	requirement is that all reportable incide	the facility is required to report ents to the Minnesota Ith electronically immediately			Resident number 70 After becomin aware of the resident s report of mis bingo winnings in the amount of \$30.0 the social worker immediately investig	ssing .00,	
	Facility policy Resic dated 6/30/2009 rea alleged violations a	dent Abuse Prevention Plan ad, "The facility will report all nd all substantiated incidents state agencies", and " In the			the allegation. When interviewed by the social worker, the resident did not receive the incident of missing money. (The resident had previously reported that	the call	

Facility ID: 00916

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	۱ (X3) DA	<u>). 0938-039</u> TE SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	VG	00	MPLETED
		245409	B. WING _			/30/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, 1875 19TH STREE	CITY, STATE, ZIP CODE	
MAPLE	MANOR NURSING AN	ID REHAB, LLC		ROCHESTER, M		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CC	DER'S PLAN OF CORRECTION IRRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 225	the resident will be	I maltreatment, the needs of immediately assessed, and s responsible party as well as	F 2	had lost the The resident bingo and co facility-spons worker interview the verified the resident possession never let him room. Resident nur 2014, the nur 2014, the nur 2014, the nur 2014, the nur pillows. The apologized to the incident for resident told contact with The resident assistant tha The Interim I the written st assistant and counseled th vulnerable ac policies. The the resident time the resident personal pro immediately	money three months ago.) had not left the facility to pla build not have won \$30.00 at sored bingo. The social riewed the resident s wife that it was improbable that had \$30.00 in his she stated that she would have that much money in his mber 29 On December 5, rsing assistant accidently hit s cheek when adjusting nursing assistant immediatel to the resident and reported to the charge nurse. The the nursing assistant that the the cheek was intentional. stated to the nursing t she was going to turn me in Director of Nurses reviewed tatements by the nursing d the charge nurse and nem on the facility s dult reporting/investigation to Social Worker interviewed December 8, 2014 at which dent reported that nothing etween herself and the staff ations of resident t or misappropriation of perty will be reported to the state/county agencies facility policy.	s y

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/25/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245409	B. WING			01/3	30/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	• ., .	
MAPLE	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	age 12	F 2	225	Compliance will be monitored by th Social Worker through an audit of t incident reports and reporting time for three months. If noncompliance noted, additional monitoring and st education will be done. Compliance discussed during the March Quality Assurance Committee meeting and reviewed during subsequent meetin Completion date: March 11, 2015	he frames is aff e will be d	

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		AND HUMAN SERVICES			FORM	: 02/25/2015 APPROVED : 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		245409	B. WING			30/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From pa	ge 13	F2	225		
F 226 SS=D	483.13(c) DEVELO ABUSE/NEGLECT		Fź	226	Page 2 of 2 Tag F225	3/11/15
	policies and proced mistreatment, negle	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.				
	by: Based on interview facility failed to fold missing money and for 2 of 3 (R70, R25 vulnerable adult. Findings included: R70's quarterly Min 11/20/14 indicated impairment with a E Status (BIMS) scor- extensive assist for dressing, toileting, f During an interview stated approximate his drawer about 3 had won the money not kept money in r missing and had m winnings in his acco- stated staff was not	NT is not met as evidenced y and document review, the witheir policy on reporting allegations of physical abuse a) residents reviewed for imum Data Set (MDS) dated R70, had moderate cognitive Brief Interview for Mental e of eleven, and required activities of daily living of transfers, and hygiene. on 1/26/15, at 1:00 p.m. R70 ly \$30.00 went missing out of months ago. R70 stated he y at bingo. R70 stated he had oom since the \$30.00 was ade it a habit to deposit bingo punt with the facility. R70 tified of the missing \$30.00. ad talked to the previous it.			Tag F226 Develop/Implement Abuse/Neglect Policies Maple Manor Nursing & Rehab, LLC has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures address the seven following components: screening, training, prevention, identification, investigation, protection and reporting/response. The policies and procedures for communicating and reporting alleged mistreatment and misappropriation of resident property were reviewed and found appropriate. During the planned mandatory meeting, staff will be instructed on the facility s	

Facility ID: 00916

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLI	E CONSTRUCTION		SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED	
		245409	B. WING _			01/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 226	Continued From pa	age 14 / on 1/28/15, at 8:23 a.m.	F 2:	26	policies and procedures including	1) the	
	R70 had reported r and stated she had been taken out of F R70 had never repo- she was aware of. During an interview SW-A stated R70's informed of the mis returned her phone not reported the mi- state agency after R a.m. R29 made an alleg immediately reported the designated stat R29's had a grieval indicated an allegat to R29. Nursing assisthe incident to the r was not immediate nor to the designated Health Compliance A letter was provide of abuse for R29. T who was accused R	nce form completed by SW-A tion of physical abuse occurred sistant (NA)-M had reported nurse however the allegation ly reported to the administrator ed state agency (Office of			types of incidents that must be rep the common entry point and/or the Minnesota Department of Health 2 reporting of incidents 3) the proced for communicating/documenting re concerns/incidents and 4) internal reporting of vulnerable adult issues staff are reeducated on the facility vulnerable adult policies at least ev twelve months and vulnerable adul reporting/investigation is addressed part of the new employee orientation process. Resident number 70 After becom aware of the resident s report of m bingo winnings in the amount of \$3 the social worker immediately inve the allegation. When interviewed b social worker, the resident did not the incident of missing money. (The resident had previously reported the had lost the money three months a The resident had not left the facility bingo and could not have won \$30 facility-sponsored bingo. The social worker interviewed the resident s who verified that it was improbable) timely lures esident s. The s very t d as on ning nissing 80.00, stigated y the recall e at he igo.) v to play .00 at l wife	
	change a different accidentally hit her her and told her it v wasn't I did it on pu turn me in." The let	old her head up and when I pillow and move my hand I on her cheek. I apologized to was an accident she say it impose and she was going to ther went on to explain NA-M nt to the licensed practical			the resident had \$30.00 in his possession she stated that she w never let him have that much mone room. Resident number 29 On Deceml 2014, the nursing assistant accident the resident s cheek when adjusti pillows. The nursing assistant imm	ey in his ber 5, ntly hit ng	

Facility ID: 00916

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION UDBER:			TIPLE CONSTRUCTION	· · ·	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG		01/30/2015	
		245409	B. WING _				
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
MAPLE N	ANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 226	Continued From pa	ge 15	F 22	26			
	reported or investigated by LPN-F Fac Vulnerable Adult Incident Reporting lat on 2/6/2013 read, "Facility staff are rec notify the administrator immediately of vulnerable adult incidents and the fede requirement is that the facility is require all reportable incidents to the Minnesot Department of Health electronically im- of knowledge of an alleged incident." Facility policy Resident Abuse Preventi dated 6/30/2009 read, "The facility will alleged violations and all substantiated to the appropriate state agencies", and event of suspected maltreatment, the r the resident will be immediately assess Notify the resident's responsible party a physician as soon as possible."			 the incident to the charge r resident told the nursing as contact with the cheek was The resident stated to the r assistant that she was goin The Interim Director of Nur the written statements by th assistant and the charge nu counseled them on the fac vulnerable adult reporting/ii policies. The Social Worke the resident December 8, 2 time the resident reported th happened between herself member. Future allegations of reside maltreatment or misapprop personal property will be re- immediately to the state/co- according to facility policy. 	esistant that the intentional. hursing ing to turn me in. reses reviewed he nursing urse and ility s nvestigation r interviewed 2014 at which that nothing and the staff		
F 241		AND RESPECT OF	F 24	Compliance will be monitor Social Worker through an a incident reports and reporti for three months. If noncom noted, additional monitoring education will be done. Con discussed during the March Assurance Committee mee reviewed during subsequer Completion date: March 11	audit of the ing time frames npliance is g and staff mpliance will be h Quality eting and nt meetings.	3/11/15	
SS=E	INDIVIDÚALITY						

Facility ID: 00916

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		AND HUMAN SERVICES			F	PRINTED: 02/25/2015 FORM APPROVED MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	245409		B. WING			01/30/2015		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				1875 19TH STREET NORTHWEST				
	MAPLE MANOR NORSING AND REITAB, LLC							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL					(X5) COMPLETION DATE	
F 241			F 241		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			

Facility ID: 00916

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PRINTED: 02/25/2015

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	X3) DATE SURVEY	
ND PLAN (PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI	NG _		COMPLETED	
		245409	B. WING			01/30/2015	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ND REHAB, LLC		-	375 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 241	were eating positio south side of the di- residents who need observed to sit. A on the table. The f letters "Stays @ Fe every meal." During interview or feeding assistant (I the table was label PFA-A stated the for residents nursing a residents nursing a residents who rece residents at risk for During interview or dietary manager (C east/west dining ro @ Feeder Table" w During interview or of nursing verified for room table labeled not appropriate and During interview or registered nurse-E R52, R61, R65, R3 east/west dining ro Document review of Dignity Audit Proce is the policy of Map Rehabilitation to pr	t 12:10 p.m., five residents ned at the large table on the ining room (south table) where ded assistance to eat were folder was observed upright older was labeled in large eeder Table" and "Mark after n 1/27/15, at 12:12 p.m., paid PFA)-A verified the folder on ed "Stays @ Feeder Table." older contained the list of assistants assisted to feed, vived thickened liquids, and r aspiration. n 1/27/15, at 3:03 p.m., certified CDM)-C stated the folder on the om south table labeled "Stays vas a folder used by nursing. n 1/27/15, at 3:25 p.m., director the folder sitting on a dining "Stays @ Feeder Table" was d should not be used. n 1/30/15, at 8:15 a.m., (RN-E) verified R51, R10, e4, R3, R30, R42 ate at the	F 24	41	to assist residents with eating in a t manner. The nursing staff were also instructed on the appropriate place urinary collection bags and that all collection bags are to be covered were residents are in a common area or room and observable from the half Assuring the resident has a dignified dining experience will be monitored dietary manager/designee through observations of meal service/reside assistance practices for one monther randomly thereafter. Compliance we appropriate placement and covering urinary collection bags will be monit by the charge nurse/designee through noted additional auditing and staff education will be done. Compliance reviewed during the next monthly of Assurance and Assessment Commission meeting. Completion Date: March 11, 2015	ed when t of urinary when in their way. ed by the routine ent and with g of itored ugh ance is e will be Quality	

If continuation sheet Page 18 of 133

TATEMEN	OF DEFICIENCIES	KOMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245409	B. WING			01/20/2015	
	PROVIDER OR SUPPLIER	245409	D. WING	STREET ADDRESS, CITY, STATE, ZIP CO		/30/2015	
	MANOR NURSING AN	ND REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 241	Resident's Rights p residents at Maple be treated with cor- recognition of his/h including privacy in his/her personal net Residents eating w area near them: During dining obse- room on 1/26/15, a (DA)-E pushed a b dining room up to a finishing eating her dishes and placed foods into a bucket During interview or dietary manager (C soiled dishes and f container on the bu- finished eating at a cart was not to be stated he expected carried soiled dishes and placed on the During observation DA-D was observe east/west dining ro where five resident completing their m soiled dishes and p scraped foods into	of facility policy Maple Manor policy dated 3/6/08, read, "All Manor Nursing Home are to asideration, respect and full her dignity and individuality a treatment and in care of beds." while staff began cleaning the arvations in the east/west dining at 5:21 p.m., dietary aide us cart into the east/west a table where a resident was r meal. DA-E cleared soiled on the bus cart. DA-D scraped t on the bus cart. n 1/27/15, at 3:03 p.m., certified CDM)-C stated he expected bods placed into a garbage us cart after all residents were a table. CDM-C stated the bus in the dining room. CDM-C d staff cleared off the tables, es and foods into the hallway	F 2	41			

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TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MUI	TIPLE CONSTRUCTION). 0938-039 TE SURVEY	
	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			MPLETED	
		245409	B. WING		01	01/30/2015	
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	E	
MAPLE I	MANOR NURSING AI	ND REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
F 241	Continued From pa	age 19	F 2	241			
	Rehabilitation to pr	ble Manor Health Care & rovide all residents with privacy cares and in activities of daily					
	Resident's Rights p residents at Maple be treated with cor recognition of his/h including privacy in his/her personal ne Staff stood to assis	of facility policy Maple Manor policy dated 3/6/08, read, "All Manor Nursing Home are to asideration, respect and full her dignity and individuality a treatment and in care of beeds." St residents to eat and staff dent to another while assisting					
	was observed duri 11:45 a.m. No res attempt to eat inde (NA)-F loudly spok a.m. telling R26 to getting cold. R26 v fingers to eat cook use your fork twice away her plate afte	other residents at a table and ng the noon meal on 1/25/15 at ident at this table made the pendently. Nursing assistant e across the table at 11:47 eat the lunch because it was was observed to use her ed carrots. NA-F told R26 to e. At 12:00 p.m. R26 pushed er eating only carrots. No staff urage R26 to eat more of her					
	observed to be sta to eat. NA-O then while standing ass 5:12 p.m. it was no sitting at the west t wheelchair and sho NA-O left the dinin 5:16 p.m. NA-O re	the evening NA-O was nding while assisting a resident moved to another table and isted the residents to eat. At oted that 2 of the 4 residents able were sleeping in their ortly after this observation g room. Four minutes later at turned to the dining room and ist residents to eat. At 5:18					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT						(X3) DATE SURVEY COMPLETED	
		245409	B. WING	ì		01/;	30/2015
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MAPLE	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	 p.m. NA-O moved t while assisting R32 Between 5:16 p.m. observed to walk free residents to eat. At room stating that shother staff assisted with food remaining from the dining room The director of nurse on 1/27/15 at 3:01 perspectations were the resident she was here resident she was here realized there was a everybody needed room. DON stated that. Lack of covering ur dignity: R68 had Foley cath collection bag that we to promote dignity. On 1/21/15, at 7:15 open, R68 was obs indwelling Foley cat lying flat on top of F foot part. The unco could be seen from showing small amo The exposed part of filled with yellow co registered nurse (R 	age 20 to the next table and stood 2 and another resident to eat. and 5:29 p.m. the NA-O was om one resident to another while assisting 5 different t 5:20 p.m. NA-O left the dining he would return tomorrow. No these residents to eat and g on plates they were moved m by NA-P and RN-A. sing (DON) was interviewed p.m. DON indicated her that staff would sit beside the elping. DON stated she a problem with that since to be "fed" in the north dining the facility needed to change the facility needed to change fine collection bag to promote theter with urine visible in was not covered consistently a a.m. R68's room door was served lying in bed. R68's theter bag was also observed R68's blanket in bed, on the vered catheter bag and tubing the door, with the bag bunt of yellow-colored urine. of the catheter tubing was also lored urine. At 7:45 a.m. RN)-C verified R68's catheter bed. At 7:38 a.m. R68's room	F	241			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY IPLETED
		245409	B. WING			01/	30/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE N	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	uncovered catheter and visible from the assistant (NA)-B wa R68's catheter bag this time NA-B state the bag every shift a the night shift on top stated the catheter below R68. NA-B a placed in a blue bag to a loop-like attach R68's Admissions F indicated R68 had o dementia, depression retention. The Physician's Oro 11/1/14 indicated R should be kept below reflux, maintain a cl POS further indicate (blue canvass) bag provide dignity." R68's care plan data required indwelling retention. Also drain canvass bag to pre- dignity."	B was still lying in bed. The bag was still on top of bed, hallway. At 8:14 a.m. Nursing as interviewed and confirmed was lying on top of bed. At ed nursing assistant's empty and must have been placed by p of R68's bed. Also NA-B bag should always be hanging dded, the urine bag should be g and hooked "here " (pointing ment on bed frame). Face Sheet printed on 1/29/15, diagnoses including psychosis, on, anxiety state and urinary ders Sheet (POS) dated 68's urinary drainage bag w bladder level to prevent osed drainage system. The ed bag "to be kept in cloth to prevent infection and ed 10/20/14 indicated R68 Foley catheter due to urinary hage bag to be kept in a blue vent infection and "provide ter Care Policy dated 7/9/09, sure bag on side of bed frame, ouch the floor, to keep the bladder at all times and to be	F2	241			
F 246	• •	ONABLE ACCOMMODATION	F 2	246			3/11/15

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· · ·	E SURVEY PLETED
		245409	B. WING _			01/:	30/2015
NAME OF I	PROVIDER OR SUPPLIER	L		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC			5 19TH STREET NORTHWEST CHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246		-	F 24	46			
SS=D	OF NEEDS/PREFE	RENCES					
	services in the facil accommodations o preferences, excep	right to reside and receive ity with reasonable f individual needs and t when the health or safety of her residents would be					
	by: Based on observative review, the facility of reach for 1 of 1 rest for meeting cares. Findings include: R17 was observed be lying in bed, awa located on the foot slightly lower than t was not within R17' assistance from stanurse (RN)-C verifiewithin R17's reach under and around FRN-C was observe the foot board then R17's left side. The admission record admitted on 8/13/0 late effects of cereat in urethra, diabetes	resis (paralysis on half of the			Tag F246 Accommodation of Needs It is the policy of Maple Manor Nurs Rehab, LLC to make reasonable accommodations to meet the need preferences of each individual resid except when the health and safety individual or other resident would b endangered. It is the policy of Maple Manor Nurs Rehab, LLC that all residents have lights within reach when they are unattended in their room or bathroo Call lights are available with severa of controls to help accommodate individual resident abilities. Staff members frequently check on resid who are unable to use their call ligh During the next planned mandatory education meeting, all nursing staff instructed on the facility policy requ that residents have a call device accessible when in their room and bathroom The Director of Nursing/designee v randomly observe for proper call lig	s and dent of an e sing & call om. al types dents nts. / will be iiring	

Facility ID: 00916

		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245409	B. WING _			01/	30/2015
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC			75 19TH STREET NORTHWEST DCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246	6 Continued From page 23		F 24	46			
F 278 SS=D	The quarterly Minim 11/5/14, indicated F impairment; and R1 staff for most activit dressing, and positi MDS did not addres R17's care plan dat self-care deficits. In to assist with mobili grooming and to pla reach. On 1/29/15, at 2:35 stated she expecter place residents can 483.20(g) - (j) ASSI ACCURACY/COOF The assessment m resident's status. A registered nurse each assessment v participation of hea A registered nurse assessment is com Each individual who assessment must s that portion of the a Under Medicare an willfully and knowin false statement in a	hum Data Set (MDS) dated A17 had moderate cognitive I7 was totally dependent on ties of daily living to include ioning in bed. However, the ss activity preferences. and 6/6/14 indicated R17 had iterventions included two staff ity in bed, dressing and ace call light within R17's p.m. the director of nursing d staff to put call lights in a reach. ESSMENT RDINATION/CERTIFIED ust accurately reflect the must conduct or coordinate with the appropriate Ith professionals. must sign and certify that the pleted.	F 2		placement for one month. If noncompliance is noted, additional auditing and staff training will be do Compliance will be reviewed during April Quality Assessment and Assur Committee meeting. Completion Date: March 11, 2015	the	3/11/15

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		AND HUMAN SERVICES			RINTED: 02/25/ FORM APPRC AB NO: 0938-0	OVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		245409	B. WING		01/30/201	5
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	ETION
F 278	willfully and knowin to certify a material resident assessment penalty of not more assessment. Clinical disagreeme material and false s This REQUIREMEN by: Based on interview facility did not ensu Set (MDS) was coor resident (R68) revise Findings include: R68's quarterly Min assessment) dated on intermittent cath mark R68 to have a R68's care plan dat required indwelling retention. The Physician's Oro 11/1/14, indicated a 10/23/14, which rea [catheter]" and dire (14French) every 2 needed. The POS f diagnoses including depression, anxiety	sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each ent does not constitute a	F 278	Tag F278 Assessment Accuracy Maple Manor Nursing & Rehab, LLC conducts and coordinates each res assessment through participation o interdisciplinary care team. The fac completes resident assessments according to CMS guidelines as out in the User s Manual for the Resid Assessment Instrument. It is the goal of Maple Manor & Reh LLC to have an accurate assessme all residents to ensure that their nee and preferences are met. Each interdisciplinary team member signs certify the accuracy of the portion o assessment they complete. A regist nurse signs to certify that the assess is complete. The Minimum Data Set (MDS) assessment for resident number 68 been modified to reflect the user of indwelling urinary catheter. The Director of Nursing and/design monitor compliance with accurate M coding of urinary catheter use throu	ident f the lity lined ent ab, nt of eds s to f the tered sment t has an ee will IDS	

Facility ID: 00916

	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		IDENTIFICATION NONDER.		NG		
-		245409	B. WING _			/30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1875 19TH STREET NORTHWEST	ODE	
MAPLE	MANOR NURSING AN	D REHAB, LLC		ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 278	meant but confirme	N)-C was not sure what "UCI" d R69 had an indwelling Foley 10/23/14 and was being	F 27	78 random audits for the next 4 noncompliance is noted ado auditing and staff training wi Completion Date: March 11,	litional Il be done.	
F 279 SS=D	stated R68 had bee catheterization from discontinued on10/2 recent quarterly ME R68 was on intermi not reflect the accu indwelling Foley cat explanation why the show R68 had an ir 483.20(d), 483.20(k COMPREHENSIVE A facility must use t	n 8/2014 until it was 2014. RN-E verified the most OS dated 12/30/14 indicated ittent catheterization, and did rate status of R68 having an theter. RN-E did not give an e MDS was not marked to ndwelling Foley catheter. (1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's	F 21	79		3/11/15
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive				
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under the right to refuse treatment				

Facility ID: 00916

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						0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245409	B. WING _		01/	30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 279	Continued From pa under §483.10(b)(4	-	F 27	9		
	by: Based on observat review, the facility fa to address a history (C-diff) and Vancom (VRE) to prevent th for 1 of 1 resident (I and VRE; failed to c interventions for 1 c dialysis. Findings include: R38 had a history of plan lacked information staff and other resid The hospital dischar noted c-diff (C. diffic mild to life-threaten include watery diarr day for several days tenderness) infection The hospital dischar indicated R38 had a considered asymptor for a disease or infe symptoms) urinary enterococcus (VRE treated. The hospital indicated R38 has a interdisciplinary not	NT is not met as evidenced ion, interview and document ailed to develop interventions of having Clostridium difficile hycin-resistant enterococcus e spread of these infections R38) who had chronic C-Diff develop specific renal dialysis of 1 resident (R62) with renal af having C-Diff and the care attion to prevent the spread to dents. Arge summary dated 12/16/14 cile infection can range from ing. Symptoms of mild cases hea, three or more times a s, with abdominal pain or on and a urinary tract infection. Arge summary dated 12/30/14 recent c-diff infection. The summary dated 1/9/15 asymptomatic (a disease is omatic if a patient is a carrier ection but experiences no vancomycin-resistant ci) for which she was not al discharge summary also a history of C-diff. The es dated 1/9/15 indicated R38 he home with VRE and		Tag F279 Comprehensive Care Plans It is the policy of Maple Manor Nu Rehab, LLC to develop a multi-disciplinary, comprehensive care which provides a working to addresses the needs of each res Care plans reflect medical condit level of socialization skills, and w the resident may be vulnerable to The care plan describes services assist the resident in attaining or maintaining the highest practicab of physical, mental and psychoso well-being. The comprehensive care plan is completed by the Interdisciplinary by day 21 of a resident s stay. T resident/family/legal representation participate in the development, re and goals of the plan of care. Th interdisciplinary care team review resident s plan of care at least e days and with changes in condition Based on a full clinical nursing assessment of a resident s cogr status and physical and social ne temporary care plan is implement admission The temporary care p addresses infections including C- VRE as well as other conditions t require special staff direction to s meet the residents needs. Resident number 38 does not cur	plan of ol that dent. ons, nether abuse. will le level cial r Team he re view, e s the very 90 on. witive eds, a read on olan Diff and hat may afely	

Facility ID: 00916

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	FIPLI		(X3) DATE	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMF	PLETED
		245409	B. WING _			01/3	80/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ND REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 279	Continued From pa	age 27 hange to a private room had	F 27	79	have active C-Diff or VRE infections	sbut	
	occurred.				does have a history of the same. The resident does not currently require a	his	
		lication record indicated R38 at staff were to empty each			private room for medical reasons. Standard precautions are used whe	n	
	shift there by possi	bly exposing R38, staff, or			caring for all residents according CE	DC 0	
		-diff. The resident required nsfers and toileting and			guidelines. Implementation of conta precautions also follows the CDC	act	
	personal hygiene ir	ncreasing the chance C-diff			guidelines and is initiated with any		
	and VRE could be	transmitted to others.			resident who has an active diagnosi may affect the safety of other reside		
		0 a.m. the director of nursing			well as staff.	ino ao	
		ewed. DON indicated if being treated then no need to			Resident number 82 receives a rena The care plan has been revised and		
	isolate the resident	. They don ' t list on care plan			updated to reflect this diet order.		
		tive with C-diff or VRE. DON ey are to develop a temporary			The DON/designee will perform rand audits for two months to ensure care	dom	
	care plan with infor	mation about C-diff and VRE.			plans are updated, current, and	6	
	However, no tempo developed.	orary care plan had been			appropriate.		
	•	Nova Dian datad 1/10/10			Completion Date: March 11, 2015		
	indicated the purpo comprehensive pla working tool for sta R62 received dialys	Care Plan dated 1/19/12 base of the multi-disciplinary in of care what to provide a iff. sis services and renal diet nterventions for renal diet.					
	diagnosis that inclu	to the facility on 11/21/14, with uded end stage renal disease rding to admissions face sheet.					
	11/21/14, revealed hemodialysis on Tu	of physician orders dated physician orders for uesdays and Saturdays and					
	(CAA) dated 12/4/1	of facility care area assessment 14, identified R62 nutrition an for therapeutic diet and was					

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		AND HUMAN SERVICES				FORM	: 02/25/2015 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245409	B. WING			01/	30/2015
NAME OF F	PROVIDER OR SUPPLIER		·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE N	ANOR NURSING AN	ID REHAB, LLC			375 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279		-	F 2	79			
	revealed R62 receir diagnosis and atter Saturday. During interview on registered dietician diet, communicates received dialysis Tu	f dietary notes dated 1/21/15, ved renal diet related to nded dialysis on Tuesday and 1/28/15, at 9:10 a.m., verified R62 received renal with dialysis dietician, uesdays and Saturdays, and with R62 to dialysis.					
F 280 SS=D	of nursing verified F identification and in restriction. 483.20(d)(3), 483.1	1/30/15, at 8:00 a.m., director R62's care plan lacked terventions for renal diet 0(k)(2) RIGHT TO NNING CARE-REVISE CP	F 2	80			3/11/15
	incompetent or othe incapacitated unde	r the laws of the State, to ing care and treatment or					
	within 7 days after to comprehensive assist interdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after					

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		AND HUMAN SERVICES				RINTED: 02/25/2015 FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245409	B. WING	i		01/30/2015
NAME OF I	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	-
MAPLE I	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 280	Continued From pa each assessment.	ge 29	F	280		
	by: Based on observative view the facility facil	during the evening meal on o.m. to 6:11 p.m. R38 was ly but ate only 25% of her R38 stated that she was on a was not sure what foods she she had breaded food for			Tag F280 It is the policy of Maple Manor Nur Rehab, LLC to develop a multi-disciplinary, comprehensive care which provides a working too addresses the needs of each resid Care plans reflect medical condition level of socialization skills, and which the resident may be vulnerable to The comprehensive care plan is completed by the interdisciplinary day 21 of a residents stay. Care p needs are reviewed and revised a resident s conditions warrant. The resident/family/legal representative participate in the development, rev and goals of the plan of care. The interdisciplinary care team update plans for residents every 90-days, change of condition, and/or as need Resident number 38 is on a regulate with no fluid restrictions and is ablic choose her preferred menus choice care plan was reviewed and revised accordingly. The Food Service Dir and the consultant Registered Dire counseled with the resident severation regarding her previous diet restricts The resident s diet order and foo preferences will continue to be dist during her care conferences that a every 90 days and with significant	plan of I that dent. ons, eether abuse. team by lanning s a ne e view, s care with eded. ar diet e to ces. The ed ector titian al times tions. d cussed are held

Facility ID: 00916

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		0938-039 SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		G	COM	PLETED	
		245409	B. WING		01/3	30/2015	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
F 280	sodium, low choles R38 ' s care plan p On 12/22/14 a prot [related to] her nee healing." The interv with regular texture care plan also had "Diet: [R38] is at ris with need for a their restriction." The in salt diet and a 2000 the care plan proble ordered by the physical The director of nurs	a diet of 1500 to 2000 mg terol, and low fat. rovided 1/27/15 was reviewed. blem of "Diet: [R38] is at risk r/t d for extra calories to aid in ventions directed a general diet is and Boost supplement. The a problem dated 1/12/15 of kk r/t her medical dx [diagnosis] rapeutic diet and fluid terventions noted a no added 0 cc fluid restriction. Neither of ems identified the exact diet sician 1/9/15.	F 28	changes in condition changes. The Food Service Director has reall care plans to ensure that the prescribed diet is accurately reflet. The Food Service Director/desig audit the care plans during the resolution of the care plans during the restrictions. If noncompliance is additional auditing and staff train done. Completion Date: March 11, 201	ected. nee will outine cy of diet noted ing will be		
F 282 SS=E	listed on the care p The certified dietar interviewed on 1/29 he had not revised doctors prescribed 483.20(k)(3)(ii) SEI PERSONS/PER C/ The services provide must be provided b accordance with ea care. This REQUIREMEN by: Based on observa	RVICES BY QUALIFIED	F 28	2 Tag F282 Services by Qualified Person/Pe	2	3/11/15	

Facility ID: 00916

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	OMB NO.	0936-03: E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
		245409	B. WING _		- 01/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
IAPLE I	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTH ROCHESTER, MN 55901	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIC DATE
F 282	Continued From pa	ge 31	F 28	32		
	2 of 3 residents (R8 assistance with per ensure 2 of 2 reside weights to assess h monitor daily intake doctors order for da indwelling catheter prevent urinary trac (R68) with a Foley of adaptive scoop plat for 1 of 1 resident (I plate to eat indeper Findings include: Lack of assistance R3 did not receive a according to care p R3's care plan date of nutrition risk relat history of needing n liquids, had history intake and dysphag	with eating: assistance with eating lan interventions. d 3/19/13, identified problem ted to history of dysphagia, nechanically altered diet and of weight loss due to poor oral ia. Approaches included soft assisted table, and wanted		Maple Manor Nursing develops an interdisc for each resident bas comprehensive asse resident s needs an nursing staff are mad resident s plan of ca routinely provided tha standards and suppor practicable level of fu well-being.The procedures for ca residents' care needs staff were reviewed a appropriate. During a meeting, the nursing that the resident care followed and that job expectations include following the care pla In reference to the re experience: The dire been instructed to re assistance care guid assistance required b 3 and 88 were review nursing assistance. P and timely assistance	ciplinary plan of care sed on a ssment of the d preferences. The de aware of each are and services are at meet professional orts the highest unction and communicating the s to the direct care and found a mandatory training staff were instructed e plans must be performance being aware of and an. esidents dining ct care staff have fer to the unit es for direction on ith eating. The eating by residents number ved with the certified roviding adequate	
	of self-care deficit r with activities of dai 1 assist with eating			In reference to perso the residents: The di been instructed to re assistance care guid meeting the resident	rect care staff have fer to the unit es for direction on s needs for	
	was in wheelchair in a large table design residents who need	n 1/28/15, at 9:45 a.m., and n the east/west dining room at nated by the facility for led assistance to eat. Also at nurse (RN)-C was assisting		assistance with person needs. The nursing a reminded to pay part cleaning eyeglasses hair, and cleaning/cu	assistants were icular attention to removal of facial	

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FORM / /IB NO.	0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (SURVEY PLETED
		245409	B. WING _			01/3	80/2015
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	IANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 282	R3 to eat. At 9:52 a alone. R3 still had p and made no attern 10:00 a.m. R3 was assistance with eat 10:12 a.m., nursing R3 with meal. R3 h from 9:52 a.m. to 1 minutes. R3 was admitted 3/ included paralysis a Lewy Bodies, accor printed 1/29/15. The facility identifie Data Set (MDS), ar to have short and lo moderately impaire dependence on 2 s total dependence o personal hygiene, a altered diet. Care Plan policy da To provide a multi-o plan of care which p profiles the needs of During interview on of nursing stated sh care plan and to pro- meals. R88 did not receive according to care p	A.m., RN-C left R3 at the table plate of food and beverages opt to eat independently. At noted to be asleep and no ing was offered or provided. At assistant (NA)-D sat to assist ad no assistance with eating 0:12 a.m. a total of 20 (19/13, with diagnosis that agitans and dementia with rding to physician orders d R3 on the annual Minimum n assessment dated 12/8/14, ong term memory problems, d decision making, total taff for activities of daily living, n 1 staff for eating and and received a mechanically ated 1/19/12, read, "Purpose: disciplinary comprehensive provides a working tool that of each resident 1/29/15, at 9:00 a.m., Director he expected staff to follow the ovide R3 with assistance for	F 28	82	grooming needs of residents number and 88 were reviewed. In reference to obtaining daily weigh The licensed and certified nursing st have been instructed to refer to the physician s orders and unit assistant care guides for direction on the freque of resident s weights. The important obtaining daily weights as instructed the care guides was reinforced with certified nursing assistants. The need assure timely weights, monitor weight changes, and report weight changes the physician directs were reviewed the licensed nurses. The physician order for daily weights and reporting weight gain for resident number 45 weights for resident number 45 weights for resident number 38: The nursing staff. In reference to monitoring fluid intakt colostomy output and weights for resident num 38. The facility s monitoring and documentation procedures were discussed as part of the staff instruction/education process. In reference to the indwelling catheter placement of the urine collection bag resident number 68: The licensed and certified nursing staff were instructed the facility policy and standards of pu- for decreasing the risk of urinary trad- infections for residents with indwelling catheters. The need for proper securement of the collection bag and infections for residents with indwelling catheters. The need for proper	er and g for nd on ractice ct ng d	
	R88's care plan dat	ted 9/10/14, identified problem			keeping the collection bag below the	e level	

Facility ID: 00916

ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
	245409	B. WING			01/3	30/2015
IAME OF PROVIDER OR SUPPLIE	R	· [S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
APLE MANOR NURSING	ND REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
 need for mechan dentation, due to for nutritional sup to need for assist decreased cognit included assist as with food/fluid. Ap included pureed of Approaches date supplement two t 9/29/14 included for swallow and g pace and uncove assisted. R88 was observe was in wheelchai room. R88 was p the facility as bein assistance to eat to be asleep and quiche, and masl cups of beverage directly in front of a.m. (total of 32 r and no staff assis to eat her meal. A assistant (TMA) food on a spoon immediately drop TMA-A left the ta assistant (PFA)-A same table, hand and PFA-A contir 	bage 33 ne in nutritional status due to cally altered food related to poor open areas with increased need port, due to abnormal labs, due ance with meals, due to ion. Approaches dated 9/10/14 a needed and as resident allows oproaches dated 9/22/14 diet with thin liquids. d 9/23/14, included house mes daily. Approaches dated alternate bites with sips, watch ive next bite/sip to maintain red cups ok when being d on 1/27/15, at 11:18 a.m., R88 r located in the east/west dining aced at a table designated by ng for residents who need Also at this time R88 appeared had a meal of pureed carrots, ned potatoes and four adaptive s with lids were on the table R88. From 11:18 a.m., to 11:50 ninutes) R88 remained asleep ted her to eat or encourage her at 11:50 a.m., trained medication A, aroused R88 and then placed and handed to R88, who ped the spoon into her lap then ple. At 11:54 a.m., paid feeding assisted another resident at ed R88 glass of chocolate milk ues to assist R88 to eat g another resident to eat.	F 2	282	of the resident s bladder was rein The bladder management plan of resident number 68 was reviewed staff. In reference to resident meal time preferences and need for adaptive equipment for resident number 32 nursing and dietary staff were instr on the resident s preference for of portions at breakfast and the need scoop plate to facilitate independe eating. The need to reference the physician s orders, care plan, res care guides and/or the dining room card for diet instructions was reinfor with the nursing and dietary staff. Compliance with care plans addre catheter care, assistance with pers cares, obtaining weights, reporting weight changes, monitoring intake will be monitored by the Director of Nursing/designee through random observation and record review for month. The Food Service Director monitor for staff compliance with of plans specifying serving portions a adaptive eating equipment/utensits through random observations for of month. If noncompliance is noted, additional monitoring and staff trai be done. Compliance will be review the next Quality Assessment and Assurance Committee meeting. Completion Date: March 11, 2015	care for with the : The ructed louble for a nce in ident n tray porced ssing sonal of /output f one will care and sone ning will wed at	

Facility ID: 00916

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		AND HUMAN SERVICES				FORM): 02/25/2018 / APPROVED). 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		TE SURVEY MPLETED
		245409	B. WING			01	/30/2015
	PROVIDER OR SUPPLIER	ID REHAB, LLC		1875 19	ADDRESS, CITY, STATE, ZIP COL TH STREET NORTHWEST STER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI ROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	diagnosis that inclu Bodies and paralys resident diagnosis The facility identifie Minimum Data Set 11/23/14, to have s moderately impaire dependence on 2 s total dependence of personal hygiene, a altered diet. R88 was again obs 1/28/15, at 9:37 a.r same table as the of was observed asle and scrambled egg beverages set befor minutes without as sat next to R88 to of 9:42 a.m., registere R88 and began to a RN-C asked if R88 cup to R88 who too handed R88 a spoo took and ate the fo R88 and the table. beverages in front to feed self. From minutes interval) R assistance to eat o eat until NA-D sat of R88 to eat. Intervie the cooked cereal w	ded dementia with Lewy is agitans according to codes printed 1/30/15. ed R88 on the quarterly (MDS), an assessment dated hort term memory problem, ed decision making, total staff for activities of daily living, on 1 staff for eating and and received a mechanically erved during breakfast on m., R88 in wheelchair at the evening meal yesterday. R88 ep with plate of cooked cereal gs, applesauce, magic cup, and ore her. At 9:41 a.m. (four sistance to eat meal) TMA-A only administer medication. At ed nurse (RN)-C sat next to assist her to eat. At 9:45 a.m., wanted juice and handed the ok the cup. At 9:47 a.m., RN-C on of cooked cereal and R88 od. At 9:52 a.m., RN-C left R88 still had plate of food and of R88 and made no attempt 9:52 a.m. until 10:12 a.m. (20 88 did not have staff r encouragement from staff to with R88 and begin to assist ew at that time, NA-D verified was cold and had not been ving it to R88. At 10:17 a.m., 8 with a drink of juice and then	F 2	82			

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY
		015400		NG		
	PROVIDER OR SUPPLIER	245409	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE		/30/2015
	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 282	Care Plan policy da To provide a multi-c plan of care which p profiles the needs of During interview on of nursing stated sh care plan for R88. Lack of providing p care plan: R88 had long facial nails which were no according to R88 's R88's care plan dat of needed assistan transfer and ambul decreased endurar included assist of o mobility, dressing, p with meals, set up f assistance when sl R88 was observed was observed with bed. On 1/28/15, at wheelchair at south room. R88 was ob finger nails and fac R88 was admitted t diagnosis that inclu Bodies and paralys resident diagnosis of	ated 1/19/12, read, "Purpose: disciplinary comprehensive provides a working tool that of each resident 1/29/15, at 9:00 a.m., Director ne expected staff to follow the ersonal cares according to 1 hair and long soiled finger of trimmed nor cleaned s care plan. ted 9/4/14, identified problem ce with activities of daily living, ation related to dementia and nee and mobility. Approaches one staff with wheel chair personal hygiene, is assisted for meals and required eepy. on 1/26/15, at 2:58 p.m., R88 long facial hairs while lying in t 9:37 a.m., R88 sat in n table in east/west dining served to have long, soiled	F 28	32		

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING		·····	01/;	30/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	 11/23/14, to have sl moderately impaire dependence on 2 s total dependence o personal hygiene, a altered diet. During interview on nursing assistant (N R88 with morning c provided facial hair stated residents are and nail care was d 10:12 a.m., NA-D v finger nails and long During interview on registered nurse (R hair and long soiled stated she expected day and as needed manicures were do She verified R88 re this day was Wedne The Care Plan polid "Purpose: To provic comprehensive plan working tool that pri- resident." The AM Cares polid Procedure: 2.The m cared for in the sam bath." 	hort term memory problem, ad decision making, total staff for activities of daily living, on 1 staff for eating and and received a mechanically (1/28/15, at 10:10 a.m., NA)-D stated they had assisted cares. NA-D verified had not removal or nail care. NA-D e shaved with morning cares done in the evenings. Also at verified R88 had long soiled g facial hairs. (1/28/15, at 11:15 a.m., RN)-F verified the long facial d finger nails for R88. RN-F d facial hair shaved on bath l. RN-F sated she expected one weekly and on bath days. eceived bath on Fridays and esday morning. (cy dated 1/19/12, read, de a multi-disciplinary n of care which provides a ofiles the needs of each (cy dated 8/31/04, read, " nouth nails, and hair are to be ne manner as for a complete (LS policy dated 3/12/08, read,	F 2	282			

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING _			01/;	30/2015
NAME OF F	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	MANOR NURSING AN	ID REHAB, LLC			375 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	of nursing stated sh care plan and to pro- meals and persona R31 was observed 1/26/15 at 1:31 p.m had dark brown/bla fingernails and eye and had tape on bo R31's care plan ind with grooming. Acc 1/30/15, RN-A state glasses were includ R31's quarterly Min 10/30/14 indicated i cognitive impairment for activities of daily dressing, hygiene, a Physician's visit pro- included diagnoses primary open angle The policy Care of I well-manicured." Lack of daily weight R45 was not weight orders and care plan accident, periphera hypertension, dyslip failure. Care plan dat risk related to medi	 1/29/15, at 9:00 a.m., Director ne expected staff to follow the ovide R88 with assistance for al care. on 1/25/2015 at 2:06 p.m., on n., 1/27/15 at 8:57 a.m. R31 ack debris underneath glasses were extremely dirty oth bows of the glasses. licated resident was one assist ording to an interview on ed fingernail care and cleaning ded in the grooming category. nimum Data Set (MDS) dated the resident had severe nt and was dependent on staff y living including toileting, and eating. ogress note dated 1/15/15 s of advanced dementia and e glaucoma. Nails read, "Keep clean and ts as directed in the care plan: ed daily according to physician an interventions. ted 12/11/14, identified or complications due to use of s related to cerebral vascular 	F 28	82			

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		AND HUMAN SERVICES					FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245409	B. WING	i			01/:	30/2015
NAME OF I	PROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP COD	Е	-	
MAPLE I	MANOR NURSING AN	ID REHAB, LLC			1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD) BE	(X5) COMPLETION DATE
F 282	Physician orders d physician orders fo congestive heart fa dated 12/12/14, for practitioner with we one day or 5 pound 220 pounds (#). R45 was admitted 1 diagnosis that inclu according to physic diabetes mellitus, o peripheral vascular admission minimum 12/16/14; and right 12/5/14, according dated 12/26/14. Document review o R45 showed weigh days from 12/12/14 12/12/14252 pour surgery 12/16/14250.4 po Hospitalized 12/2 12/26/14 12/27/14-239 pour 1/20/15243.7 pou 1/23/15-230 pound 1/24/15232.2 pou 1/26/15-231 pound	Accord weights as ordered. ated 12/10/14, revealed r daily weights due to ilure; and physician orders daily weight, notify nurse eight gain over 3 pounds in ls from baseline, admit weight to the facility on 12/10/14, with ded congestive heart failure, ian orders dated 12/10/14; erebral vascular accident, and disease, according to the n data set (MDS) dated below knee amputation to hospital discharge summary of facility record of weights for ts were done 9 times out of 35 to 1/26/15 as follows: ands expected weight loss after unds ends nds nds nds nds	F	282				

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245409	B. WING			01/	30/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MAPLE N	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	gain due to not doir report the five poun of 220 pounds or w or more. By 1/26/15 pounds over base li Document review o dated 12/26/14, rev 12/21/14 and disch 12/26/14, for diagne (stroke) secondary thromboembolism (During interview on registered nurse (R weights as physicia of evidence of nurs weight gain over 3 p 1/10/15, a gain of 4 During interview on stated she expected RN-F verified daily assignment sheet a Charting-West list f The Care Plan polid "Purpose: To provid comprehensive plan working tool that pro- resident." Policy for Weighing "It is the policy of M residents are weigh on each resident ar "Residents will be w by the physician, bu	ng weights daily nor did the ad weight gain from base line then R45 weighed 225 pounds 5 R45 weighed 231 or 11 ine weight. If hospital dismissal summary vealed R45 was hospitalized arged from the hospital on osis of pontine infarction to acute basilar (blood clot). 1/29/15, at 5:00 p.m., N)-A verified the lack of daily in ordered. RN-A verified lack e practitioner notification of pounds between 12/27/14 and .7 pounds 1/30/15, at 9:30 a.m., RN-F d R45 to be weighed daily. weights were on the nursing and on the Evening Weight for daily weights. Cy dated 1/19/12, read, de a multi-disciplinary n of care which provides a ofiles the needs of each	F 2	282			

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MLII		CONSTRUCTION). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					MPLETED
		245409	B. WING			01	/30/2015
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ND REHAB, LLC			5 19TH STREET NORTHWEST CHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 282	Continued From pa	age 40	F 2	82			
	with the plan of car as ordered by the p	e on the treatment record and physician.					
	monitor fluid intake monitor colostomy daily. The treatme intake and output r documentation rela	cord indicated staff was to e because of a fluid restriction, output, and monitor weight nt record, intake record, or ecord did not have ated to fluid intake, colostomy ghts nor was any provided					
	clinical manager (F nursing stated they being done as orde	y on 1/28/15 at 8:00 a.m. the RN)-A and the director of y were aware that this was not ered by the physician. are plan to prevent urinary tract provided:					
		erventions and services in by catheter were not followed					
	open, R68 was obs indwelling Foley ca lying flat on top of 1 7:45 a.m. registere R68's catheter bag R68's bed linens. F bag was to be plac RN-C stated, "Yes. was in the collection hold the urine bag and verified there we collected in bag. A	5 a.m. R68's room door was served lying in bed. R68's theter bag was also observed R68's blanket of his bed. At d nurse (RN)-C observed was placed directly on top of RN-C was asked if the urine ed on top of the bed linens and " On asking how much urine on bag RN-C was observed to and raised it to her eye level was about 75 milliliters of urine s RN-C was holding the bag (rubber emptying spout) was					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 02/25/2015 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245409	B. WING _			01/:	30/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MAPLE	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	uncovered and sticl in the collection bag placed the urine bas the drain spout in d the bed. At 7:38 a.m door was open and the collection bag s 8:14 a.m. Nursing a interviewed and cor was lying directly or stated nursing assis shift and must have the night shift when stated the catheter below R68. NA-B a placed in a blue clo (pointing to a loop-II NA-B then moved b R68's care plan dat required indwelling retention. The care drainage bag below and to maintain a cl R68's Admissions F indicated R68 had o dementia, depressive retention. The Physician's Oro 11/1/14 indicated R should be kept belov reflux, maintain a cl POS further indicated (blue canvass) bag provide dignity."	king out as it was not secured gs spout holder. RN-C then ag back on top of the bed with lirect contact with the linens on m. on 1/21/15 R68's room I R68 was still lying in bed with still on top of the bed linens. At assistant (NA)-B was nfirmed R68's catheter bag n top of R68's bed linen. NA-B stants empty the bag every e been placed on the bed by n they left this morning. NA-B bag should always be hanging added, urine bag should be oth cover and hooked "here" like attachment on bed frame).	F 28	32			

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED
		245409	B. WING			
	PROVIDER OR SUPPLIER	240403	2	STREET ADDRESS, CITY, STATE,		/30/2015
	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWE ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 282	not to allow bag to bag below level of inside a blue dignit The American Nurs the guidelines prov Disease Control (C associated urinary recognized the imp maintenance of the and drainage syste catheter secureme maintain drainage times (but not on fl the drainage spout R32 was observed 1/27/15 at 8:40 a.m revealed R32 did n portions and did no plate with high edg R32's care plan da significant weight le at breakfast with es 8/13/14 provide a provide shallow bo plate." R32's quarterly Mir 1/9/15 indicated wa impaired with diagr required extensive living that included dressing and hygie R32's dining room communicate dieta	cure bag on side of bed frame, touch the floor, to keep the bladder at all times and to be y bag. ses Association (ANA) adopted ided by the Centers for CDC, 2009) to prevent catheter tract infections. The guidelines bortance of proper e indwelling urinary catheter m, to include appropriate nt per facility protocol and to bag below the bladder at all oor) and to prevent contact of during breakfast meal on n. and on 1/28/15 at 8:50 a.m. ot receive double sized food ot receive a scoop plate (a es) according to the care plan. ted 1/16/15 read, "has had a bssis offered double portions ktras on tray for other meals a scoop plate at all meals, wls if unable to use scoop nimum Data Set (MDS) dated as moderately cognitively noses of dementia, and assist with activities of daily eating, toileting, transfers,	F 2			

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		AND HUMAN SERVICES			FO	ED: 02/25/2019 RM APPROVEI NO. 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245409	B. WING			01/30/2015
	PROVIDER OR SUPPLIER	ID REHAB, LLC	1	18	TREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST OCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 F 309 SS=E	certified dietary ma did not receive dou resident was support 483.25 PROVIDE C HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on observat review, the facility fir residents (R100, R ongoing services and the physician to mo status changes so fit to the physician for maintain an agreen for 1 of 1 resident (stage dialysis service Findings include: Lack of monitoring to congestive heart R100 was admitted according to the ad staff failed to monit	de a scoop plate. on 1/30/15, at 10:30 a.m. nager (CDM) verified resident ble portions and stated the osed to have a scoop plate. CARE/SERVICES FOR EING t receive and the facility must ary care and services to attain nest practicable physical, osocial well-being, in e comprehensive assessment NT is not met as evidenced tion, interview and document ailed to ensure 5 of 39 71, R45, R38, and R39) had nd treatments as ordered by onitor for significant health they could be reported timely interventions; and failed to nent with the dialysis provider R62) currently receiving end ces.		282	Tag F309 Quality of Care Maple Manor Nursing & Rehab, LLC provides the necessary care and servic to assist the resident in attaining or maintaining the highest practicable, physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The residents are routinely monitored to assure that significant heat changes are reported to the physician i timely manner. The facility s policies addressing weig fluid intake monitoring, and monitoring/reporting condition changes were reviewed. According to policy, residents are weighed monthly and mo often as order by the physician. Weight	f Ith n a nt, re

Facility ID: 00916

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245409	B. WING _		01/3	30/2015
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
IAPLE	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHW ROCHESTER, MN 55901	EST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 309	Continued From pa	ge 44	F 30	09		
	overload for R100 v congestive heart fa diuretic, and had a centimeters (cc). R100's hospital disc 1/13/15 indicated R included the diagno failure, acute hypox kidney injury on chr hypokalemia (high s to this summary the heart failure was ne (diuretic). A physician's visit n 1/19/15 indicated R the past few month with dehydration. R100's physician or Hydrochlorothiazide (mg) by mouth ever every other day, po milli-equals (mEq) k Lasix, daily weights restriction. R100's care plan da was cognitively imp activities of daily livi transfers, toileting, indicated R100 was imbalance related t directed staff of fluid monitor for dehydra R100's fluid intake and output form. F were dated from 1/ However, no fluid ir	who had a new diagnoses of ilure, had a newly prescribed fluid restriction of 1500 cubic charge summary dated 100 was cognitively intact and bees of acute congestive heart temic respiratory failure, acute conic kidney disease, and serum potassium). According e diagnoses of congestive ew and was started on Lasix ote from hematology dated 100 had been hospitalized in s for a urinary tract infection rders included e (diuretic) 12.5 milligrams ry day, Lasix 40 mg by mouth tassium chloride 20 by mouth every day while on t, and 1.5 liter (L) fluid ated 1/22/15 indicated R100 vaired, was independent with ing (dressing, hygiene, and eating). Care plan is at risk for electrolyte o diuretics and fluid restriction; d restriction, daily weights, and	F 31	are reported to the chaneeded follow up and of medical record. A sca accommodates wheele purchased. According to policy, dia staff document intake residents as ordered b The amounts are totale and documented in the According to policy, re- monitored for condition those related to conge The physician/nurse pu- notified as necessary of resident response to th and nursing plan of ca During the planned mathe the certified nursing as licensed nurses will be facility s policies for 1 documenting fluid intal a fluid restricted diet 2 documenting output fo colostomy 3) obtaining daily weights 4) reporti- weight gain/loss to the monitoring residents w condition changes require interventions such as a worsening congestive use of the new wheelc Resident number 100 condition improved and discharged from the fa 2015. Resident number 71	documented in the le that chairs was recently etary and nursing and output for by the physician. ed every 24 hours e medical record. sidents are n changes including stive heart failure. ractitioner is to be regarding the ne current medical re. andatory meeting, sistants and e reinstructed on the) monitoring and ke for residents on) monitoring and r residents with a and documenting ing significant physician 4) who are at risk for uiring immediate symptoms of heart failure and 5) hair scale. The resident s d she was	

Facility ID: 00916

	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED	
		245409	B. WING		01/3	30/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		0/2013	
MAPLE I	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 309	not been completed documentation R10 1/19/15, 1/20/15, 1/ On 1/23/15 docume of 220 ccs (cubic co intake documented intake documented total intake documented total intake documented total intake documented total intake documented forms had a 24 hou determine if they m No further documented monitoring, assessi status was located provided when reque During an interview stated she did not r between meals; and restriction. R100 was fluid she had consu explained nurses ker revealed no water p bedside. During an observat R100 had 240 ccs of 140 cc of orange ju During an interview licensed practical n dietary gave certain then R100 told the consumed. The am recorded on the fluit then shown the fluit had not been comp During an interview registered nurse (R	d. According to the 00 had no fluid intake on (21/15, 1/22/15, and 1/28/15. entation indicated a total intake entimeters), on 1/24/15 total was 120 ccs, on 1/25/15 total was 60cc's and on 1/27/15 ented was 30 cc. None of the ir totals calculated to et or exceeded fluid limit. Intation pertaining to ing, and evaluating of fluid in the medical record or uested. on 1/26/15, at 1:25 p.m. R100 receive the fluids she wanted d explained the fluid as unable to report how much imed so far that day; and ept track of that. Observation bitcher or water glass at ion on 1/28/15, at 7:48 a.m. of milk, 240 cc of water, and ice. on 1/28/15, at 7:44 a.m. urse (LPN)-D explained that n fluid amounts to R100 and nurses how much she iounts should then be id intake sheet. LPN-D was d intake sheet and verified it leted. on 1/28/15, at 7:54 a.m. IN)-A stated fluid was divided and nursing. No one is	F 309		Nurse of Nurses condition eights were was updated Nurse of Nurses condition d restriction resident is to e weighed eatif has been ent colostomy re plan has Nurse of Nurses condition r was written iction and was updated ntract with the ialysis nd is awaiting by of the in the ignee will ugh ew for one ve been take has been		

Facility ID: 00916

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY	
IND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CO	MPLETED	
		245409	B. WING _			/30/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE	
F 309	 309 Continued From page 46 During an interview on 1/28/15, at 7:56 a.m. director of nursing (DON) stated nursing should be monitoring and evaluating fluid intake. Facility policy Nutritional-hydration dated 2/1/2012 read, "Accurate intake and output records help evaluate a patient's fluid balance, suggest various diagnoses and influence choice of therapy." The policy instructed staff after a doctor 's order is received to implement 24 hour recording and the night shift was to total daily fluid intake. The policy further instructed staff to communicate recordings and monitoring to resident and nursing staff and to record total amounts consumed at meals, with medications, and between meals. The policy outlined composition of nursing narrative documentation that included "estimates of intakesany refusals of intakes." The policy also read, "There will be on-going response to the diet as ordered, weekly charting will include reflection of resident's response to diet as ordered, night nurse will total all fluids for 24 hours on each individual chart daily. and dietary weekly committee to review fluid restriction." Lack of monitoring weight and assessing for symptoms of congestive heart failure (CHF): R71's admission Minimum Data Set (MDS) dated 11/5/14, indicated he had short-term memory loss, moderately impaired decision making skills 		F 30	colostomies, and weight chan being communicated to the physician/nurse practitioner as Completion Date: March 11, 2	s ordered.		
	no or unknown wei was not on a diuret R71's hospital Hist 10/30/14, indicated respiratory failure r diastolic heart failu	required cues and supervision, ght loss or weight gain, and ic (medication to reduce fluid). ory and Physical dated diagnoses of hypoxemic esolved, secondary to chronic re, acute systolic heart failure, paroxysmal atrial fibrillation,					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245409	B. WING			01/3	30/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Physical revealed F secondary to failure from the cardiac se inpatient psychiatric severe depression. was 162 lbs. on 10/ discharge orders da received Lopressor hypertension. The continuing care inst for: Congestive hea R71's signed physic read, "daily weights [nurse practitioner]] than] 3 lbs [pounds] baseline weight. Ba [pounds]." Physicial "Lasix 10 mg [mill daily update provide [pounds] or more in more total. Update (weights, edema, lu and physician order Bilateral lower extree R71's care plan dat problem of at risk for medications related fibrillation and hype staff to notify his me of complications of to lower blood press hypo/hypertension.	herapy. The History and R71 was hospitalized to thrive and was moved evoice and transferred to an c unit for management of I talso indicated his weight /27/14. R71's hospital ated 10/30/14 indicated he r 12.5 milligrams (mg) for discharge orders for tructed, "daily weights required art failure." cian orders dated 10/31/14 s PMs [evenings], Update NP with weight gains of > [greater of in a day or 5 lbs from aseline weight 162.1 lbs in orders dated 11/7/14 read, lligram] by mouth daily, weigh er for weight gains 3 # n one day and 5 # [pounds] or provider with fluid status ungs) on 11/11 [11/11/14]" rs dated 11/1/14 read, " emity wraps for edema." ted 11/6/14 identified a or complications of cardiac d to hypertension, atrial erlipidemia. The plan instructed edical practitioner of any signs antihypertensives (drugs used sure) including	F 3	09			
		into R71 ' s medical record on aled the following weights:					

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245409	B. WING			01/3	30/2015
NAME OF	PROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
MAPLE	MANOR NURSING AN	ID REHAB, LLC			75 19TH STREET NORTHWEST DCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	ROVIDER OR SUPPLIER IANOR NURSING AND REHAB, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 11/1/14 165 lbs. (up three lbs from hospital discharge weight on 10/27/14, taken three days prior to hospital discharge) 11/2/14 163 lbs 11/10/14 127 lbs 11/10/14 127 lbs 11/16/14 155 lbs R71 had a nurse practitioner visit on 10/31/14; one day past his hospital discharge. The limited evaluation post hospital follow-up visit read, "PHYSICAL EXAMINATION: Lungs: Scattered expiratory crackles. Respirations even and unlabored. Extremities: +1 edema bilateral feet only. " Nurse practitioner visit on 11/7/14; nine days post his hospital discharge. The limited evaluation visit read, "Was admitted to Maple Manor on 10/30 after a prolonged hospitalization for issues including failure to thrive, depression, CHF [congestive heart failure] and afib [atria] fibrillation]. Nursing was to update me with fluid status on 11/3, but this information was never received. Patient is seen today after nursing home provides written communication reporting lower extremity edemaPHYSICAL EXAMINATION:Lungs: Diminished breath sounds bibasilar, otherwise clear to auscultation. Respiration unlaboredExtremities: +2 edema bilateral feet and ankles. +1 edema ankle to mid-calf. IMPRESSION/REPORT/PLAN: #1 Acute on chronic heart failure #2 possible recent MI [myocardial infarction, heart attack]. Patient was not discharged on any diuretic. He does show a bit more edema in his feet and legs than my previous visit. Most recent recorded weight at		F 3	09			

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION		D. 0938-039 TE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:		ING	()	MPLETED		
		245409	B. WING		0.	1/30/2015		
NAME OF I	PROVIDER OR SUPPLIEF	1		STREET ADDRESS, CITY, STATE, ZIF	P CODE			
MAPLE I	MANOR NURSING A	ND REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	Г			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE		
F 309	Continued From p	-	F 3	09				
	these are obtained of Lasix 10 mg [mi use TED stocking CBC [complete blo [electrolytes/creati 11/11. Nursing to u (weights, edema, l R71's interdisciplir	ill ask nursing to ensure that I. I am going to add a low dose illigrams] by mouth daily and for compression. Recheck bod count], Lytes/Cr nine to test kidney function] on update me with fluid status ungs, ect [sic].) at that time" hary progress notes were 31/14 to 11/3/14 and 11/8/14 to						
	to monitoring of date extremities or lung	aled no documentation related ally weights, edema in sounds to determine if fluid and heart was not able to a fluid.						
	R71 had physician to diagnosis of cor	2 p.m. registered nurse (RN)-E orders for daily weights related ngestive heart failure. RN-E did not complete daily weights ysician orders.						
	(DON) stated she follow the physicia	9 p.m. the director of nursing would have expected staff to n orders for daily weights and (nurse practitioner) for the ied.						
	extremity edema, monitor R71 for sy failure that does no working. Rather, it pumping power is failure, blood move	had symptoms of lower the facility failed to consistently imptoms of CHF (CHF is Heart of mean the heart has stopped means that the heart's weaker than normal. With heart es through the heart and body nd pressure in the heart						

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		AND HUMAN SERVICES			FORM	: 02/25/2015 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245409	B. WING		01/	/30/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
MAPLE	MANOR NURSING AN	D REHAB, LLC		875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	needs. The chamber by stretching to hole the body or by becch helps to keep the b muscle walls may e become unable to p the kidneys may rearest retain fluid (water) a arms, legs, ankles, the body becomes heart failure is the t condition.) R45 was not weigh assessment for cor R45 was admitted t diagnosis that inclu according to physic diabetes mellitus, c peripheral vascular admission MDS dat knee amputation 12 discharge summary Document review o 12/10/14, revealed weights for congest orders dated 12/12 nurse practitioner of pounds in one day admit weight 220# Document review o dated 12/26/14, rev 12/21/14 and disch 12/26/14, for diagnos	ers of the heart may respond d more blood to pump through oming stiff and thickened. This lood moving, but the heart eventually weaken and oump as efficiently. As a result, spond by causing the body to and salt. If fluid builds up in the feet, lungs, or other organs, congested, and congestive erm used to describe the ed daily nor had ongoing ntrol of CHF. to the facility on 12/10/14, with ded congestive heart failure, ian orders dated 12/10/14; erebral vascular accident, and disease, according to the ted 12/16/14; and right below 2/5/14, according to hospital	F 309			

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP		(X3) DAT	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	à	COM	IPLETED
		245409	B. WING	·		01/	30/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC			1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Assessment dated 243 pounds (#), die summary included a medications, abnorn pressure ulcer, 9% weight loss may be amputation, current and staff to monitor Document review o 12/31/14, revealed reflected weight los notified of need to k prosthesis on or off staff to monitor weig R45's care plan dat problem of R45 at of cardiac medication vascular accident, p hypertension, dyslip failure. Care plan a and vital signs as p Resident care plan problem as risk relat need for therapeutid directed staff monitor ordered. Document review o R45 revealed the for 1/26/15: 12/12/14252 pour surgery 12/16/14250.4 pour	12/17/14, identified weight of et of no sugar added, and at risk due to diet, multiple mal lab values, stage 2 weight loss in 3 months, some related to right below knee t weight taken with right cast, weights. of dietary progress note dated weight of 233 pounds which ss of 6.8% in 11 days, nursing know if were taken with independent in eating, and ghts. ted 12/11/14, identified risk for complications of use ons related to cerebral peripheral vascular disease, pidemia, and congestive heart approaches directed weights er orders and or policy. dated 1/8/15 identified ated to medical diagnosis and c diet. Care plan approaches or and record weights for pollowing weights 12/12/14 to hds expected weight loss after	F 3	309			

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PRINTED: 02/25/2015

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 02/25/2015 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY IPLETED
		245409	B. WING			01/	30/2015
NAME OF	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC			1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	12/27/14-239 poun 1/10/15243.7 poun 1/21/15228.5 poun 1/22/15229.3 poun 1/23/15-230 pound 1/24/15232.2 pound 1/26/15-231 pound Although physician for weights to be ch was taken on 12/12 then 11 and 14 day Although physician for notification of mo over 3 pounds in ou the nurse practition pounds between 12 weights taken in the Although physician for notification of the pounds from basel staff did not notify the 12/12/14 weight of from the 220 pound During interview or registered nurse (F weights as physician nurse practitioner most 3 pounds between of 4.7 pounds, and weights available. During interview or practitioner (NP)-G	ds inds inds inds inds s inds s unds s unds s unds s unds s unds s s unds s s unds s s unds s s unds s s unds s s unds s s unds s s unds s s unds s s unds s s unds s s unds s s und s is und s is und s apart. und vs apart. und vs apart. und	F3	309			

Facility ID: 00916

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		& MEDICAID SERVICES	(X2) MUL	TIPLE	E CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				· /	PLETED
		245409	B. WING			01/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST		
MAPLE I	MANOR NURSING AN	ND REHAB, LLC		18 R			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
	gain. NP-G state notify the nurse pra ordered and expect due to congestive I verified orders date physician orders. I documentation of r weights or weight g physician ordered of During interview or	notification of 3 pound weight d she expected the facility to actitioner of weight gain as ited daily weights as ordered, neart failure and edema. NP-G ed 12/12/14 were current NP-G verified there was no nurse practitioner notified of gain. NP-G verified the lack of daily weights.	F3				
	daily, according to assignment sheet I During interview or registered nurse (F to be weighed daily were not completed	ated R45 was to be weighed the nursing assistant but has not been done. In 1/30/15, at 9:30 a.m., RN)-F stated she expected R45 y and verified daily weights d on the nursing assignment evening Weight Charting-West s.					
	read, "It is the polic that residents are w kept on each reside "Residents will be by the physician, b	ghing Residents dated 6/7/13, cy of Maple Manor to ensure weighed and a weight record is ent and monitored routinely." weighed thereafter as ordered ut at least monthly." ring or a new colostomy, fluid ally weight					
	on 12/16/14. The h noted R38 had a p a colostomy. Hosp 12/30/14 indicated readmitted to the h	to the facility from the hospital hospital discharge summary erforated colon that resulted in bital dismissal summary dated the resident had been ospital with acute respiratory al discharge summary dated					

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245409	B. WING			01/30/2015	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	1/9/15 noted R38 h depletion and hypor Physician orders of treatment record ind and report weight ir one day or increased weight. Increased s weakness, shortness breathing, especiall The intake and outp 1/25/15 were review intake, voiding and documented. The of and not totaled for t (NA) Entry Report w through 1/26/15. T documentation of m output. The docum no daily totals of int colostomy output re for R38 from 1/9/15 reviewed. The colo and the output docu completed for 2 of 3 impossible to detern The treatment reco prevention: report w pounds in one day of baseline weight. Inc fatigue, weakness, breathing, esp. with documentation was record. Review of t	ad experienced volume natremia. 1/9/15 and the facility dicated 2 liter fluid restriction ncrease of 2 to 3 pounds in e of 5 pounds over baseline swelling, bloating, fatigue, ss of breath, difficulty ly with activity and at night. put forms for 1/14/15 through wed. The forms noted fluid bowel movement could be documentation was sporadic the day. Nursing assistant was reviewed for 12/16/14 he report allowed for neal intake, bladder and bowel nentation was inconsistent, had take, no fluid intake or urine or ecorded. The treatment record 5 through 1/30/15 was postomy was to empty each shift umented. However, it was not 3 shifts making 24 hour total	F 3	09			

Facility ID: 00916

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245409	B. WING		01/30/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	The clinical manage nursing (DON) was 8:00 a.m. They bot assistant was respondent assistant was respondent assistant was respondent assistant was respondent assistant was respondent assistant was respondent for hypovolemia (de stated they were aware the for hypovolemia (de stated they were aware the stated staff were to symptoms of fluid r sheet and that should follow. Any change documented for the placed in the interd said this was not be R39's face sheet id on 1/7/2015. The dismissal summer 1/7/15 identified R3 mild dementia, chron heart failure, atrial f history of transient diabetes mellitus, ty retinopathy, anxiety of probable Bonnet people who have lo hallucinations). The admission MD R39 had a Brief Inte (BIMS) score of 13	er (RN)-A and the director of interviewed on 1/28/15 at th indicated the nursing onsible to document intake t nursing and dietary were to They both were aware that this e consistently. They stated at R38 had been hospitalized ecreased blood volume.) Also ware that weights were not ordered by the doctor.	F 309			

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		AND HUMAN SERVICES			FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY IPLETED
		245409	B. WING		01/;	30/2015
NAME OF	PROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	mobility, transfers a walking in room and toilet use, and limite personal hygiene. R39's current physi identified that R39 n twice a day for dias mg every day for hy failure, a diet order mechanical soft wit (milliliters) fluid rest to obtain daily weig dismissal summary recommended that with daily weights to diuretic regimen are R39's care plan dat a problem related to medications related cardiovascular acci congested heart fai 1/16/15 titled Diet in related to medical of therapeutic diet and modifications and s 2 liter fluid restrictio weight of 155 pound Approaches include weights as ordered The physician visit of nursing staff were to Continue metoprolo (heart medication), (lower blood pressu	and dressing, supervision with d corridor, supervision with ed assist with eating and dician orders dated 1/29/15 received Lasix (diuretic) 40 mg stolic heart failure, Lisinopril 10 ypertension/congested heart of diabetic, no added salt, th ground meat, 2000 ml triction and staff were directed hts on evenings. The or dated 1/7/15 from the hospital respiratory and fluid status to determine if modifications to e needed. ted 1/12/15 indicated R39 had o taking multiple cardiac d to processes including ident history, hypertension and flure. The problem dated ndicated R39 was at risk diagnosis with need for a d mechanical texture she is legally blind. R39 has a on. R39 was to maintain ds (#) + or - thru next 90 days. ed staff to monitor and record on 1/14/15 indicated that o monitor daily weights. ol (treat chest pain), digoxin Lasix (diuretic) and Lisinopril	F 309			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	i	COM	PLETED
		245409	B. WING			01/3	30/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC			1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	admission, 1/7/15, t days, 10 days of we days of weights mis 1/22/15. During an interview (RN)-A on 1/19/15 a they had staffing iss me were all they had Policy for Weighing instructed staff to: will be weighed with weight. Residents of ordered by the phys meeting the director residents who have weights and the tear residents who have interventions. Lack of renal dialys services were provi R62 received dialys providing End Stage without an agreement clinic to provide diar R62 was admitted t diagnosis that inclu- and renal dialysis a sheet. Document review on 11/21/14; revealed hemodialysis on Tu During interview on administrator verifie	 through 1/29/15. Out of the 23 eights were missing with 4 easing between 1/7/15 and with the registered nurse at 3:58 p.m., RN-A stated that sues and the weights he gave d for R39. Residents, dated 6/07/15 Upon admission, all residents in 3 days to obtain an initial will be weighed thereafter as sician. At the weekly dietary r of nursing will bring the list of doctor ordered specific m will review/audit the lost weights for further is agreement to assure quality ded to residents: is services from the clinic e Renal Disease services ent between the facility and lysis services. o the facility 11/21/14, with ded end stage renal disease ccording to the admission face 	F 3	309			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 02/25/2015 MAPPROVED D: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245409	B. WING	i		/30/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
MAPLE N	IANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From pa provider where R62	-	F	309		
F 312 SS=D		ved after being requested. ARE PROVIDED FOR IDENTS	F	312		3/11/15
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal				
	by: Based on observative review, the facility factorial (R3, R88) in the same assistance, receive 2 of 3 residents (R8 dependent on staff assistance with per Findings include: LACK OF ASSIST M R3 did not receive a according to care p During observations was in wheelchair la room. R3 was place staff for residents w Also at that time, re assisting R3 to eat. table. R3 still had p	WITH EATING: assistance with eating			Tag F312 ADL Care for Dependent Residents Maple Manor Nursing & Rehab, LLC ensures that all residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and ora hygiene. Residents identified as number 88 and 3 who need assistance with eating are currently receiving assistance according their individualized plans of care. Residents identified as number 88 and 31 who need assistance with personal cares are currently receiving assistance according to their individualized plans of care. During the planned mandatory meetings, the certified nursing assistants and licensed nurses will be reinstructed on the regulatory requirements, facility policies, and performance expectation for providin resident services as outlined in the	e

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	COR MEDICARE	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO.	0938-039 E SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED	
		245409	B. WING			30/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
IAPLE	MANOR NURSING AN	ND REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 312	powdered donut, 1 glasses beverages assistance given. F assistant (NA)-D si her meal starting a without assistance R3 was admitted 3 included paralysis Lewy Bodies, acco printed 1/29/15. The facility identifie Data Set (MDS), a to have short and I moderately impaired dependence on 2 s total dependence of personal hygiene, a altered diet. Document review of assessment dated independently ate difficulty swallowing soft textures and th weight changes. R3's care plan date of nutrition risk rela- history of needing f liquids, had history intake and dysphag diet, placed at staff staff to assist with dated 3/29/13, ider	age 59 ep with f hard-boiled egg, small slice toast cut into half, and 4 in front of R3, and no staff From 10:00 a.m. until nursing at and assisted R3 to complete t 10:12 a.m. or twelve minutes to eat meal or cueing. /19/13, with diagnosis that agitans and dementia with rding to physician orders ed R3 on the annual Minimum n assessment dated 12/8/14, ong term memory problems, ed decision making, total staff for activities of daily living, on 1 staff for eating and and received a mechanically of the annual Nutritional 12/16/14; identified R3 with difficulty chewing, no g, received general diet with hin liquids, and no significant ed 3/19/13, identified problem ated to history of dysphagia, mechanically altered diet and of weight loss due to poor oral gia. Approaches included soft f assisted table, and wanted feeding skills and care plan ntified problem of self-care eeding assistance with activities	F 312		nt in eating daily ee will month to and eating residents		

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DEPART CENTEF		FORM APPROVED DMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING			01/;	30/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pare eating pureed diet. During interview on of nursing stated shows are plan and to promeals. Director of the lack of staff in R88 did not receive according to care pure according to according the pure according to according the spoon of food of following this incide assist (FA)-A assist act actor action to according the according to according the according to according the according the according the according to according the according the according to according the according the according to according the according the according to according the according the according the according the according the according to according the according to according the according to according the according the according to according the according to according the according to according the according the according to according the according th	ge 60 1/29/15, at 9:00 a.m., director he expected staff to follow the ovide R3 with assistance for hursing stated she was aware in the east/west dining room. assistance with eating lan interventions. as on 1/27/15, at 11:18 a.m., hair located at the table dents who needed assistance ast/west dining. During t time, a plate of pureed d mashed potatoes and four everages with lids were on the t of R88, who was noted to bed. From 11:18 a.m., to 11:50 R88 eyes were closed and no be at nor encouraged her to trained medication assistant R88, placed food on a spoon , R88 immediately dropped nto her lap, TMA-A left R88 nt. At 11:54 a.m., feeding sisted another resident at R88 handed R88 glass of continued to assist R88 until ng this time FA-A would stand es as FA-A was also assisting eat. 1/27/15, at 12:12 p.m., FA-A d pureed foods and any staff eat. FA-A stated R88 had netimes would eat	F 3	12	DEFICIENCY)		
	independently and o	other days needed assist with					

Facility ID: 00916

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COM	PLETED
		245409	B. WING			01/:	30/2015
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	IANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE
F 312	Continued From pa	ae 61	F 3	010			
1 012	eating. R88 was admitted to the facility 8/26/14, w diagnosis that included dementia with Lew		F C	012			
	R88 was admitted t	o the facility 8/26/14, with					
		ded dementia with Lewy is agitans according to					
		codes printed 1/30/15.					
		d R88 on the quarterly MDS,					
		ed 11/23/14, to have short em, moderately impaired					
	decision making, to	tal dependence on 2 staff for					
		ing, total dependence on 1 personal hygiene, and					
	received a mechani						
	R88's care plan dat	ed 9/10/14, identified problem					
		in nutritional status due to					
		ally altered food related to poor ben areas with increased need					
		ort, due to abnormal labs, due noce with meals, due to					
		n. Approaches dated 9/10/14					
		needed and as resident allows roaches dated 9/22/14					
	included pureed die						
		9/23/14, included house es daily. Approaches dated					
	9/29/14 included alt	ernate bites with sips, watch					
		e next bite/sip to maintain d cups ok when being					
	assisted.	a supe on which being					
		1/28/15, at 9:15 a.m.,					
		(RD)-I and surveyor read 6/15, which identified weight					
	loss of 8.5% in 2 m	onths, some weight loss may					
		na, pureed diet, eating skills nursing staff R88 lethargic					
		taff to assist resident as					

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	FORM	APPROVED					
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY
		245409	B. WING			01/;	30/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE N	MANOR NURSING AN	D REHAB, LLC			1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	resident allowed. During a second me	ige 62 eal observation on 1/28/15, at in wheelchair located at the	F 3	312			
	table designated by assistance to eat lo room. R88 was obs plate of cooked cer applesauce, magic adaptive cups with	v staff for residents who need bocated in the east/west dining served with eyes closed with real and scrambled eggs, cup, and beverages in 2 lids. At 9:41 a.m., TMA-A sat					
	taken. At 9:42 a.m. began to assist her RN-C left R88. R88 in front of her and n independently. Fro minutes) R88 had e assistance or cuein	cation to R88 then left after ., RN-C sat next to R88 and to eat until 9:52 a.m., when 8 still had food and beverages made no attempt to eat im 9:52 a.m. to 10:12 a.m. (20 eyes closed and no staff ing to eat was given. NA-D sat o complete her meal starting at					
	of nursing stated sh care plan and to pro meals and persona	1/29/15, at 9:00 a.m., Director ne expected staff to follow the ovide R88 with assistance for I cares. Director of nursing are of the lack of staff in the om.					3 NO. 0938-0391 3) DATE SURVEY COMPLETED 01/30/2015 (X5) COMPLETION
	"Purpose: To provid comprehensive plan	cy dated 1/19/12, read, de a multi-disciplinary n of care which provides a ofiles the needs of each					
	LACK of PERSONA	AL CARES:					
		l hair and long soiled finger ance with personal cares lan interventions.					

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING _			01/;	30/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	MANOR NURSING AN	D REHAB, LLC		-	375 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ige 63	F 3	12			
	R88 had visible long On 1/28/15, at 9:37 located at south tab with several other re dining room and ag nails and long facia R88 was admitted t diagnosis that inclu- Bodies and paralysi resident diagnosis of The facility identified	s on 1/26/15, at 2:58 p.m., g facial hairs while lying bed. ' a.m., R88 sat in wheelchair ble in east/west dining room residents who ate meal in this gain had long, soiled finger al hair. to the facility 8/26/14, with ided dementia with Lewy is agitans according to codes printed 1/30/15.					
	term memory proble decision making, to	em, moderately impaired otal dependence on 2 staff for ing, total dependence on 1					
	of needed assistand transfer and ambula decreased enduran included assist of o	ted 9/4/14, identified problem ce with activities of daily living, ation related to dementia and nce and mobility. Approaches one staff with wheel chair and personal hygiene.					
	stated had assisted NA-D verified had r care. NA-D stated	1/28/15, at 10:10 a.m., NA-D R88 with morning cares. Not provided shave or nail residents are shaved with nail care was done in the					
	verified the long fac nails. RN-F stated	1/28/15, at 11:15 a.m., RN-F cial hair and long soiled finger she expected facial hair y and as needed. RN-F stated					

Facility ID: 00916

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	()	TE SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED
		245409	B. WING		01	/30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 312	Continued From pa	age 64	F 3	12		
	on bath days. Also	cures were done weekly and RN-F said R88 received bath dnesdays (today) in the				
	of nursing Director expected staff to for provide R88 with as hair removal care. R31 did not receive were not cleaned to worn: Observations made 1/26/15 at 1:31 p.m revealed R31 had of underneath fingern extremely dirty and glasses.	1/29/15, at 9:00 a.m., director of nursing stated she illow the care plan and to ssistance for nail and facial a nail cares and eye glasses o promote clear vision when e on 1/25/2015 at 2:06 p.m., on n., 1/27/15 at 8:57 a.m dark brown/black debris ails and eye glasses were had tape on both bows of the PS dated 10/30/14 indicated				
	R31 had severe co dependent on staff including toileting, o Physician's visit pro included diagnoses primary open angle R31's care plan inc with grooming.	gnitive impairment and was for activities of daily living dressing, hygiene, and eating. ogress note dated 1/15/15 of advanced dementia and				
	fingernail care and completed for R31 " grooming " as no The AM Cares polic Partial baths are gi omitted." Procedur	cleaning glasses were to be as they are considered part of ted in R31's care plan. cy dated 8/31/04, read, "1. ven when complete baths are re: "2. The mouth, nails, and d for in the same manner as for				

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		AND HUMAN SERVICES		F	ITED: 02/25/2015 ORM APPROVED NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		245409	B. WING		01/30/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
	ANOR NURSING AN	ID REHAB, LLC		875 19TH STREET NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 312	Continued From pa	ge 65	F 312		
F 315 SS=E	"1. Keep clean and 483.25(d) NO CATH RESTORE BLADD	HETER, PREVENT UTI,	F 315		3/11/15
	assessment, the far resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder e.			
	by: Based on observat review, the facility f bladder assessmer for developing and urinary tract infection (R16, R6, R70, R30 with recurrent urina failed to prevent uri spread of infections not following sound Foley Catheter care 1 resident (R68) wit catheter; and the fa orders for intermitte to monitor, evaluate	NT is not met as evidenced tion, interview and document ailed to ensure comprehensive nts and an assessment of risks monitoring of symptoms for ons (UTIs) for 7 of 8 residents 0, R69, R96, R38) reviewed try tract infections; the facility nary tract infections and the s to other residents due to staff infection practices regarding e and equipment used for 1 of th an indwelling Foley toth an indwelling Foley acility failed to follow physician ent catheterizations and failed e, and assess urine output for 70) in the sample with zations.		Tag F315 Urinary Incontinence Maple Manor Nursing & Rehab, LLC ensures that a resident does not have indwelling catheter placed unless the resident s clinical condition demonstric that catheterization is necessary; and a resident who is incontinent of bladde receives appropriate treatment and services to prevent urinary tract infect and to restore as much normal bladde function as possible. Residents with o without a catheter receive appropriate care and services to prevent infection extent possible. According to the updated facility policy bladder assessment is completed for each resident on admission, quarterly with a change of condition, and as needed. Residents with risk factors for	rates that er ions er r s to y, a

Event ID:3QEK11

Facility ID: 00916

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245409	B. WING		01/3	80/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
MAPLE I	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHW ROCHESTER, MN 55901	EST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 315	Continued From pa	ige 66	F 31	5		
	of the urinary tract i bladder assessmer R16 was noted on t to have a UTI on 10 interdisciplinary tea 10/21/14 noted no documented. The quarterly Minin 10/29/14 indicated status (BIMS) score cognitively impaired to total assist to me hygiene needs, and incontinent. The care plan date functional incontine indicate R16 was a Registered nurse (I 12:45 p.m. that R16 bladder assessmer	RN)-E stated on 1/30/15 at 6 did not have a completed ht. ation of symptoms of a UTI and		urinary tract infections documented in the pro- the plan of care. According to facility po physician/nurse practiti when a resident is exhi- symptoms. The nursing urinary tract symptoms physician/nurse practiti medical/nursing interver on the effectiveness of treatments/intervention According to facility po resident requires interr catheterization or has a catheter, the output is of medical record. Indwel hung/placed below the and off of the floor with arranged to avoid kinki catheter bags are place cover. A bladder scan to/after an in and out ca perameters ordered by physician/nurse practiti of the scan and the out documented in the men- a resident refuses to bo refusal is documented	gress notes and in licy, the ioner is notified ibiting urinary tract g staff document s, notification of the ioner, and any entions. Follow up the as is documented. licy, when a nittent in and out an indwelling documented in the ling catheters are level of the bladder the tubing ing or pulling. All ed in a pouch is performed prior atheterization with r the ioner. The results tput are dical record. When e catheterized, the	
	10/27/14 and 12/10 for this time period of infections listed. The quarterly MDS R6 had a BIMS sco required extensive	he IC log to have a UTI on 1/14. Review of the IDT notes noted no signs and symptoms dated 12/26/14 was reviewed. bre of 13 or cognitively intact, to total assistance to meet hal hygiene needs, had a		record. At the planned mandat nursing assistants will placement of the urine covering the bags to m dignity, and documenti licensed nurses will be facility s policy and pro- completing bladder ass	be reinstructed on collection bags, laintain resident ng output. The instructed on the ocedures for	

Facility ID: 00916

If continuation sheet Page 67 of 133

		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING			01/3	30/2015
NAME OF F	PROVIDER OR SUPPLIER	•	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	indwelling suprapul recurrent UTIs resu hospitalization. Th interventions based assessment had be No UTI risk assess by facility when req	eatheterized. ted 12/28/15 noted an bic catheter and a history of ulting in frequent e care plan did not have d on a comprehensive bladder een completed. sment was found or provided uested. cation of symptoms of a UTI	F 3	15	tract infections, documenting the resident s urinary tract symptoms calling the physician/nurse practitio monitoring/documenting follow up of effectiveness of nursing/medical interventions, following the physicia orders for intermittent catheterizatio intervals, and notifying the physicia large residual amounts. Resident number 16 The resider bladder function (has indwelling suprapubic catheter due to a neuro bladder) was reassessed by a regis nurse including an assessment of t	an s on the an s on n of nt s ogenic stered	
	 9/29/14. The IDT r documentation of s infection were foun The quarterly MDS had a BIMS score of impaired, required toileting and person intermittently caute Again no bladder a assessment was for requested for R70. R30 lacked identified and lacked a UTI ris R30 was noted on 10/15/14, 11/7/14, s 	dated 11/20/14 indicated R70 of 11 or moderately cognitively extensive assistance to meet nal hygiene needs, and was rized. ssessment or UTI risk bund or provided when cation of symptoms of a UTI isk assessment. the IC log to have a UTI on and 11/29/14. The IDT notes lacked identification of signs			resident s risk of urinary tract infec The care plan has been reviewed a revised accordingly. Resident number 6 The resident bladder function (has indwelling suprapubic catheter due to a neuro bladder) was reassessed by a regis nurse including an assessment of t resident s risk of urinary tract infec The care plan has been reviewed a revised accordingly. Resident number 70 The resider bladder function was reassessed b registered nurse including an asses of the resident s risk of urinary tra infections. The care plan has been reviewed and revised accordingly. Resident number 30 The resider bladder function (has obstructive uropathy) was reassessed by a reg nurse including an assessment of t resident s risk of urinary tract infec The care plan has been reviewed a	and s ogenic stered the ctions. and nt s y a ssment ct nt s jistered the ctions.	
		ated 11/6/14 noted R30 had			revised accordingly. Resident number 69 The resider		

Facility ID: 00916

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED	
			A. BUILDI	NG		0011		
		245409	B. WING _			01/3	80/2015	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLE	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 315	Continued From pa	ae 68	F 3	15				
	memory impairment cauterized, had obst total dependence of personal hygiene in dated 12/15/11 that UTI related to stapplindicate an assess functional or enviro completed. Two bladder assess medical record date However, neither at UTI risk. R69 lacked identificand lacked a bladd R69 was noted on the 10/7/14, 10/31/14, inotes were reviewed signs and symptom The 30-day PPS M reviewed. The MD and long term mem required extensive personal hygiene, at a UTI in the past 30 assessment was for RN-E stated on 1/3 did not have a com	t, was intermittently structive uropathy, and had n staff to meet toileting and eeds. R30 had a care plan listed a problem of at risk for n bacteremia, but did not ment related to clinical, nmental risk factors had been sments were found in the ed 11/6/14 and 1/28/15. ssessment evaluated R30's cation of symptoms of the UTI er and UTI risk assessment. the IC log to have a UTI on 11/9/14, 11/18/14. The IDT ed and lacked identification of as of UTI. DS dated 12/15/14 was S indicated R69's short term hory were intact, that R69 assist with toileting and and that R69 had experienced 0 days. No bladder or UTI risk bund in the record. 0/15 at 12:45 p.m. that R69 pleted bladder assessment.	ΓJ		bladder function was assessed by a registered nurse February 20, 2015. assessment addressed the resident risk of urinary tract infections. The c plan has been reviewed and revised accordingly. Resident number 96 The resident bladder function was assessed by a registered nurse February 20, 2015. assessment addressed the resident risk of urinary tract infections. The c plan has been reviewed and revised accordingly. Resident number 38 The resident bladder function was assessed by a registered nurse February 20, 2015. assessment addressed the resident risk of urinary tract infections. The c plan has been reviewed and revised accordingly. Resident number 38 The resident risk of urinary tract infections. The c plan has been reviewed and revised accordingly. Resident number 68 The staff hav been reinstructed on keeping the uri collection bag below the level of the bladder and to cover the bag whene the resident is in a common area or room and visible from the hallway. T care plan was reviewed and updated Resident number 70 The physicia orders for intermittent catheterization bladder scans were reviewed with th licensed nurses. Documentation of t catheterizations and bladder scans also addressed. The care plan was reviewed and updated.	The sare ts The ts ts are ts ts ts ts are ts are ts are ts are ts an and he the was		
	assessment	ler assessment and a UTI risk			The Director of Nursing/designee wi perform random audits through observation and record review for or	ne		
		on 12/2/14. The hospital dated 12/2/14 noted R96 had			month to ensure catheterization profision for the symplectic structure with symplex that residents with symplex that the symplex structure structu			

Facility ID: 00916

	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION	<u>OMB NO.</u>	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	· · /		· · ·	PLETED
		245409	B. WING		01/30/2015	
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
IAPLE I	MANOR NURSING AN	ND REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 315	Continued From pa	age 69	F 31	5		
	chronic UTI and wa (antibiotic).	as on suppression Bactrim		of urinary tract infection have app documentation and follow up, and bladder assessments are comple	that	
	The admission MDS dated 12/9/16 indicated a BIMS score of 14 or no cognitive impairment, extensive to total assist with toileting and personal hygiene needs, frequent incontinence, and a UTI in the past 30 days. No bladder or UTI risk assessment was found in the medical record nor provided when requested.		scheduled. Completion Date: March 11, 201			
		30/15 at 12:45 p.m. that R96 pleted bladder assessment.				
	R38 lacked a bladd assessment.	der assessment and a UTI risk				
	admission MDS da had BIMS score of impaired, required meet toileting and p an ostomy, and had infection during the always incontinent.	with a UTI 12/16/14. The ated 12/22/14 indicated R38 10 or moderately cognitively extensive to total assistance to personal hygiene needs, had d experienced a urinary tract e previous 30 days, and was No bladder or UTI risk found in the record.				
		30/15 at 12:45 p.m. that R38 pleted bladder assessment.				
	provided by the dire included 1) Chronic dated 5/2/12 and 2 Residents dated 4/ direct staff to evalu UTIs and did not in	p.m. UTI policies were ector of nursing. The policies c Urinary Tract Infection Policy) Prevention of UTI's at Risk 3/12. The policies did not late the risk for developing iclude signs and symptoms of en to document. The policies				

		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING			01/:	30/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	assessment that ind comorbidities relate cognitive function, r or the environment RN-A was interview RN-A stated he had for infections, but th form had been deve was to document th observed in the nur On 1/28/15 at 10:10 nursing (DON) were the facility did not h criteria available to from. They stated t policy/procedure on tract infections. On 1/30/15 at 9:30 bladder assessment assessment and the do a narrative note R68's Foley cathete infection control pra draining tubing and collection bag place infection or prevent On 1/21/15, at 7:15 open, R68 was obs indwelling Foley cat lying flat on top of F 7:45 a.m. registered R68's catheter bag R68's bed linens. R bag was to be place	cluded contributing factors or ed to medical conditions, medications, physical function red on 1/28/15 at 9:40 a.m. d a form that listed the criteria hat no policy related to the eloped. RN-A stated nursing he criteria for infections rsing notes. D a.m. RN-A and the director of e interviewed. They indicated ave a list of infection or UTI staff to use and document the facility did not have a in the management of urinary a.m. the DON indicated the ti did not include a UTI risk at staff were not expected to	F	315			

Facility ID: 00916

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING			01/;	30/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	was in the collection hold the urine bag a and verified there w collected in bag. As up, the bag's drain observed to have b not placed in the de uncovered and stick in the collection bag placed the urine bat the drain spout in d the bed. At 7:38 a.m door was open and the collection bag s 8:14 a.m. Nursing a interviewed and cor was lying directly or stated nursing assis shift and must have the night shift when stated the catheter below R68. NA-B a placed in a blue clo (pointing to a loop-II NA-B then moved b R68's Admissions F indicated R68 had o dementia, depressin retention. The Physician's Oro 11/1/14 indicated R should be kept belo reflux, maintain a cl POS further indicated	n bag RN-C was observed to and raised it to her eye level vas about 75 milliliters of urine s RN-C was holding the bag (rubber emptying spout) was een clamped, however, it was esignated bag pouch but king out as it was not secured gs spout holder. RN-C then g back on top of the bed with irect contact with the linens on n. on 1/21/15 R68's room R68 was still lying in bed with till on top of the bed linens. At assistant (NA)-B was nfirmed R68's catheter bag n top of R68's bed linen. NA-B stants empty the bag every been placed on the bed by they left this morning. NA-B bag should always be hanging dded, urine bag should be th cover and hooked "here" ike attachment on bed frame).	F 3	315			

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						0.0938-039	
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	TE SURVEY MPLETED	
		245409	B. WING		01	01/30/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 315	R68's care plan dat required indwelling retention. The care drainage bag below and to maintain a c The facility's Cather directed staff to see not to allow bag to bag below level of the inside a blue dignity The American Nurse the guidelines prov Disease Control (C associated urinary recognized the imp maintenance of the and drainage syste catheter securement maintain drainage to times (but not on flot the drainage spout. R70 lacked every for prevent urinary trace problems. On 12/8/14 R70 file that pertained to sta four hours as order bladder scans had catheterization. Grid hours without being the removal of 1000 R70's quarterly Min 11/20/14 indicated urinary catheterization	ted 10/20/14 indicated R68 Foley catheter due to urinary plan directed staff to keep v bladder level to prevent reflux losed drainage system. ter Care Policy dated 7/9/09, cure bag on side of bed frame, touch the floor, to keep the bladder at all times and to be y bag. ses Association (ANA) adopted ided by the Centers for DC, 2009) to prevent catheter tract infections. The guidelines ortance of proper indwelling urinary catheter m, to include appropriate nt per facility protocol and to bag below the bladder at all por) and to prevent contact of	F 3	15			

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING			01/;	30/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	Status (BIMS) score extensive assist for dressing, toileting, t R70's current care 1/28/15 indicated R and gave staff direc plan indicated resid deficit and directed in a shift. Care plan diagnosis of hyperte hyperplasia (enlarg and required interm directed staff to per catheterization as o size and type of urin (straight versus cou- catheter tip for easy obstruction in the u- did not include the p scan if needed first. Signed physician's included diagnoses Lewy bodies, hyper the bladder making complete urinating prostatic hyperplasi enlargement of the difficult to pass urin Signed physician's included in and out (Cath) every four ho cath for retention/di and "ok to bladder s cath if scanned am- centimeters (cc). H	e of eleven, and required activities of daily living of transfers, and hygiene. plan provided by the facility on 870 occasionally refused cares ction to chart refusals. Care lent was at risk for fluid volume staff to report no urine output also indicated R70's onic bladder, benign prostatic ed prostate) with obstruction, nittent catheterization and form intermittent ordered. The care plan lacked nary intermittent catheter ude catheter is a curved y insertion for people with rethra) to use. The care plan physicians order to bladder orders dated 12/19/14 of Parkinson's, dementia with tonicity (increased tension of it more rigid, hampering ability) of bladder and benign ia (BPH which is an prostate) making it more	F 3	315			

Facility ID: 00916

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		AND HUMAN SERVICES			FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245409	B. WING		01/:	30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE N	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	Continued From pa	ige 74	F 315			
	the size matters to tissue damage whe	promote comfort and prevent on catheterizing.				
	indicated scheduled a.m., 5:00 a.m., 9 a 9:00 p.m. However, cath was completed	ministration record (TAR) d I and O cath times were 1:00 a.m., 1:00 p.m., 5:00 p.m., and , the documentation to indicate d was inconsistent; outputs except intermittently during the n. treatment time.				
	November, Deceml indicated I and O ca amount of outputs r catheterization. How	Bladder Scan Sheets for ber 2014 and January 2015 atheterization times and resulting from urinary wever, the use of the bladder bleted prior to any I & O done.				
	1/1/15 through 1/30 cathed a total of 11 opportunities. There from cathing proceed cc and above and 1 were 1000 cc and a month of January 2	sheet documentation from 0/15 reflected R70 had I and O 0 times out of 180 e were 63 times urine obtained dure resulted in amounts 500 11 times collection amounts above. At no point during the 2015 documentation reflected athed every four hours per				
	Institute of health (N December 2013) it	icle published by the National NIH Publication No. 14-3195 read, "A normal bladder acts can hold 1.5 [360 cc] to 2 ne."				
	licensed practical n resident often refus	on 01/30/15, at 1:57 p.m. Jurse (LPN)-C explained sed to be cathed or had been C stated refusals would be				

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MI II T	IPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
		245409	B. WING _		01/30/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 315	Continued From pa	ige 75	F 31	5		
	TAR. These docun found to be inconcl	adder scan sheet or on the nents were reviewed and usive if R70 had refused or a nurse had not completed for				
	director of nursing	o on 1/30/15, at 11:30 a.m. (DON) stated, "They should be he cath is not getting done as				
F 318 SS=D	catheterization.	have a policy for in and out EASE/PREVENT DECREASE TION	F 31	8		3/11/15
	resident, the facility with a limited range appropriate treatme	orehensive assessment of a r must ensure that a resident of motion receives ent and services to increase d/or to prevent further of motion.				
	by: Based on observa review, the facility f	NT is not met as evidenced tion, interview, and document ailed to assess the benefits or ge of motion (ROM) services		F-318 Range of Motion		
		(R31) reviewed for range of		R31 was evaluated by therapies set-up for a passive ROM progra tolerated. Therapies in-serviced	am as	
	Findings included:			appropriate ROM specific to this Other residents who would bene	resident.	
	and was not reasse	rices discontinued by nursing essed for a maintenance range to maintain functionality of		range of motion program will be for referral in the interdisciplinary conference schedule. The facilit	assessed / care	

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	<u>0938-039</u> E SURVEY IPLETED		
		0.15.000						
	PROVIDER OR SUPPLIER	245409	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CO		30/2015		
	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE		
F 318	joints, prevent com of range of motion and lower extremiti Physician 's visit n diagnoses of major degenerative arthri knees, and osteope R31's quarterly Mir 10/30/14 indicated cognitive impairme for activities of daily dressing, hygiene, mechanical lift for t On 1/26/2015 at 12 sitting in her wheel room. NA-C stated she usually very sleepy during really good meal a During an interview licensed practical r limited range of mo hips and R31 did n have a range of mo R31's care plan inc program was disco Nursing progress n "maintenance care stretches discontin comfort cares [resi medical interventio	plications, or slow progression impairment in the shoulders es. ote dated 1/15/15 included depressive disorder, tis in shoulders, hands, and enia. himum Data Set (MDS) dated the resident had severe nt and was dependent on staff y living including toileting, and eating. R31 required a ransfers. 2:25 p.m. R31 was observed chair located in the dining eats good during breakfast and lunch period and eats one	F 31	8 process of developing a rest nursing program which will e assessment and treatment fo of decreased ROM as well a therapy directed restorative p Nursing management or des responsible for monitoring by monthly audits and a nurse r be assigned to be program r Completion Plan Date: 3/11/	nhance or prevention s provide orograms. ignee will be / random nanager will nanager.			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING			01/:	30/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MAPLE	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	No further assessm motion program was since program was During an interview LPN-D stated " we the past and we con LPN-D indicated wh active range of mot LPN-D had no furth passive range of mot During an interview registered nurse (R aide care plan, main provided. " During RN-A stated they w documentation that was discontinued re- services. During an interview physical therapy as Sometimes we wou of motion if it 's not Providing passive ra- burden of care. " P programs are reass completely and wou need and appropria quarterly basis. PTA evaluated by physic program. During an interview nursing assistant (N receive passive ran	ent for need of range of s found in the medical record discontinued. on 1/28/15, at 1:43 p.m., tried to do range of motion in ntinue to reposition her ". nen the R31 ate independently ion was being performed. er examples of how active or otion had been provided. on 1/28/15, at 2:05 p.m. N)-A stated " according to the ntenance is not being another interview on 1/29/15 ere not aware of indicated R31 ' s program elated to pain or refusal of on 1/29/15, at 8:27 a.m. sistant (PTA)-J stated, " Id recommend passive range going to cause pain. ange of motion could ease the TA-J explained typically ressed prior to discontinuing ild recommende R31 being teness for programs on a A-J recommended R31 being cal therapy for a maintenance on 1/29/15, at 9:12 a.m. IA)-K stated R31 did not ge or motion at this time and allow and tolerate receiving	F	318			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245409	B. WING			01/3	30/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	MANOR NURSING AN	D REHAB, LLC			75 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	Continued From pa	ge 78	F 3	18			
	nurse practitioner (I	on 1/30/15 at 10:00 a.m. NP) stated, " I think she [R31] hefit from a passive range of					
F 322 SS=D		REATMENT/SERVICES - à SKILLS	F 3	22			3/11/15
		rehensive assessment of a must ensure that					
	alone or with assist tube unless the res	has been able to eat enough ance is not fed by naso gastric ident ' s clinical condition use of a naso gastric tube was					
	gastrostomy tube re treatment and servi pneumonia, diarrhe metabolic abnorma	s fed by a naso-gastric or eceives the appropriate ces to prevent aspiration a, vomiting, dehydration, lities, and nasal-pharyngeal e, if possible, normal eating					
	by: Based on observat review, the facility c administration via g	NT is not met as evidenced ion, interview and document lid not ensure medication astric tube was followed for 1 observed for medication ugh gastric tube.			Tag F322 Naso-Gastric Tubes Maple Manor Nursing & Rehab, LLC ensures that residents who are fed		

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ATE SURVEY OMPLETED	
01/30/2015	
(X5) COMPLETIC DATE	
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is r n. nd	

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		AND HUMAN SERVICES			FO	ED: 02/25/201 RM APPROVEI NO. 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245409	B. WING			01/30/2015
	PROVIDER OR SUPPLIER	ID REHAB, LLC		1	TREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322 F 323 SS=D	directed staff to foll giving medication tl include flushing wit before and then 30 administration. The 60 cc vs. 30 cc per 483.25(h) FREE OI HAZARDS/SUPER The facility must er environment remain as is possible; and	ow the "standard procedure" in hrough gastrostomy tube to h 30 milliliters (ml) of water ml of water after medication physician specifically ordered policy. F ACCIDENT	F3			3/11/15
	by: Based on observative facility factories the facility factories fall comprehensive fall completed for 1 of a falls. Findings include: The admission Min 12/9/14 indicated Fill mental status (BIM intact. The MDS id experienced a fall with facility. The MI included a fracture.	risk assessment was 3 residents (R96) reviewed for imum Data Set (MDS) dated 196 had a brief interview of S) score of 14/15 or cognitively entified that R96 had with injury prior to admission to DS listed diagnoses that R96 ' s care plan printed agnoses that included fracture			Tag F323 Accidents Maple Manor Nursing & Rehab, LLC provides an environment as free of accident hazards as is possible and eau resident has adequate supervision and assistance devices to prevent avoidable accidents. A comprehensive fall risk assessment is completed on all residents on admissio with a change of condition, and as needed. The care plan identifies risk factors and interventions that are initiate to prevent avoidable falls. If a resident does have a fall, referrals are made and intervention initiated as appropriate. Th	e s n, ed

Event ID:3QEK11

Facility ID: 00916

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		E SURVEY
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à	CON	IPLETED
		245409	B. WING		01/	/30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
MAPLE N	ANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From pa	ge 81	F 323	3		
	on the bed with ice stated that she had home about 11 wee On 1/25/15 at 2:07 (LPN)-B stated R96 admission to facility The interdisciplinar 1/1/15 indicated R96 during a transfer be and received no inj registered nurse (R problems identified R96 ' s are plan had fall risk, related to r plan directed to ass needed and to use other individualized prevent falls for R9 identifying contribut related to medical of medications, physic that could contribut found or provided b R96.	p.m. licensed practical nurse b had fallen on 1/1/15 (after y) but sustained no injuries. y team notes (IDT) dated 6 had been lowered to floor ecause she had weak knees ury. The clinical manager N)-A documented no		plan of care is reviewed and accordingly. The fall risk assessment for has been completed. The policy and procedure fo accidents/falls was reviewed At the next Nurses meeting in-serviced on the policy and for fall risk assessments and implementation. The Director of Nursing and, will monitor for compliance b audits for the next 4 weeks. Completion Date: March 11,	resident 96 r d and revised. staff will be d procedure d intervention for designee by random	
	and stated no fall ri located for R96.	e was provided when				
F 325 SS=D	requested.	NUTRITION STATUS	F 325			3/11/15

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		AND HUMAN SERVICES	ſ			FORM	02/25/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245409	B. WING			01/3	80/2015
NAME OF F	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
	IANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	resident - (1) Maintains accept status, such as boot unless the resident demonstrates that to (2) Receives a ther nutritional problem. This REQUIREMENT by: Based on observative review, the facility fongoing nutritional and accurate weigh and monitor for weigh (R38, R96, and R32 nutrition concerns. Findings include: R38 lacked the corr intake and also lack significant weight for for needs. R38 was observed independently. She had eaten less than interviewed on 1/26 on a fluid restriction restrictions, but need find out what the restriction	cility must ensure that a ptable parameters of nutritional by weight and protein levels, 's clinical condition this is not possible; and apeutic diet when there is a NT is not met as evidenced tion, interview and document ailed to ensure accurate and reassessments and consistent ths were provided to determine ght loss for 3 of 4 residents 2) in the sample reviewed for rect diet and monitoring of ked ongoing monitoring for oss and nutritional assessment on 1/26/15 at 5:20 p.m. eating e left the table at 5:35 p.m. and n 25% of the meal. R38 was 6/15 at 6:11 p.m. and she was n and was sure she had dietary eded to talk to a dietician to strictions were.	F	325	F-325 Maintain Nutritional Status I Unavoidable Maple Manor is developing the proc for communicating and evaluating in for resident meal consumption that being recorded by dietary staff, and incorporate fluid monitoring for resid identified for restrictions. Residents R96, R32) have been assessed and be referred to the Dietician for furthe interventions. The daily log sheets will be returned the day s final meal to the CDM for identification of residents consumin than 50% or not meeting fluid guide per physician order. The facility has purchased a wheel scale to better monitor weights as ordered. Residents who trigger for meal consumption will be referred to Dietician for weekly review and recommendation of enhanced monito of nutritional needs and physician o	cess ntakes is will dents (R38, d will er d after g less lines chair low o the toring	
	R38 was admitted t	strictions were. to the facility from the hospital ling to the hospital discharge			recommendation of enhanced moni	rdered	

Facility ID: 00916

		& MEDICAID SERVICES	1				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245409	B. WING			01/3	30/2015
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MAPLE	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 325	colon that resulted prescribed diet of g summary dated 12, had been readmitter respiratory failure, I hypophosphatemia chronic anemia. Th with low residual. The hospital dischar noted R38 had exp hyponatremia. Th to 1500-2000 millig cholesterol, and low The physician order to monitor weights, However, an admis The hospital weigh and the weight on t 1/9/15 showed a w pound (12%) weigh The registered diet assessment on 12/ diet and to monitor expected. Ideal bo current weight 162 The 12/24/14 dieta general diet, boost day for extra calorie pounds. On 1/25/15 a readr was completed by	ted R38 had a perforated in a colostomy and had a general diet. Hospital dismissal /30/14 indicated the resident ed to the hospital with acute hyponatremia, a, hypomagnesaemia and he diet prescribed was general arge summary dated 1/9/15 perienced volume depletion and e prescribed diet was changed grams (ml) sodium, low w fat. ers of 12/30/14 noted continue blood pressures, and pulse. esion weight was not obtained. t of 12/28/14 was 161 pound the temporary care plan dated eight of 141 pounds, or 20 nt loss. ician completed an 17/14 that indicated a regular initial intake. Weight loss not ody weight 135-165 pounds and		25	for evaluating intakes and commu concerns to nursing and physician interventions to nutritional concern Random monthly audits will be cor by Administration or designee for s implementation and compliance. Completion Date: 3/11/15	s for the s. nducted	

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION		0938-039 E SURVEY
ND PLAN (OF CORRECTION	DENTIFICATION NUMBER:				`́сом	PLETED
		245409	B. WING			01/3	30/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ND REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 325	Continued From pa	age 84	F 3	325			
		nt weight changes (significant as 14% weight loss in one					
	a no added salt die include the physici	re noted a fluid restriction and et. The tray card did not an orders (1/9/15 hospital 0-2000 mg sodium, low fat, low					
	administer 2 ounce medication pass du wound, and meal in physician order of (240 cc) twice a da document that they boost, but the medi did not indicate the supplements taken nurse (LPN)-D was 9:25 a.m. and state to Ensure (2.0) so during the medicat a.m. registered nur regarding document supplement intake documented if R38	1/14/15 noted staff were to es of dietary supplement 2.0 at ue to weight loss, stage II ntake of less than 50%. The 12/13/14 also included boost ay. The facility continued to y were offering both the 2.0 and lication administration record e percentage of these two n by R38. Licensed practical s interviewed on 1/29/15 at ed the boost had been changed R38 would receive the Ensure ion pass. On 1/29/15 at 10:10 rse (RN)-A was interviewed ntation of nutritional and stated that nursing only 8 refused the supplement and ten during the medication pass.					
	was reviewed and sporadically this wa monitoring for 1/14	or 12/16/14 through 1/26/15 the intake was documented as found for the fluid intake 1/15 to 1/26/15. Also none of s totaled to determine if intake R38.					
	was adequate for F R38 ' s care plan p						

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING			01/;	30/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	1/12/15 included int and a 2000 cc (cub During an interview director of nursing (had two conflicting Clinical manager (F were interviewed or both stated the nurs to document the int dietary were to revie they were aware tha this time. They both were not being dom The certified dietary interviewed on 1/28 that R38 was not or was to be watching would look only at th computer system a weights were not be the registered dietic admissions, annual resident with a sign The RD was intervie and stated she was were an issue in the received a cardiac of diet only. RD stated and annual reasses at weight listings wi was aware that inta and she was unsure	eral diet. Care plan dated tervention of no added salt diet tic centimeter) fluid restriction. on 1/2/15 at 4:25 p.m. the (DON) verified the care plan orders for R38's diet. RN-A) and director of nursing n 1/28/15 at 8:00 a.m. They sing assistant was responsible take and that nursing and ew the totals. They stated at this was not being done at h were aware the weights e as ordered. y manage (CDM) was 8/15 at 8:10 a.m. CDM stated n his list of residents that he weight on. CDM stated he he weights that were in the nd that he was aware that the eing done. CDM would have cian (RD) assess new I reassessments, and any ificant weight loss. ewed on 1/28/15 at 8:35 a.m. s aware that taking of weights e facility. RD stated that R38 diet which was a low sodium d she would see admissions assment residents and did look ith each visit to see if there he should see. RD stated she ake was not being monitored e of the accuracy for weights	F3	225	DEFICIENCY)		
		e of the accuracy for weights					

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING	i		01/;	30/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	During an interview a.m. CDM stated th to 6 grams (4000 to verified that exceed 1500-2000 milligrar interview on 1/29/15 the general diet was fat/low cholesterol. served the regular of shaker is given. Cook (C)-A was inte a.m. and said that a resident was not set that everything else time C-C stated tha would be served that to foods offered no may have. On 1/30, that residents on a the same as the oth or bacon. R96 lacked the corr monitoring of interv weight loss having and nutritional asse R96 was observed 1/25/15. She had r regular portions. R receive smaller por gastric bypass. R95 5:15 p.m. stating th today had had lost a admission. On 1/2	with CDM on 1/29/15 at 940 the average diet served was 4 o 6000 mg) sodium and ded R38's recommended ms of sodium. During an 5 at 10:20 a.m. CDM stated s not considered to be low CDM stated R38 would be diet but no added salt from salt erviewed on 1/30/15 at 7:55 a no added salt diet meant the erved sausage or bacon, but e would be ok to serve. At this at at breakfast every resident e same thing with no change matter what restrictions they /15 at 8:10 a.m. C-B stated no added salt diet received her residents just no sausage rect diet also lacked consistent e and also lacked ongoing rentions to prevent further had a significant weight loss		325			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 02/25/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245409	B. WING			01/	/30/2015
	PROVIDER OR SUPPLIER	D REHAB, LLC		18	TREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	She stated that she since she gets it at had had a gastric b smaller portions. To meal serving and at Review of the diet of small portions. Dur 9:15 a.m. R96 state scalloped potatoes cucumbers and sor said that was a lot of high calories and ha sugar readings from carbohydrates com home. The hospital dismis and day of admission had diagnoses of po hyperlipidemia, hyp and anemia. Order "Diabetes Manager twice daily. Diabetion R96's Insulin Flow S 1/30/15 was review blood glucose range of noon blood glucos the afternoon blood 388, and the bedtim 288. On 1/20/15 th scale insulin. American diabetes range as follows: Fasting (before mean mg/dL (3.9-7.2 mm Postprandial (1-2 ho	d on 1/26/15 at 11:50 a.m. was tired of canned fruit every meal. She stated she y-pass and should receive oday she had a full portion te less than 50% of the meal. card on her tray did not noted ring an interview on 1/30/15 at ed that last night she had with ham, creamed nething else (bread). R96 of carbs (carbohydrates) with as been having high blood in the increase in pared to when she lived at sal summary dated 12/2/14 on to the home identified R96 ost renal transplant, ertension, hypothyroidism, rs for continuing care read, nent, check blood sugars c diet." Sheet from 1/1/15 through ed from 81 to 154; the range ose readings was 118 to 301, glucose ranged from 113 to ne glucose range from 96 to e physician ordered sliding recommends blood sugars als; upon waking):70-130	F	325			

Facility ID: 00916

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 02/25/2015 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245409	B. WING		01/	/30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 325	be higher dependin The RD completed 12/3/14. The asses history of gastric by transplant, but not of listed no laboratory weight of 117 to 143 calorie or carbohyd did identify the reside related to a gastric the need for a diabe assessment listed the reside related to a gastric the need for a diabe assessment listed the reside noted the resident re- was offered a diabe physician order. The certified nursin Report provided by food intake from 12 intake of food was of not completely. R96's admission we weight form read, "- request the residen had a weight of 147 pounds or 6.4% from R96's Care plan da need for a theraped of offered a diabetic	age 88 ag on each resident and doctor. a nutritional assessment on assment listed a diagnosis ypass, history of a kidney of diabetes. The assessment values, listed an ideal body 3 pounds, but no estimated frate need. The assessment dent received insulin for gars. The assessment ent would eat small amounts bypass, but did not indicate etic diet. The nutritional the weight at 146 pounds (the tal discharge summary dated rea assessment dated 12/15/14 received a therapeutic diet and etic no sugar added diet per ag assistants (CAN) Entry the facility was reviewed for 2/3/14 through 1/26/14. R96's documented sporadically and eight documented on the 157 pounds." At the surveyor at was weighed on 1/26/15 and 7 pounds or a weight loss of 10 om 12/2/14 to 1/26/15. ated 12/15/14 indicated the utic diet and had interventions c no added sugar diet. wed on 1/27/15 at 8:20 a.m.	F 32			

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		AND HUMAN SERVICES			FORM	02/25/2015 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245409	B. WING		01/	30/2015
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 325	He stated that adm deferred for a coup admitted from hosp overload and theref stated he did not kr done monthly or as RN-A and DON wet 8:00 a.m. Both stat were to record food to review the total of consistent weights DON said they were being completed fo The RD was intervit She stated she was recording weights we they were not done was nursing's respon- information on the of changes were need interviewed on 1/28 gastric bypass to re- treatment consisted offered vs. larger the that weight loss was know R96 lost any we The nurse practition 1/30/15 at 9:00 a.m. was not appropriate been complaining of afternoon and woul closeness of the bru- no change was dom- need for smaller model that weight complaining of afternoon and woul	ission weight were being le weeks since residents bitals frequently had a fluid fore showed a weight loss. He now why the weights were not ordered by the physician. re interviewed on 1/28/15 at ted that nursing assistants d intake and that nursing was consumed. When asked about being taken both RN-A and e aware of lack of weights				

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		AND HUMAN SERVICES				FORM	: 02/25/2015 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		E SURVEY IPLETED
		245409	B. WING	à		01/	30/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MAPLE	MANOR NURSING AN	ID REHAB, LLC			1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT	D BE	(X5) COMPLETION DATE
F 325	weighting of reside is the policy of Map residents are weigh on each resident au Residents are to be admission and ther physician, but at lea R32 had a weight le days, declined in ea reassessment was loss and determine weight loss. R32's quarterly Min 1/9/15 indicated wa impaired with diagr incontinent of bowe assist with activities toileting, transfers, R32's physician's n the diagnoses of Le mellitus, and const R32's most recent facility on 1/27/15 in significant weight le diet with soft textur liquids. Care plan in the dining room an assisted to eat as n proper technique o therapy (ST) recorn also instructed staff meals or a shallow plate and provide of R32's physician or the following medic constipation: Sena	nts was reviewed and read, "It ble Manor to ensure that ned and a weight record is kept nd monitored routinely." weighed within 3 days of reafter as ordered by the ast monthly. oss of 9.6 pounds in thirty ating meals, however, no completed to assess weight interventions to prevent more mum Data Set (MDS) dated as moderately cognitively noses of dementia, always el, and required extensive s of daily living (eating, dressing and hygiene). ote dated 12/16/14 included ewy body dementia, diabetes	F	32			

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245409	B. WING	i		01/3	30/2015
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	•	
MAPLE I	MANOR NURSING AN	ID REHAB, LLC		-	75 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	Miralax 17 grams b (original order date solution 30 milliliter (original order date orders also include by mouth at noon a R32's dietary asses reviewed: note on 8 independent with e difficulty with swallo not eat a lot for lund indicated R32 switc to mechanically sof related to coughing to monitor intake. N R32 eats 50-75% of and swallowing, ha last 30 days or 9.5 pudding at lunch ar Dietary assessmen indicated R32 had months and read, " on foot and weight staff to monitor wei dietary manager, re Dietary assessmen indicated intake wa and noted an overa or 10.3% of body w Dietary assessmen assessment and ev failed to address in maintain or regain w R32's meal intake of through 1/26/15 dio meals. Based on de consumed an avera meal, 51-75% of no	by mouth two times daily of 4/30/09), and Sorbitol 70% s (ml) by mouth one time daily r of 1/21/09). Physician's d Seroquel 25 milligrams (mg) and 37.5 mg at 6:00 p.m. ssment progress notes were 3/5/14 indicated R32 was ating, weight is stable, no owing or chewing, and does ch or dinner. Note on 9/3/14 ched from regular texture foods it and nectar thickened liquids during meals and staff were Note from 10/24/14 indicated of meal, had difficulty chewing d a 4.8% weight loss in the pounds, and R32 was offered nd supper for weight gain. It note written on 11/19/14 a weight loss of 7.3% in 6 However, resident has a brace may/may not include brace, ght, intake, notify certified egistered dietician." it note written on 1/16/15 is 50-75% of food at meals all weight loss of 20.6 pounds weight in 180 days. Its lacked a comprehensive valuation of weight loss and terventions that would	F	325			

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245409	B. WING			01/3	30/2015
NAME OF	PROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE	-	
MAPLE	MANOR NURSING AN	ID REHAB, LLC		-	875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	been consumed for Physician visit note of R32's behaviors Physician visit note dietary assessment weight loss in 30 da weight loss and reach challenge " Physician visit note R32's appetite was meals" under beha mention of the 7.3% R32 was treated by through 9/6/14 for r in texture of diet rel and improving abilit discharge R32 spe required verbal cue swallowing and R33 function. R32's dining room f communicate dieta included the instruct breakfast and provi During observation on 1/26/15. Nursing assisting residents was not assisting F lap until NA-0 gave the end of the mea of pudding indepen of food R32 took in meal. When R32 w table, 75% of food did not ask R32 if h R32 from table. During an observat	r meals was not tracked. dated 8/14/14 identified one as "refuses meals" dated 10/28/14 (visit after t had identified a 9.5 pound ays) had no mention of the ad " No other active new dated 12/16/14 indicated fair, however listed "refuses viors. The note had no % weight loss in 6 months. y speech therapy from 8/5/14 recommendations for change lated difficulty masticating food ty to swallow fluids safely. On ech therapy indicated resident es from staff for safe 2 would not regain swallowing tray card (card used to ry information to staff) ction to give double portions at	F 3	25			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION). 0938-039 TE SURVEY
	PF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245409	B. WING		01	/30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
MAPLE I	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 325	Continued From pa	ge 93	F 3	25		
		ng the meal. At 8:31 a.m.				
	feeding assistant (FA)-A assisted R32 with eating. R32 had a difficult time chewing hardboiled egg. It was observed R32 could not swallow the egg					
		a bite of hot cereal. FA-A did				
		s on use swallowing technique				
	to promote ease of	swallowing. R32 did not				
		pendently during the meal.				
		on 1/27/15, at 2:19 p.m.				
		2 required assistance with I, "He does not require any				
		t or special dining needs."				
		on 1/27/15, at 2:23 p.m.				
	NA-O stated, "Sor	netimes he eats and				
		sn't, somebody needs to sit				
	next to him the enti	re time during the whole				
		on 1/27/15, at 2:25 p.m.				
		urse (LPN)-D stated, "75% of				
		o be fed. Aide staff should be				
	sitting in close prox	on 1/27/15, at 2:30 p.m.				
		nager (CDM) explained R32				
		rtions at breakfast because he				
		ast. CDM also explained he				
		of meal intakes from the				
		ocumentation, and there was				
		nat identified exactly how much consumed. The CDM stated				
	the resident had no					
		I nursing had not been				
	involved in address	ing need for dietary				
		stated R32 has had a weight				
		luced food intake; however no				
	why he was losing w	been assessed to determine				
		on 1/27/15, at 3:01 p.m.				
		DON) explained her				
	expectation would b		1			1

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245409	B. WING		01/30/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		30/2015
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 325 F 329 SS=D	next to R32 during he is eating and sw further explained w change of condition the nurse practition cause (medication, assistants, food tex and possibly get sp During an interview registered dietician been evaluated from needs more assista environment has no During an interview speech therapist (S him he would eat o allowed staff to fee she was not aware referral had not bee his swallowing/eatin 483.25(I) DRUG RF UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u	the entire meal to ensure that vallowing correctly. DON then there is a decline or n, nursing should confer with ther, try to identify the root environment, need for sture versus disease process), beech therapy involved. on 1/28/15, at 7:35 a.m. (RD) stated, "R32 has not m a dietary standpoint if he ance at meals and ot been evaluated." on 1/28/15, at 9:22 a.m. SP)-M stated, "When we saw nly 25% of his food then d him up to 75%." SP-M said R32 had weight loss and a en made for her to reevaluate ng status. EGIMEN IS FREE FROM DRUGS	F 32			3/11/15

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOF	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		245409	B. WING _		C	1/30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
MAPLE N	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	record; and residen drugs receive gradu behavioral intervent contraindicated, in a drugs.	locumented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these	F 3:	29		
	by: Based on observat review, the facility d effects monitoring v assessment tool to use of psychotropic residents (R68) who antipsychotic medic ongoing bowel asse medications or a cu as to why they are r (R32) reviewed for Findings include: R68 received an an (Seroquel) and was side effects. On 1/28/15, at 8:14 room and seated ca not protest when nu suggested to braid handshake with sur you" pleasantly to c with the braided hai	 NT is not met as evidenced ion, interview and document id not ensure adequate side vas completed or other like determine side effects for the medications for 1 of 5 p received Seroquel and ation; failed to ensure an assment for use of three bowel rrent physicians justification necessary for 1 of 5 residents unnecessary medications. tipsychotic medication not monitored for possible a.m. R68 was observed in almly in wheelchair. R68 did ursing assistant (NA)-B R68's hair. R68 had a firm veyor and R68 stated, "Thank ompliment about looking nice r. R68 smiled as NA-B m room toward the dining 		Tag F329 Unnecessary Drugs Maple Manor Nursing & Reh assures that each resident is free from unnecessary dru resident s drug regime is re- staff, physician and consulta to assure that medications a excessive doses, for excess without adequate monitoring adequate indications, or in th of adverse consequences. T medication review includes r unnecessary duplicate thera The policies related to comp Abnormal Involuntary Mover assess (AIMS) for adverse e antipsychotic medications ar of bowel preparations were r found appropriate. AIMS ass continue to be done monthly months and then every six m bowel management plan of o	s drug regin ugs. The eviewed by the int pharmaci- ire not used ive duration l, without ne presence The monitoring for py. eletion of the ment Scale the effects of and for the us reviewed and sessments we for three nonths; the	ne st in or o e

Facility ID: 00916

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	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
				3		
		245409				30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1875 19TH STREET NORTHWEST	E	
MAPLE N	IANOR NURSING AN	D REHAB, LLC		ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 329	Continued From pa	ae 96	F 329	9		
	room for breakfast.	9	. 020	continue to be routinely review	ed by the	
				interdisciplinary care team, ph	armacist	
		p.m. NA-C was asked if she anted behaviors and NA-C		and physician with updates by	the medical	
		served R68 manifesting		practitioner as indicated.		
		or delusions or hallucinations.		During mandatory meetings, the	ne nursing	
	-			staff were instructed on 1) the		
		p.m. NA-B stated she would it manifesting a behavior but		follow the facility policy on ass side effects of antipsychotic m		
		rved any delusions or		2) the importance of documen		
	hallucinations from	R68. NA-C was not aware		observed target behaviors 3) t		
		nitored for delusions or		ongoing physician justification		
	hallucinations.			multiple laxatives and 3) the in tracking and documenting the		
	On 1/28/15 at 2:08	p.m. registered nurse (RN)-C		bowel function. During the con		
	enumerated R68's	arget behaviors as "angry,		pharmacist s monthly medica	tion audits	
		e, does not like everybody."		and the quarterly care planning		
		s will document in the progress behaviors and/or possible side		the resident s medications wi to be reviewed to assure that t		
		ins occur, otherwise no		is receiving the lowest effective		
		needed. RN-C stated that		medication dose with appropri		
		k orthostatic blood pressures		indications and monitoring.		
		f anti-psychotic medications if		Desident number 22 The nu	***	
		r's order. RN-C did not 's hallucinations and delusions		Resident number 32 The nu practitioner reassessed the res		
	being monitored.			bowel function on February 19		
				MeriLAX was discontinued and		
		p.m. RN-A stated R68's target		was increased to 30 cc three t		
	"delusions about sta	naking accusations, also had		The nursing staff have been in monitor the resident s bowel		
		R68] were a bunch of lesbians		to notify the physician/nurse p		
	trying to take advan	tage of [R68]." RN-A verified		the new regime is ineffective.	The care	
		ehaviors he mentioned were		plan has been reviewed and u	pdated.	
		ior monitoring sheet. RN-A hart if the behaviors occur.		Resident number 68 The All	MS	
		effects of psychotropic		assessment was completed F		
	medications were b	eing monitored, RN-A replied,		2015; no adverse reactions to	the	
	"Probably not becau monitor." When ask	use they said no need to		psychotropic medication were The care plan was updated to		

Facility ID: 00916

STATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED	
			A. BUILDI	NG			
		245409	B. WING _			30/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,			
MAPLE I	MANOR NURSING AI	ND REHAB, LLC		1875 19TH STREET NORTHWE ROCHESTER, MN 55901	51		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 329	 329 Continued From page 97 answered, "The previous owner and the previous DON [director of nursing]." RN-A confirmed staff has not been monitoring R68 for side effects of the antipsychotic medications such as urinary retention, orthostatic hypotension, and was not sure if Abnormal Involuntary Movement Scale (AIMS - a tool used to monitor for side effects of anti-psychotic medications) was completed for R68. R68's Medication Administration Record (MAR) for 1/1/15 through 1/31/15, listed R68's diagnoses including psychosis, dementia, depression, anxiety state and urinary retention. The MAR also indicated R68 was on Seroquel (an antipsychotic) 6.25 milligram (mg) every morning and Seroquel 12.5 mg every afternoon; Remeron (antidepressant) 15 mg during hours of sleep. 		F 32	29 target behaviors justifyin and to reflect monitoring The nursing assistants document observed targ The Director of Nurses/ Consultant Pharmacist monitor for compliance side effect monitoring, k documentation, and duy therapy during the routi reviews and more often Completion date: March	g for side effects. will continue to get behaviors. designee and the will continue to with antipsychotic behavior related blicate drug ne quarterly record if indicated.		
	The care plan date risk for falls related use. Interventions orders. However, s medications in rela	ed 1/27/14 indicated R68 was at d to psychotropic medication include giving medications per side effects of psychotropic ation to falls were not identified ifically planned to be					
	R68's care plan dated 4/24/14, identified behavior symptoms of "some paranoia of people talking about [R68] and is easily angered." Approaches included "nurse to administer medications as ordered and monitor possible side effects." The care plan did not give directions on monitoring resident-specific target behavior and it did not identify specific side effects of psychotropic medications to be monitored.						
	medications in rela and were not spec monitored. R68's care plan da symptoms of "som about [R68] and is included "nurse to ordered and monit care plan did not g resident-specific ta identify specific sic medications to be On 1/29/15, at 1:23	ation to falls were not identified ifically planned to be ated 4/24/14, identified behavior te paranoia of people talking easily angered." Approaches administer medications as or possible side effects." The ive directions on monitoring arget behavior and it did not be effects of psychotropic					

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING	i		01/;	30/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	effects of any media CP agreed orthosta should be completed developed while on On 1/29/15 at 1:28 unable to locate an p.m. the director of was no record on fi completed for R68 though the resident antipsychotic media The facility's Use of Medications policy of monitor drugs for si monitoring for gait of disorders, signs of effects such as dry The policy further d baseline AIMS and three months for the medications. R32 received three was no physician ju bowel medications dose of Miralax. R32's physician or the diagnoses of Le mellitus, and consti R32's physician or the following medic constipation: Senna three times daily (of Miralax 17 grams b (original order date solution 30 milliliters (original order date	cations should be monitored. atic blood pressure and AIMS ed to determine if side effects anti-psychotic medications. p.m. RN-E stated they were AIMS assessment. At 1:43 nursing (DON) verified there le to show AIMS was within the last year even a had received the cation. f Psychotherapeutic dated 4/11/08, directed staff to ide effects daily, to include disorders, movement hypotension, and cholinergic mouth and urinary retention. lirected staff to assess for to do reassessment every e use of antipsychotic bowel medications and there astification for need of three and exceeded recommended ote dated 12/16/14 included ation orders to treat a-S tablet 2 tabs by mouth riginal order date of 4/16/08), y mouth two times daily of 4/30/09), and Sorbitol 70% s (ml) by mouth one time daily	F	329			

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		& MEDICAID SERVICES	0.0). 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245409	B. WING		01	/30/2015	
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP (CODE		
MAPLE I	MANOR NURSING AN	ID REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 329	dose was 17 grams The directions indic	-	F 3	29			
	directed unless directed by a physician. Also there was no justification by the doctor to exceed the recommended Miralax dose or use beyond the 7th day. R32's bowel movement (BM) documentation was reviewed. Bowel movement documentation was						
	found in two differe and electronic med was found to be inc formats. Document	ent formats; paper flow sheet lical record. Documentation consistent between the two tation revealed R32 routinely BM daily. The electronic form					
	of documentation la formed, hard, etc.) large) of BMs and t consistency of BMs would make it diffic	acked consistency (soft, and size (small, medium or the paper flow chart lacked s. This lack of information cult to determine if the					
	went daily. The last physician ' that justified the ne	ective or was too much as R32 's assessment and evaluation ed for three medications for pharmacy) medication was					
	suppositoriesand does have very l	d, "does not tolerate d will become angry at times arge bowel movements with					
	bowel movement for progress notes revi	f not given he may not have a or up to 5 or 6 days. Physician iewed did not indicate rationale e than manufacturer's daily ded dose					
	R32's quarterly Min 1/9/15 indicated wa impaired with diagr	nimum Data Set (MDS) dated as moderately cognitively noses of dementia, always el, and required extensive					

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		NG	COMPLETED	
		245409	B. WING _		01/	30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MAPLE I	MANOR NURSING AN	ID REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 329 F 334 SS=E	transfers, dressing R32's care plan did history of constipati interventions to pro as increased fluids, increased activity, r habits, use of toilet During an interview registered nurse (R aware of specific red different bowel med know why the dose recommended. RN an assessment or p use of the three boy During an interview consulting pharmac has a diagnoses that recommended dose care planned and the note the reasons for then monitor routine During an interview nurse practitioner (I medication should B After informing NP medication and dail 483.25(n) INFLUEN IMMUNIZATIONS The facility must det that ensure that (i) Before offering the each resident, or the representative rece	s of daily living (toileting, and hygiene). I not address constipation or ion or non-pharmacological mote bowel movements such adding roughage to diet, maintaining routine daily bowel or commode, etc. on 1/27/15, at 2:05 p.m. N)-A indicated he was not easons why R32 had 3 dications. RN-A also did not of Miralax was higher than -A stated he was not aware of obysicians recent justified for wel medications. on 1/27/15, at 3:34 p.m. cist (CP) stated if a resident at required more than a e of medication it should be ne physician to address or or the increased amount and ely. on 1/30/15, at 9:30 a.m. NP) stated, "[R32 ' s] bowel be looked at and reduced." of R32 ' s three bowel ly bowel movements. NZA AND PNEUMOCOCCAL evelop policies and procedures ne influenza immunization,	F 32			3/11/15

Facility ID: 00916

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	OMB NC (X3) DA	TE SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	COI	MPLETED	
		245409	B. WING		01	/30/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE			
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHW ROCHESTER, MN 55901	EST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE	
F 334	(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;		F 3	334			
	 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza 						
	immunization; and (B) That the reside	ent either received the tion or did not receive the tion due to medical					
	that ensure that (i) Before offering th immunization, each	resident, or the resident's					
	the benefits and po immunization; (ii) Each resident is	e receives education regarding tential side effects of the offered a pneumococcal ss the immunization is					
	medically contraind already been immu (iii) The resident or	licated or the resident has nized;					
	immunization; and (iv) The resident's r	nedical record includes indicated, at a minimum, the					

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		AND HUMAN SERVICES			F	FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	SURVEY PLETED
		245409	B. WING			01/3	80/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 334	the benefits and po pneumococcal imm (B) That the reside pneumococcal imm the pneumococcal imm the pneumococcal contraindication or (v) As an alternative and practitioner rec pneumococcal imm years following the immunization, unless	provided education regarding tential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative	F3	334			
	by: Based on interview facility failed to dev directed staff to ask residents with influe 2014. This had the residents in the fac Findings include: The facility policy Ir Outbreak Managen reviewed. The poli the facility would ok all residents, provic education, obtain p resident/families re In October the facil vaccine and proces	NT is not met as evidenced v and document review, the elop an influenza policy that c residents and provide enza vaccine after October e potential to affect all 69 ility. nfluenza Prevention and nent Policy dated 1/14/13 was cy identified that in September otain a creatinine clearance of led annual influenza ermission forms from lated to influenza vaccination. ity would obtain the influenza ed to have staff members and ed. The policy then proceeded			Tag F334 Influenza and pneumococcal immunizations Maple Manor Nursing & Rehab, LLC offers each resident education regard benefits and potential side effects of t influenza immunization. Each resider offered the influenza vaccine October through May 31 annually unless contraindicated or have already recei it. All residents are offered the current education and the influenza vaccine f October 1 through May 31 each year. Consent forms are signed by the resident/family/responsible party. The immunization is documented on the consent form and in the medical reco The policy and procedure for	ding the nt is er 1 ived from c. e	

Facility ID: 00916

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		. 0938-039 TE SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à	CON	MPLETED	
		245409	B. WING		01,	/30/2015	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
F 334 F 353 SS=F	to outbreak manag lacked direction to re-educate each re- risk/benefits for any vaccinated, and do lacked direction rel admitted after Octovaccination elsewh direction to provide admitted residents The director of nur- 1/28/15 at 11:25 a. vaccine. She verifi provision of the infl October. DON sta given after October be rewritten. 483.30(a) SUFFIC PER CARE PLANS The facility must ha provide nursing an- maintain the higher and psychosocial v determined by resid individual plans of The facility must pr numbers of each o personnel on a 24- care to all residents care plans: Except when waive	ement. The policy/procedure staff related to how to sident or guardian on the y resident refusing to be cumenting that education; ated to questions residents ober if they had received the ere for the year; and lacked the vaccination to newly after October 2014. sing (DON) was interviewed on m. related to the influenza ed the policy did not address uenza vaccination after ted the vaccination could be r, but that the policy needed to IENT 24-HR NURSING STAFF ave sufficient nursing staff to d related services to attain or st practicable physical, mental, well-being of each resident, as dent assessments and	F 334	administration of the influenza va was reviewed and revised. At the next Nurses meeting staff in-serviced on the policy and pro- for influenza vaccination. The Director of Nursing and/or of will monitor for compliance by ra audits for the next 4 weeks. Completion Date: March 11, 201	f will be ocedure lesignee indom	3/11/15	

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		I AND HUMAN SERVICES		C	FORM APP MB NO. 093		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SUF COMPLET		
		245409	B. WING _		01/30/2	01/30/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLE I	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE CON	(X5) /PLETIO DATE	
F 353	Except when waive section, the facility nurse to serve as a duty. This REQUIREMED by: Based on observa review, the facility f provide sufficient si assessed needs fo provided. This has residents in the fac Findings include: SEE F241: On 1/2 (11:45 a.m.) R26 w residents and only seated helping ano same time NA-F we tale for other reside residents did eat in periods of time for at 5:09 p.m. the su five dependent resi residents were sea	A under paragraph (c) of this must designate a licensed a charge nurse on each tour of NT is not met as evidenced tion, interview, and document cailed to ensure a system to taffing to meet all residents r care and treatments was the potential to affect all 69	F 35	,	ide for our We s being care ntal II ment is The nd g. The <i>v</i> ide		
	giving that resident repeating this proce room and did not re and registered nurs from the table and attempted to assist their meal. Also sta staffed as evidence	ad then moving to another table a bit of food then would be ess until NA-O left the dining eturn. A short time later NA-F se (RN)-A moved the residents neither NA-F or RN-A the five residents to complete off stated they were short ed by depended residents at in a continuous period of		accountability during a dignified difference. Staff have been educe that our residents who cannot speat themselves are equally deserving quality uninterrupted care inclusive assistive dining in a dignified mane In addition, we will be adding a resinursing program to provide for inclu- quality of life within the care implementation system. The plan	ated ak for of e of er. torative reased		

Facility ID: 00916

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE	0938-039 SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:				COM	PLETED	
		245409	B. WING _			01/30/2015		
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLE I	MANOR NURSING AI	ND REHAB, LLC			375 19TH STREET NORTHWEST OCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 353	time as staff went a few bites then m staff not assisting minutes and food assisted the reside residents time to e food debris and ha food scraps next to still eating; and fail bag to promote dig who was observed collection bag with other residents, sta SEE F282 & F312 interview, and doc to provide services care plan for 2 of 5 assistance with ea minutes for staff to waited during noor minutes at one me eat while having he entire time and wa 20 minutes for staff eating. During inte director of nursing	ontinued From page 105 ne as staff went from resident to resident giving few bites then moving on to the next resident or aff not assisting residents for periods up to 20 inutes and food was cool by the time staff isisted the residents to eat.; failed to allow sidents time to eat before cleaning the table of od debris and had parked the BUS cart with od scraps next to table where residents were ill eating; and failed to cover a urine collection ag to promote dignity for 1 of 1 resident (R68) no was observed with an uncovered urine ollection bag with urine set on bed and visible to her residents, staff, and visitors. EE F282 & F312: Based on observation, terview, and document review, the facility failed provide services as directed on each residents are plan for 2 of 5 residents (R3, R88) for esistance with eating as R3 waited over 20 inutes for staff to assist her to eat and R88 aited during noon meal on 1/27/15 for 32 inutes at one meal before staff assisted her to at while having her food set in front of her the thire time and waited at breakfast on 1/28/15 for 0 minutes for staff to return to help her finish ating. During interview on 1/29/15, at 9:00 a.m., rector of nursing stated she expected staff to llow the care plan and to provide R3 & R88 with		53	work in progress and will adapt to changing needs of our resident population. All department manage have been educated to the system changes and will assist in monitor success in our goal of dignity, ada and overall quality of life. Administration and each designed responsible for the ongoing succe evaluation of the program. Completion Plan Date: 3/11/15	gers n design ing the aptability, e is		
	assistance for meals. Director of nursing stated she was aware of the lack of staff in the east/wes dining room.; for 2 of 3 residents (R88 & R31) assessed to need assistance with personal care as R88 was observed with long, soiled nails on a fingers, and visible long facial hair that was not removed also R31 was observed to have dark brown debris under finger nails and eye glasses that were visibly soiled preventing clear vision for the resident ; and failed to ensure 2 of 2 Residen							

Facility ID: 00916

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		& MEDICAID SERVICES). 0938-039			
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	TE SURVEY MPLETED			
		245409	B. WING	·····	01	01/30/2015			
NAME OF	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZIP COD	E				
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE			
F 353	interview it was lea short staffed. Also monitored for daily consistently done; 1 of 1 Resident (R3 weights: failed to for interventions and s infections for 1 of 1 catheter. SEE F309: Based document review, t 39 residents (R100 had ongoing service by the physician to status changes so to the physician for congestive heart fa of fluid intake was respirations, lung s blood pressure or h order to determine medications was a changes needed to timely. R71 also ha did not receive ord sounds, respiration R45 also had cong physician ordered of lung sounds, worse R38 had a new col- ordered daily weigh restriction, and ong healing and bowel weights per doctor heart failure and or sounds, monitoring During an interview	rned it was because they were R38 was to have fluids intake and this was not failed to monitor daily intake for 88) with doctors order for daily ollow indwelling catheter ervices to prevent urinary tract resident (R68) with a Foley on observation, interview and he facility failed to ensure 5 of r, R71, R45, R38, and R39) es and treatments as ordered monitor for significant health they could be reported timely interventions as R100 had illure and ongoing monitoring not completed, nor was ounds, monitoring of edema, heart rate monitored closely in		53					

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING	i		01/:	30/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	Continued From pa	ige 107	F	353			
	they had staffing iss me were all they ha	sues and the weights he gave ad for R39.					
	document review, th comprehensive black assessment of risks monitoring of sympi infections (UTIs) fo R70, R30, R69, R9 recurrent urinary tra- to prevent urinary tra- to prevent urinary tra- following sound infe- Foley Catheter care 1 resident (R68) with catheter; and the fa- orders for intermitter monitor, evaluate, a- of 1 residents (R70 intermittent catheter	on observation, interview and he facility failed to ensure dder assessments and an s for developing and toms for urinary tract r 7 of 8 residents (R16, R6, 6, R38) reviewed with act infections; the facility failed ract infections and the spread er residents due to staff not ection practices regarding e and equipment used for 1 of th an indwelling Foley acility failed to follow physician ent cauterization and failed to and assess urine output for 1) in the sample with rizations. R70 had physicians thour catheterization which y provided.					
	1/28/15 at 4:15 p.m provided adequate that she did not wor resident cares. DOI be 7 nursing assista and 2 trained medic	sing was interviewed on a. she stated she felt the facility staffing numbers. She stated rk on the floor providing direct N said that ideal staffing would ants and 3 licensed nurses cation aides each day shift and along with administrative					
	interviewed on 1/29	nanager (RN-A) was 0/15 at 8:05 a.m. He stated he idents had complained about levels.					

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		AND HUMAN SERVICES & MEDICAID SERVICES			I	FORM	02/25/2015 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (>		E SURVEY PLETED	
		245409	B. WING			01/:	30/2015	
NAME OF I	PROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE			
MAPLE I	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 369	Continued From pa	ge 108	F 3	69				
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING		F 3				3/11/15	
		ovide special eating equipment idents who need them.						
	This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide a scoop plate or similar device at all meals for 1 of 1 resident (R32) who utilized the scoop plate to enhance ability to eat independently. Findings include: Dinner meal on 1/26/15 at 5:00 p.m., R32 was not provided with a scoop plate (a plate with high edges) according to the care plan. During breakfast meals on 1/27/15 at 8:40 a.m. and on 1/28/15 at 8:50 a.m. R32 again did not receive double sized portions or a scoop plate according to their care plan. R32's quarterly Minimum Data Set (MDS) dated 1/9/15 indicated was moderately cognitively impaired with diagnoses of dementia, and required extensive assist with activities of daily living that included eating, toileting, transfers, dressing and hygiene. R32's physician's note dated 12/16/14 included but was not limited to the diagnoses of Lewy body dementia. R32 's care plan dated 1/16/15 read, "Has had a significant weight lossis offered double portions at breakfast with extras on tray for other meals staff to bring resident to dining room and sit at a supervised table where tray is prepped and is assisted as needed to eat, staff to prompt in				F-369 Assistive Devises- Eating Equipment Resident R32 was assessed for adapt equipment and is now utilizing a scoo plate. Other residents in need of ada equipment for dining will be screened admission, with any significant chang and reviewed within the interdisciplin care conference schedule. The CDM be responsible for ongoing compliant and Administration or designee will conduct random audits. Completion Date: 3/11/15	ptive op aptive d on ge ary ⁄I will		

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		AND HUMAN SERVICES			FOR	D: 02/25/201 M APPROVEI O. 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) D	ATE SURVEY OMPLETED
		245409	B. WING		0	1/30/2015
	PROVIDER OR SUPPLIER	ID REHAB, LLC		1	TREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE
F 369 F 371 SS=E	meals, provide sha scoop plate." R32's dining room to communicate dieta included the instruct breakfast and provid During an interview certified dietary ma did not receive dou resident was support 483.35(i) FOOD PF STORE/PREPARE The facility must - (1) Procure food from considered satisfact authorities; and	brovide a scoop plate at all llow bowls if unable to use tray card (card used to ry information to staff) etion to give double portions at de a scoop plate. on 1/30/15, at 10:30 a.m. nager (CDM) verified resident ble portions and stated the used to have a scoop plate. ROCURE, /SERVE - SANITARY		369		3/11/15
	by: Based on observat kitchen tour the fac refrigerated foods h removed from serv that appear they ha had the potential to facility. Findings include:	NT is not met as evidenced tion and interview, during the ility failed to identify when have expired and should be ice and to remove fresh foods twe lost their freshness. This affect most residents in the			F-371 Food Store/Prepare/Serve-Sanitary Food deliveries are processed twice weekly with labeling and dating prior to storage. All opened and partially used items will be covered and dated to be used or disposed of as their expiration date approaches. All dietary staff have been in-serviced to the safe handling and labeling of food to be stored. The CDM of	

Facility ID: 00916

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		AND HUMAN SERVICES			MB NO.	APPROVED 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY IPLETED		
		245409	B. WING		01/	30/2015		
NAME OF	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZIP CODE				
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 371 F 373 SS=D	the walk in cooler n romaine lettuce wit lettuce. The bag ha The head cook veri and stated, "We thi used by date" and t lettuce. Observation further pasteurized eggs th in a reach in cooler absence of date an bags should be dat Facility policy Gene Handling read, "Foo swollen cans, or foo or odor will not be s Facility policy Food be dated as it is pla marking to indicate ready to eat, potent consumed, sold or high risk foodsa labeled, and dated. 483.35(h) FEEDING TRAINING/SUPER A facility may use a defined in §488.30 assistant has succe State-approved trai requirements of §4 residents; and the u consistent with Stat	d cook (HC)-A. Observation of evealed an open bag of h several brown pieces of d a "use by date" of 1/24/15. ified the lettuce was out of date row out food that is past the then proceeded to toss the revealed 2 bags of liquid hat were not labeled or dated . The Head cook verified the d label and commented the ed and labeled. eral Food preparation and bd in broken packages or od with abnormal appearance served." Storage read, "Food should ace on the shelves, date the date or day by which a tially hazardous food should be discarded will be visible on II foods should be covered, " G ASST - VISION/RESIDENT a paid feeding assistant, as 1 of this chapter, if the feeding essfully completed a ning course that meets the 83.160 before feeding use of feeding assistants is te law. must work under the gistered nurse (RN) or licensed	F 37	designee is responsible for weekly to assure food is safely stored. Completion Date: 3/11/15	v audits	3/11/15		

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING			01/;	30/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 373	Continued From pa	ge 111	F 3	73			
		feeding assistant must call a or help on the resident call					
		re that a feeding assistant s who have no complicated					
	not limited to, difficu	g problems include, but are ulty swallowing, recurrent lung be or parenteral/IV feedings.					
		use resident selection on the essment and the resident's and plan of care.					
	regulatory requirem feeding assistants r program with the fo specified at §483.16 o A State-approved	d training course for paid must include, at a minimum, 8					
	Feeding techniq Assistance with Communication Appropriate resp	ues. feeding and hydration. and interpersonal skills. ponses to resident behavior. rgency procedures, including					
	Infection control Resident rights. Recognizing cha inconsistent with the importance of repor						
	supervisory nurse.						

		AND HUMAN SERVICES				RINTED: 02/25/2015 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
		245409	B. WING	i		01/30/2015
NAME OF I	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
MAPLE I	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 373	A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.			373		
	by: Based on observat review, the facility f (R88, R68, R66) re eating, were compr safely assisted to e feeding assistant (F Findings include: PFA-A assisted R84 although the facility residents to be safe eat. R88 was assisted t assessment as safe R88 was admitted t diagnosis that inclu Bodies and paralys resident diagnosis of The facility identifie Minimum Data Set 11/23/14, to have s moderately impaire dependence on 2 s total dependence o	8, R68, R66 with eating had not assessed these three to have PFA-A help them all o eat by PFA-A without			Tag F373 Feeding Assistants Plan of Correction The goal of Maple Manor Nursing a Rehab, LLC. Is to ensure not only th safety of R66, R88, and R68 but for residents in the facility that require assistance with feeding. Maple Mar Nursing and Rehab, LLC is assess residents who require assistance wi feeding to ensure that it is safe and appropriate to be aided by a trained feeding assistant. The facility policies/procedures for assessing a resident who requires assistance with feeding were review Those residents who were assesse free of aspiration and choking risk v evaluated as safe to be aided by a t feeding assistant. A list of these res was made available to the trained fe assistant and placed in a binder alo with the resident assessments. This available for review and is updated needed. At the next CNA/Nurses meeting, th will be instructed on the policies and procedures for assisting residents v eating.	ved. d to be vere trained idents eeding ng s is as he staff

Facility ID: 00916

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY		
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	IPLETED		
		245409	B. WING _			30/2015		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE		
F 373	Continued From pa	age 113	F 37	3				
	Document review of physician orders dated 9/22/14, revealed orders for pureed diet with thin liquids. Document review of dietary notes dated 1/26/15, revealed R88 received pureed diet, dependent eating skills, staff assist as R88 allowed, current weight 135 pounds (#), weight down 8.5% in 2 months, some weight loss may be due to decreased edema.			will be responsible for monitorin compliance by random audits for 4 weeks to ensure that these policies/procedures are being for	or the next			
				Completion date: March 11, 20	15			
	problem of at risk f due to need for me to poor dentation, o increased need for abnormal labs, due meals, due to decr dated 9/10/14 inclu resident allows with 9/22/14 included p Approaches dated supplement two tin 9/29/14 included at for swallow and giv	ated 9/10/14, identified or decline in nutritional status echanically altered food related due to open areas with nutritional support, due to e to need for assistance with eased cognition. Approaches ided assist as needed and as n food/fluid. Approaches dated ureed diet with thin liquids. 9/23/14, included house nes daily. Approaches dated ternate bites with sips, watch re next bite/sip to maintain ed cups ok when being						
	R88 was in wheeld room positioned at side of the dining re- residents who need observed to sit. Du a plate of pureed c potatoes and four a with lids were on th	s on 1/27/15, at 11:18 a.m., hair in the east/west dining the large table on the south oom (south table) where ded assistance to eat were uring observations at that time, arrots, quiche, and mashed adaptive cups of beverages to table directly in front of R88, t 11:54 a.m., PFA-A assisted						

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245409	B. WING			01/;	30/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 373	another resident at glass of chocolate r stood to assist R88 another until R88 w During interview on verified had assiste R88 received puree assist R88 to eat. P days when R88 ate days needed assist During interview on of nursing verified F be assisted to eat b R68 was assisted to assessment as safe R68 was admitted 4 included dementia, anxiety, according t 1/29/15. R68's quarterly MD was independent in or swallowing, rece R68's care plan dat of at nutritional risk decreased cognition dehydration. Appro assist with any tray self care deficit date independent with ea During observations PFA-A was observe	 same table, then handed R88 milk. At 12:06 p.m., PFA-A to eat one bite of food after vas finished eating. 1/27/15, at 12:12 p.m., PFA-A ed R88 to eat. PFA-A stated ed foods and any staff could PFA-A stated R88 had good independently, and other twith eating. 1/29/15, at 9:00 a.m., director R88 had not been assessed to by PFA. o eat by PFA-A without et o be assisted. 4/17/13 with diagnosis that psychosis, depression, and to physician orders printed S dated 1/5/15 revealed R68 eating, no difficulty chewing ived regular diet. ted 4/17/13, revealed problem related to pneumonia, n, and potential for baches read, "I want staff to prep." Care plan problem of ed 4/18/13, read R68 was 	F3	373			

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES				MB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		245409	B. WING			01/:	30/2015	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLE I	MANOR NURSING AN	D REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 373	R68 eat and finish f On 1/28/15, at 8:37 assist R68 eat her to R66 was assisted to assessment as safe R66 was admitted 1 included dementia a according to physic Document review o 11/14/14, revealed of R66's annual nutrition revealed R66 feeds and no difficulty che R66's care plan dat of nutritional risk rel with set up and sup Approaches include staff assist with tray dated 12/18/12, ide approaches include eating at times. During observations PFA-A was observe and completed her Document review o Feeding During Mea the PFA could assis R66 were not on the During interview on	her meal at 12:12 p.m. a.m., PFA-A was observed to breakfast meal. o eat by PFA-A without e to be assisted. 12/7/12, with diagnosis that and chronic airway obstruction ian orders printed 1/29/15. If physician orders dated orders for general diet. on assessment dated 12/3/14 s self, staff assist with set up, ewing or swallowing. ted 12/3/14, identified problem lated to need for staff assist pervision with reminders to eat. ed offered a general diet and y prep. Care plan problem intified self care deficit and ed needed limited assist with s on 1/28/15, at 7:30 a.m., ed to help R66 eat bites of food meal with PFA-A ' s help. If the facility Resident List for al Time, identified residents st, however, R88, R68, and		373				

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		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245409	B. WING			01/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 373 F 428 SS=D	Feeding During Me residents who had I to eat by a PFA in w included on this list During interview on of nursing verified t assessments to def were safe to be ass assistant. Document review o Paid Feeding Assis A trained feeder [er PFA course] can no complicated feeding with: 1. Recurrent Iu swallowing, 3. Profe tubes, 4. Requires t an example, not ex would have to be fee h.) Initial Assessme 1. Dismissal Summ admission PM [p.m General Maintenan Manager audits forn 4. PM Clinical Mana decide who needs t CNA [certified nursi Feeding Assistant). 483.60(c) DRUG R IRREGULAR, ACT The drug regimen of reviewed at least of pharmacist.	al Time was the list of been assessed to be assisted which R88, R68, R66 were not		428			3/11/15

Facility ID: 00916

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			FOI OMB N	ED: 02/25/2015 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		()	DATE SURVEY COMPLETED
		245409	B. WING	ì		01/30/2015
NAME OF F	PROVIDER OR SUPPLIER	-	-		STREET ADDRESS, CITY, STATE, ZIP CODE	
	ANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	This REQUIREMEN by: Based on observat review, the facility fi irregularities identifi pharmacist were act for 3 of 3 residents for unnecessary me Findings include: R39's face sheet id on 1/7/2015 and R3 antipsychotic daily v effects assessment pharmacist recomm The dismissal summ 1/7/15 identified R3 mild dementia, chro heart failure, atrial fi history of transient diabetes mellitus, ty	AT is not met as evidenced tion, interview and document ailed to ensure medication ied by the consultant ddressed in a timely manner (R39, R68 and R32) reviewed edications.	F	428		nth ist nd
	of probable Bonnet people who have lo hallucinations). The admission Min 1/14/15 indicated th	Syndrome (a condition among ost their sight. It causes visual imum Data Set (MDS) dated nat R39 had a Brief Interview BIMS) score of 13, which			These issues will be reviewed during the April 2015 Quality Assurance and Assessment Committee meeting which the Consultant Pharmacist and Medical Director attend. The pharmacist reviews each resident s medication regimen monthly and will continue to routinely au for appropriate indications justifying	e 3

Facility ID: 00916

If continuation sheet Page 118 of 133

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245409 B. WING NAME OF PROVIDER OR SUPPLIER ST MAPLE MANOR NUBSING AND REHABILLO	E CONSTRUCTION (X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER S MAPLE MANOR NURSING AND REHAB, LLC ID (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID F 428 Continued From page 118 F 428 R39 's current physician orders dated 1/29/15 identified that R39 was receiving Seroquel 50 mg one tab twice a day (an anti-psychotic medication). F 428 The consultant pharmacist s medication regimen review dated 1/16/15 identified that R39 was recently admitted on Seroquel for management of dementia-related behaviors. Please ensure a baseline AIMS (abnormal involuntary movement scale) exam has been completed on this resident to assess for tardive dyskinesia side effects (a neurological disorder of involuntary movements caused by long term use of antipsychotic drugs). It is recommended and a standard of care that this exam be assessed before initiation of an antipsychotic medication (or upon admission with) and at least every 6 months thereafter while on the medication. During an interview with R39 on 1/29/15 at 2:15 p.m., the resident indicated she was aware of the medications (Seroquel) that she was receiving but did not know how long she had been taking them. It was noted R39 had a slight tremor during the interview. During an interview with the registered nurse (RN)-A on 1/29/15 at 1:41 p.m., RN-A stated that	COMPLETED
MAPLE MANOR NURSING AND REHAB, LLC ID (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID F 428 Continued From page 118 F 428 R39 's current physician orders dated 1/29/15 identified that R39 was receiving Seroquel 50 mg one tab twice a day (an anti-psychotic medication). F 428 The consultant pharmacist s medication regimen review dated 1/16/15 identified that R39 was recently admitted on Seroquel for management of dementia-related behaviors. Please ensure a baseline AIMS (abnormal involuntary movement scale) exam has been completed on this resident to assess for tardive dyskinesia side effects (a neurological disorder of involuntary movements caused by long term use of antipsychotic drugs). It is recommended and a standard of care that this exam be assessed before initiation of an antipsychotic medication (or upon admission with) and at least every 6 months thereafter while on the medication. During an interview with R39 on 1/29/15 at 2:15 p.m., the resident indicated she was aware of the medications (Seroquel) that she was receiving but did not know how long she had been taking them. It was noted R39 had a slight tremor during the interview. During an interview with the registered nurse (RN)-A on 1/29/15 at 1:41 p.m., RN-A stated that	01/30/2015
MAPLE MANOR NURSING AND REHAB, LLC ID (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID F 428 Continued From page 118 F 428 R39 's current physician orders dated 1/29/15 identified that R39 was receiving Seroquel 50 mg one tab twice a day (an anti-psychotic medication). F 428 The consultant pharmacist s medication regimen review dated 1/16/15 identified that R39 was recently admitted on Seroquel for management of dementia-related behaviors. Please ensure a baseline AIMS (abnormal involuntary movement scale) exam has been completed on this resident to assess for tardive dyskinesia side effects (a neurological disorder of involuntary movements caused by long term use of antipsychotic drugs). It is recommended and a standard of care that this exam be assessed before initiation of an antipsychotic medication. During an interview with R39 on 1/29/15 at 2:15 p.m., the resident indicated she was aware of the medications (Seroquel) that she was receiving but did not know how long she had been taking them. It was noted R39 had a slight tremor during the interview. During an interview with the registered nurse (RN)-A on 1/29/15 at 1:41 p.m., RN-A stated that	TREET ADDRESS, CITY, STATE, ZIP CODE
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F 428 Continued From page 118 F 428 R39 's current physician orders dated 1/29/15 identified that R39 was receiving Seroquel 50 mg one tab twice a day (an anti-psychotic medication). F 428 The consultant pharmacist s medication regimen review dated 1/16/15 identified that R39 was recently admitted on Seroquel for management of dementia-related behaviors. Please ensure a baseline AIMS (abnormal involuntary movement scale) exam has been completed on this resident to assess for tardive dyskinesia side effects (a neurological disorder of involuntary movements caused by long term use of antipsychotic drugs). It is recommended and a standard of care that this exam be assessed before initiation of an antipsychotic medication (or upon admission with) and at least every 6 months thereafter while on the medication. During an interview with R39 on 1/29/15 at 2:15 p.m., the resident indicated she was aware of the medications (Seroquel) that she was receiving but did not know how long she had been taking them. It was noted R39 had a slight tremor during the interview. During an interview with the registered nurse (RN)-A on 1/29/15 at 1:41 p.m., RN-A stated that	875 19TH STREET NORTHWEST OCHESTER, MN 55901
 R39 's current physician orders dated 1/29/15 identified that R39 was receiving Seroquel 50 mg one tab twice a day (an anti-psychotic medication). The consultant pharmacist s medication regimen review dated 1/16/15 identified that R39 was recently admitted on Seroquel for management of dementia-related behaviors. Please ensure a baseline AIMS (abnormal involuntary movement scale) exam has been completed on this resident to assess for tardive dyskinesia side effects (a neurological disorder of involuntary movements caused by long term use of antipsychotic drugs). It is recommended and a standard of care that this exam be assessed before initiation of an antipsychotic medication (or upon admission with) and at least every 6 months thereafter while on the medication. During an interview with R39 on 1/29/15 at 2:15 p.m., the resident indicated she was aware of the medications (Seroquel) that she was receiving but did not know how long she had been taking them. It was noted R39 had a slight tremor during the interview. During an interview with the registered nurse (RN)-A on 1/29/15 at 1:41 p.m., RN-A stated that 	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5)
 identified that R39 was receiving Seroquel 50 mg one tab twice a day (an anti-psychotic medication). The consultant pharmacist s medication regimen review dated 1/16/15 identified that R39 was recently admitted on Seroquel for management of dementia-related behaviors. Please ensure a baseline AIMS (abnormal involuntary movement scale) exam has been completed on this resident to assess for tardive dyskinesia side effects (a neurological disorder of involuntary movements caused by long term use of antipsychotic drugs). It is recommended and a standard of care that this exam be assessed before initiation of an antipsychotic medication (or upon admission with) and at least every 6 months thereafter while on the medication. During an interview with R39 on 1/29/15 at 2:15 p.m., the resident indicated she was aware of the medications (Seroquel) that she was receiving but did not know how long she had been taking them. It was noted R39 had a slight tremor during the interview. During an interview with the registered nurse (RN)-A on 1/29/15 at 1:41 p.m., RN-A stated that 	
The consultant pharmacist s medication regimen review dated 1/16/15 identified that R39 was recently admitted on Seroquel for management of dementia-related behaviors. Please ensure a baseline AIMS (abnormal involuntary movement scale) exam has been completed on this resident to assess for tardive dyskinesia side effects (a neurological disorder of involuntary movements caused by long term use of antipsychotic drugs). It is recommended and a standard of care that this exam be assessed before initiation of an antipsychotic medication (or upon admission with) and at least every 6 months thereafter while on the medication. During an interview with R39 on 1/29/15 at 2:15 p.m., the resident indicated she was aware of the medications (Seroquel) that she was receiving but did not know how long she had been taking them. It was noted R39 had a slight tremor during the interview. During an interview with the registered nurse (RN)-A on 1/29/15 at 1:41 p.m., RN-A stated that	psychotropic medications, monitoring for adverse effects of antipsychotic medications, and duplicate drug therapy.
 the medication. During an interview with R39 on 1/29/15 at 2:15 p.m., the resident indicated she was aware of the medications (Seroquel) that she was receiving but did not know how long she had been taking them. It was noted R39 had a slight tremor during the interview. During an interview with the registered nurse (RN)-A on 1/29/15 at 1:41 p.m., RN-A stated that 	During the planned mandatory meetings, the nursing staff will be instructed to 1) identify specific target behaviors that justify the use of a psychotropic medications 2) complete AIMS assessments according to facility policy 3) be alert to orders for duplicative bowel medications and 4) follow the facility policy for documenting bowel function. Resident number 39 An Abnormal Involuntary Movement Scale assessment (AIMS) was completed February 20, 2015. The care plan addresses monitoring of side effects of antipsychotic medications.
the first MDS assessment (which was completed on 1/14/15).	Resident number 68 The AIMS assessment was completed February 20, 2015; no adverse reactions to the psychotropic medication were observed. The care plan was updated to identify the target behaviors justifying use of Seroquel and to reflect monitoring for side effects. The nursing assistants will continue to document observed target behaviors. Resident number 32 The nurse practitioner reassessed the resident s bowel function on February 19, 2015.
During an interview with the director of nurses (DON) on 1/29/15 at 1:40 p.m., the DON stated the resident had not had an AIMS completed.	MeriLAX was discontinued and Sorbital was increased to 30 cc three times daily. The nursing staff have been instructed to monitor the resident s bowel function and to notify the physician/nurse practitioner if

Facility ID: 00916

		& MEDICAID SERVICES			E CONSTRUCTION		E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _		COM	PLETED
		245409	B. WING _			01/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 428	re-admissions for a (1) anti-psychotic m R68 received an ar (Seroquel) and was side effects. On 1/28/15, at 8:14 room and seated c not protest when m suggested to braid handshake with su you" pleasantly to c with the braided ha pushed R68 out fro room for breakfast. On 1/28/15 at 1:49 saw R68 have unw said she had not of negative behaviors On 1/28/15 at 1:52 redirect any resider denied having obse hallucinations from R68 was being mo hallucinations. On 1/28/15 at 2:08	would be filled out on new and iny resident on the following: nedication. httpsychotic medication is not monitored for possible a.m. R68 was observed in almly in wheelchair. R68 did ursing assistant (NA)-B R68's hair. R68 had a firm rveyor and R68 stated, "Thank compliment about looking nice ir. R68 smiled as NA-B om room toward the dining	F 42	28	 plan has been reviewed and update To monitor compliance, for one modelized of Nursing/designee will a records for 1) timely monitoring of effects for antipsychotic medicatio 2) care planning for and tracking of behaviors justifying psychotropic update consultant pharmacist will continue routinely monitor records for identition of target behaviors justifying antipsychotic medications, and during therapy. Compliance will be right during the June quarterly Quality Assessment and Assurance meetition on the Director of Nurses/designee at Consultant Pharmacist will continue monitor for compliance with antipsyste effect monitoring, behavior redocumentation, and duplicate drugt therapy during the routine quarterly reviews and more often if indicated completion Date: March 11, 2015 	onth the udit adverse ns and f target se. The e to fication sychotic of olicate eviewed ng and and the le to ychotic lated y record	
	yelling, making nois RN-C stated nurses notes when target I effects of medicatio documentation was nurses do not check even with the use of	se, does not like everybody." se, does not like everybody." s will document in the progress behaviors and/or possible side ons occur, otherwise no s needed. RN-C stated that k orthostatic blood pressures of anti-psychotic medications if r's order. RN-C did not					

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		AND HUMAN SERVICES				FORM	: 02/25/2015 APPROVED : 0938-0391
STATEMENT	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY IPLETED
		245409	B. WING _			01/:	30/2015
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	mention about R68 being monitored. On 1/28/15 at 4:02 behaviors include n "delusions about sta catheterization on [trying to take advar the specific target b not written in behav stated nurses will c When asked if side medications were b "Probably not becar monitor." When ask answered, "The pre DON [director of nu has not been monit the antipsychotic m retention, orthostati sure if Abnormal Inv (AIMS - a tool used anti-psychotic medi R68. R68's Medication A for 1/1/15 through 1 including psychosis anxiety state and un indicated R68 was 6.25 milligram (mg) 12.5 mg every after (antidepressant) 15 The care plan dated risk for falls related use. Interventions in orders. However, si	"s hallucinations and delusions p.m. RN-A stated R68's target naking accusations, also had aff who were doing R68] were a bunch of lesbians ntage of [R68]." RN-A verified behaviors he mentioned were vior monitoring sheet. RN-A thart if the behaviors occur. e effects of psychotropic being monitored, RN-A replied, use they said no need to ked who " They" were, RN-A evious owner and the previous ursing]." RN-A confirmed staff toring R68 for side effects of redications such as urinary ic hypotension, and was not voluntary Movement Scale to monitor for side effects of ications) was completed for administration Record (MAR) 1/31/15, listed R68's diagnoses s, dementia, depression, rinary retention. The MAR also on Seroquel (an antipsychotic)) every morning and Seroquel	F 42	28			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245409	B. WING			01/;	30/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	ANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	monitored. R68's care plan dat symptoms of "some about [R68] and is e included "nurse to a ordered and monitor care plan did not giv resident-specific tar identify specific side medications to be n On 1/29/15, at 1:25 pharmacist (CP) sta effects of any medic CP agreed orthosta should be complete developed while on On 1/29/15 at 1:28 unable to locate an p.m. the director of was no record on fil completed for R68 though the resident antipsychotic medic The facility's Use of Medications policy of monitor drugs for si monitoring for gait of disorders, signs of l effects such as dry The policy further d baseline AIMS and	 ed 4/24/14, identified behavior e paranoia of people talking easily angered." Approaches administer medications as or possible side effects." The ve directions on monitoring rget behavior and it did not e effects of psychotropic nonitored. p.m. the consultant ated his expectations that side cations should be monitored. tic blood pressure and AIMS ed to determine if side effects anti-psychotic medications. p.m. RN-E stated they were AIMS assessment. At 1:43 nursing (DON) verified there le to show AIMS was within the last year even had received the cation. Psychotherapeutic dated 4/11/08, directed staff to de effects daily, to include disorders, movement hypotension, and cholinergic mouth and urinary retention. irected staff to assess for to do reassessment every 	F 4	128	DEFICIENCY)		
	medications.	e use of antipsychotic bowel medications and there					

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						TE SURVEY		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	COMPLETED		
		245409	B. WING _	·····	01	/30/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
MAPLE	MANOR NURSING AN	ND REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE		
F 428	was no physician ju bowel medications dose of Miralax. R32's physician's r the diagnoses of Li- mellitus, and const R32's physician ord the following medic constipation: Senn three times daily (of Miralax 17 grams b (original order date solution 30 milliliter (original order date solution 30 milliliter (original order date The dose of Mirala recommended dos manufacturers labe dose was 17 gram The directions indic days and instructed directed unless direct there was no justifit the recommended the 7th day. R32's bowel mover reviewed. Bowel m found in two different and electronic med was found to be inter formats. Document had more than one of documentation I formed, hard, etc.) large) of BMs and	ustification for need of three and exceeded recommended note dated 12/16/14 included ewy body dementia, diabetes ipation. ders dated 12/16/14 included cation orders to treat a-S tablet 2 tabs by mouth original order date of 4/16/08), by mouth two times daily e of 4/30/09), and Sorbitol 70% rs (ml) by mouth one time daily er of 1/21/09). x ordered exceeds the daily	F 42	28				

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			()(0) 1			0. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	TE SURVEY MPLETED
		245409	B. WING _		01	/30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 428		ed for three medications for	F 42	28		
 	bowel regime (polypharmacy) medication was last addressed on April 30, 2009. The documentation read, "does not tolerate suppositoriesand will become angry at times					
	does have very l suppositories and i	arge bowel movements with f not given he may not have a br up to 5 or 6 days. Physician				
	progress notes rev	iewed did not indicate rationale e than manufacturer's daily				
	1/9/15 indicated wa	nimum Data Set (MDS) dated as moderately cognitively noses of dementia, always				
	assist with activities transfers, dressing					
	history of constipat interventions to pro	I not address constipation or ion or non-pharmacological mote bowel movements such				
	increased activity, in habits, use of toilet					
	registered nurse (F aware of specific re	v on 1/27/15, at 2:05 p.m. RN)-A indicated he was not easons why R32 had 3				
	know why the dose recommended. RN	dications. RN-A also did not of Miralax was higher than -A stated he was not aware of				
	use of the three bo During an interview	/ on 1/27/15, at 3:34 p.m.				
	has a diagnoses th recommended dos	cist (CP) stated if a resident at required more than a e of medication it should be				
	note the reasons for then monitor routin	he physician to address or or the increased amount and ely. 1 on 1/30/15, at 9:30 a.m.				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245409	B. WING			01/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428 F 431 SS=E	nurse practitioner (I medication should b After informing NP medication and dail 483.60(b), (d), (e) D	NP) stated, "[R32 ' s] bowel be looked at and reduced." of R32 ' s three bowel y bowel movements.	F4 F4				3/11/15
	a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order	nploy or obtain the services of sist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug r and that an account of all maintained and periodically					
	labeled in accordan professional princip appropriate access	als used in the facility must be ice with currently accepted les, and include the ory and cautionary e expiration date when					
	facility must store a locked compartmer	State and Federal laws, the Il drugs and biologicals in hts under proper temperature t only authorized personnel to keys.					
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri	ovide separately locked, I compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can					

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PRINTED: 02/25/2015

		AND HUMAN SERVICES			F	ORM	02/25/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245409	B. WING			01/30/2015	
NAME OF I	PROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	D REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From pa	ge 125	F 4	431			
	by: Based on observat review, the facility of medications were medication rooms is Medication Room a carts; in addition the was dated when wh expiration date for of Findings include: On 1/28/15, at 2:28 medication storage several expired me included the followin R1's half full bottle tablets labeled with pharmacy label indi 6/2014 while the ma expiration date as 6 would go by the pha On 1/29/15, at 9:36 contained R15's La ointment expired or On 1/29/15, at 9:49 cart contained a fac (antacid) that expire	of Antacid expired on 8/2014; e of Bisacodyl (laxative) 5 mg two expiration dates. The icated expiration date as anufacturer's label indicated 5/2015. RN-C stated the facility armacy label of 6/2014. a.m. the East medication cart crilube eye ointment. The eye n 12/2014 a.m. the West medication cility stock of Geri-lanta			Tag F431 Medication Storage In coordination with the consultation pharmacist, Maple Manor Nursing & Rehab, LLC provides for 1) safe and secure storage and safe handling (including disposition) of all medicatio 2) accurate labeling and 3) a system of medication records that enables perior accurate reconciliation and accounting all controlled medications. The facility utilizes only persons authorized under state requirements to administer medications. Outdated and expired dr and biologicals are routinely discarded according to accepted practice standa The policies for storage of medication were reviewed and found appropriate medications and biologicals. On a rou basis, a nurse or trained medication a will be assigned by the Director of Nur to audit the medication carts for expire medication and appropriate dating of insulin vials During the planned mandatory meeting the licensed nurses and trained medication aides will be instructed on the procedures for processing	of odic ig of / r rugs id ards. ards. All ked utine aid ursing red	

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		0938-039 SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		G		COMPLETED	
		245409	B. WING		01/3	30/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLE	MANOR NURSING AN	ID REHAB, LLC		1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 431	bottle of Nitrostat 0 on 2/2014. On 1/28/15, at 2:45 North/South medica insulin was observed did not have a date 30 days from openi Orders Sheet (POS had diabetes with r further indicated Re units by sub-cutane During interview on registered nurse (R responsible in mak store for use were r On 1/29/15, at 2:15 (LPN)-D and nursin expired medication from carts and disc On 1/29/15, at 1:25 pharmacist stated a medications should storage rooms and medications such a when opened. An undated policy of Facility provided tha immediately remov according to proced and reordered from exists. The policy fu	ed 10/2013; R44's unopened .4 milligram (mg) that expired 6 p.m. during inspection of the ation refrigerator, R63's Lantus ed to have been opened but it was opened as it expires in ing for use. The Physician's 6) dated 1/29/15 indicated R63 enal manifestations. The POS 63 was to be given Lantus 20 eous injection daily at noon. 1/28/15, at 2:28 p.m., N)-C stated all nurses were ing sure that medications in not expired. 6 p.m. licensed practical nurse ng assistant (NA)-K stated the s should have been removed	F 43	1 discontinued and outdated medic and biologicals and 2) dating oper insulin vials. Compliance with dating of insulin disposition of outdated medications/biologicals will be m every two weeks for one month to Director of Nurses/designee and quarter by the consultant pharma noncompliance is noted additions monitoring and staff education w done. Compliance will be reviewed the March Quality Assessment a Assurance Committee meetings. Completion Date: March 11, 2015	vials and onitored by the every icist. If al ill be ed during nd		

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED
		245409	B. WING			/30/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 1875 19TH STREET NORTHWEST	DE	
MAPLE	MANOR NURSING AN	D REHAB, LLC		ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 431		-	F 43	1		
	dated 7/12/04, indic has been opened, t	on Stocking Regular Insulin cated once a bottle of insulin he bottle needs to be dated,				
F 441 SS=F		xpire 30 days from that date. I CONTROL, PREVENT	F 44	1		3/11/15
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.				
	Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to (3) Maintains a reco	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective				
	determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each di	ead of Infection ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted				

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		AND HUMAN SERVICES			FORM	02/25/2015 APPROVED 0938-0391	
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245409	B. WING _		01/30/2015		
	PROVIDER OR SUPPLIER	ID REHAB, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 441	transport linens so infection. This REQUIREMEI by: Based on interview failed to develop poinfection control pra- infections identifica maintain an infection included ongoing st analyzing and trend residents (R16, R6, reviewed for having (UTIs). The lack of effective infection p program has the point residents currently Findings include: LACK OF UTI SYM R16, R6, R70, R30 facility as having fai infections (UTI) but symptoms: R16 was noted on the to have a urinary trans-	NT is not met as evidenced v and record review, the facility blicy and procedures to direct actices related to urinary tract tion (UTI) and failed to on control program that urveillance and timely ding of data. Five of Five , R70, R30, and R69) were g urinary tract infection/s policy, procedure and an oreventions and control otential to affect all 69	F 44	Tag F441 Infection Control Maple Manor Nursing & Rehab, L established and maintains an infe control program designed to provi safe, sanitary, and comfortable environment and to prevent the development of disease and infec The infection control program 1) investigates, controls, and preven infections in the facility 2) determin appropriate procedures, if any, that implemented (such as isolation) for resident with an infectious disease maintains a record of incidences of infections and tracks any alternatia actions taken related to infection of The facility has comprehensive im control policies and procedures the the process of being reviewed and to more closely reflect the current standards of practice and the stat regulations. The policies address surveillance and investigation of in	ction de a tion. ts nes the at will be or each e and 3) of ve control. fection at are in d revised e/federal the		
	symptoms of a UTI R6 was noted on th			and maintenance of accurate and comprehensive records of resider infections. The revised policies ar procedures will provide additional	nt Id		

Facility ID: 00916

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		AND HUMAN SERVICES			0		APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · ·	SURVEY PLETED
		245409	B. WING			01/3	80/2015
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ID REHAB, LLC			875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 441	Continued From pa	ge 129	F 4	41			
	for this time period of infections listed.	noted no signs and symptoms			guidance to the nursing staff for ide and reporting symptoms of possibl infections and documenting/trackin	е	
9/2 do	9/29/14. The IDT r	the IC log to have a UTI on notes were reviewed and no igns and symptoms of the d.			related symptoms. The licensed nurse assigned the responsibility to oversee the review implementation of the policies and	<i>i</i> and	
	10/15/14, 11/7/14, a	the IC log to have a UTI on and 11/29/14. The IDT notes lacked identification of signs ITI.			procedures has been counseled or completion of the tracking logs. A reference guide will be provided to nurses to assist in identifying	-	
	10/7/14, 10/31/14,	the IC log to have a UTI on 11/9/14, and 11/18/14. The iewed and lacked identification oms of UTI.			symptoms/conditions that may be indicative of a urinary tract infectior need reporting to the physician/nur practitioner.		
	provided by the dire included 1) Chronic dated 5/2/12 and 2 Residents dated 4/3 direct staff to evalu	p.m. UTI policies were ector of nursing. The policies c Urinary Tract Infection Policy) Prevention of UTIs at Risk 3/12. The policies did not ate the risk for developing clude signs and symptoms of en to document.			During the planned mandatory meet the licensed staff will be instructed policies and procedures for identify urinary tract symptoms that may in an infection and when it is appropri- report the symptoms to the physician/nurse practitioner. The n documentation of symptoms of infe- and follow up after an antibiotic is prescribed will be addressed. The	on the ring dicate iate to eed for ection	
	1/28/15 at 9:40 a.m that listed the criter policy/directions rel had been develope document the criter	RN)-A was interviewed on a. RN-A stated he had a form ia for infections, but that no ated to completing the form d. RN-A stated nursing was to ria for infections observed in			of the record reviews for residents number 16, 6, 70, 30, and 69 will b shared with the staff for teaching purposes. Compliance with facility policies an	e	
	nursing (DON) were indicated the facility	0 a.m. RN-A and the director of e interviewed. They both / did not have a list of infection able to staff to use and			regulatory requirements will be mo by the Director of Nurses/designee through record review and audits o infection control logs and reports for months and randomly thereafter. T results of the infection control surve	f the or two he	

Facility ID: 00916

TATEMEN	FOF DEFICIENCIES OF CORRECTION	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245409	B. WING		01/	20/2015
NAME OF	PROVIDER OR SUPPLIER	210100		STREET ADDRESS, CITY, STATE, ZI		30/2015
MAPLE	MANOR NURSING AN	ND REHAB, LLC		1875 19TH STREET NORTHWES ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 441	did not have a polic management of uri LACK OF ANALYS INFECTIONS TO F INFECTIONS TO F INFECTION: On 1/26/15 at 2:00 (LPN)-C stated she identified infections had not yet reviewe infections. LPN-C so on the floor and that an infection. LPN- residents with upper tested positive for it was quarantined. completed a line liss sick to see if a trent timely analysis of it would have allowed staff education to p to other residents at The surveillance lop provided when LPN record keeping on LPN-C said she hat January 1 to 26, 20 On 1/29/15 at 5:00 indicated LPN -C h Infections preventia as coordinator of th control program).	a tool. They stated the facility cy/procedure on the inary tract infections. US AND SURVEILLANCE OF PREVENT THE SPREAD OF p.m. licensed practical nurse e reviewed the resident s at the end of the month, but ed the December 2014 stated she had been working at was how she knew who had C stated in December, 5 of 6 er respiratory infections had influenza and so the building LPN-C stated she had not sting on the residents that were id had developed. However, infections in December 2014 d corrective actions such as prevent the spread of infections and staff. g for December 2014 was N-C had just completed the 1/26/15 at 6:30 p.m. Also id not started to complete the 015 infection log. p.m. the director of nursing had been designated as the onist (This person will serves he infection preventions and DON continued to say there information related to	F 44	and investigation activities monthly as part of the cor improvement program. C reviewed during the Marc Quality Assessment and / Committee meeting and c Completion date: March 1	ntinuous quality ompliance will be h quarterly Assurance ongoing.	

If continuation sheet Page 131 of 133

		AND HUMAN SERVICES			FORM	APPROVED
	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES		OI PLE CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245409	B. WING		01/	20/2015
NAME OF I	PROVIDER OR SUPPLIER	210100		STREET ADDRESS, CITY, STATE, ZIP CODE	01/5	30/2015
				1875 19TH STREET NORTHWEST		
MAPLE	MANOR NURSING AN	D REHAB, LLC		ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE
	4		1	DEFICIENCY)		
F 466	Continued From no	ao 191				
F 466		EDURES TO ENSURE	F 466 F 466			3/11/15
SS=C	WATER AVAILABIL		F 400	5		3/11/13
		tablish procedures to ensure ble to essential areas when				
	there is a loss of no					
		NT is not met as evidenced				
	by:	and decument review, the		F-466		
		and document review, the ure potable		Policy & Procedure to Ensure Wate	er	
	water needs for res	ident use in the facility were		Availability		
		ess of normal water supply potential to affect all 69		The policy and precedure have bee	'n	
		the facility, as well as staff		The policy and procedure have bee updated to include estimated water		
	and visitors.	,,,,		required for resident and staff use of		
	Findings include:			per day basis. The supplier has confirmed mobile service of potable	e water	
	-			on a daily basis during emergency		
		had an emergency water he procedure lacked a		interruption to include a minimum o gallon per resident and sufficient wa		
		ting estimated water required		staff to provide food preparation an		
	for residents and st			care needs.		
	Review of the facilit	y Emergency Water Supply		Completed: 3/11/15		
		dated 4/29/05, read, "In the				
	event of a complete	e loss of water for the facility				
		ter or a broken water main I repair, the facility has an				
		ulk hauler to transport portable				
	water to the facility.	" The procedure identified				
		secure from storage and				
		gallon containers as follows: wo to east wing, two to north				
	wing, one to dietary	r, and each wing will have a				
	container labeled di	rinking and another labeled				

		AND HUMAN SERVICES				FORM	02/25/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245409	B. WING			01/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	D REHAB, LLC			375 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 466	of bottled water for 60 gallons of bottled drinking, and a bulk per day for cleaning water procedure lac calculating estimate and staff use per da During interview on administrator verifie supply procedure la estimated water rec use. He stated the	ursing to purchase 20 gallons drinking, dietary to purchase d water for cooking and tank to deliver 6000 gallons g and toilets. The emergency cked a procedure for ed water required for residents	F 4	466			

Facility ID: 00916

If continuation sheet Page 133 of 133

		AND HUMAN SERVICES & MEDICAID SERVICES	F	垳 (109022	FORM	02/25/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' <i>'</i>		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245409	B. WING			01/	26/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	MANOR NURSING AN	D REHAB, LLC			B75 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	ĸ	000			
	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA ACCORDANCE WI A Life Safety Code Minnesota Departm Fire Marshal Divisio Maple Manor Nursi substantial complia participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA) Code (LSC), Chapt	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. Survey was conducted by the nent of Public Safety - State on. At the time of this survey, ng Home was found not in nce with the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection Standard 101, Life Safety er 19 Existing Health Care. THE PLAN OF R THE FIRE SAFETY spections Division Suite 145		#1	EPOC		
		DER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		(X6) DATE
	ically Signed	LINGULLIN KELKLOLINIAHVES SIGI					02/23/2015

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.

		AND HUMAN SERVICES & MEDICAID SERVICES			0		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245409	B. WING			01/	26/2015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	ANOR NURSING AN				75 19TH STREET NORTHWEST		
				R	OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K 0	00			
	By email to: Marian.Whitney@s Angela.Kappenmar						
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.			ά I		
	2. The actual, or pr	oposed, completion date.					
	3. The name and/o responsible for corr prevent a reoccurre	r title of the person rection and monitoring to ence of the deficiency.					2
	The building was co The original buildin was determined to with a partial baser constructed and was	ng Home is a 1-story building. onstructed at 2 different times. g was constructed in 1964 and be of Type II(111) construction, nent. In 1974, addition was as determined to be of Type , with a full basement.			(<u>*)</u>		
	are of the same typ construction type a	al building and the 1 addition be of construction and meet the llowed for existing buildings, veyed as one building.			-22*	5	
	fire alarm system w detection and space	r sprinkled. The facility has a vith full corridor smoke es open to the corridors that is matic fire department				.82	
	The facility has a c	apacity of 81 beds and had a					

Facility ID: 00916

If continuation sheet Page 2 of 6

		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	OMB NO	APPROVEI 0938-039 E SURVEY IPLETED
		245409	B. WING _		01/	26/2015
	PROVIDER OR SUPPLIER	D REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	Continued From pa census of 70 at the	•	K 00	00		
K 062 SS≃D	NOT MET as evide NFPA 101 LIFE SA Required automatic continuously mainta condition and are ir	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD c sprinkler systems are ained in reliable operating nspected and tested .6, 4.6.12, NFPA 13, NFPA 25,	K 06	52		3/11/15
	Based on observat facility failed to mai in accordance with NFPA 101, Sections 25, sections 2-3.2 a practice could affect Findings include: On facility tour betw on 01/26/2015, obs following was found 1. Basement - spri	s not met as evidenced by: tion and staff interview, the ntain the fire sprinkler system the requirements of 2000 s 19.3.5 and 9.7, 1998 NFPA and 2-4.1.4. This deficient et all 15 out of 70 residents.	A	 In reference to K62 Basement -spare sprinkler h does not contain 2 of each type of sprinkler head Basement -Sprinkler riser Ga over 5 years. Plan of Correction In reference to Basement spare heads not in the box Maintenand Director contacted Summit Fire f contractor and asked them to go whole facility to make sure we have each sprinkler heads that our loop place in box by 2-26-2015. 	of auge is Sprinkler e acility through ave 2 of	
		re sprinkler head box does not a type of sprinkler heads in the		In reference to sprinkler riser Ga 5 years. Maintenance Supervisor contact Summit Fire and set up the 5 year	ed	

Event ID: 3QEK21

Facility ID: 00916

If continuation sheet Page 3 of 6

		AND HUMAN SERVICES		F OME	NTED: 02/25/20 ORM APPROVE NO: 0938-039
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (XX 01 - MAIN BUILDING 01	3) DATE SURVEY COMPLETED
		245409	B. WING		01/26/2015
	ROVIDER OR SUPPLIER	ID REHAB, LLC	1	STREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
K 062	Facility Maintenanc Administrator (KS)	ctices were confirmed by the e Director (JT) and at the time of discovery.	K 062	inspection and Annual inspection to ta place on 2-26-2015. 2-26- would be the Facility's new Annual date. Note that the Facility's name is under new ownership management and new Name so we have a solution date from May to February. The Maintenary Supervisor also created a 5 year sprint check on tels Schedule. Documentation attached to this report showing 5 years check added to preventive maintenary plan on Tels. When sprinkler work is completed Maintenance Supervisor we email pictures and contractor check sheets to Gary Schroeder, Mn state for inspector.	he the nave e nce nkler ion is r nce vill
K 144 SS=F	Generators are insp under load for 30 m accordance with NF This STANDARD is Based on docume	s not met as evidenced by: ntation review and staff	K 144	In reference to k144 the weekly gene check not being inspected on 6/15/20	3/11/15 erator
	emergency generative requirements of 20	y failed to inspect the tor in accordance with the 00 NFPA 101 - 9.1.3 and 1999 6-4.1. The deficient practice esidents.		The facility on 6/15/2014 did not have computer based scheduled program	a

Event ID: 3QEK21

Facility ID: 00916

		& MEDICAID SERVICES			O. 0938-039 ATE SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMPLETED
		245409	B, WING		1/26/2015
NAME OF F	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
MAPLE	IANOR NURSING AN	D REHAB, LLC		875 19TH STREET NORTHWEST ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 144	Continued From pa	ge 4	K 144		
	Findings include:	•		the time which shows and documents a	
				the checks each week, monthly, annual	
		veen 12:30 PM and 2:30 PM umentation review of the		bi annually and 5 years if necessary. The Maintenance Supervisor has in-serviced	
	weekly inspection k	ogs for the natural gas		all staff on how to use tels and create	
		or revealed, that the		logs. Tels also has a icon on the schedu	le
		or weekly inspection logs from nuary 2015, indicated that the		showing it is a life Safety Code item therefore takes priority	/
	week of 06/15/14 w			to be completed and on time. The	
				maintenance Supervisor also has	
	This deficient practi	ice was confirmed by the		in-serviced his assistant and maintenand staff complete these scheduled items or	
	Facility Maintenanc			time and document someone is on	
	Administrator (KS)	at the time of discovery.		vacation. Maintenance Supervisor has	
				attached signed in service forms to this document.	
K 147 SS=D	NFPA 101 LIFE SA	FETY CODE STANDARD	K 147		3/11/15
		d equipment is in accordance onal Electrical Code. 9.1.2			
					e
		s not met as evidenced by:		K147	
		ion and staff interview, the ntain electrical supply in	-	K147	
	accordance with the	e requirements of 2000 NFPA		1. In resident room 12 power- cord goi	ng
	101 - 9.1.2, 1999 N	IFPA 70, and 2007 Minnesota		to wall light was exposed.	
	could affect 2 out of	5.7. The deficient practice f 70 residents		The wall light cord plug was fixed.	
				Maintenance Supervisor is working with	
	Findings include:			Administration, Don, safety committee and all staff to in-service staff to report	
	On facility tour betw	veen 12:30 PM and 2:30 PM		frayed cords or any potential hazard tha	t I
	on 01/26/2015, obs	ervation revealed, that the		could jeopardize safety of others. This ir	า 🗍
1	following items were	e found:		service is expected to be completed on before 2-26-2015 or earlier and	or
	1. In resident room			documentation will be emailed to Gary	

Event ID: 3QEK21

Facility ID: 00916

If continuation sheet Page 5 of 6

ATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY PLETED
		245409	B, WING		01/2	26/2015
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST		
IAPLE	MANOR NURSING AN	ID REHAB, LLC		ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
К 147	wall light has expose 2. Basement - med lights have been m and is not properly These deficient pra Facility Maintenand Administrator (KS)	sed wiring dical records room ceiling odified from the original listing wired actices were confirmed by the ce Director (JT) and at the time of discovery.	К 147	Schroeder Mn State fire inspecto 2. In Medical Records room ce are not properly wired Plan of Co On February 5 2015 Winkels Ele Rochester Mn electric Contracto completed work. Before and afte and completed Maple Manor wor attached for documentation.	iling lights prrection ectric a r r pictures	

Facility ID: 00916

If continuation sheet Page 6 of 6



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted February 13, 2015

Mr. Patrick Blum, Administrator Maple Manor Nursing And Rehab, Llc 1875 19th Street Northwest Rochester, Minnesota 55901

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5409025

Dear Mr. Blum:

The above facility was surveyed on January 25, 2015 through January 30, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Maple Manor Nursing And Rehab, Llc February 13, 2015 Page 2

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kumalu Fiske Downing

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

Enclosure(s)

cc: Original - Facility Licensing and Certification File

Minnesc	ota Department of He	ealth				
-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY PLETED
		00916	B. WING		01/3	80/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	MANOR NURSING AN		H STREET NO FER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued ey. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	corrected requires requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	o participate in the electronic onsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE
	ically Signed					02/23/15

If continuation sheet 1 of 115

ND PLAN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00916	B. WING		01/	30/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	1	
	ANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for St enter the word "cor text. You must ther State licensure pro completion date, th	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for in indicate in the electronic beess, under the heading he date your orders will be electronically submitting to the nent of Health.				
	surveyors of this D above provider and orders are issued. electronic plan of c	, 27, 28, 29 & 30, 2015 epartment's staff, visited the d the following correction Please indicate in your correction that you have lers, and identify the date when eted.	ı			
	the State Licensing federal software. T	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "IE statute/rule out of o "Summary Stateme and replaces the "T correction order. T findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMI "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED	
		00916	B. WING		01/30/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	ANOR NURSING AN		TH STREET N STER, MN 55	IORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
2 000	Continued From pa	age 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560		3/11/15	
	comprehensive pla objectives and time long- and short-tern and mental and psy identified in the cor assessment. The of must include the in	of plan of care. The n of care must list measurable etables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on observat review, the facility f to address a history (C-diff) and Vancor (VRE) to prevent th for 1 of 1 resident (and VRE; failed to	ent is not met as evidenced ion, interview and document ailed to develop interventions y of having Clostridium difficile nycin-resistant enterococcus he spread of these infections R38) who had chronic C-Diff develop specific renal dialysis of 1 resident (R62) with renal		See Federal Regulation responses		
	Findings include:					
		of having C-Diff and the care ation to prevent the spread to dents.				
	The hospital discha	arge summary dated 12/16/14				

STATE FORM

3QEK11

If continuation sheet 3 of 115

00916 B. WING 01/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 01/30/2015 MAPLE MANOR NURSING AND REHAB, LLC 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X4) COMP	STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
WARE OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE MAPLE MANOR NURSING AND REHAB, LLC 1875 197H STREET NORTHWEST BOCHESTER, MN 55901 MAND TO SUMMARY STREMARY OF DEPORTNESS PROVEMENT AND CONTRECTION OF DEPORTNESS SUMMARY STREMARY OF DEPORTNESS PROVEMENT AND CONTRECTION OF DEPORTNESS SUMMARY STREMARY OF DEPORTNESS PROVEMENT AND CONTRECTION OF DEPORTNESS SUMMARY STREMARY STREMARY STREMARY SUMMARY STREMARY SUMMARY STREMARY STREMARY STREMARY SUMMARY STREMARY SUMMARY STREMARY STREMARY SUMMARY SUMMARY STREMARY SUMMARY STREMARY SUMMARY SUMMARY SUMMARY STREMARY SUMMARY STREMARY SUMMARY SUMMARY SUMMARY STREMARY SUMMARY STREMARY STREMARY SUMMARY SUMMARY STREMARY SUMMARY STREMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMMARY SUMMARY STREMARY SUMMARY			00916	_		01/20/2015	
MAPLE MANOR NURSING AND REHAB, LLC 1875 19TH STREET NORTHWEST mochESTER, NN 55301 (PAU) D PREFIX (EACH DEPICERCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE, SIDENTIFING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE (EACH CORRECTIVE ACTION SHOLD BE (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE (EACH CORRECTIVE ACTION SHOLD BE (EACH CORRECTIVE ACTION SHOLD BE DEFICIENCY) ID ID 2 560 Continued From page 3 2 560 2 560 ID							30/2015
Inclusion Inclusion <t< th=""><th></th><th></th><th>1875 19</th><th></th><th></th><th></th><th></th></t<>			1875 19				
EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISG IDENTIFYING INFORMATION) PREDX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT INF APPROPRIATE COMINGENERATION 2 560 Continued From page 3 2 560 noted c-diff (C. difficile infection can range from mild to life-threatening. Symptoms of mild cases include watery diarrhea, three or more times a day for several days, with abdominal pain or tenderness) infection and a urinary tract infection. The hospital discharge summary dated 12/01/4 indicated R38 had recent c-diff infection. The hospital discharge summary dated 12/01/15 indicated R38 had asymptomatic (a) disease is considered asymptomatic (a) disease is considered asymptomatic (a) disease is considered asymptomatic (a) disease is indicated R38 had asymptomatic (a) disease is considered R38 has a history of C-diff. The interdisciplinary notes dated 19/15 indicated R38 was readmitted to the home with VHE and therefore a room change to a private room had occurred. The treatment/medication record indicated R38 had a colostomy that staff were to empty each shift there by possibly exposing R38, staff, or other resident to C-diff. The resident required assistance with trasfers and toleting and personal hygiene increasing the chance C-diff and VHE could be transmitted to others. On 1/30/15 at 11:50 a.m. the director of nursing (DON) was interviewed. DON indicated if colonized, but not being treated then no need to is solate the resident. They don't bits on care plan unless they are active with C-diff or VHE. DON continued to say they are to develop a tempoprary care plan with information about C-diff and VRE. However, no tempor			ROCHES	STER, MN 559	01		
noted c-diff (C, difficile infection can range from mild to life-threatening. Symptoms of mild cases include watery diarrhea, three or more times a day for several days, with abdominal pain or tenderness) infection and a urinary tract infection. The hospital discharge summary dated 1/2/01/4 indicated R38 had recent c-diff infection. The hospital discharge summary dated 1/2/01/4 indicated R38 had asymptomatic (a disease is considered asymptomatic (a disease is considered asymptomatic (a disease is considered asymptomatic (f a patient is a carrier for a disease or infection but experiences no symptoms) urinary vancomycin-resistant enterococcus (VRE) for which she was not treated. The hospital discharge summary also indicated R38 has a history of C-diff. The interdisciplinary notes dated 1/9/15 indicated R38 was readmitted to the home with VRE and therefore a room change to a private room had occurred. The treatment/medication record indicated R38 had a colostomy that staff were to empty each shift there by possibly exposing R38, staff, or other resident to C-diff. The resident required assistance with transfers and toileting and personal hygiene increasing the chance C-diff and VRE could be transmitted to others. On 1/30/15 at 11:50 a.m. the director of nursing (DON) was interviewed. DON indicated if colonized, but not being treated then no need to isolate the resident. They don't list on care plan unless they are active with C-diff or VRE. DON continued to say they are to develop a temporary care plan with information about C-diff and VRE, However, no temporary care plan had been developed. The facility policy Care Plan dated 1/19/12	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
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		(DON) was intervie colonized, but not l isolate the resident unless they are act continued to say th care plan with infor However, no tempo	ewed. DON indicated if being treated then no need to t. They don ' t list on care plan tive with C-diff or VRE. DON ney are to develop a temporary rmation about C-diff and VRE.				
Intersota Department of Health	monote D	indicated the purpo					

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COM	PLETED
		00916	B. WING		01/	30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	ige 4	2 560			
	comprehensive pla working tool for sta	n of care what to provide a ff.				
		sis services and renal diet terventions for renal diet.				
	diagnosis that inclu	to the facility on 11/21/14, with ded end stage renal disease ding to admissions face sheet				
	11/21/14, revealed hemodialysis on Tu renal diet. Document review of (CAA) dated 12/4/1 triggered to care pl offered a renal diet					
	printed 1/28/15, rev diet. Document review of revealed R62 recei diagnosis and atter Saturday. During interview on registered dietician diet, communicates received dialysis Tu	of R62's resident care plan realed no care plan for renal of dietary notes dated 1/21/15, ved renal diet related to inded dialysis on Tuesday and 1/28/15, at 9:10 a.m., verified R62 received renal s with dialysis dietician, uesdays and Saturdays, and				
	During interview on of nursing verified I	with R62 to dialysis. 1/30/15, at 8:00 a.m., directo R62's care plan lacked terventions for renal diet	r			
	The director of nurse educate staff on co	THOD OF CORRECTION: sing (DON) or designee could mponents needed for care perform audits to ensure				

If continuation sheet 5 of 115

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		00916	B. WING		01/30/2015
IAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
	MANOR NURSING AN		H STREET N TER, MN 55	IORTHWEST 901	
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2 560	Continued From pa	ge 5	2 560		
	compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		3/11/15
		omprehensive plan of care personnel involved in the			
	by: Based on observati review, the facility f directed on each re residents (R3, R88) 2 of 3 residents (R8 assistance with per ensure 2 of 2 reside weights to assess h monitor daily intake doctors order for da indwelling catheter prevent urinary trac (R68) with a Foley of adaptive scoop plat	ent is not met as evidenced on, interview, and document ailed to provide services as sidents care plan for 2 of 5) for assistance with eating; for 38 & R31) assessed to need sonal care; and failed to ent (R45 & R38) with daily health status change; failed to for 1 of 1 Resident (R38) with aily weights: failed to follow interventions and services to at infections for 1 of 1 resident catheter; and failed to provide the as directed in the care plan R32) assessed to need scoop indently.		See Federal Regulation responses	
	Findings include:				
	Lack of assistance	-			
	R3 did not receive a	assistance with eating			

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00916	B. WING		01/	30/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 6	2 565			
	according to care p	plan interventions.				
	of nutrition risk rela history of needing r liquids, had history intake and dysphag	ed 3/19/13, identified problem ated to history of dysphagia, mechanically altered diet and of weight loss due to poor oral gia. Approaches included soft i assisted table, and wanted feeding skills.				
	of self-care deficit	ed 3/29/13, identified problem related to needing assistance ily living. Approaches included pureed diet.	1			
	was in wheelchair i a large table design residents who need this time registered R3 to eat. At 9:52 a alone. R3 still had and made no atten 10:00 a.m. R3 was assistance with eat 10:12 a.m., nursing R3 with meal. R3 h	on 1/28/15, at 9:45 a.m., and in the east/west dining room at nated by the facility for ded assistance to eat. Also at a nurse (RN)-C was assisting a.m., RN-C left R3 at the table plate of food and beverages npt to eat independently. At noted to be asleep and no ting was offered or provided. A g assistant (NA)-D sat to assist ad no assistance with eating 0:12 a.m. a total of 20	t			
	included paralysis	/19/13, with diagnosis that agitans and dementia with rding to physician orders				
	Data Set (MDS), and to have short and le moderately impaired	ed R3 on the annual Minimum n assessment dated 12/8/14, ong term memory problems, ed decision making, total staff for activities of daily living,				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	or connection	DENTITION TONION DET.	A. BUILDING: _			
		00916	B. WING		01/3	30/2015
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
IAPLE N	MANOR NURSING AN		H STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 7	2 565			
		on 1 staff for eating and and received a mechanically				
To pro plan o profile Durin of nur care p	To provide a multi-	ated 1/19/12, read, "Purpose: disciplinary comprehensive provides a working tool that of each resident				
	of nursing stated s	n 1/29/15, at 9:00 a.m., Director he expected staff to follow the rovide R3 with assistance for	r			
	R88 did not receive according to care p	e assistance with eating blan interventions.				
	of at risk for decline need for mechanic dentation, due to o for nutritional supp to need for assista decreased cognitic included assist as with food/fluid. App included pureed di Approaches dated supplement two tin 9/29/14 included al for swallow and giv	ted 9/10/14, identified problem e in nutritional status due to ally altered food related to poor pen areas with increased need ort, due to abnormal labs, due nce with meals, due to on. Approaches dated 9/10/14 needed and as resident allows proaches dated 9/22/14 et with thin liquids. 9/23/14, included house nes daily. Approaches dated lternate bites with sips, watch <i>ve</i> next bite/sip to maintain ed cups ok when being	r			
	was in wheelchair room. R88 was pla the facility as being assistance to eat.	on 1/27/15, at 11:18 a.m., R88 located in the east/west dining loced at a table designated by g for residents who need Also at this time R88 appeared				
iesota De TE FORI	epartment of Health M		6899 30	QEK11	If continuation	on cheet 8 of

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		01/30/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE	1	
	MANOR NURSING AN		H STREET NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 8	2 565			
	quiche, and mashe cups of beverages directly in front of F a.m. (total of 32 mi and no staff assiste to eat her meal. At assistant (TMA)-A, food on a spoon ar immediately dropp TMA-A left the tabl assistant (PFA)-A a same table, hande and PFA-A continu	ad a meal of pureed carrots, ed potatoes and four adaptive with lids were on the table R88. From 11:18 a.m., to 11:50 inutes) R88 remained asleep ed her to eat or encourage her 11:50 a.m., trained medication aroused R88 and then placed nd handed to R88, who ed the spoon into her lap then e. At 11:54 a.m., paid feeding assisted another resident at d R88 glass of chocolate milk es to assist R88 to eat another resident to eat.				
	diagnosis that inclu Bodies and paralys resident diagnosis The facility identifie Minimum Data Set 11/23/14, to have s moderately impaire dependence on 2 s total dependence of	to the facility 8/26/14, with uded dementia with Lewy sis agitans according to codes printed 1/30/15. ed R88 on the quarterly (MDS), an assessment dated short term memory problem, ed decision making, total staff for activities of daily living, on 1 staff for eating and and received a mechanically				
	1/28/15, at 9:37 a.r same table as the was observed asle and scrambled egg beverages set befor minutes without as sat next to R88 to o	served during breakfast on m., R88 in wheelchair at the evening meal yesterday. R88 ep with plate of cooked cereal gs, applesauce, magic cup, and ore her. At 9:41 a.m. (four sistance to eat meal) TMA-A only administer medication. At ed nurse (RN)-C sat next to	4			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		01/	30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	IANOR NURSING A		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 9	2 565			
	RN-C asked if R88 cup to R88 who too handed R88 a spo took and ate the for R88 and the table. beverages in front to feed self. From minutes interval) R assistance to eat of eat until NA-D sat R88 to eat. Intervi the cooked cereal warmed before set NA-D assisted R88 went to reheat color Care Plan policy da To provide a multi-	ated 1/19/12, read, "Purpose: disciplinary comprehensive provides a working tool that				
		n 1/29/15, at 9:00 a.m., Directo he expected staff to follow the	r			
	Lack of providing p care plan:	personal cares according to				
		I hair and long soiled finger ot trimmed nor cleaned s care plan.				
	of needed assistar transfer and ambu decreased endurat included assist of o mobility, dressing,	tted 9/4/14, identified problem nee with activities of daily living, lation related to dementia and nee and mobility. Approaches one staff with wheel chair personal hygiene, is assisted for meals and required				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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2 565	Continued From pa	age 10	2 565			
	assistance when sl	ееру.				
	was observed with bed. On 1/28/15, at wheelchair at south	on 1/26/15, at 2:58 p.m., R88 long facial hairs while lying in t 9:37 a.m., R88 sat in t table in east/west dining served to have long, soiled ial hair unshaven.				
	diagnosis that inclu Bodies and paralys	to the facility 8/26/14, with Ided dementia with Lewy is agitans according to codes printed 1/30/15.				
	Minimum Data Set 11/23/14, to have s moderately impaire dependence on 2 s total dependence o	ed R88 on the quarterly (MDS), an assessment dated hort term memory problem, ed decision making, total staff for activities of daily living, on 1 staff for eating and and received a mechanically				
	nursing assistant (N R88 with morning of provided facial hair stated residents are and nail care was of	NA)-D stated they had assisted cares. NA-D verified had not removal or nail care. NA-D e shaved with morning cares done in the evenings. Also at verified R88 had long soiled g facial hairs.	1			
	registered nurse (F hair and long soiled stated she expecte day and as needed manicures were do	1/28/15, at 11:15 a.m., N)-F verified the long facial finger nails for R88. RN-F d facial hair shaved on bath RN-F sated she expected one weekly and on bath days. eceived bath on Fridays and esday morning.				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•		
	MANOR NURSING AN		TH STREET NO				
		ROCHES	STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 11	2 565				
	"Purpose: To provid comprehensive pla	cy dated 1/19/12, read, de a multi-disciplinary an of care which provides a rofiles the needs of each					
	Procedure: 2.The r	cy dated 8/31/04, read, " nouth nails, and hair are to be me manner as for a complete					
	The CARE OF NAI "1. Keep clean and	ILS policy dated 3/12/08, read, I well manicured."					
	of nursing stated s	n 1/29/15, at 9:00 a.m., Directo he expected staff to follow the rovide R88 with assistance for al care.	r				
	1/26/15 at 1:31 p.m had dark brown/bla fingernails and eye and had tape on bo R31's care plan inc with grooming. Acc 1/30/15, RN-A state glasses were include	on 1/25/2015 at 2:06 p.m., on n., 1/27/15 at 8:57 a.m. R31 ack debris underneath glasses were extremely dirty oth bows of the glasses. dicated resident was one assis cording to an interview on ed fingernail care and cleaning ded in the grooming category. himum Data Set (MDS) dated	t				
	10/30/14 indicated cognitive impairme for activities of dail dressing, hygiene, Physician's visit pro	the resident had severe ent and was dependent on staff y living including toileting,					
	primary open angle The policy Care of well-manicured."						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		01/	30/2015
AME OF F	PROVIDER OR SUPPLIER	4	DDRESS, CITY, ST	TATE, ZIP CODE	• • • •	
	IANOR NURSING AN		TH STREET NO STER, MN 559	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE
2 565	Continued From pa	age 12	2 565			
	R45 was not weigh orders and care pla	ned daily according to physiciar an interventions.	ו			
	problem of at risk f cardiac medication accident, periphera hypertension, dysli failure. Care plan and vital signs as p R45's care plan da risk related to med therapeutic diet. C staff monitor and re Physician orders for congestive heart fa dated 12/12/14, for practitioner with w	ted 12/11/14, identified for complications due to use of its related to cerebral vascular al vascular disease, pidemia, and congestive heart approaches directed weights ber orders and or policy. Atted 1/8/15 identified problem a lical diagnosis and need for care plan approaches directed ecord weights as ordered. dated 12/10/14, revealed or daily weights due to ailure; and physician orders r daily weight, notify nurse eight gain over 3 pounds in ds from baseline, admit weight	t			
	diagnosis that inclu according to physic diabetes mellitus, o peripheral vascular admission minimu 12/16/14; and right 12/5/14, according dated 12/26/14.	to the facility on 12/10/14, with uded congestive heart failure, cian orders dated 12/10/14; cerebral vascular accident, and r disease, according to the m data set (MDS) dated t below knee amputation to hospital discharge summar				
	R45 showed weigh days from 12/12/14	nts were done 9 times out of 35 4 to 1/26/15 as follows:				
	12/12/14252 pou surgery	nds expected weight loss after				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	MANOR NURSING AN	ID REHAB. LLC	H STREET NO				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 13	2 565				
	12/16/14250.4 po Hospitalized 12/2 12/26/14 12/27/14-239 poun 1/10/15243.7 pou 1/21/15228.5 pou 1/22/15229.3 pound 1/23/15-230 pound 1/24/15232.2 pou 1/26/15-231 pound	21/14 and returned to facility or ds inds inds inds s inds	r				
	gain due to not doin report the five pour of 220 pounds or w	not report a three day weight ng weights daily nor did the nd weight gain from base line when R45 weighed 225 pounds 5 R45 weighed 231 or 11 line weight.					
	dated 12/26/14, rev 12/21/14 and disch						
	registered nurse (F weights as physicia of evidence of nurs	n 1/29/15, at 5:00 p.m., RN)-A verified the lack of daily an ordered. RN-A verified lack se practitioner notification of pounds between 12/27/14 and I.7 pounds					
	stated she expecte RN-F verified daily	n 1/30/15, at 9:30 a.m., RN-F d R45 to be weighed daily. weights were on the nursing and on the Evening Weight for daily weights.					
	The Care Plan poli	cy dated 1/19/12, read,					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	IATE, ZIP CODE			
	MANOR NURSING AN		H STREET NO				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 14	2 565				
	comprehensive pla	de a multi-disciplinary In of care which provides a rofiles the needs of each					
	"It is the policy of M residents are weigh on each resident a "Residents will be v	g Residents dated 6/7/13, read laple Manor to ensure that ned and a weight record is kep nd monitored routinely." weighed thereafter as ordered ut at least monthly."					
		on of services in accordance e on the treatment record and physician.					
	monitor fluid intake monitor colostomy daily. The treatme intake and output r documentation rela	cord indicated staff was to because of a fluid restriction, output, and monitor weight nt record, intake record, or ecord did not have ated to fluid intake, colostomy ghts nor was any provided					
	clinical manager (F nursing stated they	y on 1/28/15 at 8:00 a.m. the RN)-A and the director of y were aware that this was not ered by the physician.					
	Lack of following ca infections were not	are plan to prevent urinary trac provided:	t				
		erventions and services in y catheter were not followed					
	open, R68 was obs	5 a.m. R68's room door was served lying in bed. R68's theter bag was also observed					

Innesota Department of TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00916		B. WING		30/2015
IAME OF PROVIDER OR SUPPL	IER STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
APLE MANOR NURSING		TH STREET NO			
	ROCHES	STER, MN 559	01		1
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 565 Continued From	i page 15	2 565			
7:45 a.m. regist R68's catheter & R68's bed linea bag was to be p RN-C stated, "Y was in the collect hold the urine b and verified the collected in bag up, the bag's dr observed to hav not placed in the uncovered and in the collection placed the urine the drain spout the bed. At 7:38 door was open a the collection ba 8:14 a.m. Nursin interviewed and was lying direct stated nursing a shift and must h the night shift w stated the cathe below R68. NA- placed in a blue (pointing to a low NA-B then move R68's care plan required indwell retention. The c drainage bag be and to maintain	of R68's blanket of his bed. At ered nurse (RN)-C observed bag was placed directly on top of s. RN-C was asked if the urine laced on top of the bed linens an es." On asking how much urine ction bag RN-C was observed to ag and raised it to her eye level re was about 75 milliliters of urine . As RN-C was holding the bag ain (rubber emptying spout) was re been clamped, however, it was e designated bag pouch but sticking out as it was not secured bags spout holder. RN-C then bag back on top of the bed with in direct contact with the linens or a.m. on 1/21/15 R68's room and R68 was still lying in bed with ag still on top of the bed linens. At ng assistant (NA)-B was confirmed R68's catheter bag y on top of R68's bed linen. NA-E issistants empty the bag every ave been placed on the bed by hen they left this morning. NA-B ter bag should always be hanging B added, urine bag should be cloth cover and hooked "here" op-like attachment on bed frame) ed bag from bed. dated 10/20/14 indicated R68 ing Foley catheter due to urinary are plan directed staff to keep elow bladder level to prevent reflu a closed drainage system. hs Face Sheet printed on 1/29/15				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE	•		
	MANOR NURSING AN		H STREET NO TER, MN 5590				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 16	2 565				
	dementia, depress retention.	ion, anxiety state and urinary					
	11/1/14 indicated F should be kept belo reflux, maintain a c POS further indicat	ders Sheet (POS) dated 868's urinary drainage bag ow bladder level to prevent closed drainage system. The ted bag "to be kept in cloth g to prevent infection and					
	directed staff to see not to allow bag to	ter Care Policy dated 7/9/09, cure bag on side of bed frame, touch the floor, to keep the bladder at all times and to be y bag.					
	the guidelines prov Disease Control (C associated urinary recognized the imp maintenance of the and drainage syste catheter secureme maintain drainage	e indwelling urinary catheter em, to include appropriate nt per facility protocol and to bag below the bladder at all oor) and to prevent contact of					
	1/27/15 at 8:40 a.m revealed R32 did n portions and did no plate with high edg R32's care plan da significant weight lo at breakfast with ex 8/13/14 provide a	during breakfast meal on n. and on 1/28/15 at 8:50 a.m. tot receive double sized food of receive a scoop plate (a es) according to the care plan. ted 1/16/15 read, "has had a ossis offered double portions xtras on tray for other meals a scoop plate at all meals, wls if unable to use scoop					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY
			A. BUILDING: _			
	00916		B. WING	B. WING		30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN	ID REHABILIC	H STREET NO STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	age 17	2 565			
	impaired with diagr required extensive living that included dressing and hygie R32's physician's r but was not limited dementia. R32's dining room communicate dieta included the instruct breakfast and prov During an interview certified dietary ma did not receive dou resident was suppor SUGGESTED MET The administrator of system to educate	to the diagnoses of Lewy body tray card (card used to try information to staff) ction to give double portions at ide a scoop plate. of on 1/30/15, at 10:30 a.m. anager (CDM) verified resident ible portions and stated the psed to have a scoop plate. THOD OF CORRECTION: or designee could develop a staff and develop a monitoring staff are providing care as				
2 570	(21) days. MN Rule 4658.040	R CORRECTION: Twenty-one 5 Subp. 4 Comprehensive	2 570			3/11/15
	care must be revie interdisciplinary tea physician, a register for the resident, an disciplines as deter and, to the extent participation of the guardian or choser	sion A comprehensive plan of wed and revised by an am that includes the attending ered nurse with responsibility d other appropriate staff in rmined by the resident's needs practicable, with the resident, the resident's legal n representative at least n seven days of the revision of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		01/3	01/30/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
	MANOR NURSING AN	JD REHAR LLC	H STREET N TER, MN 55	IORTHWEST 901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
2 570	Continued From pa	age 18	2 570				
	the comprehensive by part 4658.0400,	e resident assessment required subpart 3, item B.					
	by:	ent is not met as evidenced					
	review the facility fa	ion, interview and document ailed to ensure revision of the or 1 of 3 residents (R38) etary meal change.		See Federal Regulation re	esponses		
	Findings include:						
	1/26/15 from 5:20 p eating independent meal. At 6:11 p.m. fluid restriction and	during the evening meal on p.m. to 6:11 p.m. R38 was tly but ate only 25% of her R38 stated that she was on a was not sure what foods she she had breaded food for d supper.					
	12/22/14 indicated mental status (BIM possible 15 or was impaired. The MD independent with e therapeutic diet. R summaries dated 1 listed diagnoses the	linimum Data Set dated she had a brief interview of S) score of 10 out of a moderately cognitively S indicated R38 was ating and was not on a eview of the hospital discharge (2/16/14, 12/30/14, and 1/9/15 at included: cardiac concerns, ce, chronic anemia, and					
	discharge summar general diet and ph was for a general lo orders noted on the	ers noted on the hospital y dated 12/16/14 was for a hysician orders on 12/30/13, ow residual diet. The physician e hospital discharge summary a diet of 1500 to 2000 mg sterol, and low fat					

IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00916			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING		01/30/2015		
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NC STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 19	2 570			
	On 12/22/14 a prot [related to] her nee healing." The interview with regular texture care plan also had "Diet: [R38] is at ris with need for a their restriction." The in salt diet and a 2000 the care plan proble ordered by the physical		t] f			
	1/28/15 at 4:25 p.m	sing (DON) was interviewed or n. DON indicated the diet Ian was written by dietary staff				
	interviewed on 1/29	y manager (CDM) was 9/15 at 9:20 a.m. CDM stated the care plan to reflect the orders on 1/9/15.				
	The director of nurst staff related to the	THOD OF CORRECTION: sing or designee could educate need to evaluate and update nitor for compliance.	9			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One				
2 800	MN Rule 4658.051 Staffing requirement	0 Subp. 1 Nursing Personnel; nts	2 800			3/11/15
	home must have o number of qualified registered nurses,	g requirements. A nursing n duty at all times a sufficient I nursing personnel, including licensed practical nurses, and to meet the needs of the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
		1875 197		IORTHWEST			
MAPLE I	MANOR NURSING AN	ID REHAB, LLC ROCHES	STER, MN 55	901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
2 800	Continued From pa	age 20	2 800				
	in all buildings if mo	ses' stations, on all floors, and ore than one building is udes relief duty, weekends, cements.					
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system to provide sufficient staffing to meet all residents assessed needs for care and treatments was provided. This has the potential to affect all 69 residents in the facility.			See Federal Regulation r	esponses		
	Findings include:						
	(11:45 a.m.) R26 w residents and only seated helping and same time NA-F we tale for other reside residents did eat in periods of time for at 5:09 p.m. the su five dependent resi residents were sea NA-O was observe resident a bit of foc giving that resident repeating this proce room and did not re and registered nurs from the table and attempted to assist their meal. Also sta staffed as evidence	5/15 during the noon meal ras seated with several other nursing assistant (NA)-F was ther resident to eat. At the ould speak loudly across the ents to eat. None of these dependently and waited long assistance to eat. On 1/26/15 pper meal, NA-O was assisting idents to eat and these five ted at two different tables. d to stand while giving one of then moving to another table a bit of food then would be ess until NA-O left the dining eturn. A short time later NA-F se (RN)-A moved the residents neither NA-F or RN-A the five residents to complete off stated they were short ed by depended residents at in a continuous period of					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	00916 E		B. WING	B. WING		30/2015
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/2010
	MANOR NURSING AN	ID REHABILIC 1875 19T	H STREET NO	ORTHWEST		
		ROCHES	TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 800	Continued From pa	ige 21	2 800			
	staff not assisting minutes and food with assisted the resident residents time to ear food debris and had food scraps next to still eating; and faile bag to promote dig who was observed collection bag with other residents, state SEE F282 & F312: interview, and docut to provide services care plan for 2 of 5 assistance with eatt minutes for staff to waited during noon minutes at one mear eat while having he entire time and wair 20 minutes for staff eating. During inter director of nursing a follow the care plan sistance for mear she was aware of the dining room.; for 2 assessed to need a as R88 was observed fingers, and visible removed also R31 brown debris under that were visibly so the resident ; and far (R45 & R38) who h were not consistent the staff of the sta	Based on observation, iment review, the facility failed as directed on each residents residents (R3, R88) for ing as R3 waited over 20 assist her to eat and R88 meal on 1/27/15 for 32 al before staff assisted her to or food set in front of her the ted at breakfast on 1/28/15 for it to return to help her finish view on 1/29/15, at 9:00 a.m., stated she expected staff to and to provide R3 & R88 with ls. Director of nursing stated he lack of staff in the east/west of 3 residents (R88 & R31) assistance with personal care red with long, soiled nails on all long facial hair that was not was observed to have dark finger nails and eye glasses iled preventing clear vision for ailed to ensure 2 of 2 Resident ad orders for daily weights tly done and during a staff rned it was because they were				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00916		B. WING	B. WING		30/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
	MANOR NURSING AN	ID REHABILIC	TH STREET NO STER, MN 559			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 800	Continued From pa	age 22	2 800			
	monitored for daily intake and this was not consistently done; failed to monitor daily intake for 1 of 1 Resident (R38) with doctors order for daily weights: failed to follow indwelling catheter interventions and services to prevent urinary tract infections for 1 of 1 resident (R68) with a Foley catheter.					
	document review, t 39 residents (R100 had ongoing servic by the physician to status changes so to the physician for congestive heart fa of fluid intake was respirations, lung s blood pressure or h	on observation, interview and the facility failed to ensure 5 of 0, R71, R45, R38, and R39) res and treatments as ordered monitor for significant health they could be reported timely interventions as R100 had allure and ongoing monitoring not completed, nor was counds, monitoring of edema, neart rate monitored closely in				
	changes needed to timely. R71 also ha did not receive ordo sounds, respiration R45 also had cong physician ordered o	ffective or acute health b be responded to by the docto ad congestive heart failure and ered daily weights nor lung is, blood pressure, edema, etc estive heart failure and lacked daily weights, monitoring of				
	R38 had a new collordered daily weight restriction, and ong healing and bowel weights per doctor	ening of edema of legs, etc. ostomy, and lacked doctor nts, monitoring of a fluid going assessment of colostomy function. R39 lacked daily ' s order due to congestive ngoing monitoring of lung	/			
	sounds, monitoring During an interview (RN)-A on 1/19/15	for edema and fluid overload. with the registered nurse at 3:58 p.m., RN-A stated that sues and the weights he gave				

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
	00916		B. WING	B. WING		30/2015	
NAME OF F	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
	MANOR NURSING AN	ID REHAR LLC	TH STREET NO STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	age 23	2 800				
	comprehensive bla assessment of risk monitoring of symp infections (UTIs) for R70, R30, R69, R9 recurrent urinary tra- to prevent urinary tra- to finfections to othe following sound infe- Foley Catheter carr 1 resident (R68) with catheter; and the fa- orders for intermitted monitor, evaluate, a of 1 residents (R70) intermittent catheter	the facility failed to ensure adder assessments and an s for developing and otoms for urinary tract or 7 of 8 residents (R16, R6, 16, R38) reviewed with act infections; the facility failed ract infections and the spread er residents due to staff not ection practices regarding e and equipment used for 1 of ith an indwelling Foley acility failed to follow physician ent cauterization and failed to and assess urine output for 1 b) in the sample with erizations. R70 had physicians r hour catheterization which ly provided.					
	1/28/15 at 4:15 p.m provided adequate that she did not wo resident cares. DO be 7 nursing assist and 2 trained medi	sing was interviewed on n. she stated she felt the facility staffing numbers. She stated rk on the floor providing direct N said that ideal staffing would ants and 3 licensed nurses cation aides each day shift and along with administrative	I				
	interviewed on 1/29 was aware that res the lack of staffing SUGGESTED ME The administrator of evaluate current re	manager (RN-A) was 9/15 at 8:05 a.m. He stated he idents had complained about levels. THOD OF CORRECTION: or director of nursing could sident care needs and needs based on these needs.					

Minneso	ta Department of He	alth		FO	RM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY OMPLETED
		00916	B. WING		01/30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
	MANOR NURSING AN		H STREET N TER, MN 55	IORTHWEST 901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From pa	lge 24	2 800		
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One			
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830		3/11/15
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on id preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident in bed.			
	by: Based on observati review, the facility f residents (R100, R ongoing services a the physician to mo status changes so to the physician for maintain an agreen	ent is not met as evidenced ion, interview and document ailed to ensure 5 of 39 71, R45, R38, and R39) had nd treatments as ordered by onitor for significant health they could be reported timely interventions; and failed to nent with the dialysis provider R62) currently receiving end ces.		See Federal Regulation responses	
	Findings include: Lack of monitoring to congestive heart	health status for changes due failure (CHF):			
	R100 was admitted	I to the facility on 1/13/15			
Minnesota Do STATE FORM	epartment of Health M		6899	3QEK11 If continu	uation sheet 25 of 115

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00916	B. WING		01/	30/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		
IAPLE I	MANOR NURSING AN	ID REHAR LLC				
		RUCHES	TER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 25	2 830			
	staff failed to monit intake for dehydration congestive heart faiding overload for R100 v congestive heart faiding diversion of the second diuretic, and had a centimeters (cc). R100's hospital dis 1/13/15 indicated F included the diagno failure, acute hypook kidney injury on chu hypokalemia (high to this summary the heart failure was no (diuretic). A physician's visit m 1/19/15 indicated F the past few month with dehydration. R100's physician o Hydrochlorothiazide (mg) by mouth eve every other day, po milli-equals (mEq) Lasix, daily weights restriction. R100's care plan d was cognitively imp activities of daily liv transfers, toileting, indicated R100 was imbalance related to directed staff of flui monitor for dehydra R100's fluid intake and output form. F were dated from 1/	e (diuretic) 12.5 milligrams ry day, Lasix 40 mg by mouth otassium chloride 20 by mouth every day while on s, and 1.5 liter (L) fluid ated 1/22/15 indicated R100 paired, was independent with ring (dressing, hygiene, and eating). Care plan s at risk for electrolyte to diuretics and fluid restriction; id restriction, daily weights, and ation. was recorded on the intake Fluid intake and output forms 19/15 through 1/28/15. ntake monitoring forms for				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/2010	
IAPLE M	ANOR NURSING AN		H STREET NO				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 26	2 830				
	forms provided were not been completed documentation R10 1/19/15, 1/20/15, 1/ On 1/23/15 docume of 220 ccs (cubic c intake documented intake documented total intake documented forms had a 24 hou determine if they m No further docume monitoring, assess status was located provided when requ During an interview stated she did not r between meals; an restriction. R100 was fluid she had consu explained nurses k revealed no water p bedside. During an observat R100 had 240 ccs 140 cc of orange ju During an interview licensed practical n dietary gave certair then R100 told the consumed. The am recorded on the flu	20 had no fluid intake on /21/15, 1/22/15, and 1/28/15. entation indicated a total intake entimeters), on 1/24/15 total I was 120 ccs, on 1/25/15 total I was 60 cc and on 1/27/15 ented was 30 cc. None of the ur totals calculated to net or exceeded fluid limit. Intation pertaining to ing, and evaluating of fluid in the medical record or uested. y on 1/26/15, at 1:25 p.m. R100 receive the fluids she wanted d explained the fluid as unable to report how much umed so far that day; and ept track of that. Observation pitcher or water glass at tion on 1/28/15, at 7:48 a.m. of milk, 240 cc of water, and nice. y on 1/28/15, at 7:44 a.m. hurse (LPN)-D explained that n fluid amounts to R100 and nurses how much she nounts should then be id intake sheet. LPN-D was d intake sheet and verified it pleted.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00916	B. WING	B. WING		30/2015
IAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	• • •	
	ANOR NURSING AN		OTH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 830	Continued From pa	age 27	2 830			
	During an interview director of nursing be monitoring and Facility policy Nutri read, "Accurate int evaluate a patient's diagnoses and influ- policy instructed st received to implem night shift was to to further instructed st and monitoring to r to record total amo medications, and b outlined composition documentation that intakesany refusa- read, "There will be as ordered, weekly of resident's respon nurse will total all fl individual chart dai committee to revier Lack of monitoring symptoms of conger R71's admission M 11/5/14, indicated H loss, moderately in for daily living that no or unknown wei was not on a diurer R71's hospital Hist 10/30/14, indicated	r R100 ' s fluid intake. v on 1/28/15, at 7:56 a.m. (DON) stated nursing should evaluating fluid intake. tional-hydration dated 2/1/201 ake and output records help s fluid balance, suggest variou uence choice of therapy." The aff after a doctor ' s order is nent 24 hour recording and the bal daily fluid intake. The poli- taff to communicate recording resident and nursing staff and punts consumed at meals, with between meals. The policy on of nursing narrative t included "estimates of als of intakes." The policy also e on-going response to the dia r charting will include reflection nse to diet as ordered, night luids for 24 hours on each ly. and dietary weekly w fluid restriction." weight and assessing for estive heart failure (CHF): finimum Data Set (MDS) date he had short-term memory npaired decision making skills required cues and supervision ight loss or weight gain, and tic (medication to reduce fluid fory and Physical dated d diagnoses of hypoxemic resolved, secondary to chronic	us ecy gs n o et n d s n,).			

ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00916	B. WING		01/30/2015	
ME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	• • •	
APLE MANOR NURSING AN		H STREET NO			
REFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830 Continued From pa	ige 28	2 830			
electroconvulsive th Physical revealed F secondary to failure from the cardiac se inpatient psychiatric severe depression. was 162 lbs. on 10/ discharge orders da received Lopressor hypertension. The continuing care inst for: Congestive hea R71's signed physic read, "daily weights [nurse practitioner] than] 3 lbs [pounds	status post eleven sessions of herapy. The History and R71 was hospitalized to thrive and was moved ervice and transferred to an c unit for management of It also indicated his weight /27/14. R71's hospital ated 10/30/14 indicated he 12.5 milligrams (mg) for discharge orders for tructed, "daily weights required art failure." cian orders dated 10/31/14 s PMs [evenings], Update NP with weight gains of > [greater] in a day or 5 lbs from aseline weight 162.1 lbs				
"Lasix 10 mg [mil daily update provid [pounds] or more ir more total. Update (weights, edema, lu and physician orde	n orders dated 11/7/14 read, ligram] by mouth daily, weigh er for weight gains 3 # n one day and 5 # [pounds] or provider with fluid status ungs) on 11/11 [11/11/14]" rs dated 11/11/14 read, " emity wraps for edema."				
problem of at risk for medications related fibrillation and hype staff to notify his mo					
Summary entered i	ties Weights and Vitals nto R71 ' s medical record on aled the following weights:				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00916	B. WING		01/30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN	ID REHAR LLC	TH STREET NO STER, MN 559			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 29	2 830			
	discharge weight o prior to hospital dis 11/2/14 163 lbs 11/9/14 107 lbs 11/10/14 127 lbs 11/10/14 127 lbs 11/13/14 132 lbs 11/16/14 155 lbs 11/18/14 155 lbs 11/18/14 155 lbs R71 had a nurse pro one day past his hose evaluation post hos "PHYSICAL EXA expiratory crackles unlabored. Extremi only. " Nurse pract days post his hospi evaluation visit read Manor on 10/30 aft for issues including CHF [congestive ho fibrillation]. Nursing status on 11/3, but received. Patient is home provides writ lower extremity ede EXAMINATION:Lu sounds bibasilar, o Respiration unlabo bilateral feet and an mid-calf. IMPRESS Acute on chronic ho MI [myocardial infa was not discharged show a bit more ed my previous visit. M nursing home is 16	ractitioner visit on 10/31/14; ospital discharge. The limited spital follow-up visit read, MINATION: Lungs: Scattered . Respirations even and ties: +1 edema bilateral feet itioner visit on 11/7/14; nine ital discharge. The limited d, "Was admitted to Maple er a prolonged hospitalization failure to thrive, depression, eart failure] and afib [atrial was to update me with fluid this information was never seen today after nursing ten communication reporting				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00916	B. WING		01/30/2015	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		00/2010
	MANOR NURSING AN	ID BEHAB LLC 1875 197	H STREET NO STER, MN 559	DRTHWEST		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
2 830	Continued From pa	age 30	2 830			
	of Lasix 10 mg [mil use TED stocking f CBC [complete blo [electrolytes/creatir 11/11. Nursing to u (weights, edema, lu R71's interdisciplin reviewed from 10/3 11/10/14 and revea to monitoring of da extremities or lung was accumulating a function to remove On 1/29/15 at 12:1 R71 had physician to diagnosis of con	2 p.m. registered nurse (RN)-E orders for daily weights related gestive heart failure. RN-E did not complete daily weights				
	(DON) stated she was follow the physician	p.m. the director of nursing would have expected staff to n orders for daily weights and (nurse practitioner) for the ed.				
	extremity edema, the monitor R71 for syn failure does not me working. Rather, it pumping power is w failure, blood move at a slower rate, and increases. As a res	and symptoms of lower the facility failed to consistently mptoms of CHF (CHF is Heart ean the heart has stopped means that the heart's weaker than normal. With hear is through the heart and body id pressure in the heart sult, the heart cannot pump d nutrients to meet the body's				

TATEMEN ND PLAN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	MANOR NURSING AN	ID REHABILIC	TH STREET NO STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pa	age 31	2 830				
	helps to keep the b muscle walls may a become unable to the kidneys may re retain fluid (water) arms, legs, ankles, the body becomes	oming stiff and thickened. This blood moving, but the heart eventually weaken and pump as efficiently. As a result spond by causing the body to and salt. If fluid builds up in the feet, lungs, or other organs, congested, and congestive term used to describe the	.,				
	R45 was not weigh assessment for co	ed daily nor had ongoing ntrol of CHF.					
	diagnosis that inclu according to physic diabetes mellitus, o peripheral vascular admission MDS da	to the facility on 12/10/14, with uded congestive heart failure, cian orders dated 12/10/14; cerebral vascular accident, and r disease, according to the uted 12/16/14; and right below 2/5/14, according to hospital y dated 12/26/14.					
	12/10/14, revealed weights for conges orders dated 12/12 nurse practitioner pounds in one day	of physician orders dated physician orders for daily tive heart failure; and physician 2/14, for daily weight, notify with weight gain over 3 or 5 pounds from baseline, # with right pylon cast.	n				
	dated 12/26/14, rev 12/21/14 and disch 12/26/14, for diagn	of hospital dismissal summary vealed R45 was hospitalized harged from the hospital on osis of pontine infarction e basilar thromboembolism.					
	Assessment dated	of Dietary Nutritional 12/17/14, identified weight of et of no sugar added, and					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVE COMPLETED	
		00010	B. WING		01/00/0015	
		00916			01/30/2015	
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S H STREET NC			
IAPLE N	MANOR NURSING AN		TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMP THE APPROPRIATE DA	X5) PLE ATE
2 830	Continued From pa	age 32	2 830			
	medications, abnor pressure ulcer, 9% weight loss may be amputation, curren and staff to monitor Document review of 12/31/14, revealed reflected weight lo notified of need to I prosthesis on or off staff to monitor wei R45's care plan da problem of R45 at of cardiac medicati vascular accident, hypertension, dyslig failure. Care plan a and vital signs as p	of dietary progress note dated weight of 233 pounds which ss of 6.8% in 11 days, nursing know if were taken with f, independent in eating, and				
	problem as risk rela need for therapeuti	ated 1/8/15 identified ated to medical diagnosis and ic diet. Care plan approaches tor and record weights as				
		of facility record of weights for ollowing weights 12/12/14 to				
	surgery 12/16/14250.4 po Hospitalized 12/2 12/26/14	21/14 and returned to facility on				
	12/27/14-239 poun 1/10/15243.7 pou 1/21/15228.5 pou epartment of Health	inds				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00916	B. WING		01/	30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ^Y	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 830	Continued From pa	age 33	2 830			
	1/22/15229.3 роц 1/23/15-230 pound 1/24/15232.2 роц 1/26/15-231 pound	ls ınds				
	for weights to be cl	orders dated 12/10/14, were hecked daily, the first weight 2/14, or 2 after the order, and <i>y</i> s apart.				
	for notification of n over 3 pounds in o the nurse practition	orders dated 12/12/14, were urse practitioner of weight gain ne day, the staff did not notify ner of weight gain of 4.7 2/27/14 and 1/10/15, the only at period of time.				
	for notification of the pounds from basel staff did not notify t	orders dated 12/12/14, were ne nurse practitioner of 5 ine, admit weight 220 #, the the nurse practitioner of 252 pounds, a 30 pound gain ds baseline.				
	registered nurse (F weights as physicia nurse practitioner r 3 pounds between	n 1/29/15, at 5:00 p.m., RN)-A verified the lack of daily an ordered, lack of evidence of notification of weight gain over 12/27/14 and 1/10/15, a gain stated the facility had no other				
	practitioner (NP)-G dated 12/10/14 for nurse practitioner r gain. NP-G state notify the nurse prac	n 1/30/15, at 9:00 a.m., nurse a verified the physician orders daily weights, and 12/12/14 for notification of 3 pound weight d she expected the facility to actitioner of weight gain as ted daily weights as ordered,	-			

-	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED	
		00916	B. WING	B. WING		30/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MAPLE	MANOR NURSING AN		H STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 34	2 830			
	verified orders date physician orders. If documentation of r weights or weight of physician ordered of During interview or assistant (NA)-E st daily, according to assignment sheet If During interview or registered nurse (F to be weighed daily were not complete sheet and on the E list for daily weights The Policy for Weig read, "It is the polic that residents are weighed that residents are weighed that residents will be weighed by the physician, b R39's face sheet ic on 1/7/2015. The dismissal sum 1/7/15 identified R3 mild dementia, chr heart failure, atrial history of transient diabetes mellitus, t retinopathy, anxiety of probable Bonner	n 1/30/15, at 9:15 a.m., nursing tated R45 was to be weighed the nursing assistant but has not been done. n 1/30/15, at 9:30 a.m., RN)-F stated she expected R45 y and verified daily weights d on the nursing assignment Evening Weight Charting-West				

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IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
	MANOR NURSING AN		H STREET NO TER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 35	2 830			
	R39 had a Brief Int (BIMS) score of 13 intact. R39 require mobility, transfers a walking in room an toilet use, and limit personal hygiene.	S dated 1/14/15 indicated that erview for Mental Status , which indicated cognitively ed extensive assist with bed and dressing, supervision with d corridor, supervision with ed assist with eating and				
	identified that R39 twice a day for dias mg every day for h failure, a diet order mechanical soft wit (milliliters) fluid res to obtain daily weig dismissal summary recommended that	ician orders dated 1/29/15 received Lasix (diuretic) 40 mg stolic heart failure, Lisinopril 10 ypertension/congested heart of diabetic, no added salt, th ground meat, 2000 ml triction and staff were directed yhts on evenings. The y dated 1/7/15 from the hospita t respiratory and fluid status o determine if modifications to e needed.				
	a problem related t medications related cardiovascular acc congested heart fa 1/16/15 titled Diet i related to medical therapeutic diet an modifications and s 2 liter fluid restriction weight of 155 pour	ted 1/12/15 indicated R39 had to taking multiple cardiac d to processes including ident history, hypertension and ilure. The problem dated ndicated R39 was at risk diagnosis with need for a d mechanical texture she is legally blind. R39 has a bn. R39 was to maintain ids (#) + or - thru next 90 days. ed staff to monitor and record 1.				
	nursing staff were to Continue metoprole	on 1/14/15 indicated that to monitor daily weights. ol (treat chest pain), digoxin Lasix (diuretic) and Lisinopril				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00916			01/	01/30/2015	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
	MANOR NURSING AN						
	SUMMARY ST		STER, MN 559	PROVIDER'S PLAN OF		(YE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pa	age 36	2 830				
	(lower blood press	ure).					
	admission, 1/7/15, days, 10 days of w	e reviewed from the day of through 1/29/15. Out of the 23 eights were missing with 4 ssing between 1/7/15 and	3				
	(RN)-A on 1/19/15	v with the registered nurse at 3:58 p.m., RN-A stated that sues and the weights he gave ad for R39.					
	instructed staff to: will be weighed wit weight. Residents ordered by the phy meeting the director residents who have weights and the tea	g Residents, dated 6/07/15 Upon admission, all residents hin 3 days to obtain an initial will be weighed thereafter as sician. At the weekly dietary or of nursing will bring the list of e doctor ordered specific am will review/audit the e lost weights for further					
	Lack of renal dialys services were prov	sis agreement to assure quality rided to residents:	/				
	providing End Stag without an agreem clinic to provide dia R62 was admitted diagnosis that inclu	sis services from the clinic ge Renal Disease services ent between the facility and alysis services. to the facility 11/21/14, with uded end stage renal disease according to the admission face	e				
	11/21/14; revealed hemodialysis on Tu	of physician orders dated R62 was to receive uesdays and Saturdays. n 1/28/15, at 4:20 p.m., the					

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PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MANOR NURSING AI					
(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
Continued From pa	age 37	2 830			
contract or an agre	eement with the dialysis				
No policy was received after being requested.					
review the facility f comprehensive fal	ailed to ensure a I risk assessment was				
Findings include:					
12/9/14 indicated F mental status (BIM intact. The MDS id experienced a fall the facility. The M included a fracture 1/27/15 included d	R96 had a brief interview of IS) score of 14/15 or cognitivel dentified that R96 had with injury prior to admission to DS listed diagnoses that R96 ' s care plan printed iagnoses that included fracture				
on the bed with ice stated that she had	packs on both legs. R96 broken both legs in a fall at	9			
(LPN)-B stated R9 admission to facilit The interdisciplina 1/1/15 indicated R9 during a transfer b and received no in registered nurse (F	6 had fallen on 1/1/15 (after y) but sustained no injuries. ry team notes (IDT) dated 96 had been lowered to floor ecause she had weak knees jury. The clinical manager RN)-A documented no				
	PROVIDER OR SUPPLIER MANOR NURSING AI SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From pa administrator verifi contract or an agre provider where R6 No policy was rece Based on observar review the facility f comprehensive fal completed for 1 of falls. Findings include: The admission Mir 12/9/14 indicated F mental status (BIN intact. The MDS id experienced a fall the facility. The M included a fracture 1/27/15 included d of lower end of fen On 1/25/15 at 2:20 on the bed with ice stated that she had home about 11 we On 1/25/15 at 2:07 (LPN)-B stated R9 admission to facilit The interdisciplina 1/1/15 indicated R during a transfer b and received no in registered nurse (F	OF CORRECTION IDENTIFICATION NUMBER: 00916 00916 PROVIDER OR SUPPLIER STREET A MANOR NURSING AND REHAB, LLC 1875 197 REQULATORY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 37 administrator verified the facility did not have a contract or an agreement with the dialysis provider where R62 received dialysis. No policy was received after being requested. Based on observation, interview, and record review the facility failed to ensure a comprehensive fall risk assessment was completed for 1 of 3 residents (R96) reviewed for falls. Findings include: The admission Minimum Data Set (MDS) dated 12/9/14 indicated R96 had a brief interview of mental status (BIMS) score of 14/15 or cognitivel intact. The MDS identified that R96 had experienced a fall with injury prior to admission to the facility. The MDS listed diagnoses that included a fracture. R96 's care plan printed 1/27/15 included diagnoses that included fracture of lower end of femur.	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00916 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MANOR NURSING AND REHAB, LLC 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECOEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX Continued From page 37 2 830 administrator verified the facility did not have a contract or an agreement with the dialysis provider where R62 received dialysis. PREFIX No policy was received after being requested. Based on observation, interview, and record review the facility failed to ensure a comprehensive fail risk assessment was completed for 1 of 3 residents (R96) reviewed for fails. Findings include: The admission Minimum Data Set (MDS) dated 12/9/14 indicated R96 had a brief interview of mental status (BIMS) score of 14/15 or cognitively intact. The MDS identified that R96 had experienced a fail with injury prior to admission to the facility. The MDS listed diagnoses that included a fracture. R96's care plan printed 1/27/15 included diagnoses that included fracture of lower end of femur. On 1/25/15 at 2:20 p.m. R96 was observed sitting on the bed with ice packs on both legs. R96 stated Hat she had broken both legs in a fail at home about 11 week ago. Image: R96 stated R96 had failen on 1/1/15 (after admission to facility) but sustained no injuries. The interdisciplinary team notes (IDT) dated 1/1/15 inficlicated R96 had been lowered to floor during a	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00916 B. WING 01/ PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MANOR NURSING AND REHAB, LLC 1875 19TH STREET NORTHWEST ROCHESTER NM 55901 OTHER OF CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDERS PLAN OF CORRECTION COULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY ON USE THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDERS PLAN OF CORRECTION COULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 37 2 830 COM STATE COMPRIATE DEFICIENCY 2 830 Continued From page 37 2 830 South of the facility did not have a contract or an agreement with the dialysis provider where R62 received dialysis. COM SECRETION FACILITIES (FIGURES INCLUE) PREFIX No policy was received after being requested. Based on observation, interview, and record review the facility failed to ensure a comprehensive fail risk assessment was completed for 1 of 3 residents (R96) reviewed for fails. The admission Minimum Data Set (MDS) dated 1/2/1/1 indicated R96 had a brief interview of mental status (BIMS) score of 14/15 or cognitively intact. The MDS identified that R96 had experienced a fail with injury prior to admission to the facility. The MDS identified diagnoses that included a fracture. R96 's care plan printed 1/2/2/15 included diagnoses that included fractu

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00916	B. WING	B. WING		01/30/2015	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ITY, STATE, ZIP CODE			
	MANOR NURSING AN		TH STREET NO STER, MN 559	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 38	2 830				
	fall risk, related to r plan directed to ass needed and to use other individualized prevent falls for R9 identifying contribu- related to medical of medications, physi- that could contribu- found or provided b R96. On 1/29/15 at 5:00 and stated no fall r located for R96. No policy/procedur requested. SUGGESTED MET The director of nur- staff to comprehen interventions to en- residents are provi- promote their highe program could be e ongoing assessme interventions in res	heed for assistance. The care sist R96 with mobility as a mechanical lift, but lacked l interventions to reduce or 6. No fall risk assessment ting factors or comorbidities conditions, cognitive function, cal function or the environmen te to R96's risk for falls was by the staff when requested for p.m. RN-A was interviewed isk assessment could be e was provided when THOD FOR CORRECTION: sing or designee could direct sively assess and implement	t				
	review, the facility of administration via g	ion, interview and document did not ensure medication gastric tube was followed for 1 observed for medication ugh gastric tube.					

TATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00916	B. WING	B. WING		01/30/2015	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
	MANOR NURSING AN		TH STREET NC STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pa	age 39	2 830				
	Findings include:						
	that R69 was admi Diagnosis section of diagnoses to includ cerebrovascular dia ability to communic	sease; dysphasia (impaired ate due to brain injury or kidney disease; hypertension					
	meds [medications	ders dated 1/1/15, read, "Flush] with 60 cc [cubic centimeters ter and 5 cc H2O [water]					
	have an ongoing fe (g-tube). R69 gave observe registered medications throug observed to stop th then secured the tij intravenous (IV) po Asepto syringe (a t bulb-fitted, blunt-tip medication from a pushed it through t however; RN-D did water before the in	8 a.m., R69 was observed to beding through the gastric tube permission for surveyor to nurse (RN)-D administer th R69's g-tube. RN-D was be ongoing tube feeding, and p of the tubing in the le. RN-D immediately took the rademark for a large oped syringe), drew the first mini plastic medication cup, he g-tube, then stopped I not flush the g-tube with 60 cu itial medication was sh the food from the tubing.					
		a.m. RN-D verified she did with water before giving the					
	Medication via a Pe Gastrostomy (PEG	dure for the Administration of ercutaneous Endoscopic) Tube policy dated 7/24/08, ow the "standard procedure" in	h				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		00916	B. WING		01/30/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	
2 830	Continued From pa	age 40	2 830			
	include flushing wit before and then 30 administration. The 60 cc vs. 30 cc per SUGGESTED MET The DON can inse tube feedings med accepted current p for compliance.	hrough gastrostomy tube to h 30 milliliters (ml) of water ml of water after medication physician specifically ordere policy. THOD OF CORRECTION: rvice all staff responsible for ication administration to use ractices. Also to monitor staff R CORRECTION: Twenty-one				
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range c	of 2 895		3/11/15	
	that is directed tow through positioning implemented and r comprehensive res of nursing services	motion. A supportive progra ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the directo must coordinate the nursing care plan which)			
	receives appropriat	th a limited range of motion te treatment and services to notion and to prevent further of motion.				
	by: Based on observat review, the facility f risk to continue ran	ent is not met as evidenced ion, interview, and document ailed to assess the benefits o ge of motion (ROM) services (R31) reviewed for range of	r	See Federal Regulation responses		

Minneso	ta Department of He	ealth			FORM APPRO	VLD
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,
		00916	B. WING		01/30/2015	5
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	MANOR NURSING AN		H STREET N TER, MN 55	IORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL	LETE
2 895	Continued From pa	age 41	2 895			
	motion.					
	Findings included:					
	and was not reass of motion services joints, prevent com	vices discontinued by nursing essed for a maintenance range to maintain functionality of pplications, or slow progression impairment in the shoulders ies.				
	diagnoses of major	ote dated 1/15/15 included r depressive disorder, itis in shoulders, hands, and enia.				
	10/30/14 indicated cognitive impairme for activities of dail	nimum Data Set (MDS) dated the resident had severe ent and was dependent on staff y living including toileting, and eating. R31 required a transfers.				
	sitting in her wheel room. NA-C stated she usually	2:25 p.m. R31 was observed chair located in the dining eats good during breakfast and lunch period and eats one day.				
	licensed practical r limited range of mo hips and R31 did n	v on 1/26/15 at 12:06 p.m. hurse (LPN)-B stated R31 had otion in neck, shoulders, and tot use orthotics and did not otion (ROM) program in place.				
		dicated the range of motion on the state of				
linnoasta D	Nursing progress r	note dated 1/16/14 read,				
TATE FOR			6899 3	3QEK11	If continuation sheet 42	2 of 11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	DDRESS, CITY, STATE, ZIP CODE			
	MANOR NURSING AN						
(X4) ID	SUMMARY ST		STER, MN 559	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLE DATE	
2 895	Continued From pa	age 42	2 895				
	stretches discontin comfort cares [resignedical intervention note lacked assess No further assesses motion program was since program was During an interview LPN-D stated " we the past and we co LPN-D indicated will active range of mot LPN-D had no furth passive range of mot	s- passive range of motion, ued 1/29/14- resident is dent does not wish for heroic ns to prolong life] ". Progress sment, evaluation, and plan. nent for need of range of as found in the medical record discontinued. y on 1/28/15, at 1:43 p.m., tried to do range of motion in ntinue to reposition her ". hen the R31 ate independently tion was being performed. her examples of how active or lotion had been provided. y on 1/28/15, at 2:05 p.m. RN)-A stated " according to the	,				
	aide care plan, mai provided. " During RN-A stated they w documentation that was discontinued re services.	intenance is not being another interview on 1/29/15 vere not aware of t indicated R31 's program elated to pain or refusal of					
	physical therapy as Sometimes we would of motion if it 's no Providing passive r burden of care. " F programs are rease	v on 1/29/15, at 8:27 a.m. esistant (PTA)-J stated, " uld recommend passive range t going to cause pain. range of motion could ease the PTA-J explained typically sessed prior to discontinuing uld recommend evaluating					
	need and appropria quarterly basis. PT	ateness for programs on a A-J recommended R31 being cal therapy for a maintenance					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	•		
	MANOR NURSING AN		TH STREET NO STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 895	Continued From pa	age 43	2 895				
	nursing assistant (receive passive ran thought R31 would ROM services with During an interview nurse practitioner (v on 1/29/15, at 9:12 a.m. NA)-K stated R31 did not nge or motion at this time and allow and tolerate receiving yout any difficulty. v on 1/30/15 at 10:00 a.m. (NP) stated, " I think she [R31] nefit from a passive range of					
	The DON, director could review and re and procedures rea maintaining proper DON, director of th provide an in-servic providing treatmen care. The DON, dire	THOD FOR CORRECTION: of therapy or designee(s) evise as necessary the policies garding implementing and range of motion care. The herapy or designee(s) could ce for all appropriate staff on t per each resident's plan of rector of therapy or designee(s soure residents receive proper eatment.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	•				
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910			3/11/15	
	have a continuous management to re- unnecessary use of comprehensive res home must ensure A. a resident w without an indwellin unless the resident	ence. A nursing home must program of bowel and bladder duce incontinence and the of catheters. Based on the sident assessment, a nursing that: who enters a nursing home ng catheter is not catheterized t's clinical condition indicates n was necessary; and					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		01/30/2015	
AME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE		
	MANOR NURSING AN		H STREET N TER, MN 55	IORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
2 910	Continued From pa	age 44	2 910			
	receives appropriat prevent urinary trac	ho is incontinent of bladder te treatment and services to ct infections and to restore as der function as possible.				
	by: Based on observat review, the facility f bladder assessmer for developing and urinary tract infection (R16, R6, R70, R30 with recurrent urina failed to prevent urina fail	ent is not met as evidenced ion, interview and document failed to ensure comprehensive ints and an assessment of risks monitoring of symptoms for ons (UTIs) for 7 of 8 residents 0, R69, R96, R38) reviewed ary tract infections; the facility inary tract infections and the s to other residents due to staff d infection practices regarding e and equipment used for 1 of th an indwelling Foley acility failed to follow physician ent catheterizations and failed e, and assess urine output for 70) in the sample with zations.		See Federal Regulation resp	oonses	
	of the urinary tract	cation of signs and symptoms infection (UTI) and lacked a nt and assessment of UTI risk.				
	to have a UTI on 10 interdisciplinary tea	the infection control (IC) logs 0/17/14. Review of the am notes (IDT) of 10/8/14 to signs or symptoms of a UTI				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00916	B. WING	B. WING		30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	IANOR NURSING AN		TH STREET NC STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 45	2 910			
	10/29/14 indicated status (BIMS) scor cognitively impaire to total assist to me	num Data Set (MDS) dated a brief interview of mental e of 12 or moderately d, that R16 required extensive eet toileting and personal d that R16 was frequently				
		ed 9/13/11 noted R16 had ence. The care plan did not at risk for UTIs.				
		RN)-E stated on 1/30/15 at 6 did not have a completed nt.				
	R6 lacked identification lacked a UTI risk a	ation of symptoms of a UTI and assessment.	ŀ			
	10/27/14 and 12/10	he IC log to have a UTI on 0/14. Review of the IDT notes noted no signs and symptoms				
	R6 had a BIMS sco required extensive toileting and perso	dated 12/26/14 was reviewed ore of 13 or cognitively intact, to total assistance to meet nal hygiene needs, had a r and obstructive uropathy, and catheterized.				
	indwelling suprapu recurrent UTIs resu hospitalization. Th	le care plan did not have d on a comprehensive bladder				
	No UTI risk assess by facility when rec epartment of Health	sment was found or provided quested.				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	MANOR NURSING AN					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	DID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 46	2 910			
	R70 lacked identification of symptoms of a UTI and lacked a UTI risk assessment					
	9/29/14. The IDT r	the IC log to have a UTI on notes were reviewed and no igns and symptoms of the d.				
	had a BIMS score of impaired, required	dated 11/20/14 indicated R70 of 11 or moderately cognitively extensive assistance to meet nal hygiene needs, and was rized.				
		ssessment or UTI risk ound or provided when				
	R30 lacked identific and lacked a UTI ri	cation of symptoms of a UTI sk assessment.				
	10/15/14, 11/7/14, a	the IC log to have a UTI on and 11/29/14. The IDT notes lacked identification of signs JTI.				
	memory impairmer cauterized, had obs total dependence of personal hygiene n dated 12/15/11 that UTI related to stapl indicate an assess	ated 11/6/14 noted R30 had tt, was intermittently structive uropathy, and had on staff to meet toileting and eeds. R30 had a care plan t listed a problem of at risk for h bacteremia, but did not ment related to clinical, nmental risk factors had been				
		sments were found in the ed 11/6/14 and 1/28/15.				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•		
	MANOR NURSING AN		TH STREET NO STER, MN 559	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 47	2 910				
	However, neither a UTI risk.	ssessment evaluated R30's					
		cation of symptoms of the UTI ler and UTI risk assessment.					
	10/7/14, 10/31/14,	the IC log to have a UTI on 11/9/14, 11/18/14. The IDT ed and lacked identification of ns of UTI.					
	reviewed. The MD and long term men required extensive personal hygiene, a	IDS dated 12/15/14 was IS indicated R69's short term nory were intact, that R69 assist with toileting and and that R69 had experienced 0 days. No bladder or UTI risk bund in the record.					
		30/15 at 12:45 p.m. that R69 pleted bladder assessment.					
	R96 lacked a blade assessment	der assessment and a UTI risk					
	dismissal summary	on 12/2/14. The hospital y dated 12/2/14 noted R96 had as on suppression Bactrim					
	BIMS score of 14 c extensive to total a personal hygiene n and a UTI in the pa	S dated 12/9/16 indicated a or no cognitive impairment, ssist with toileting and needs, frequent incontinence, ast 30 days. No bladder or nt was found in the medical d when requested.					
		30/15 at 12:45 p.m. that R96 pleted bladder assessment.					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		01/	30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 48	2 910			
	R38 lacked a bladder assessment and a UTI risk assessment.					
	admission MDS da had BIMS score of impaired, required meet toileting and p an ostomy, and had infection during the always incontinent.	with a UTI 12/16/14. The ated 12/22/14 indicated R38 10 or moderately cognitively extensive to total assistance to personal hygiene needs, had d experienced a urinary tract e previous 30 days, and was No bladder or UTI risk found in the record.				
		30/15 at 12:45 p.m. that R38 pleted bladder assessment.				
	provided by the direct included 1) Chronic dated 5/2/12 and 2 Residents dated 4/ direct staff to evalue UTIs and did not in UTIs and what/whe did not direct a com assessment that in comorbidities related	p.m. UTI policies were ector of nursing. The policies c Urinary Tract Infection Policy) Prevention of UTI's at Risk 3/12. The policies did not late the risk for developing include signs and symptoms of en to document. The policies inprehensive nursing included contributing factors or ed to medical conditions, medications, physical function				
	RN-A stated he had for infections, but the form had been dev	ved on 1/28/15 at 9:40 a.m. d a form that listed the criteria hat no policy related to the reloped. RN-A stated nursing he criteria for infections rsing notes.				
		0 a.m. RN-A and the director o e interviewed. They indicated	f			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			SURVEY PLETED
		00916	B. WING		01/3	30/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLE
PREFIX TAG		-SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE
2 910	Continued From pa	age 49	2 910			
	criteria available to from. They stated	nave a list of infection or UTI staff to use and document the facility did not have a n the management of urinary				
	bladder assessme assessment and the	a.m. the DON indicated the nt did not include a UTI risk nat staff were not expected to related to UTI risk.				
	infection control pr draining tubing and collection bag plac	er care did not promote sound actices when handling the d collection bag nor was the ed to prevent the spread of t a urinary tract infection.				
	open, R68 was obs indwelling Foley ca lying flat on top of 1 7:45 a.m. registere R68's catheter bag R68's bed linens. F bag was to be plac RN-C stated, "Yes. was in the collection hold the urine bag and verified there w	5 a.m. R68's room door was served lying in bed. R68's atheter bag was also observed R68's blanket of his bed. At ed nurse (RN)-C observed g was placed directly on top of RN-C was asked if the urine sed on top of the bed linens and " On asking how much urine on bag RN-C was observed to and raised it to her eye level was about 75 milliliters of urine				
	up, the bag's drain observed to have to not placed in the d uncovered and stic in the collection ba placed the urine ba the drain spout in c	s RN-C was holding the bag (rubber emptying spout) was been clamped, however, it was esignated bag pouch but cking out as it was not secured gs spout holder. RN-C then ag back on top of the bed with direct contact with the linens on m. on 1/21/15 R68's room				
nesota De	door was open and	d R68 was still lying in bed with still on top of the bed linens. At				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00916	B. WING		01/	30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	ANOR NURSING A		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 910	Continued From pa	age 50	2 910			
	interviewed and co was lying directly of stated nursing ass shift and must hav the night shift whe stated the catheter below R68. NA-B a placed in a blue cle (pointing to a loop- NA-B then moved R68's Admissions indicated R68 had	assistant (NA)-B was onfirmed R68's catheter bag on top of R68's bed linen. NA-E istants empty the bag every e been placed on the bed by n they left this morning. NA-B r bag should always be hanging added, urine bag should be oth cover and hooked "here" like attachment on bed frame) bag from bed. Face Sheet printed on 1/29/15 diagnoses including psychosis ion, anxiety state and urinary	g ,			
	11/1/14 indicated F should be kept bel reflux, maintain a o POS further indica	rders Sheet (POS) dated R68's urinary drainage bag ow bladder level to prevent closed drainage system. The ted bag "to be kept in cloth g to prevent infection and				
	required indwelling retention. The care drainage bag below	ated 10/20/14 indicated R68 g Foley catheter due to urinary e plan directed staff to keep w bladder level to prevent reflu closed drainage system.	x			
	directed staff to se not to allow bag to	eter Care Policy dated 7/9/09, cure bag on side of bed frame touch the floor, to keep the bladder at all times and to be ty bag.	,			
	the guidelines prov	ses Association (ANA) adopted vided by the Centers for CDC, 2009) to prevent catheter				

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00916	B. WING	B. WING		01/30/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
	MANOR NURSING AN		TH STREET NO				
		ROCHES	STER, MN 5590				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 910	Continued From pa	age 51	2 910				
	associated urinary tract infections. The guidelines recognized the importance of proper maintenance of the indwelling urinary catheter and drainage system, to include appropriate catheter securement per facility protocol and to maintain drainage bag below the bladder at all times (but not on floor) and to prevent contact of the drainage spout.						
		our hour catheterization to ct infections and bladder					
	that pertained to st four hours as order bladder scans had catheterization. Gri hours without being	ed a grievance with the facility aff not catheterizing him every red by the physician and not been performed prior to ievance indicated R70 went six g catheterized; which lead to 0 milliliters (ml) of urine.					
	11/20/14 indicated urinary catheterizat impairment with a l Status (BIMS) scor extensive assist for	nimum Data Set (MDS) dated R70 required intermittent tion, had moderate cognitive Brief Interview for Mental re of eleven, and required r activities of daily living of transfers, and hygiene.					
	1/28/15 indicated F and gave staff dire- plan indicated resid deficit and directed in a shift. Care plar diagnosis of hypert hyperplasia (enlarg	plan provided by the facility on R70 occasionally refused cares ction to chart refusals. Care dent was at risk for fluid volume I staff to report no urine output n also indicated R70's tonic bladder, benign prostatic ged prostate) with obstruction, nittent catheterization and	9				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		01/	30/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
	MANOR NURSING AN	ID REHAR LLC	H STREET NO STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 52	2 910				
	(straight versus con catheter tip for eas obstruction in the u did not include the scan if needed first Signed physician's included diagnoses Lewy bodies, hyper the bladder making complete urinating prostatic hyperplas	orders dated 12/19/14 s of Parkinson's, dementia with rtonicity (increased tension of g it more rigid, hampering ability) of bladder and benign ia (BPH which is an prostate) making it more					
	included in and out (Cath) every four h cath for retention/d and "ok to bladder cath if scanned am centimeters (cc). H lacked size and typ	orders dated 12/19/14 (I and O) catheterization ours scheduled, may I and O iscomfort as needed (PRN) scan prior to I and O and hold ount is less than 200 cubic However, the physician orders be of catheter to use for R70 as promote comfort and prevent en catheterizing.					
	indicated schedule a.m., 5:00 a.m., 9 a 9:00 p.m. However cath was complete	Iministration record (TAR) d I and O cath times were 1:00 a.m., 1:00 p.m., 5:00 p.m., and r, the documentation to indicate d was inconsistent; outputs except intermittently during the n. treatment time.)				
	November, Decem indicated I and O c amount of outputs	Bladder Scan Sheets for ber 2014 and January 2015 atheterization times and resulting from urinary wever, the use of the bladder					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00916			01/	30/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
	MANOR NURSING AN	ID REHAR LLC	TH STREET NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
2 910	Continued From pa	age 53	2 910			
	scan was not completed prior to any I & O done. The bladder scan sheet documentation from 1/1/15 through 1/30/15 reflected R70 had I and O cathed a total of 110 times out of 180 opportunities. There were 63 times urine obtained from cathing procedure resulted in amounts 500 cc and above and 11 times collection amounts were 1000 cc and above. At no point during the month of January 2015 documentation reflected R70 was I and O cathed every four hours per physician's orders.					
	According to an article published Institute of health (NIH Publication December 2013) it read, "A norm like a reservoir and can hold 1.5 cups [480 cc] of urine."	NIH Publication No. 14-3195 read, "A normal bladder acts can hold 1.5 [360 cc] to 2				
	licensed practical r resident often refus at an activity. LPN- indicated on the bla TAR. These docur found to be inconc	v on 01/30/15, at 1:57 p.m. hurse (LPN)-C explained sed to be cathed or had been C stated refusals would be adder scan sheet or on the nents were reviewed and lusive if R70 had refused or e nurse had not completed for				
	director of nursing	v on 1/30/15, at 11:30 a.m. (DON) stated, "They should be he cath is not getting done as				
	The facility did not catheterization.	have a policy for in and out				
	The director of nur	THOD OF CORRECTION: sing could inservice all sible for preventing urinary				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00916	B. WING		01/30/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
	MANOR NURSING AN		TH STREET N STER, MN 55	IORTHWEST 901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 910	Continued From pa	age 54	2 910		
	develop interventio infections. The dire all employees resp orders for intermitte compliance. The di inservice all employ	the need to assess and ns to prevent urinary tract ector of nursing could inservice onsible to follow physician ent cauterization and audit for rector of nursing could yees responsible for ting and assessing urine output liance.			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one			
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920		3/11/15
	comprehensive res home must ensure B. a resident who activities of daily liv	o is unable to carry out ing receives the necessary n good nutrition, grooming,			
	by: Based on observat review, the facility f (R3, R88) in the sa assistance, receive 2 of 3 residents (R8	ent is not met as evidenced ion, interview, and document failed to ensure 2 of 5 residents mple dependent on staff for ed assistance with eating, and 88, R31) in the sample for personal care, received rsonal cares.	5	See Federal Regulation responses	
	Findings include:				
	LACK OF ASSIST	WITH EATING:			
	R3 did not receive	assistance with eating			

STATE FORM

3QEK11

If continuation sheet 55 of 115

	ta Department of H					APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00916	B. WING		01/3	30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AI		H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 920	Continued From pa	age 55	2 920			
	according to care	olan interventions.				
	was in wheelchair room. R3 was place staff for residents we Also at that time, re- assisting R3 to east table. R3 still had p front of R3 with no a.m., R3 was aslee powdered donut, 1 glasses beverages assistance given. If assistant (NA)-D s her meal starting a without assistance R3 was admitted 3 included paralysis Lewy Bodies, accor printed 1/29/15.	hs on 1/28/15, at 9:45 a.m., R3 located in the east/west dining ced at a table designated by who needed assistance to eat. egistered nurse (RN)-C was at 9:52 a.m., RN-C left the blate of food and beverages in attempt to feed self. At 10:00 ep with f hard-boiled egg, small slice toast cut into half, and 4 in front of R3, and no staff From 10:00 a.m. until nursing at and assisted R3 to complete to eat meal or cueing.				
	Data Set (MDS), a to have short and I moderately impaire dependence on 2 s total dependence of	ed R3 on the annual Minimum n assessment dated 12/8/14, ong term memory problems, ed decision making, total staff for activities of daily living, on 1 staff for eating and and received a mechanically				
	assessment dated independently ate difficulty swallowin	of the annual Nutritional 12/16/14; identified R3 with difficulty chewing, no g, received general diet with hin liquids, and no significant				
anaacta D	· · · · · · · · · · · · · · · · · · ·	ed 3/19/13, identified problem				
nesota De	epartment of Health VI		⁶⁸⁹⁹ 30	QEK11	If continuatio	n sheet 56 of

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00916	B. WING	B. WING		30/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NC STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 920	Continued From pa	age 56	2 920			
	of nutrition risk related to history of dysphagia, history of needing mechanically altered diet and liquids, had history of weight loss due to poor oral intake and dysphagia. Approaches included soft diet, placed at staff assisted table, and wanted staff to assist with feeding skills and care plan dated 3/29/13, identified problem of self-care deficit related to needing assistance with activities of daily living. Approaches included 1 assist with eating pureed diet.		6			
	of nursing stated s care plan and to pr meals. Director of of the lack of staff	n 1/29/15, at 9:00 a.m., director he expected staff to follow the rovide R3 with assistance for nursing stated she was aware in the east/west dining room.				
	according to care p	e assistance with eating plan interventions.				
	R88 was in wheeld designated for resi with eating in the e observations at that carrots, quiche, an adaptive cups of be table directly in from have her eyes close a.m. (32 minutes) staff assisted her to	ns on 1/27/15, at 11:18 a.m., chair located at the table idents who needed assistance east/west dining. During at time, a plate of pureed id mashed potatoes and four everages with lids were on the nt of R88, who was noted to sed. From 11:18 a.m., to 11:50 R88 eyes were closed and no o eat nor encouraged her to trained medication assistant				
	and handed to R88 the spoon of food of following this incide assistant (FA)-A as 's table, then FA-A chocolate milk and	e R88, placed food on a spoor 8, R88 immediately dropped onto her lap, TMA-A left R88 ent. At 11:54 a.m., feeding ssisted another resident at R88 A handed R88 glass of I continued to assist R88 until ring this time FA-A would stand				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•		
	MANOR NURSING AN		TH STREET NO STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	age 57	2 920				
	to assist R88 at tim another resident to	ies as FA-A was also assisting eat.					
	stated R88 receive could assist R88 to good days and son	a 1/27/15, at 12:12 p.m., FA-A d pureed foods and any staff e eat. FA-A stated R88 had netimes would eat other days needed assist with					
	diagnosis that inclu Bodies and paralys	to the facility 8/26/14, with Ided dementia with Lewy is agitans according to codes printed 1/30/15.					
	an assessment dat term memory prob decision making, to activities of daily liv	d R88 on the quarterly MDS, ed 11/23/14, to have short em, moderately impaired otal dependence on 2 staff for ing, total dependence on 1 personal hygiene, and ically altered diet.					
	of at risk for decline need for mechanic dentation, due to o for nutritional support to need for assistant decreased cognitio included assist as a with food/fluid. App included pureed dia Approaches dated	ted 9/10/14, identified problem e in nutritional status due to ally altered food related to poo pen areas with increased need ort, due to abnormal labs, due nce with meals, due to n. Approaches dated 9/10/14 needed and as resident allows roaches dated 9/22/14 et with thin liquids. 9/23/14, included house nes daily. Approaches dated	r				
	9/29/14 included al for swallow and giv	ternate bites with sips, watch e next bite/sip to maintain ed cups ok when being					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00916	B. WING		01/	30/2015
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
	MANOR NURSING AN	ID REHABILIC	H STREET NO TER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 920	Continued From pa	age 58	2 920			
	registered dietician RD-I's notes on 1/2 loss of 8.5% in 2 m be decreased eden are dependent, per during meals and s resident allowed. During a second m 9:37 a.m., R88 sat table designated by assistance to eat lo room. R88 was ob plate of cooked cer applesauce, magic adaptive cups with to administer medio taken. At 9:42 a.m began to assist her RN-C left R88. R88 in front of her and r independently. Fro minutes) R88 had e assistance or cueir	1/28/15, at 9:15 a.m., (RD)-I and surveyor read (RD)-I and surveyor rea				
	of nursing stated sl care plan and to pr meals and persona stated she was awa east/west dining ro					
	"Purpose: To provio comprehensive pla	cy dated 1/19/12, read, de a multi-disciplinary n of care which provides a ofiles the needs of each				

	PROVIDER OR SUPPLIER	00916		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
(X4) ID	PROVIDER OR SUPPLIER		B. WING		01/3	30/2015
(X4) ID		STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 559			
TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 59	2 920			
	LACK of PERSONAL CARES: R88 had long facial hair and long soiled finger nails without assistance with personal cares according to care plan interventions.					
	R88 had visible lon On 1/28/15, at 9:37 located at south tal with several other r	s on 1/26/15, at 2:58 p.m., Ig facial hairs while lying bed. 7 a.m., R88 sat in wheelchair ble in east/west dining room residents who ate meal in this gain had long, soiled finger al hair.				
	diagnosis that inclu Bodies and paralys	to the facility 8/26/14, with ided dementia with Lewy is agitans according to codes printed 1/30/15.				
	an assessment dat term memory prob decision making, to	ed R88 on the quarterly MDS, ted 11/23/14, to have short lem, moderately impaired otal dependence on 2 staff for ring, total dependence on 1 personal hygiene.				
	of needed assistan transfer and ambul decreased endurar included assist of c	ted 9/4/14, identified problem ace with activities of daily living, ation related to dementia and ace and mobility. Approaches one staff with wheel chair and personal hygiene.				
	stated had assisted NA-D verified had care. NA-D stated	n 1/28/15, at 10:10 a.m., NA-D d R88 with morning cares. not provided shave or nail d residents are shaved with nail care was done in the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	MANOR NURSING AN						
(X4) ID	SUMMABY ST		STER, MN 559	PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET	
2 920	Continued From pa	age 60	2 920				
	verified the long fac nails. RN-F stated shaved on bath da she expected man on bath days. Also	n 1/28/15, at 11:15 a.m., RN-F cial hair and long soiled finger she expected facial hair y and as needed. RN-F stated icures were done weekly and RN-F said R88 received bath idnesdays (today) in the					
	of nursing Director expected staff to for	n 1/29/15, at 9:00 a.m., director of nursing stated she Illow the care plan and to ssistance for nail and facial					
	were not cleaned to worn: Observations made 1/26/15 at 1:31 p.m revealed R31 had o underneath fingern extremely dirty and glasses. R31's quarterly MD R31 had severe co dependent on staff including toileting, o Physician's visit pro included diagnoses primary open angle R31's care plan ind with grooming.	licated resident was one assist	t				
	fingernail care and completed for R31 " grooming " as no The AM Cares poli	erview on 1/30/15, RN-A stated cleaning glasses were to be as they are considered part of oted in R31's care plan. cy dated 8/31/04, read, "1. ven when complete baths are					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00916	B. WING		01/30/2015
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S		
MAPLE I	MANOR NURSING AN		H STREET NO STER, MN 559		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE
2 920	Continued From pa	age 61	2 920		
		re: "2. The mouth, nails, and d for in the same manner as for	r		
	The CARE OF NAI "1. Keep clean and	LS policy dated 3/12/08, read, well manicured."			
	The director of nurs	THOD OF CORRECTION: sing could monitor personal esidents to determine eds, educate staff, and unce.			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One			
2 930	MN Rule 4658.052 Nasogastric, Gastro	5 Subp. 7 B. Rehab - ostomy tubes	2 930		3/11/15
	and feeding syringes. Based o	ric tubes, gastrostomy tubes, on the comprehensive resident sing home must ensure that:			
	gastrostomy tube o appropriate treatme aspiration pneumor dehydration, metab	who is fed by a nasogastric or or feeding syringe receives the ent and services to prevent nia, diarrhea, vomiting, polic abnormalities, and lcers and to restore, if eding function.			
	by: Based on observat	ent is not met as evidenced ion, interview and document did not ensure medication		See Federal Regulation responses	3

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00916	B. WING		01/	30/2015
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	MANOR NURSING AN	ID REHAR LLC	TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 930	Continued From pa	age 62	2 930			
		gastric tube was followed for 1 observed for medication ugh gastric tube.				
	Findings include:					
	that R69 was admir Diagnosis section of diagnoses to includ cerebrovascular dis ability to communic damage); chronic k and prostate proble	sease; dysphasia (impaired cate due to brain injury or kidney disease; hypertension				
] with 60 cc [cubic centimeters ter and 5 cc H2O [water]]			
	have an ongoing fe (g-tube). R69 gave observe registered medications throug observed to stop th then secured the tij intravenous (IV) po Asepto syringe (a t bulb-fitted, blunt-tip medication from a pushed it through th however; RN-D did water before the in	8 a.m., R69 was observed to beding through the gastric tube permission for surveyor to nurse (RN)-D administer th R69's g-tube. RN-D was be ongoing tube feeding, and p of the tubing in the le. RN-D immediately took the rademark for a large oped syringe), drew the first mini plastic medication cup, he g-tube, then stopped I not flush the g-tube with 60 co itial medication was sh the food from the tubing.				
		2 a.m. RN-D verified she did with water before giving the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		00916	B. WING		01/30/2015
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	
	MANOR NURSING AN	ID REHAR IIC	H STREET NO TER, MN 559		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
2 930	Continued From pa	age 63	2 930		
	Medication via a Pe Gastrostomy (PEG directed staff to foll giving medication t include flushing wit before and then 30	dure for the Administration of ercutaneous Endoscopic) Tube policy dated 7/24/08, ow the "standard procedure" in hrough gastrostomy tube to h 30 milliliters (ml) of water ml of water after medication e physician specifically ordered policy.			
	The DON can inset tube feedings medi accepted current p for compliance.	THOD OF CORRECTION: rvice all staff responsible for ication administration to use ractices. Also to monitor staff			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one			
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965		3/11/15
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident stitutes of similar nutritive value residents who refuse food			
	by: Based on observat review, the facility f ongoing nutritional and accurate weigh	ent is not met as evidenced ion, interview and document ailed to ensure accurate and reassessments and consistent nts were provided to determine ight loss for 3 of 4 residents		See Federal Regulation responses	

	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00916	B. WING		01/	30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1	
	MANOR NURSING AN		H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 965	Continued From pa	age 64	2 965			
	(R38, R96, and R3 nutrition concerns.	2) in the sample reviewed for				
	Findings include:					
	intake and also lac	rect diet and monitoring of ked ongoing monitoring for oss and nutritional assessment				
	independently. She had eaten less that interviewed on 1/26 on a fluid restriction	on 1/26/15 at 5:20 p.m. eating e left the table at 5:35 p.m. and n 25% of the meal. R38 was 6/15 at 6:11 p.m. and she was n and was sure she had dietary eded to talk to a dietician to estrictions were.				
	on 12/16/14 accord summary which no colon that resulted prescribed diet of g summary dated 12 had been readmitte respiratory failure, hypophosphatemia	to the facility from the hospital ding to the hospital discharge ted R38 had a perforated in a colostomy and had a general diet. Hospital dismissa /30/14 indicated the resident ed to the hospital with acute hyponatremia, a, hypomagnesaemia and he diet prescribed was general				
	noted R38 had exp hyponatremia. Th	arge summary dated 1/9/15 perienced volume depletion and e prescribed diet was changed grams (ml) sodium, low w fat.				
	to monitor weights, However, an admis	ers of 12/30/14 noted continue blood pressures, and pulse. ssion weight was not obtained. t of 12/28/14 was 161 pound				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00916	B. WING		01/30/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
	MANOR NURSING AN	ID REHAR LLC	TH STREET NO STER, MN 559			
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC	TION SHOULD BE	(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC		DATE
2 965	Continued From pa	age 65	2 965			
		the temporary care plan dated eight of 141 pounds, or 20 nt loss.				
	assessment on 12/ diet and to monitor	ician completed an /17/14 that indicated a regular initial intake. Weight loss not ody weight 135-165 pounds and pounds.	k			
	general diet, boost	ry care area assessment noted nutritional supplement twice a es and a weight of 163				
	was completed by (CDM) and include other changes. R3 noted no significan	mission nutritional assessment the certified dietary manager d a no added salt diet with any 88 weight was 139 pounds and t weight changes (significant is 14% weight loss in one				
	a no added salt die include the physicia	re noted a fluid restriction and et. The tray card did not an orders (1/9/15 hospital -2000 mg sodium, low fat, low				
	administer 2 ounce medication pass du wound, and meal in physician order of (240 cc) twice a da	1/14/15 noted staff were to es of dietary supplement 2.0 at ue to weight loss, stage II ntake of less than 50%. The 12/13/14 also included boost by. The facility continued to y were offering both the 2.0 and				
	boost, but the med did not indicate the supplements taken	percentage of these two by R38. Licensed practical interviewed on 1/29/15 at				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		01/	30/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
	IANOR NURSING AN		H STREET NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	age 66	2 965			
	to Ensure (2.0) so during the medicat a.m. registered nur regarding documer supplement intake documented if R38 not the amount tak The meal intake fo was reviewed and sporadically this wa monitoring for 1/14	ed the boost had been changed R38 would receive the Ensure ion pass. On 1/29/15 at 10:10 rse (RN)-A was interviewed ntation of nutritional and stated that nursing only refused the supplement and en during the medication pass. r 12/16/14 through 1/26/15 the intake was documented as found for the fluid intake /15 to 1/26/15. Also none of s totaled to determine if intake R38.				
	and included a diet intervention of gen 1/12/15 included in and a 2000 cc (cub During an interview director of nursing	rinted 1/27/15 was reviewed t plan dated 12/22/14 with an eral diet. Care plan dated tervention of no added salt die pic centimeter) fluid restriction. y on 1/2/15 at 4:25 p.m. the (DON) verified the care plan orders for R38's diet.	t			
	were interviewed o both stated the nur to document the in dietary were to revi they were aware th	RN-A) and director of nursing n 1/28/15 at 8:00 a.m. They rsing assistant was responsible take and that nursing and iew the totals. They stated hat this was not being done at th were aware the weights he as ordered.				
	interviewed on 1/28 that R38 was not o was to be watching would look only at t	y manage (CDM) was 3/15 at 8:10 a.m. CDM stated n his list of residents that he g weight on. CDM stated he the weights that were in the and that he was aware that the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00916	B. WING		01/30/2015	
AME OF PRO	VIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	1	
APLE MAN	NOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
The action of th	e registered dietid dmissions, annual sident with a sign ne RD was intervi- nd stated she was ere an issue in th ceived a cardiac et only. RD state nd annual reasses weight listings w as any resident s as aware that inta- nd she was unsur- eing taken by staf uring an interview m. CDM stated th 6 grams (4000 to prified that exceed 500-2000 milligra terview on 1/29/1 e general diet was t/low cholesterol. erved the regular naker is given.	eing done. CDM would have cian (RD) assess new I reassessments, and any hificant weight loss. iewed on 1/28/15 at 8:35 a.m. is aware that taking of weights e facility. RD stated that R38 diet which was a low sodium ed she would see admissions ssment residents and did look ith each visit to see if there he should see. RD stated she ake was not being monitored re of the accuracy for weights	t			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
	MANOR NURSING AN		H STREET NO				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 965	Continued From pa	age 68	2 965				
	monitoring of intake monitoring of intervi- weight loss having and nutritional asse R96 was observed 1/25/15. She had r regular portions. R receive smaller por gastric bypass. RS 5:15 p.m. stating th today had had lost admission. On 1/2	rect diet also lacked consistent e and also lacked ongoing ventions to prevent further had a significant weight loss essment for needs. to eat lunch in her room on received a regular meal with 896 stated that she was to tions because she had had a 96 was observed on 1/26/15 at hat she had been weighed about 10 pounds since 7/15 at 8:30 a.m. R96 was acon and waffles for breakfast.					
	She stated that she since she gets it at had had a gastric b smaller portions. T meal serving and a Review of the diet of small portions. Du 9:15 a.m. R96 state scalloped potatoes cucumbers and son said that was a lot of high calories and h sugar readings from	ed on 1/26/15 at 11:50 a.m. e was tired of canned fruit every meal. She stated she py-pass and should receive oday she had a full portion tte less than 50% of the meal. card on her tray did not noted ring an interview on 1/30/15 at ed that last night she had with ham, creamed mething else (bread). R96 of carbs (carbohydrates) with as been having high blood m the increase in spared to when she lived at					
	and day of admissi had diagnoses of p hyperlipidemia, hyp and anemia. Orde	essal summary dated 12/2/14 on to the home identified R96 post renal transplant, pertension, hypothyroidism, rs for continuing care read, ment, check blood sugars c diet."					

STATEMEN	ta Department of Here T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		01/	30/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
	ANOR NURSING AN		H STREET NO TER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 965	Continued From pa	age 69	2 965			
	1/30/15 was review blood glucose rang of noon blood gluc the afternoon blood 388, and the bedtin 288. On 1/20/15 th scale insulin. American diabetes range as follows: Fasting (before me mg/dL (3.9-7.2 mm Postprandial (1-2 h greater than 180 m be higher dependin The RD completed 12/3/14. The asses history of gastric by transplant, but not listed no laboratory weight of 117 to 14 calorie or carbohyd did identify the resid related to a gastric the need for a diab assessment listed same as the hospin 12/2/14). The dietary care an	v Sheet from 1/1/15 through ved. Readings for morning ged from 81 to 154; the range ose readings was 118 to 301, d glucose ranged from 113 to ne glucose range from 96 to ne physician ordered sliding recommends blood sugars eals; upon waking):70-130 nol/L) nours after the start of a meal): ng/dL (10.0 mmol/L) which may ng on each resident and doctor. I a nutritional assessment on assment listed a diagnosis ypass, history of a kidney of diabetes. The assessment values, listed an ideal body 3 pounds, but no estimated drate need. The assessment dent received insulin for gars. The assessment ent would eat small amounts bypass, but did not indicate vetic diet. The nutritional the weight at 146 pounds (the tal discharge summary dated rea assessment dated 12/15/14				
		etic no sugar added diet per				
		ng assistants (CAN) Entry the facility was reviewed for				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
AME OF F	PROVIDER OR SUPPLIEF		DDRESS, CITY, ST	TATE, ZIP CODE			
	IANOR NURSING A		TH STREET NO STER, MN 559	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE	
2 965	Continued From p	age 70	2 965				
		2/3/14 through 1/26/14. R96 's documented sporadically and	S				
	weight form read, surveyor request t 1/26/15 and had a	weight documented on the " 157 pounds. " At the he resident was weighed on weight of 147 pounds or a pounds or 6.4% from 12/2/14 to					
	need for a therape	dated 12/15/14 indicated the eutic diet and had interventions ic no added sugar diet.					
	He stated that adm deferred for a cour admitted from hos overload and there stated he did not k	wed on 1/27/15 at 8:20 a.m. nission weight were being ple weeks since residents pitals frequently had a fluid efore showed a weight loss. He snow why the weights were not s ordered by the physician.					
	8:00 a.m. Both sta were to record foo to review the total consistent weights	ere interviewed on 1/28/15 at ated that nursing assistants d intake and that nursing was consumed. When asked about being taken both RN-A and re aware of lack of weights or residents.					
	She stated she wa recording weights they were not done was nursing's resp information on the changes were need interviewed on 1/2	viewed on 1/28/15 at 8:35 a.m. as aware that taking and was an ongoing problem as e as required. She stated that bonsibility to obtain the correct diets and inform dietary if eded. The RD was again 18/15 and was aware R96 had reduce weight and the	it				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE			
	MANOR NURSING AN		TH STREET NO STER, MN 5590				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 965	Continued From pa	age 71	2 965				
	offered vs. larger th that weight loss wa know R96 lost any The nurse practitio 1/30/15 at 9:00 a.m was not appropriate been complaining of afternoon and wou closeness of the br no change was dor need for smaller m The facility policy d	d of small frequent meals nree meals per day. RD felt s expected but that she did no weight since admission. ner (NP)-A was interviewed on n. NP-A stated a regular diet e for R96. The resident had of high blood sugars in the ld complain about the eakfast and lunch meal. But ne to accommodate R96 ' s ore frequent meals. ated 6/7/13 regarding					
	is the policy of Map residents are weigh on each resident a Residents are to be	nts was reviewed and read, "It ble Manor to ensure that hed and a weight record is kep nd monitored routinely." e weighed within 3 days of reafter as ordered by the ast monthly.					
	days, declined in easessment was	oss of 9.6 pounds in thirty ating meals, however, no completed to assess weight interventions to prevent more					
	1/9/15 indicated wa impaired with diagr incontinent of bowe assist with activities toileting, transfers, R32's physician's n the diagnoses of Le mellitus, and const R32's most recent	nimum Data Set (MDS) dated as moderately cognitively noses of dementia, always el, and required extensive s of daily living (eating, dressing and hygiene). ote dated 12/16/14 included ewy body dementia, diabetes ipation. care plan provided by the ncluded R32 has had a					

TATEMENT OF DEFICIEN ND PLAN OF CORRECTIO	ES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00916	B. WING		01/30/2015	
AME OF PROVIDER OR S		ET ADDRESS, CITY, ST			30/2013
	1875	19TH STREET NO			
	NG AND REHAR ITC	HESTER, MN 559			
PREFIX (EACH D	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL AY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 965 Continued	om page 72	2 965			
diet with so liquids. Car the dining r assisted to proper tech therapy (ST also instruc- meals or a plate and p R32's phys the followin constipation three times Miralax 17 (original ord solution 30 (original ord solution 30 (original ord solution 30 (original ord orders also by mouth a R32's dieta reviewed: r independer difficulty wit not eat a lo indicated R to mechani related to c to monitor i R32 eats 5 and swallow last 30 days pudding at Dietary ass indicated R months and on foot and staff to mor	eight loss, had a mechanically alter textures and nectar thickened plan instructed staff to bring R32 or and sit at supervised table and at as needed and staff to prompt que of swallowing per speech recommendations. The care plan d staff to provide a scoop plate a nallow bowl if unable to use a sco vide double portions at meal time an orders dated 12/16/14 include medication orders to treat Senna-S tablet 2 tabs by mouth aily (original order date of 4/16/08 ams by mouth two times daily r date of 4/30/09), and Sorbitol 70 illiliters (ml) by mouth one time d r dater of 1/21/09). Physician's necluded Seroquel 25 milligrams (r noon and 37.5 mg at 6:00 p.m. assessment progress notes wer te on 8/5/14 indicated R32 was with eating, weight is stable, no swallowing or chewing, and does or lunch or dinner. Note on 9/3/14 2 switched from regular texture for ally soft and nectar thickened liqui aghing during meals and staff wei ake. Note from 10/24/14 indicate 75% of meal, had difficulty chewin ng, had a 4.8% weight loss in the or 9.5 pounds, and R32 was offer nch and supper for weight gain. assment note written on 11/19/14 2 had a weight loss of 7.3% in 6 ead, "However, resident has a br reight may/may not include brace or weight, intake, notify certified ger, registered dietician."	to d is in t all op es. ed 3), 0% aily mg) e s 4 ods ds re d ng ed ace			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00916	B. WING		01/30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO			
		ROCHES	STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 965	Continued From pa	age 73	2 965			
	and noted an overa or 10.3% of body w Dietary assessment assessment and ev failed to address in maintain or regain R32's meal intake of through 1/26/15 did meals. Based on d consumed an avera meal, 51-75% of no evening meal. Cald been consumed fo Physician visit note of R32's behaviors Physician visit note dietary assessmen weight loss in 30 di weight loss and rea challenge " Physician visit note 's appetite was fait meals " under beh mention of the 7.39 R32 was treated by through 9/6/14 for r in texture of diet re and improving abili discharge R32 spe required verbal cue swallowing and R3 function. R32's dining room communicate dieta included the instruct breakfast and prov During observation on 1/26/15. Nursing	nts lacked a comprehensive valuation of weight loss and terventions that would weight. documentation from 1/1/15 d not show meal intake for 32 ocumented meal intake R32 age of 51-75% of breakfast con meal, and 26-50% for pries consumed or what had r meals was not tracked. e dated 8/14/14 identified one as "refuses meals." e dated 10/28/14 (visit after t had identified a 9.5 pound ays) had no mention of the ad " No other active new e dated 12/16/14 indicated R32 r, however listed " refuses aviors. The note had no % weight loss in 6 months. y speech therapy from 8/5/14 recommendations for change lated difficulty masticating food ty to swallow fluids safely. On ech therapy indicated resident es from staff for safe 2 would not regain swallowing tray card (card used to try information to staff) ction to give double portions at	1			

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		00/2013	
	MANOR NURSING AN		H STREET NO				
(X4) ID	SUMMARY STA		ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLE DATE	
2 965	Continued From pa	age 74	2 965				
	lap until NA-0 gave the end of the mea of pudding indepen of food R32 took in meal. When R32 w table, 75% of food did not ask R32 if h R32 from table. During an observat R32 was brought o single sized portion bowl was used duri feeding assistant (f R32 had a difficult t It was observed R3 until he was given a not give verbal cue to promote ease of attempt to eat indep During an interview NA-N explained R3 eating. NA-N stated adaptive equipmen During an interview NA-O stated, " Sor sometimes he does next to him the entit meal." During an interview certified dietary ma received double po ate more at breakfa averaged the range nursing assistant d	R32, he sat with arms folded in another bite of food. Toward I at 5:38 p.m. R32 took a bite idently. This was the only bite dependently throughout the vas moved from the dining remained on the plate. NA-O ne was done eating just moved tion on 1/28/15 at 8:50 a.m. ut to breakfast and was served is. No scoop plate or shallow ing the meal. At 8:31 a.m. FA)-A assisted R32 with eating time chewing hardboiled egg. B2 could not swallow the egg a bite of hot cereal. FA-A did s on use swallowing technique swallowing. R32 did not pendently during the meal. <i>y</i> on 1/27/15, at 2:19 p.m. B2 required assistance with d, "He does not require any t or special dining needs." <i>y</i> on 1/27/15, at 2:23 p.m. metimes he eats and sn't, somebody needs to sit ire time during the whole <i>y</i> on 1/27/15, at 2:25 p.m. nurse (LPN)-D stated, "75% of to be fed. Aide staff should be cimity" <i>y</i> on 1/27/15, at 2:30 p.m. mager (CDM) explained R32 writons at breakfast because he ast. CDM also explained he e of meal intakes from the ocumentation, and there was hat identified exactly how much					

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00916	 В. WING		01/	01/30/2015	
AME OF PRO	OVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		00/2010	
IAPLE MA	NOR NURSING AN		H STREET NO TER, MN 5590				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE	
2 965 C	ontinued From pa	age 75	2 965				
th sir slod w D d e n h fi o th c a a D reb n e D s h a sre h S T o re th w	the resident had not upplement yet and volved in address upplements. CDM oss because of rec- etermination had f thy he was losing puring an interview irector of nursing xpectation would f ext to R32 during e is eating and sw urther explained w hange of condition ause (medication, ssistants, food tex- nd possibly get sp puring an interview egistered dietician een evaluated from eeds more assistant in he would eat o form he would eat o lowed staff to fee he was not aware eferral had not been is swallowing/eatin UGGESTED MET he RD and director urrent policies and esidents who expen- neir nutritional nee	v on 1/27/15, at 3:01 p.m. (DON) explained her be someone should be sitting the entire meal to ensure that vallowing correctly. DON when there is a decline or n, nursing should confer with her, try to identify the root , environment, need for kture versus disease process), beech therapy involved. v on 1/28/15, at 7:35 a.m. (RD) stated, "R32 has not m a dietary standpoint if he ance at meals and ot been evaluated." v on 1/28/15, at 9:22 a.m. SP)-M stated, "When we saw only 25% of his food then d him up to 75%." SP-M said R32 had weight loss and a en made for her to reevaluate ng status. THOD OF CORRECTION: or of nursing could review d procedures regarding erienced weight loss to ensure eds met and the changes in zed in a timely manner. The					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3	DATE SURVEY COMPLETED
		00916	B. WING		01/30/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
	MANOR NURSING AN	ID REHAB. LLC	H STREET N FER, MN 55	ORTHWEST 901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 965	Continued From pa	ge 76	2 965		
		could be done. The results of brought to the quality w.			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
21080	MN Rule 4658.065 Clean,free from spo	0 Subp. 1 Food Supplies; pilage	21080		3/11/15
	wholesome, free free adulteration and mi human consumptio which has been pr	All food must be clean, om spoilage, free from sbranding, and safe for n. Canned or preserved food ocessed in a place other than processing establishment is by nursing homes.			
	by: Based on observati kitchen tour the fac refrigerated foods h removed from serv that appear they ha	ent is not met as evidenced ion and interview, during the ility failed to identify when have expired and should be ice and to remove fresh foods we lost their freshness. This affect most residents in the		See Federal Regulation responses	
	Findings include:				
	was guided by head the walk in cooler re romaine lettuce with lettuce. The bag ha The head cook veri and stated, "We thr	bur on 1/25/15, at 10:11 a.m. d cook (HC)-A. Observation of evealed an open bag of h several brown pieces of d a "use by date" of 1/24/15. fied the lettuce was out of date row out food that is past the then proceeded to toss the			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00916	B. WING		01/30/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21080	pasteurized eggs th in a reach in cooler absence of date an bags should be dat Facility policy Gene Handling read, "For swollen cans, or for or odor will not be s Facility policy Food be dated as it is pla marking to indicate	r revealed 2 bags of liquid nat were not labeled or dated . The Head cook verified the id label and commented the ed and labeled. eral Food preparation and od in broken packages or od with abnormal appearance	21080			
	consumed, sold or high risk foodsa labeled, and dated. SUGGESTED MET The dietary manag develop and impler train staff, assure for reduce spoilage an by the best used da systems to ensure	discarded will be visible on Il foods should be covered,				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21375	Program Subpart 1. Infection home must establis	0 Subp. 1 Infection Control; on control program. A nursing sh and maintain an infection signed to provide a safe and nt.	21375			3/11/15

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		00916	B. WING		01/30/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
	MANOR NURSING A		H STREET N TER, MN 55	IORTHWEST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE
21375	Continued From pa	age 78	21375		
	by: Based on interview failed to develop prinfection control prinfections identificate maintain an infection included ongoing se analyzing and trend residents (R16, R6) reviewed for having (UTIs). The lack of effective infection program has the presidents currently	his MN Requirement is not met as evidenced		See Federal Regulation responses	
	-	IPTOMS IDENTIFIED:			
	R16, R6, R70, R30 facility as having fa), R69 were identified by the acility acquired urinary tract t lacked identification of			
	to have a urinary tr Review of the inter	the infection control (IC) logs act infection (UTI) on 10/17/14 disciplinary team notes (IDT) /14 noted no signs or I documented.			
	10/27/14 and 12/10	ne IC log to have a UTI on 0/14. Review of the IDT notes noted no signs and symptoms			
	9/29/14. The IDT	the IC log to have a UTI on notes were reviewed and no signs and symptoms of the			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00916	B. WING		01/	30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	IANOR NURSING AI		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 79	21375			
	infection were four	nd.				
	10/15/14, 11/7/14, were reviewed and and symptoms of U R69 was noted or 10/7/14, 10/31/14, IDT notes were rev of signs and symp On 1/27/15 at 2:00 provided by the dir included 1) Chroni dated 5/2/12 and 2 Residents dated 4, direct staff to evalu	the IC log to have a UTI on 11/9/14, and 11/18/14. The viewed and lacked identification toms of UTI. 9 p.m. UTI policies were ector of nursing. The policies c Urinary Tract Infection Policy 2) Prevention of UTIs at Risk /3/12. The policies did not uate the risk for developing include signs and symptoms of				
	1/28/15 at 9:40 a.n that listed the crite policy/directions re had been develope	(RN)-A was interviewed on n. RN-A stated he had a form ria for infections, but that no elated to completing the form ed. RN-A stated nursing was to ria for infections observed in	5			
	nursing (DON) wer indicated the facilit or UTI criteria avai document from as did not have a poli	0 a.m. RN-A and the director of re interviewed. They both by did not have a list of infection lable to staff to use and a tool. They stated the facility cy/procedure on the inary tract infections.	1			
		SIS AND SURVEILLANCE OF PREVENT THE SPREAD OF				

	ta Department of H T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		01/	30/2015
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	ANOR NURSING A		TH STREET NO			
		ROCHES	STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	age 80	21375			
	 Continued From page 80 On 1/26/15 at 2:00 p.m. licensed practical nurse (LPN)-C stated she reviewed the resident identified infections at the end of the month, but had not yet reviewed the December 2014 infections. LPN-C stated she had been working on the floor and that was how she knew who had an infection. LPN-C stated in December, 5 of 6 residents with upper respiratory infections had tested positive for influenza and so the building was quarantined. LPN-C stated she had not completed a line listing on the residents that were sick to see if a trend had developed. However, timely analysis of infections in December 2014 would have allowed corrective actions such as staff education to prevent the spread of infections to other residents and staff. The surveillance log for December 2014 was 		9			
	provided when LPI record keeping on	N-C had just completed the 1/26/15 at 6:30 p.m. Also ad not started to complete the				
	indicated LPN -C h Infections preventi as coordinator of t control program).	p.m. the director of nursing had been designated as the onist (This person will serves he infection preventions and DON continued to say there information related to ed.				
	The director of nur employees respon program to include	THOD OF CORRECTION: sing could in-service sible for infection control tracking, evaluating, event the spread of infection.				
	TIME PERIOD FO (21) days. epartment of Health	R CORRECTION: Twenty One)			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		00916	B. WING		01/30/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE	
	MANOR NURSING AN	D REHABILIC 1875 19TH	I STREET NO	DRTHWEST	
		ROCHEST	ER, MN 559	01	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21530	MN Rule 4658.1310) A.B.C Drug Regimen Review	21530		3/11/15
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Finance This standard is ind available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the ad report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to t if the medical direct physician for the ophysician does not must be referred fo assessment and as by part 4658.0070. the medical director must refer the matter	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports to by the time of the next boner, if indicated by the rposes of this part, "acted cceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur 's recommendation, or does te justification, and the s the resident's quality of life is ected, the pharmacist must he medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter r review to the quality surance committee required If the attending physician is or, the consulting pharmacist er directly to the quality surance committee.			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE	1		
	MANOR NURSING AN		TH STREET N STER, MN 55	IORTHWEST 901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC) CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLET DATE	
21530	Continued From pa	ige 82	21530				
	by: Based on observat review, the facility f irregularities identif pharmacist were ad	ent is not met as evidenced ion, interview and document ailed to ensure medication ied by the consultant ddressed in a timely manner (R39, R68 and R32) reviewed edications.		See Federal Regulation re	sponses		
	Findings include:						
	on 1/7/2015 and R3 antipsychotic daily	entified that R39 was admitted 39 received Seroquel an without having a base line side t completed per the nendation.					
	1/7/15 identified R3 mild dementia, chro heart failure, atrial f history of transient diabetes mellitus, ty retinopathy, anxiety of probable Bonnet	mary from the hospital dated 9 had diagnoses to include onic left ventricular diastolic fibrillation, hypertension, ischemic attack (TIA), ype 2 with diabetic proliferative v and depression and history Syndrome (a condition amony ost their sight. It causes visual	g				
	1/14/15 indicated th	imum Data Set (MDS) dated hat R39 had a Brief Interview BIMS) score of 13, which y intact.					
		sician orders dated 1/29/15 was receiving Seroquel 50 mg / (an anti-psychotic					

1011111620	ta Department of He	<u>ealth</u>				APPROVE	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
			A. BUILDING.				
		00916	B. WING		01/3	/30/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	MANOR NURSING AN		TH STREET NO				
		ROCHES	STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21530	Continued From pa	age 83	21530				
	The consultant phareview dated 1/16/ recently admitted of dementia-related b baseline AIMS (abustication) scale) exam has but to assess for tardive neurological disord caused by long terr It is recommended this exam be assest antipsychotic media and at least every of the medication. During an interview p.m., the resident i medications (Seroo but did not know ho	armacist s medication regimen 15 identified that R39 was on Seroquel for management o behaviors. Please ensure a normal involuntary movement een completed on this resident ve dyskinesia side effects (a ler of involuntary movements m use of antipsychotic drugs). and a standard of care that ssed before initiation of an cation (or upon admission with 6 months thereafter while on v with R39 on 1/29/15 at 2:15 ndicated she was aware of the quel) that she was receiving ow long she had been taking d R39 had a slight tremor	f)				
	(RN)-Å on 1/29/15 R39 should have h the first MDS asse on 1/14/15). During an interview	v with the registered nurse at 1:41 p.m., RN-A stated that ad an AIMS completed before ssment (which was completed v with the director of nurses					
	(DON) on 1/29/15 the resident had no	at 1:40 p.m., the DON stated ot had an AIMS completed.					
	that an AIMS form	S, dated 6/3/03, instructed staff would be filled out on new and any resident on the following: nedication.					
	(Seroquel) and was side effects.	ntipsychotic medication s not monitored for possible					
nesota De	epartment of Health M		6899 30	QEK11	1	n sheet 84 of	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00916	B. WING		01/30/2015	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	ANOR NURSING A		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 84	21530			
	room and seated of not protest when n suggested to braid handshake with su you" pleasantly to with the braided ha pushed R68 out fro room for breakfast	4 a.m. R68 was observed in calmly in wheelchair. R68 did ursing assistant (NA)-B R68's hair. R68 had a firm irveyor and R68 stated, "Thank compliment about looking nice air. R68 smiled as NA-B om room toward the dining 				
	saw R68 have unw said she had not o	vanted behaviors and NA-C bserved R68 manifesting or delusions or hallucinations.				
	redirect any reside denied having obs hallucinations from	p.m. NA-B stated she would nt manifesting a behavior but erved any delusions or n R68. NA-C was not aware nitored for delusions or				
	enumerated R68's yelling, making noi RN-C stated nurse notes when target effects of medicati documentation wa nurses do not chee even with the use there was no doctor	p.m. registered nurse (RN)-C target behaviors as "angry, se, does not like everybody." swill document in the progress behaviors and/or possible side ons occur, otherwise no s needed. RN-C stated that ck orthostatic blood pressures of anti-psychotic medications if or's order. RN-C did not B's hallucinations and delusions				
	behaviors include "delusions about s	p.m. RN-A stated R68's target making accusations, also had taff who were doing [R68] were a bunch of lesbians				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00916	B. WING		01/30/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	ANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21530	Continued From pa	age 85	21530			
	the specific target I not written in behaves stated nurses will of When asked if side medications were I "Probably not beca monitor." When as answered, "The pro- DON [director of nu- has not been moni- the antipsychotic m- retention, orthostat sure if Abnormal In (AIMS - a tool used anti-psychotic med R68.	ntage of [R68]." RN-A verified behaviors he mentioned were vior monitoring sheet. RN-A chart if the behaviors occur. e effects of psychotropic being monitored, RN-A replied, suse they said no need to ked who "They" were, RN-A evious owner and the previous ursing]." RN-A confirmed staff toring R68 for side effects of nedications such as urinary tic hypotension, and was not ivoluntary Movement Scale d to monitor for side effects of lications) was completed for				
	for 1/1/15 through including psychosis anxiety state and u indicated R68 was 6.25 milligram (mg 12.5 mg every afte	Administration Record (MAR) 1/31/15, listed R68's diagnoses s, dementia, depression, irinary retention. The MAR also on Seroquel (an antipsychotic)) every morning and Seroquel rnoon; Remeron 5 mg during hours of sleep.	,			
	risk for falls related use. Interventions orders. However, s medications in rela	ed 1/27/14 indicated R68 was a to psychotropic medication include giving medications per side effects of psychotropic tion to falls were not identified ifically planned to be	t			
	symptoms of "som about [R68] and is included "nurse to	ted 4/24/14, identified behavior e paranoia of people talking easily angered." Approaches administer medications as or possible side effects." The	ſ			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00916	B. WING		01/30/2015	
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
	IANOR NURSING AN		H STREET NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 86	21530			
	resident-specific ta identify specific sid medications to be a On 1/29/15, at 1:25 pharmacist (CP) st effects of any med CP agreed orthosta should be complete developed while or On 1/29/15 at 1:28 unable to locate an p.m. the director of was no record on f	5 p.m. the consultant cated his expectations that side ications should be monitored. atic blood pressure and AIMS ed to determine if side effects anti-psychotic medications. p.m. RN-E stated they were AIMS assessment. At 1:43 in ursing (DON) verified there ile to show AIMS was within the last year even t had received the				
	Medications policy monitor drugs for s monitoring for gait disorders, signs of effects such as dry The policy further of baseline AIMS and three months for the medications. R32 received three was no physician ju	of Psychotherapeutic dated 4/11/08, directed staff to side effects daily, to include disorders, movement hypotension, and cholinergic mouth and urinary retention. directed staff to assess for to do reassessment every he use of antipsychotic				
	dose of Miralax. R32's physician's r the diagnoses of L mellitus, and const R32's physician or	and exceeded recommended note dated 12/16/14 included ewy body dementia, diabetes ipation. ders dated 12/16/14 included cation orders to treat				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING	B. WING		01/30/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	MANOR NURSING AN	ID REHAR LIC	TH STREET NO STER, MN 559				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE	
21530	Continued From pa	age 87	21530				
	(original order date solution 30 milliliter (original order date The dose of Mirala recommended dos manufacturers labe dose was 17 grams The directions indic days and instructed directed unless dire there was no justifie the recommended the 7th day. R32's bowel mover reviewed. Bowel m found in two differe and electronic med was found to be ind formats. Document had more than one of documentation la formed, hard, etc.) large) of BMs and t consistency of BMs would make it diffic	x ordered exceeds the daily					
	that justified the ne bowel regime (poly last addressed on A	's assessment and evaluation ed for three medications for pharmacy) medication was April 30, 2009. The d, "does not tolerate					
	suppositoriesand does have very I suppositories and i bowel movement for	d will become angry at times arge bowel movements with f not given he may not have a br up to 5 or 6 days. Physician iewed did not indicate rationale					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		01/30/2015	
						30/2015
	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ T H STREET NC			
MAPLE	MANOR NURSING AN		STER, MN 559			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
21530	Continued From pa	age 88	21530			
	Miralax recommender R32's quarterly Min 1/9/15 indicated way impaired with diagr incontinent of bower assist with activities transfers, dressing R32's care plan did history of constipati interventions to pro as increased fluids, increased activity, r habits, use of toilet During an interview registered nurse (F aware of specific re- different bowel med know why the dose recommended. RN an assessment or p use of the three boy During an interview consulting pharmace has a diagnoses th recommended dos care planned and th note the reasons for then monitor routing During an interview nurse practitioner (medication should After informing NP medication and dai SUGGESTED MET The administrator, consulting pharmace policies and proced medication usage a	aimum Data Set (MDS) dated as moderately cognitively noses of dementia, always el, and required extensive s of daily living (toileting, and hygiene). I not address constipation or ion or non-pharmacological mote bowel movements such , adding roughage to diet, maintaining routine daily bowel or commode, etc. or on 1/27/15, at 2:05 p.m. RN)-A indicated he was not easons why R32 had 3 dications. RN-A also did not of Miralax was higher than -A stated he was not aware of ohysicians recent justified for wel medications. or on 1/27/15, at 3:34 p.m. cist (CP) stated if a resident at required more than a e of medication it should be he physician to address or or the increased amount and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00916	B. WING		01/30/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN	ID REHAB. LLC	H STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMP	
21530	Continued From pa	age 89	21530			
	designee could mo	sary. The director of nursing o nitor medications on a regular npliance with state and federa				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				
21535	MN Rule4658.1315 Drug Usage; Gene	Subp.1 ABCD Unnecessary ral	21535		3/11/1	
	must be free from t unnecessary drug i A. in excessive therapy; B. for excessive D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finano This standard is ind available through th	quate indications for its use; or ince of adverse consequences dose should be reduced or lrug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for acilities, published by the lith and Human Services, corporated by reference. It is ne Minitex interlibrary loan tte Law Library. It is not				
	by:	ent is not met as evidenced ion, interview and document		See Federal Regulation respons	95	

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00916	B. WING		01/30/2015	
AME OF PROVIDER OR SUPP	JER STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
APLE MANOR NURSING	AND REHABILIC	TH STREET NO STER, MN 559			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535 Continued From	n page 90	21535			
effects monitor assessment to use of psychotic residents (R68 antipsychotic m ongoing bowel medications or as to why they (R32) reviewed Findings includ R68 received a (Seroquel) and side effects. On 1/28/15, at room and seate not protest whe suggested to b handshake with you" pleasantly with the braidee pushed R68 ou room for break	n antipsychotic medication was not monitored for possible 3:14 a.m. R68 was observed in ed calmly in wheelchair. R68 did n nursing assistant (NA)-B raid R68's hair. R68 had a firm o surveyor and R68 stated, "Thank to compliment about looking nice d hair. R68 smiled as NA-B t from room toward the dining fast.				
saw R68 have said she had n	:49 p.m. NA-C was asked if she unwanted behaviors and NA-C ot observed R68 manifesting iors or delusions or hallucinations.				
redirect any res denied having hallucinations f	:52 p.m. NA-B stated she would ident manifesting a behavior but observed any delusions or rom R68. NA-C was not aware monitored for delusions or				
On 1/28/15 at 2 nesota Department of Health	:08 p.m. registered nurse (RN)-C				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00916	B. WING		01/30/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	1	
	ANOR NURSING AN		H STREET NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
21535	Continued From pa	age 91	21535			
	yelling, making nois RN-C stated nurse notes when target effects of medicatio documentation was nurses do not cheo even with the use of there was no doctor mention about R68 being monitored. On 1/28/15 at 4:02 behaviors include r "delusions about st catheterization on trying to take advant the specific target I not written in behave stated nurses will of When asked if side medications were the "Probably not beca monitor." When as answered, "The pro DON [director of nu has not been monit the antipsychotic monitor if Abnormal In (AIMS - a tool used	target behaviors as "angry, se, does not like everybody." s will document in the progress behaviors and/or possible side ons occur, otherwise no s needed. RN-C stated that ck orthostatic blood pressures of anti-psychotic medications if or's order. RN-C did not 8's hallucinations and delusions p.m. RN-A stated R68's target making accusations, also had taff who were doing [R68] were a bunch of lesbians ntage of [R68]." RN-A verified behaviors he mentioned were vior monitoring sheet. RN-A chart if the behaviors occur. e effects of psychotropic being monitored, RN-A replied, use they said no need to ked who " They" were, RN-A evious owner and the previous ursing]." RN-A confirmed staff toring R68 for side effects of nedications such as urinary ic hypotension, and was not voluntary Movement Scale d to monitor for side effects of ications) was completed for				
	for 1/1/15 through including psychosis anxiety state and u indicated R68 was	Administration Record (MAR) 1/31/15, listed R68's diagnoses s, dementia, depression, rinary retention. The MAR also on Seroquel (an antipsychotic)) every morning and Seroquel				

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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	MANOR NURSING AN		H STREET NO			
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21535	Continued From pa	age 92	21535			
	12.5 mg every afte (antidepressant) 1	rnoon; Remeron 5 mg during hours of sleep.				
	risk for falls related use. Interventions orders. However, s medications in rela	d 1/27/14 indicated R68 was a d to psychotropic medication include giving medications per side effects of psychotropic tion to falls were not identified ifically planned to be	t			
	symptoms of "som about [R68] and is included "nurse to ordered and monit care plan did not g resident-specific ta	ted 4/24/14, identified behavior e paranoia of people talking easily angered." Approaches administer medications as or possible side effects." The ive directions on monitoring urget behavior and it did not le effects of psychotropic monitored.				
	pharmacist (CP) st effects of any med CP agreed orthost should be complete	5 p.m. the consultant rated his expectations that side ications should be monitored. atic blood pressure and AIMS ed to determine if side effects in anti-psychotic medications.				
	unable to locate ar p.m. the director of was no record on f					
	Medications policy monitor drugs for s	of Psychotherapeutic dated 4/11/08, directed staff to side effects daily, to include disorders, movement				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		E SURVEY PLETED
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NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		00/2010
	ANOR NURSING AN	ID REHABILIC				
(X4) ID	SUMMARY STA		ID ID	PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE
21535	Continued From pa	ige 93	21535			
	effects such as dry The policy further d baseline AIMS and three months for th medications. R32 received three was no physician ju bowel medications dose of Miralax. R32's physician's n the diagnoses of Le mellitus, and consti R32's physician ord the following medic constipation: Senna three times daily (o Miralax 17 grams b (original order date solution 30 milliliter (original order date The dose of Miralax recommended dose manufacturers labe dose was 17 grams The directions indic days and instructed there was no justifie the recommended the 7th day.	ders dated 12/16/14 included action orders to treat a-S tablet 2 tabs by mouth riginal order date of 4/16/08), by mouth two times daily of 4/30/09), and Sorbitol 70% s (ml) by mouth one time daily r of 1/21/09). x ordered exceeds the daily				
	reviewed. Bowel me found in two differe and electronic med was found to be inc	ovement documentation was nt formats; paper flow sheet ical record. Documentation consistent between the two				
nanata Da	had more than one	ation revealed R32 routinely BM daily. The electronic form acked consistency (soft,				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
AME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
	MANOR NURSING AN	1875 101	H STREET NO				
		ROCHES	TER, MN 559	01			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
21535	Continued From pa	age 94	21535				
	large) of BMs and t consistency of BMs would make it diffic medication was affe went daily. The last physician ' that justified the ne bowel regime (poly last addressed on A documentation read suppositoriesand does have very I suppositories and i bowel movement fo progress notes revi for prescribing mor Miralax recommend R32's quarterly Min 1/9/15 indicated wa impaired with diagr incontinent of bowe assist with activities transfers, dressing R32's care plan did history of constipati interventions to pro as increased fluids increased activity, r habits, use of toilet During an interview registered nurse (F aware of specific re different bowel med know why the dose recommended. RN an assessment or p use of the three bo During an interview	d, "does not tolerate d will become angry at times arge bowel movements with f not given he may not have a or up to 5 or 6 days. Physician iewed did not indicate rationale e than manufacturer's daily ded dose. himum Data Set (MDS) dated as moderately cognitively noses of dementia, always el, and required extensive s of daily living (toileting, and hygiene). I not address constipation or ion or non-pharmacological mote bowel movements such , adding roughage to diet, maintaining routine daily bowel or commode, etc. on 1/27/15, at 2:05 p.m. RN)-A indicated he was not easons why R32 had 3 dications. RN-A also did not e of Miralax was higher than -A stated he was not aware of physicians recent justified for					

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		00916	B. WING		01/30/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
MAPLE I	MANOR NURSING AN		H STREET N STER, MN 55	IORTHWEST 901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
21535	Continued From pa	ige 95	21535		
	care planned and the note the reasons for then monitor routine During an interview nurse practitioner (medication should After informing NP medication and dai SUGGESTED MET The director of nurse in-service all staff re on the need to meet under this licensing	on 1/30/15, at 9:30 a.m. NP) stated, "[R32 ' s] bowel be looked at and reduced." of R32 ' s three bowel ly bowel movements. THOD OF CORRECTION: sing or pharmacist could esponsible for medication use et the requirements as written			
21550	Medications; Pharn Subpart 1. Pharma	5 Subp. 1 Adminiatration of nacy Serv. acy services. A nursing home e provision of pharmacy	21550		3/11/15
	by: Based on observative review, the facility of medications were r medication rooms I Medication Room a carts; in addition th was dated when who	ent is not met as evidenced ion, interview and document did not ensure expired emoved from 1 of 2 ocated on the East/West and from 3 of 3 medications e facility did not ensure insulin nen opened to determine 1 of 1 resident (R63).		See Federal Regulation responses	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
	IANOR NURSING AN		TH STREET NO STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
21550	Continued From pa	age 96	21550				
	Findings include:						
	medication storage	B p.m. the East/West e room was inspected and edications were observed that ing:					
	R69's half full bottle tablets labeled with pharmacy label inco 6/2014 while the mexpiration date as	of Antacid expired on 8/2014; e of Bisacodyl (laxative) 5 mg n two expiration dates. The licated expiration date as nanufacturer's label indicated 6/2015. RN-C stated the facility narmacy label of 6/2014.	/				
		6 a.m. the East medication carl acrilube eye ointment. The eye n 12/2014					
		9 a.m. the West medication cility stock of Geri-lanta red on 11/2014.					
	cart contained R5's softener) that expire	5 p.m. the North Medication s half full bottle of Senna (stool red 10/2013; R44's unopened 0.4 milligram (mg) that expired					
	North/South medic insulin was observ did not have a date 30 days from open Orders Sheet (POS had diabetes with r further indicated R	5 p.m. during inspection of the action refrigerator, R63's Lantus ed to have been opened but a it was opened as it expires in ing for use. The Physician's S) dated 1/29/15 indicated R63 renal manifestations. The POS 63 was to be given Lantus 20 eous injection daily at noon.					
	During interview or	n 1/28/15, at 2:28 p.m.,					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00916	B. WING		01/	30/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	MANOR NURSING A		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21550	Continued From pa	age 97	21550			
		RN)-C stated all nurses were king sure that medications in not expired.				
	(LPN)-D and nursi	5 p.m. licensed practical nurse ng assistant (NA)-K stated the ns should have been removed carded.				
	pharmacist stated medications should storage rooms and	5 p.m. the consultant as safety precaution, expired d be removed from medication carts and time sensitive as insulins must be labeled				
	Facility provided th immediately remove according to proce and reordered from exists. The policy f	on Medication Storage in the at outdated medications are ved from stock, disposed of dures for medication disposal n pharmacy if a current order urther gave directions for staff ion storage quarterly.				
	dated 7/12/04, indi has been opened,	on Stocking Regular Insulin cated once a bottle of insulin the bottle needs to be dated, expire 30 days from that date.				
	The director of nur educate all staff re storage to remove	THOD OF CORRECTION: sing and or pharmacist can sponsible for medicaiton outdated medications to use by resident/s. Also to ance.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DATE SURVEY COMPLETED	
		00916	B. WING		01/30/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
IAPLE N	MANOR NURSING AN		TH STREET N STER, MN 55	IORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET E DATE	
21565	Continued From pa	age 98	21565			
21565	MN Rule 4658.132 Medications Self A	5 Subp. 4 Administration of dmin	21565		3/11/15	
	self-administer med resident assessme care as required in 4658.0405 indicate is a written order fr	ninistration. A resident may dications if the comprehensive ent and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.				
	by: Based on observat review, the facility f (R96) was assesse to self-administer n Findings include:	ent is not met as evidenced ion, interview and record failed to ensure 1 of 1 resident ed and provided the opportunity nedications. on 1/25/15 at 12:00 p.m. R96	/	See Federal Regulation responses		
	was observed to ea interviewed and sh related to her gastr and diabetes. On indicated that she r	at regular meals and was e knew foods allowed to eat ric by-pass, kidney transplant, 1/30/15 at 9:15 a.m. R96 managed her diabetes ome and that the blood sugar				
	dated 12/9/14 indic of mental status (B possible 15 points MDS also noted that	Minimum Data Set (MDS) ated R96 had a brief interview IMS) score of 14 out of a or was cognitively intact. The at R96 had no functional range of shoulders, arms, wrists, or				
	1/30/15 at 10:20 a. would like to mana of insulin she need that nursing did not	ner (NP)-A was interviewed on m. NP-A stated that R96 ge and determine the amount led. NP-A stated R96 was told t have a lock box so she could n supplies in her room for				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	00916	B. WING	B. WING		30/2015
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ANOR NURSING AN					
(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 99	21565			
self-use.					
stated that nursing R96 to tell staff how because nurses co residents, it was no not follow through determine R96 's a	was asked by NP-A to allow w much insulin she needed, bu ould not take orders from of allowed. RN-A stated he did with an assessment to ability safely gives herself				
the administration of at home she gave pen. She stated th the amount of insu would give her own that she would like	of her insulin. R96 stated that her own insulin using an insulin there the nurse would dial in lin to be given and that she n insulin injection. R96 stated to be totally independent in				
1/30/15 at 10:45 a. would need to be a	m. DON indicated residents assessed prior to the	1			
The director of nur- regarding the proce- resident capability medications and pr self-administer me- conducted to identi- have the capability self-administration.	ses could inservice staff ess for determination of to safely self-administer rovided the opportunity to dications. An audit could be ify and assess residents who to participate in . This could be part of the				
	PROVIDER OR SUPPLIER MANOR NURSING AN SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From para self-use. The case manager stated that nursing R96 to tell staff how because nurses cond residents, it was not not follow through and determine R96 's and insulin and takes bo At 10:30 a.m. on 1/2 the administration and the amount of insufficient would give her own that she would like managing the insufficient No policy related to medication was pro- The director of nur- regarding the proce- resident capability medications and po- self-administration	OF CORRECTION IDENTIFICATION NUMBER: 00916 00916 PROVIDER OR SUPPLIER STREET A MANOR NURSING AND REHAB, LLC 1875 191 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IDENTIFICATION NUMBER: Continued From page 99 self-use. The case manager registered nurse (RN)-A stated that nursing was asked by NP-A to allow R96 to tell staff how much insulin she needed, but because nurses could not take orders from residents, it was not allowed. RN-A stated he did not follow through with an assessment to determine R96 's ability safely gives herself insulin and takes blood sugars. At 10:30 a.m. on 1/30/15 R96 was asked about the administration of her insulin. R96 stated that at home she gave her own insulin using an insulir pen. She stated that here the nurse would dial in the amount of insulin to be given and that she would give her own insulin injection. R96 stated that she would like to be totally independent in managing the insulin. No policy related to self-administration of medication was provided upon request.	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00916 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST 1875 19TH STREET NO ROCHESTER, MN 5599 Image: Continued From page 99 SUBMARY STATEMENT OF DEFICIENCIES ID Image: Continued From page 99 Submark of the context o	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00916 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES IB 75 19TH STREET NORTHWEST ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CROSS-REFERENCED TO DEFICIENCY Continued From page 99 21565 CROSS-REFERENCED TO DEFICIENC TAG 21565 Continued From page 99 21565 CROSS-REFERENCED TO DEFICIENC TAG CROSS-REFERENCED TO DEFICIENC Continued From page 99 21565 CROSS-REFERENCED TO DEFICIENC CROSS-REFERENCED TO DEFICIENC Continued From page 99 21565 CROSS-REFERENCED TO DEFICIENC CROSS-REFERENCED TO DEFICIENC Continued From page 99 21565 CROSS-REFERENCED TO DEFICIENC CROSS-REFERENCED TO DEFICIENC Continued From page 99 21565 CROSS-REFERENCED TO DEFICIENC CROSS-REFERENCED TO DEFICIENC Continued From page 99 21565 CROSS-REFERENCED TO DEFICIENC CROSS-REFERENCED TO DEFICIENC Continued From page 99 Stated that nursing using an usuin insulin and takes blood sugars. CROSS-REFERENCED TO DEFICIENC At 10:30 a.m. on 1/30/15 R96 was asked about the administration of the insulin. R96 stated that she would like t	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 001/ ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 01/ RANOR NURSING AND REHAB, LLC 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 01/ SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LSC DENTIFYING INFORMATION) ID PREFX PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 99 self-use. 21565 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY The case manager registered nurse (RN)-A stated that nursing was asked by NP-A to allow R95 to tell staff how much insulin she needed, but because nurses could not take orders from residents, it was not allowed. RN-A stated he did not follow through with an assessment to determine R96 's ability safely gives herself insulin and takes blood sugars. At 10:30 a.m. on 1/30/15 R96 was asked about the administration of her insulin. R96 stated that at home she gave her own insulin using an insulin pen. She stated that here the nurse would dial in the amount of insulin. To B46 stated that she would like to be totally independent in managing the insulin. No policy related to self-administration of medication was provided upon request. Suggester DMETHOD OF CORRECTION: The director of nurses could inservice staff regarding the process for determination of resident capability to astications. SUGGESTED METHOD OF CORRECTION: The director of nurses could inservice staff regident capability to astications. Sugle-administration. The could be portunity to self-administer medications. An audt could be conducted to identify

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	MANOR NURSING AN		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21565	Continued From pa	uge 100	21565			
	(21) days.					
21800	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	21800			3/11/15
	residents shall, at a are legal rights for stay at the facility o treatment and main that these are desc written statement o responsibilities set case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and orga advocacy and legal residential program accommodations s communication imp speak a language of facility policies, insp local health authorit the written stateme to patients, residen chosen representat to the administrator person, consistent	tion about rights. Patients and admission, be told that there their protection during their r throughout their course of otenance in the community and oribed in an accompanying f the applicable rights and forth in this section. In the mitted to residential programs on 253C.01, the written to describe the right of a d or older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide services for patients in its. Reasonable hall be made for those with pairments and those who other than English. Current bection findings of state and ties, and further explanation of int of rights shall be available ts, their guardians or their tives upon reasonable request r or other designated staff with chapter 13, the Data section 626.557, relating to	5			
	This MN Requirem	ent is not met as evidenced				

STATEMEN	DIT DEPARTMENT OF HE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		01/	30/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21800	Continued From pa	ge 101	21800			
	facility failed to prov Nursing Facility Adv (SNFABN) or a unit skilled nursing facil Medicare Part A sk provide appropriate residents (R28, R6 liability notices; and notice prior to disch for 2 of 5 residents liability notices.	and document review, the vide the required Skilled vanced Beneficiary Notice form denial letter to be used by ities upon termination of all illed services; and failed to e liability notices for 4 of 5 56, R77 & R88) reviewed for I failed to provide two day marge from Medicare services (R77, R88) reviewed for		See Federal Regulation re	esponses	
	Findings include:					
	INACCURATE SKI ADVANCED BENE	LLED NURSING FACILITY FICIARY NOTICE:				
	Notice of Noncover provided was not for Also no residents in	ved Advance Beneficiary rage. However, the form or skilled nursing facility use. In the sample selected option 1 bmitted to Medicare for review.				
	Notice of Noncover (03/08)) used by th read, " Option 1. I above. You may as want Medicare bille payment, which is a Summary Notice (M Medicare doesn't p payment, but I can following the directi does pay, you will r you, less co-pays of this option, the faci	of the Advance Beneficiary rage (Form CMS-R-131 e facility, options selection want the (D) Services listed sk to be paid now, but I also ed for an official decision on sent to me on a Medicare <i>M</i> SN). I understand that if ay, I am responsible for appeal to Medicare by ons on the MSN. If Medicare efund any payments I made to or deductibles." According to lity would bill residents until lecision and then would refund e by the resident				

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	MANOR NURSING AN		H STREET NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21800	Continued From pa	age 102	21800			
	Medicaid Services Noncoverage, form facilities (SNF) mus	ected to be denied under				
	business office ass and R88 had receiv were discharged fr remained in the fac Advance Beneficia	n 1/28/15, at 2:00 p.m., sistant (BOA)-A verified R77 ved Medicare Part A services, om Medicare Part A, and cility. BOA-A verified the ry Notice of Noncoverage was Beneficiary Notice of I by the facility.				
		D NURSING FACILITY FICIARY NOTICE:				
	services on 12/5/14 Medicare Non-Cov notice. R28 remain failed to provide Sk Beneficiary Notice, would allow R28 th bill to Medicare for 1/28/15, at 2:00 p.r receive Skilled Nur Notice or a uniform potential liability for	ed from Medicare Part A 4, according to R28's Notice of erage, a Medicare liability ned in the facility. The facility killed Nursing Facility Advance a Medicare liability notice that e choice to submit the facility review. During interview on m., BOA-A verified R28 did not sing Advanced Beneficiary denial letter to inform of r non-covered services and of the denial to Medicare.				
	services on 8/25/14 of Non-Coverage, a remained in the fac Notice of Medicare	ed from Medicare Part A 4, according to R66 ' s Notice a Medicare liability notice. R66 cility. Document review of the Non-Coverage, revealed a essage was left and the notice				

00916 B. WING 01/30/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 01/30/2015 MAPLE MANOR NURSING AND REHAB, LLC 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901 10 PROVIDER'S PLAN OF CORRECTION (X5)	STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
STREET ADDRESS, CITY, STATE, ZIP CODE TAG STREET ADDRESS, CITY, STATE, ZIP CODE TAG STREET ADDRESS, CITY, STATE, ZIP CODE TAG SUMMARY STATEMENT OF DEPENSIONS PROVIDERS FLAND CORRECTIVE ACTOR STOLLD BE PROVIDER FLAND CORRECTIVE ACTOR STOLLD BE PROVIDER FLAND CORRECTIVE ACTOR STOLLD BE PROVIDER FLAND TO CORRECTIVE ACTOR STOLLD BE PROVIDER FLAND TO CORRECTIVE ACTOR STOLLD BE PROVIDER FLAND TO CORRECTIVE ACTOR STOLLD BE PROVID			00916	B. WING		01/30/2015	
MANDE MANOR NURSING AND HELAB, LLC ROCHESTER, MN 55901 (M) D PHETX TAC SUMMARY STATEMENT OF DEFICIENCES (FAOL DEFICIENCY MUST DE PRECEDE BY FULL REGULATORY ON LSC DENTIFYING WROMMATCM) D PARTY TAC D POVIDERTS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE AND SHOULD BE DEFICIENCY) 00% 21800 Continued From page 103 21800 21800 was mailed on 8/22/14. The notice lacked signature of patient or representative. There was no evidence of follow-up contact. The facility failed to provide Stilled Nursing Facility Advance Beneficiary Notice, a Medicare liability notice that would allow R66 the choice to submit the facility bill to Medicare for review. During interview on 1/28/15, at 2:00 p.m., BOA-A verified R66 did not receive Skilled Nursing Advanced Beneficiary Notice or a uniform denial to Medicare. BA-A verified lack of signature, no turther representative contact, and R66 did not receive Skilled Nursing Advanced Beneficiary Notice or a uniform denial letter to inform of potential liability for non-covered services and of his right to appeal the denial to Medicare. BA-A verified lack of signature, no turther appeal the denial to Medicare. R77 was discharged from Medicare Part A services on 9/19/14, according to R77: Notice of Medicare Non-Coverage, a Medicare isability notice, which was signed by representative on 9/22/14, 4 days after Medicare coverage ended. R77 remained in the facility. There was no evidence of when the resident or family was notified of non-coverage prior to Medicare services ended. During interview on 1/28/15, at 2:00 p.m., BOA-A verified there was no evidence that the facility Motice, signed by representative on 9/22/14, 4 days after Medicare services ended. During interview on 1/28/15, at 2:00 p.m	NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
Image SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION COMPLEX TAG EGUIDATORY OR LSC IDENTIFYING INFORMATION) PIETRY TAG CARDEFIGIENCY WIST GE PRECEDED BY FULL (EACH DEFICIENCY WIST GE PRECEDED BY FULL (EACH DEFICIENCY) PIETRY TAG PROVIDERS PLAN OF CORRECTION COMPLET (EACH DEFICIENCY) 21800 Continued From page 103 21800 21800 PIETRY TAG DEFICIENCY) 21810 Continued From page 103 21800 21800 PIETRY TAG DEFICIENCY) 21800 Was mailed on 8/22/14. The notice lacked signature of patient or representative. There was no evidence of follow-up contact. The facility failed to provide Skilled Nursing Advanced Beneficiary Notice or a uniform denial letter to inform of potential liability for non-covered services and of his right to appeal the denial to Medicare. BA-A verified lack of signature, no turther representative contact, and R66 did not receive Skilled Nursing Advanced Beneficiary Notice or a uniform denial letter to inform of potential liability for non-covered services and of his right to appeal the denial to Medicare. AA R77 was discharged from Medicare Bart A services on 9/19/14, according to R77s Notice of Medicare Non-Coverage, a Medicare Isability notice, which was signed by representative on 9/22/14, 4 days after Medicare coverage ending. R77 received Skilled Nursing Advanced Beneficiary Notice, signed by representative on 9/22/14, a days after Medicare services ended. During interview on 1/28/15, at 2:00 p.m.,	MAPLE	MANOR NURSING A					
 was mailed on 8/22/14. The notice lacked signature of patient or representative. There was no evidence of follow-up contact. The facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notice, a Medicare liability notice that would allow R66 the choice to submit the facility bill to Medicare for review. During interview on 1/28/15, at 2:00 p.m., BOA-A verified R66 did not receive Skilled Nursing Advanced Beneficiary Notice or a uniform denial letter to inform of potential liability for non-covered services and of his right to appeal the denial to Medicare. BA-A verified R66 did not receive Skilled Nursing Advanced Beneficiary Notice or a uniform denial letter to inform of potential liability for non-covered services and of his right to appeal the denial to Medicare. BA-A verified lack of signature, no further representative contact, and R66 did not receive Skilled Nursing Advanced Beneficiary Notice or a uniform denial letter to inform of potential liability for non-covered services and of his right to appeal the denial to Medicare. LACKED 2 DAY NOTICE PRIOR TO DISCHARGE FROM MEDICARE SERVICES: R77 was discharged from Medicare Part A services on 9/19/14, according to R77's Notice of Medicare Non-Coverage, and edicare liability notice, which was signed by representative on 9/22/14, 4 days after Medicare coverage ended. R77 remained in the facility. There was no evidence of when the resident or farmily was notified of non-coverage prior to Medicare services ended. During interview on 1/28/15, at 2:00 p.m., BO-A verified Here was no evidence that the facility Notice, after Medicare services. 	PRÉFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	COMPLET
signature of patient or representative. There was no evidence of follow-up contact. The facility failed to provide Skilled Nursing Facility Advance Beneficiary Notice, a Medicare liability notice that would allow R66 the choice to submit the facility bill to Medicare for review. During interview on 1/28/15, at 2:00 p.m., BOA-A verified R66 did not receive Skilled Nursing Advanced Beneficiary Notice or a uniform denial letter to inform of potential liability for non-covered services and of his right to appeal the denial to Medicare. BA-A verified lack of signature, no further representative contact, and R66 did not receive Skilled Nursing Advanced Beneficiary Notice or a uniform denial letter to inform of potential liability for non-covered services and of his right to appeal the denial to Medicare. LACKED 2 DAY NOTICE PRIOR TO DISCHARGE FROM MEDICARE SERVICES: R77 was discharged from Medicare Part A services on 9/19/14, according to R77's Notice of Medicare Non-Coverage, a Medicare liability notice, which was signed by representative on 9/922/14, 4 days after Medicare coverage ended. R77 remained in the facility. There was no evidence of when the resident or family was notified of non-coverage prior to Medicare coverage ending. R77 received Skilled Nursing Advanced Beneficiary Notice, signed by representative on 9/22/14, 4 days after Medicare services ended. During interview on 1/28/15, at 2:00 p.m., BOA-A verified there was no evidence that the facility had notified R77 the required 2 days prior to discharge from Medicare services.	21800	Continued From pa	age 103	21800			
DISCHARGE FROM MEDICARE SERVICES: R77 was discharged from Medicare Part A services on 9/19/14, according to R77's Notice of Medicare Non-Coverage, a Medicare liability notice, which was signed by representative on 9/22/14, 4 days after Medicare coverage ended. R77 remained in the facility. There was no evidence of when the resident or family was notified of non-coverage prior to Medicare coverage ending. R77 received Skilled Nursing Advanced Beneficiary Notice, signed by representative on 9/22/14, 4 days after Medicare services ended. During interview on 1/28/15, at 2:00 p.m., BOA-A verified there was no evidence that the facility had notified R77 the required 2 days prior to discharge from Medicare services.		signature of patien no evidence of folk failed to provide SI Beneficiary Notice, would allow R66 th bill to Medicare for 1/28/15, at 2:00 p.1 receive Skilled Nur Notice or a uniform potential liability fo his right to appeal verified lack of sign representative con Skilled Nursing Adu uniform denial letter for non-covered set	tor representative. There was ow-up contact. The facility killed Nursing Facility Advance , a Medicare liability notice that ne choice to submit the facility review. During interview on m., BOA-A verified R66 did not rsing Advanced Beneficiary n denial letter to inform of r non-covered services and of the denial to Medicare. BA-A nature, no further stact, and R66 did not receive vanced Beneficiary Notice or a er to inform of potential liability ervices and of his right to				
R88 was discharged from Medicare Part A		DISCHARGE FRC R77 was discharge services on 9/19/14 Medicare Non-Cow notice, which was 9/22/14, 4 days aft R77 remained in th evidence of when the notified of non-cow coverage ending. Advanced Beneficion representative on services ended. 2:00 p.m., BOA-A that the facility had	MEDICARE SERVICES: ed from Medicare Part A 4, according to R77's Notice of verage, a Medicare liability signed by representative on the Medicare coverage ended. the facility. There was no the resident or family was rerage prior to Medicare R77 received Skilled Nursing iary Notice, signed by 9/22/14, 4 days after Medicare During interview on 1/28/15, at verified there was no evidence I notified R77 the required 2				
nesota Department of Health		-	ed from Medicare Part A				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/30/2015	
		00916	B. WING			
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/2010
	ANOR NURSING AN		TH STREET NC			
			STER, MN 559	PROVIDER'S PLAN OF C		0.75
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21800	Continued From pa	age 104	21800			
	Medicare Non-Cov notice, which was a 10/2/14, 4 days afte R88 remained in the evidence of when t notified of non-cove coverage ending. Advanced Benefici representative on 1 services ended. 2:00 p.m., BOA-A w that the facility had days prior to dischar	4, according to R88's Notice of erage, a Medicare liability signed by representative on er Medicare coverage ended. he facility. There was no he resident or family was erage prior to Medicare R88 received Skilled Nursing ary Notice, signed by 0/2/14, 4 days after Medicare During interview on 1/28/15, at verified there was no evidence notified R88 the required 2 arge from Medicare services.				
	verified R28, R66, Medicare Part A se Medicare Part A, an BOA-A verified the resident or represe	n 1/28/15, at 2:00 p.m., BOA-A R77, and R88 had received rvices, were discharged from nd remained in the facility. facility lacked evidence of intative notification. BOA-A id not have a written policy or ity notices.				
	The administrator of policies and proceed the appropriate liab Medicare services are acted upon. The all appropriate staff	THOD OF CORRECTION: could review and revise dures to ensure staff provide pility notices at the end of and to ensure resident rights ne administrator could educate f to provide the liability notices. could monitor staff compliance				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			3/11/15

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00916	B. WING		01/	01/30/2015	
AME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
IAPLE I	MANOR NURSING AN		TH STREET N STER, MN 55	NORTHWEST 5901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
21805	Continued From pa	age 105	21805				
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ect for their individuality by ersons providing service in a					
	by: Based on observat review, the facility f of 10 residents (R5 R3, R30, R42, and to eat there was a f visible to other residents to allow residents ti table of food debris to table; and failed promote dignity for	ent is not met as evidenced ion, interview, and document ailed to promote dignity for 10 i1, R10, R52, R61, R65, R34, R26) who received assistance folder on the table which was dents, staff and visitors; failed ime to eat before cleaning the and parked food scraps next to cover urine collection bag to 1 of 1 resident (R68) who was ncovered urine collection bag		See Federal Regulation r	esponses		
	a table with a folder R51, R10, R52, R6 were identified by that one table in the e	eived assistance with eating at r that said,"Feeder table." i1, R65, R34, R3, R30, R42 he facility to be assisted to eat east/west dining room labeled needed assistance to eat.					
		ble in the east/west dining resting on top of the table er table."					
	folder which sat up	ng room had one table with a right on the table. The outside "Stays @ Feeder Table" and neal."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00916	B. WING		01/30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MAPLE	MANOR NURSING AN		TH STREET NO STER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	During dining obse room on 1/27/15, a were eating positio south side of the di residents who need observed to sit. A on the table. The f letters "Stays @ Fe every meal." During interview or feeding assistant (I the table was labeled PFA-A stated the for residents nursing a residents who rece residents at risk for During interview or dietary manager (C east/west dining ro @ Feeder Table" w During interview or of nursing verified to room table labeled not appropriate and During interview or registered nurse-E R52, R61, R65, R3 east/west dining ro Document review of Dignity Audit Proce is the policy of Map Rehabilitation to pr	rvations in the east/west dining it 12:10 p.m., five residents ned at the large table on the ining room (south table) where ded assistance to eat were folder was observed upright older was labeled in large beder Table" and "Mark after n 1/27/15, at 12:12 p.m., paid PFA)-A verified the folder on ed "Stays @ Feeder Table." older contained the list of assistants assisted to feed, vived thickened liquids, and r aspiration. n 1/27/15, at 3:03 p.m., certifier CDM)-C stated the folder on the om south table labeled "Stays vas a folder used by nursing. n 1/27/15, at 3:25 p.m., directo the folder sitting on a dining "Stays @ Feeder Table" was d should not be used. n 1/30/15, at 8:15 a.m., (RN-E) verified R51, R10, i4, R3, R30, R42 ate at the	d e r	DEFICIEN		

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00916	B. WING		01/30/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	• • •	
	ANOR NURSING AN	ID REHABILIC	TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 107	21805			
	Resident's Rights p residents at Maple be treated with con recognition of his/h	of facility policy Maple Manor policy dated 3/6/08, read, "All Manor Nursing Home are to asideration, respect and full her dignity and individuality a treatment and in care of peeds."				
	Residents eating warea near them:	hile staff began cleaning the				
	room on 1/26/15, a (DA)-E pushed a b dining room up to a finishing eating her	rvations in the east/west dining at 5:21 p.m., dietary aide us cart into the east/west a table where a resident was r meal. DA-E cleared soiled on the bus cart. DA-D scraped t on the bus cart.				
	dietary manager (C soiled dishes and f container on the bu finished eating at a cart was not to be i stated he expected	n 1/27/15, at 3:03 p.m., certified CDM)-C stated he expected oods placed into a garbage us cart after all residents were table. CDM-C stated the bus in the dining room. CDM-C d staff cleared off the tables, es and foods into the hallway bus cart.	ł			
	DA-D was observe east/west dining ro where five resident completing their masoiled dishes and p	is on 1/30/15, at 1:05 p.m., d to push the bus cart into om up to touching the table is in wheelchairs were eal. DA-D began to clear off blaced on the bus cart. DA-D a bucket on the bus cart.				
	Dignity Audit Proce	of facility policy Privacy and edure dated 12/19/06, read, "It ble Manor Health Care &				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		01/	01/30/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
MAPLE I	MANOR NURSING AN	ND REHAB. LLC	TH STREET NO STER, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	age 108	21805				
		ovide all residents with privacy cares and in activities of daily	,				
	Resident's Rights p residents at Maple be treated with con recognition of his/h	of facility policy Maple Manor policy dated 3/6/08, read, "All Manor Nursing Home are to asideration, respect and full her dignity and individuality treatment and in care of beds."					
		st residents to eat and staff dent to another while assisting					
	was observed durin 11:45 a.m. No resi attempt to eat inde (NA)-F loudly spok a.m. telling R26 to getting cold. R26 v fingers to eat cook use your fork twice away her plate afte	other residents at a table and ng the noon meal on 1/25/15 a ident at this table made the pendently. Nursing assistant e across the table at 11:47 eat the lunch because it was was observed to use her ed carrots. NA-F told R26 to . At 12:00 p.m. R26 pushed er eating only carrots. No staff urage R26 to eat more of her					
	observed to be sta to eat. NA-O then while standing assi 5:12 p.m. it was no sitting at the west t wheelchair and sho NA-O left the dining 5:16 p.m. NA-O ref again stood to assi	the evening NA-O was nding while assisting a residen moved to another table and isted the residents to eat. At ted that 2 of the 4 residents able were sleeping in their ortly after this observation g room. Four minutes later at turned to the dining room and ist residents to eat. At 5:18 to the next table and stood	ıt				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		01/30/2015	
AME OF F	PROVIDER OR SUPPLIEF		DDRESS, CITY, ST	TATE, ZIP CODE		
	MANOR NURSING A		TH STREET NO STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21805	Continued From p	age 109	21805			
	Between 5:16 p.m observed to walk f resident standing residents to eat. A room stating that s other staff assisted with food remainin	2 and another resident to eat. . and 5:29 p.m. the NA-O was from one resident to another while assisting 5 different At 5:20 p.m. NA-O left the dinin she would return tomorrow. No d these residents to eat and ng on plates they were moved om by NA-P and RN-A.				
	on 1/27/15 at 3:01 expectations were resident she was I realized there was everybody needed	rsing (DON) was interviewed p.m. DON indicated her that staff would sit beside the helping. DON stated she a problem with that since to be fed in the north dining d the facility needed to change				
	Lack of covering u dignity:	rine collection bag to promote				
		theter with urine visible in was not covered consistently				
	open, R68 was ob indwelling Foley ca lying flat on top of foot part. The unce could be seen from showing small am The exposed part filled with yellow ca registered nurse (bag was on top of door was open. Ref	5 a.m. R68's room door was pserved lying in bed. R68's atheter bag was also observed R68's blanket in bed, on the overed catheter bag and tubing n the door, with the bag ount of yellow-colored urine. of the catheter tubing was also olored urine. At 7:45 a.m. RN)-C verified R68's catheter bed. At 7:38 a.m. R68's room 68 was still lying in bed. The er bag was still on top of bed,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00916	B. WING		01/30/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	MANOR NURSING AN		H STREET NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21805	Continued From pa	age 110	21805			
	R68's catheter bag this time NA-B stat the bag every shift the night shift on to stated the catheter below R68. NA-B a placed in a blue ba to a loop-like attack R68's Admissions I indicated R68 had	as interviewed and confirmed was lying on top of bed. At ed nursing assistant's empty and must have been placed by op of R68's bed. Also NA-B bag should always be hanging added, the urine bag should be g and hooked "here " (pointing ment on bed frame). Face Sheet printed on 1/29/15, diagnoses including psychosis ion, anxiety state and urinary	3			
	11/1/14 indicated F should be kept belo reflux, maintain a c POS further indicat	ders Sheet (POS) dated 868's urinary drainage bag bw bladder level to prevent closed drainage system. The ted bag "to be kept in cloth to prevent infection and				
	required indwelling retention. Also drai	ted 10/20/14 indicated R68 Foley catheter due to urinary nage bag to be kept in a blue event infection and "provide				
	directed staff to see not to allow bag to	ter Care Policy dated 7/9/09, cure bag on side of bed frame, touch the floor, to keep the bladder at all times and to be y bag.				
	The administrator, could provide staff	THOD OF CORRECTION: director or nursing or designee education related to dignified monitor for compliance				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00916	B. WING		01/30/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	MANOR NURSING AN		H STREET NO	-		
		ROCHES	TER, MN 559	01		
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21805	Continued From pa	age 111	21805			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One				
21980	MN St. Statute 626 Maltreatment of Vu	0.557 Subd. 3 Reporting - Ilnerable Adults	21980			3/11/15
	reporter who has re vulnerable adult is or who has knowle has sustained a ph reasonably explain information to the o individual is a vulne the individual is adu reporter is not requ	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult sysical injury which is not ed shall immediately report the common entry point. If an erable adult solely because mitted to a facility, a mandated sired to report suspected e individual that occurred prior ss:				
	another facility and believe the vulnera previous facility; or (2) the reporter k that the individual ii in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in thi known or suspecte knows or has rease been made to the o (d) Nothing in thi reporter from also agency. (e) A mandated reason to believe the	knows or has reason to believe s a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the section may voluntarily report				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00916	B. WING		01/30/2015	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
IAPLE I	MANOR NURSING AN		TH STREET N STER, MN 55	IORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
21980	Continued From pa	age 112	21980			
	time believes that a agency will determ the reported error w the criteria under s 17, paragraph (c), facility may provide directly to the lead how the event mee 626.5572, subdivis (5). The lead agen	reporter or a facility, at any an investigation by a lead ine or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining ets the criteria under section ion 17, paragraph (c), clause ncy shall consider this naking an initial disposition of ubdivision 9c.				
	by: Based on interview facility failed to inve allegations of miss to the administrato	ent is not met as evidenced and document review, the estigate and immediately repor ing money and physical abuse r and designated state agency (R70 & R29) reviewed for ports.		See Federal Regulation resp	oonses	
	11/20/14 indicated impairment with a l Status (BIMS) scor extensive assist for dressing, toileting, During an interview stated approximate his drawer about 3 had won the money not kept money in	himum Data Set (MDS) dated R70, had moderate cognitive Brief Interview for Mental re of eleven, and required r activities of daily living of transfers, and hygiene. y on 1/26/15, at 1:00 p.m. R70 by \$30.00 went missing out of months ago. R70 stated he y at bingo. R70 stated he had room since the \$30.00 was lade it a habit to deposit bingo ount with the facility. R70				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00916	B. WING		01/	30/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S			
		1875 191	H STREET NO			
	ANOR NURSING AN	ROCHES	STER, MN 559	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21980	Continued From pa	age 113	21980			
	administrator about During an interview licensed social wor R70 had reported r and stated she had been taken out of F R70 had never repo- she was aware of. During an interview SW-A stated R70's informed of the mis- returned her phone not reported the mi- state agency after H a.m. R29 made an alleg immediately reported the designated stat R29's had a grieva indicated an allegaton was not if administrator nor to (Office of Health Co A letter was provide of abuse for R29. T who was accused H face during cares. [reference to an arg [R29] pillow and I h change a different accidentally hit her her and told her it w wasn't I did it on put turn me in." The let	v on 1/28/15, at 8:23 a.m. ker (SW)-A was notified the nissing money to this surveyor I not been aware money had R70's drawer. SW-A stated orted anything missing that v on 1/29/15, at 8:12 a.m. family member was just ssing money but has not e call. Also SW-A said she had ssing money to the designated being informed of it yesterday ation of abuse but it was not ed to the administrator or to the agency. nce form completed by SW-A tion of physical abuse occurred Nursing assistant (NA)-M had nt to the nurse however the immediately reported to the o the designated state agency				
inesota De	nurse (LPN)-F. During an interview	<i>i</i> on 1/29/15, at 3:47 p.m.				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
			B. WING			
		00916			01/	30/2015
	PROVIDER OR SUPPLIER	1875 101	DDRESS, CITY, S ⁻ T H STREET NC			
IAPLE	MANOR NURSING AN		TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	age 114	21980			
	reported or investig Vulnerable Adult In on 2/6/2013 read, " notify the administr vulnerable adult incorrequirement is that all reportable incide Department of Hear of knowledge of an Facility policy Resid dated 6/30/2009 re alleged violations a to the appropriate se event of suspected the resident will be Notify the resident's physician as soon a SUGGESTED MET The administrator of need to immediated to the designated se point.	dent Abuse Prevention Plan ad, "The facility will report all and all substantiated incidents state agencies", and " In the maltreatment, the needs of immediately assessed, and s responsible party as well as	t			