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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3QEK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00916

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

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

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 04/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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,

Kamala Fiske-Downing

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

MINNESOTA MDH DEPARTMENT OF HEALTH

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

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,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245409	A. Building B. Wing	4/27/2015

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/17/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/17/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **04/17/2015**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **04/17/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/17/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/17/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/17/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/17/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	04/29/2015	31221	04/27/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/30/2015			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
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	(Y2) Multiple Construction	(Y3) Date of Revisit
00916	A. Building B. Wing	4/27/2015

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 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
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **04/17/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **04/17/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **04/17/2015**
ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **04/17/2015**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **04/17/2015**	ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **04/17/2015**
ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **04/17/2015**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **04/17/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	04/29/2015	31221	04/27/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/30/2015				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3QEK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00916

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

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

4. TYPE OF ACTION: 7 (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/20/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 04/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245409	A. Building B. Wing	3/20/2015

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **03/11/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/11/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **03/11/2015**
ID Prefix **F0278** Reg. # **483.20(q) - (i)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/11/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/11/2015**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **03/11/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0369** Reg. # **483.35(g)** LSC	Correction Completed **03/11/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	03/30/2015	15425	03/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0373** Reg. # **483.35(h)** LSC	Correction Completed **03/11/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/11/2015**
ID Prefix **F0466** Reg. # **483.70(h)(1)** LSC	Correction Completed **03/11/2015**				

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/30/2015	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	R 03/20/2015

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{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on March 18, 19 & 20, 2015. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected and/or new tags were issued at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the plan of care was followed for 2 of 3 residents (R38, R32) reviewed for care plan interventions. Findings include:	{F 282}	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	4/17/15

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

Electronically Signed | 03/31/2015

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{F 282}	Continued From page 1 LACK of OBTAINING WEEKLY WEIGHTS: R38's physician orders dated 3/19/15, revealed orders to check weights Monday, Wednesday, and Friday. Document review of resident care plan dated 3/19/15, revealed a care plan problem of diet, dated 2/17/15, with intervention to weigh Monday, Wednesday, and Friday. Document review of facility treatment sheets dated 3/11/15 to 3/18/15, revealed check weights Monday, Wednesday, and Friday. However, the treatment sheet revealed no weights were identified out of 4 times possible. Document review of facility resident vitals/weights monitoring revealed from 3/11/15 to 3/18/15, no weights were identified out of 4 times possible. According to the same monitoring, most recent weight prior to 3/11/15 and was checked on 2/25/15. During interview on 3/20/15, at 8:10 a.m., director of nursing stated the weights for R38 had been discontinued. At 9:05 a.m., director of nursing stated R38 ' s weights were changed by the nurse practitioner on 3/10/15, to check weights per routine. Director of nursing stated facility routine was to check weights weekly. Director of nursing verified staff were to check weights Monday, Wednesday, and Friday, according to the treatment sheet and care plan. Director of nursing verified weights were not checked according to physician orders, treatment sheet, or resident care plan. LACK OF CONSISTENT COLOSTOMY	{F 282}	comprehensive assessment of the resident□s needs and preferences. The nursing staff are made aware of each resident□s plan of care and services are routinely provided that meet professional standards and supports the highest practicable level of function and well-being. The procedures for communicating the residents' care needs to the direct care staff were reviewed and found appropriate. During a mandatory training meeting, the nursing staff were instructed that the resident care plans must be followed and that job performance expectations include being aware of and following the care plan. In reference to personal care provided to the residents: The direct care staff have been instructed to refer to the unit assistance care guides for direction on meeting the residents□ needs for assistance with personal care/hygiene needs. The nursing assistants were reminded to pay particular attention to cleaning eyeglasses, removal of facial hair, and cleaning/cutting fingernails. The grooming needs of resident number 32 were reviewed. Auditing by qualified staff will be monitored to identify any additional grooming needs. Residents number 38 and 70 have both been discharged from the facility. In reference to obtaining weights: The licensed and certified nursing staff have been instructed to refer to the physician□s orders and unit assistance care guides for direction on the frequency of resident□s weights. The importance of obtaining	

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{F 282}	Continued From page 2 OUTPUT RECORDED: R38 had a physician orders dated 3/19/15, revealed orders to empty colostomy every shift and as needed and document output every shift. The order was dated 1/9/15. Document review of resident care plan dated 3/19/15, revealed a care plan problem of altered elimination. Approaches included to record ostomy output every shift. Document review of facility treatment sheets dated 3/11/15 to 3/18/15, revealed staff directed to empty colostomy every shift and as needed and document output. Document review of treatment sheets for 3/11/15 to 3/18/15, revealed colostomy output was documented 12 out of 24 possible shifts. Document review of facility bowel movement charting (colostomy) for 3/11/15 to 3/18/15, revealed bowel movement output (colostomy) was documented 17 out of 24 possible shifts. During interview on 3/20/15, 8:10 a.m., director of nursing verified colostomy output was not recorded each shift. Director of nursing stated the facility bowel movement sheets were nursing assistant documentation of bowel movements (colostomy) and treatment sheet was nurse documentation of colostomy output. Director of nursing stated she expected nursing assistants to report colostomy output to the nurse and nurse to document colostomy output on the treatment sheet. Director of nursing verified the facility lacked consistent monitoring of R38 ' s colostomy output. Document review of facility Care Plan policy	{F 282}	weights as instructed on the care guides was reinforced with the certified nursing assistants. The need to assure timely weights, monitor weight changes, and report weight changes as the physician directs were reviewed with the licensed nurses. In reference to monitoring colostomy output and weights for residents: The nursing staff have been instructed on the need to follow the physician□s orders for monitoring output and weights. Residents who require monitoring and output by physician order will be tracked for changes to weight and output. The facility□s monitoring and documentation procedures were discussed as part of the staff instruction/education process. Compliance with care plans addressing assistance with personal cares, obtaining weights, reporting of weight changes, monitoring output, will be monitored by the Director of Nursing/designee through random observation and record review for one month. Compliance will be reviewed at the next Quality Assessment and Assurance Committee meeting. Completion Date: April 17, 2015	

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{F 282}	Continued From page 3 reviewed dated 2/2015, indicated the purpose of the care plan was, " To provide a multi-disciplinary, comprehensive plan of care which provides a working tool that addresses the needs of each resident. " LACK OF NAIL AND FACIAL HAIR GROOMING: R32's facility admission record indicated R32 had diagnoses that included but was not limited to dementia with Lewy bodies, diabetes, and generalized muscle weakness. 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 current care plan was provided by the facility on 3/18/15 and reviewed. The care plan indicated R32 was extensive assist with activities of daily living however, lacked direction to staff when, how, and by whom grooming and hygiene assistance would be provided. The care plan also indicated the R32 could be resistive to cares and directed staff to re-approach R32 at a different time to provide necessary care. During an observation on 3/18/15 at 11:55 a.m., R32 had very long soiled fingernails. Left hand contracture caused finger nails to leave indentations on the palm of the hand. R32 also was not cleanly shaven; had long facial hair above the upper lip and on chin and neck. R32 stated he liked to be shaved daily. During an interview on 3/18/15, at 4:11 p.m., nursing assistant (NA)-A verified R32 ' s long fingernails and had facial hair. NA-A offered R32 a shave and fingernail care however, R32 declined. NA-A explained R32 sometimes became agitated with cares and would refuse. NA-A stated if a resident refused cares a nurse	{F 282}		

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{F 282}	Continued From page 4 would be notified. During an observation on 3/19/15, at 8:51 a.m. R32 continued to have long soiled nails and had facial hair. R32 ' s nursing notes were reviewed from 3/18/15; notes did not indicate resident had refused cares or further attempts or offers were made to provide hygiene assistance. A facility policy on providing grooming/hygiene assistance was not provided.	{F 282}		
{F 312} SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to meet the assessed grooming needs for 1 of 3 residents (R32) who had soiled fingernails and long facial hairs. Findings included: R32's facility admission record indicated R32 had diagnoses that included but was not limited to dementia with Lewy bodies, diabetes, and generalized muscle weakness. 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.	{F 312}	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 oral hygiene. Resident 32 identified as needing assistance with personal care is currently receiving assistance according to the individualized plan of care. Nursing staff are auditing residents for grooming needs and nail care. During the next CNA/Nurses meeting staff	4/17/15

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{F 312}	Continued From page 5 R32's current care plan was provided by the facility on 3/18/15 and reviewed. The care plan indicated R32 was extensive assist with activities of daily living however, lacked direction to staff when, how, and by whom grooming and hygiene assistance would be provided. The care plan also indicated the R32 could be resistive to cares and directed staff to re-approach R32 at a different time to provide necessary care. During an observation on 3/18/15 at 11:55 a.m., R32 had very long soiled fingernails. Left hand contracture caused finger nails to leave indentations on the palm of the hand. R32 also was not cleanly shaven; had long facial hair above the upper lip and on chin and neck. R32 stated he liked to be shaved daily. During an interview on 3/18/15, at 4:11 p.m., nursing assistant (NA)-A verified R32 ' s long fingernails and had facial hair. NA-A offered R32 a shave and fingernail care however, R32 declined. NA-A explained R32 sometimes became agitated with cares and would refuse. NA-A stated if a resident refused cares a nurse would be notified. During an observation on 3/19/15, at 8:51 a.m. R32 continued to have long soiled nails and had facial hair. R32 ' s nursing notes were reviewed from 3/18/15; notes did not indicate resident had refused cares or further attempts or offers were made to provide hygiene assistance. A facility policy on providing grooming/hygiene assistance was not provided.	{F 312}	will be in-serviced on the policy & procedures for meeting the resident needs based on the individualized care plan. The Director of Nursing/designee will perform random audits will be conducted for one month to ensure that personal hygiene and eating needs are being met for those residents requiring assistance and are addressed on the care plan. Completion Date: April 17, 2015	
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	{F 315}		4/17/15

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{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: Based on observation, interview and document review, the facility failed to ensure a comprehensive bladder assessment and an assessment of risks for developing urinary tract infections (UTIs) was completed for 2 of 3 residents (R23 & R70) reviewed with recurrent urinary tract infections and the facility failed to follow physician orders for intermittent catheterizations and failed to monitor, evaluate, and assess urine output for 1 of 1 residents (R70) in the sample with scheduled physician ordered catheterizations. Findings Include: R23's nursing notes and treatment administration record (TAR) were reviewed from 3/11/15-3/19/15. Nursing notes did not indicate indwelling catheter was being monitored for signs and symptoms of infection, integrity of indwelling catheter and urine, and if general maintenance care had been provided. The treatment administration record had two different areas that output had been recorded; the entries of output are inconsistent and were incomplete. The TAR lacked 24 hour totals on all daily entries recorded; 24 hour totals were not assessed.	{F 315}	Tag F315 Urinary Incontinence Maple Manor Nursing & Rehab, LLC ensures that a resident does not have an indwelling catheter placed unless the resident□s clinical condition demonstrates that catheterization is necessary; and that 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. Residents with or without a catheter receive appropriate care and services to prevent infections to extent possible. According to the updated facility policy, a bladder assessment is completed for each resident on admission, quarterly, with a change of condition, and as needed. Residents with risk factors for urinary tract infections will have this documented in the progress notes and in the plan of care. According to facility policy, the physician/nurse practitioner is notified	

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{F 315}	Continued From page 7 R23's quarterly Minimum Data Set (MDS) dated 3/20/15 indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 13, was dependent on staff for activities of daily living (ADLs) of bed mobility, eating, toilet use, and personal hygiene, had diagnoses that included but was not limited to heart failure, hypertension, diabetes, hemiplegia, and required an indwelling urinary catheter (the facilities disease index report indicated R23 had diagnoses of neurogenic bladder). R23's current care plan provided by the facility on 3/19/15 included the direction to care for indwelling catheter that included but not limited to monitor for signs and symptoms of infection (included decreased urine output) related to indwelling catheter, and check and empty urine collection bag every shift, apply leg strap, placement of drainage bag, maintain a closed drainage system, and change catheter per policy. R23's current physician's orders provided by the facility included a 2 liter fluid restriction and measure output every shift, and change catheter every month on the 14th of every month. R23's physician orders and care plan lacked catheter size, retention balloon size, frequency of cleaning maintenance care, and frequency of checking catheter patency integrity. The care plan failed to address risk for infection associated with use of indwelling Foley catheter with associated interventions to minimize risk for infection. R23's medical record did not contain an indwelling catheter assessment. During an interview on 3/19/15, at 9:39 a.m., registered nurse (RN)-A explained routine catheter care (cleaning and maintenance) instructions would be on the TAR and nursing notes would address urine integrity and if the catheter was patent. RN-A stated catheter care	{F 315}	when a resident is exhibiting urinary tract symptoms. The nursing staff document urinary tract symptoms, notification of the physician/nurse practitioner, and any medical/nursing interventions. Follow up on the effectiveness of the treatments/interventions is documented. According to facility policy, when a resident requires intermittent in and out catheterization or has an indwelling catheter, the output is documented in the medical record. Indwelling catheters are hung/placed below the level of the bladder and off of the floor with the tubing arranged to avoid kinking or pulling. All catheter bags are placed in a pouch cover. A bladder scan is performed prior to/after an in and out catheterization with perameters ordered by the physician/nurse practitioner. The results of the scan and the output are documented in the medical record. When a resident refuses to be catheterized, the refusal is documented in the medical record. At the mandatory meetings, the nursing assistants will be reinstructed on placement of the urine collection bags, covering the bags to maintain resident dignity, and documenting output. The licensed nurses will be instructed on the facility□s policy and procedures for completing bladder assessments, assessing the resident□s risk of urinary tract infections, documenting the resident□s urinary tract symptoms prior to calling the physician/nurse practitioner, monitoring/documenting follow up on the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 315}	Continued From page 8 (cleaning and maintenance) should be in the care 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 explained aide staff would alert nurses if there was a concern with the catheter. During an interview on 3/19/15, at 9:53 a.m., RN-C explained catheter care entailed; emptying collection bag once per shift, cleaning the collection bag with vinegar if the leg bag is applied, and new catheter was inserted once per month. RN-C stated, "I think they change the collection bag once per week, but I ' m not sure." During an interview on 3/19/15, at 9:58 a.m., nursing assistant (NA)-B explained catheter care entailed; cleaning the collection bag with vinegar and cleaning the tube with every incontinent bowel episode. In response to the question, "How often do you check the tubing for kinks to ensure patency?" NA-B stated the catheter bag was checked at the beginning and end of the shift and with each incontinent episode. During an interview on 3/19/15, at 10:30 a.m. director of nursing (DON) stated output monitoring should have been recorded on the TAR, and the aides should be providing cleaning of catheter. The DON explained she was not familiar with routine checking catheter tubing for patency. Facility policy, physician orders, and the care plan did not instruct staff to clean the collection bag with vinegar, if it should be cleaned, how often it should be cleaned or how often the collection bag should be changed. According to the Centers for Disease Control and Prevention (CDC) article in regards to Guideline	{F 315}	effectiveness of nursing/medical interventions, following the physician□s orders for intermittent catheterization intervals, and notifying the physician of large residual amounts. Resident number 23 □ The resident□s bladder function (has indwelling suprapubic catheter due to a neurogenic bladder) was reassessed by a registered nurse including an assessment of the resident□s risk of urinary tract infections. The care plan has been reviewed and revised accordingly. Resident number 70 was discharged from the facility on March 23, 2015. The Director of Nursing/designee will perform random audits through observation and record review for one month to ensure catheterization protocol is followed, that residents with symptoms of urinary tract infection have appropriate documentation and follow up, and that bladder assessments are completed as scheduled. Completion Date: April 17, 2015	

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{F 315}	Continued From page 9 for prevention of catheter-associated urinary tract infections 2009." Recommends, "Keep the catheter and collecting tube free from kinking, routine hygiene is appropriate (cleansing of the meatal surface during daily bathing or showering). Routine installation of antiseptic or antimicrobial solutions into urinary drainage bags is not recommended." R70's quarterly Minimum Data Set (MDS) dated 2-10-15 revealed R70 had a BIMS score of 13 indicating intact cognition, required extensive assistance to meet personal hygiene needs, required limited assist to meet toileting needs and was intermittently cauterized. R70's record review lacked a comprehensive bowel and bladder assessment and a comprehensive UTI risk assessment even though R70 had a current history of UTIs. R70's current care plan provided by the facility on 3/19/15 indicated R70 occasionally refused cares and gave staff direction to chart refusals. Care plan indicated resident was at risk for fluid volume deficit and directed staff to report no urine output in a shift. Care plan also indicated R70's diagnosis of hypertonic bladder, benign prostatic hyperplasia (enlarged prostate) with obstruction, and required intermittent catheterization and directed staff to perform intermittent catheterization as ordered. The care plan did not include the physicians order to bladder scan if needed first. Signed physician's orders dated 12/19/14 included diagnoses of Parkinson's, dementia with Lewy bodies, hypertonicity (increased tension of the bladder making it more rigid, hampering complete urinating ability) of bladder and benign	{F 315}		

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{F 315}	Continued From page 10 prostatic hyperplasia (BPH which is an enlargement of the prostate) making it more difficult to pass urine. Signed physician's orders dated 12/19/14 included in and out (I and O) catheterization (Cath) every four hours scheduled, may I and O cath for retention/discomfort as needed (PRN) and "ok to bladder scan prior to I and O and hold cath if scanned amount is less than 200 cubic centimeters (cc). R70's treatment administration record (TAR) indicated scheduled I and O cath times were 1:00 a.m., 5:00 a.m., 9 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. However, the documentation to indicate cath was completed was inconsistent. The Maple Manor Bladder Scan Sheets for March 2015 indicated I and O catheterization times and amount of outputs resulting from urinary catheterization. However, the use of the bladder scan was not completed prior to any I & O done. The bladder scan sheet documentation from 3-11-15 to 3-17-15 reflected R70 had I and O cathed a total of 31 times out of 42 opportunities. There were 12 times urine obtained from cathing procedure resulted in amounts 500 cc and above and 8 times collection amounts were 1000 cc and above. At no point during the review from 3-11-15 to 3-17-15 documentation reflected R70 was I and O cathed every four hours per physician's orders or a reason why R70 refused to have it completed. According to an article published by the National Institute of health (NIH Publication No. 14-3195 December 2013) it read, "A normal bladder acts	{F 315}		

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{F 315}	Continued From page 11 like a reservoir and can hold 1.5 [360 cc] to 2 cups [480 cc] of urine." On 3/18/15 at 3:33 p.m. the director of nursing verified R70's TAR indicated scheduled I and O cath times were 1:00 a.m., 5:00 a.m., 9 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. and verified the documentation to indicate catheterization was completed was inconsistent. The DON stated she expected the staff to let the nurse practitioner know, if R70 was refusing to be cathed and stated the facility should look at adjusting the order if R70 was refusing the be cathed. The DON stated it looked like R70 was being catheterized every 8 hours and maybe that would be a more appropriate order for resident. The DON stated there was no documentation in the nurses ' progress notes to say R70 was refusing to being catheterized. The DON stated the comprehensive bowel and bladder assessment and the risk for UTI assessments that were completed for R70 on 2-20-15 were not comprehensive assessments. The DON stated a comprehensive assessment would provide a complete summary of a resident so a person reviewing the record would have a clear picture of the resident and their need for catheterization and why the resident was at risk for UTIs. The DON stated she just made sure the assessments were completed and did not review the assessments to see if they were comprehensive. The DON stated she delegated these assessments to MDS coordinator to complete, but then stated she should have made sure she understood how to complete the comprehensive assessments for Bowel and bladder and at risk for UTI. The DON stated parameters in place for catheterization were not to cath R70 if the bladder scan was less than 200 cc per the physician order and verified	{F 315}		

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{F 315}	Continued From page 12 the physicians order did not have parameters of when to notify resident 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 nurses they were not aware they could not pull that much urine at a time. The DON stated R70 needed to be assessed for appropriate catheter use and stated we should be looking look at doing something different for R70 if he is making that much urine and the staff cannot keep up with the every four hour schedule, the facility needs to look at this and I will bring this forward to the provider for assessment. The DON stated pulling 1000 cc of urine at one time staff could cause hypotension, bladder spasms and stated his bladder should not be that full. The DON stated staff is not assessing the amount of urine being pulled and reporting concerns to the provider for R70. On 3/19/15 at 2:41 p.m. the certified nurse practitioner (CNP)-A stated staff need to cath R70 per his physician order and stated if R70 refused to be cathed they need to report it to the charge nurse and educate the resident and family on the refusals. CNP-A stated she was unaware this was a problem for R70 and stated if he refused to be cathed and was having this high of urine output the facility needed to look at placing a Foley catheter for this resident. CNP-A stated pulling off 1300 cc of urine was a huge amount and stated there would be potential for harm to the resident. CNP-A stated she expected to be notified if R70 refused to be cathed three times in a row or if the staff was pulling off over 750 cc three times in a row and stated this would need to be addressed. CNP-A stated the physician's order should have	{F 315}		

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{F 315}	Continued From page 13 parameters of when to notify the provider of high urine outputs. On 3/19/15 at 3:09 p.m. licensed practical nurse (LPN)-A stated R70 was cathed two times on his shift. LPN-A stated he bladder scanned R70 depending him on what his urine outputs were and documented the urine output on the sheet (Maple Manor Bladder Scan Sheet). LPN-A stated R70 would often refuse to be bladder scanned and just wanted to be cathed. LPN-A stated he documented R70's urine output in the book and the nurse practitioner could look at it in the book is she wanted to see R70's outputs. LPN-A stated he would fill out an SBAR (communication to the provider of a concern) for the nurse practitioner when R70 had urine output below 200 cc. LPN-A stated we are not going to turn in a report on R70's urine outputs weekly as the CNP didn't have time for that. LPN-A verified he would notify the CNP of low urine output anything under 200 cc but stated he has never reported any high urine outputs to the CNP. On 3/20/15 at 9:42 a.m. licensed practical nurse (LPN)-B stated she usually tried to cath R70 twice a day on her shift. LPN-B stated there were five times R70 was cathed for over 1000 cc at one time and three times R70 was cathed for 1000 cc at one time between 3-11-15 and 3-17-15 and the nurse practitioner should have been informed of the high urine output. The facility did not have a policy for in and out catheterization.	{F 315}		
{F 318} SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	{F 318}		4/17/15

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{F 318}	Continued From page 14 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess the benefits and risks of continuing ROM (range of motion) services for 1 of 3 residents (R32) reviewed for ROM services. Findings included: R32's facility admission record indicated R32 had diagnoses that included but was not limited to dementia with Lewy bodies, hemiplegia (right side), diabetes, and generalized muscle weakness. R32's quarterly Minimum Data Set (MDS) dated 1/9/15 indicated was moderately cognitively impaired and required extensive assist with activities of daily living that included eating, toileting, transfers, dressing and hygiene. R32 ' s current care plan was provided by the facility on 3/18/15 and reviewed. The care plan indicated R32 was extensive assist with activities of daily living, had the potential for pain related to degenerative joint disease and limited mobility, had a right hand contracture and utilized a splint during the night; R32 did not ambulate, and required a mechanical lift for transfers. The care plan identified R32 had resistive behaviors that included interventions to prevent or minimize behaviors. The care plan also indicated R32 had Parkinson ' s that had been treated with	{F 318}	Tag F318 Range of Motion R32 was evaluated by therapies and set-up for active/ passive ROM program as tolerated. Other residents who may benefit from a range of motion program will be assessed for referral in the interdisciplinary care conference schedule. In addition to wheelchair positioning and appropriate mechanical lift assessment, therapies are evaluating for range of motion programs to maintain or enhance residents well-being. As residents transition from active PT and OT interventions, staff will be trained for ongoing maintenance. Nursing management or designee will be responsible for monitoring by random monthly audits. Completion Plan Date: April 17, 2015	

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{F 318}	Continued From page 15 medications. Diagnosis of Parkinson ' s was not indicated on the MDS, physician ' s orders, or the facility ' s disease index report for this resident. R32 ' s care plan also revealed a range of motion and exercise program had been in place and was discontinued. The care plan read, " Resident refuses and becomes abusive when attempted (even when he has agreed to ROM) to perform maintenance cares with this resident puts the resident and staff in harm ' s way. " The care plan did not indicate a date when ROM or exercise program was discontinued. The only documentation that indicated R32 displayed disruptive behaviors or refusal of ROM program was entered into a nursing note on 5/2/14; the note read, "Seated bilateral L.E. [lower extremity] exercises, 5 reps [repetitions] daily.-supine exercises 10 x [times] daily. Resident refuses, becomes agitated (hitting, kicking, biting, etc.) continue to encourage. A referral to physical therapy (PT) or a comprehensive assessment to determine appropriateness of the program that had been in place and/or an assessment to determine ongoing treatment and or interventions to prevent or slow decline of mobility was not found in the medical record. There was no documentation that indicated the physician had been notified or consulted ROM program/exercise program had been discontinued. Furthermore, evidence could not be found in the medical record resident and family members were given education of risk/benefits for continuing or discontinuing ROM/exercise programs. During an interview on 3/19/15, at 1:29 p.m. physical therapist assistant (PTA)-A stated R32 had not received physical or occupational services for ROM services in the last year nor did nursing make a referral to evaluate for	{F 318}		

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{F 318}	Continued From page 16 appropriateness of ROM services in the last year. During an interview on 3/19/15, at 1:34 p.m. doctor of physical therapy (DPT)-A explained if a resident displayed behaviors or nursing had difficulties with residents performing ROM/exercises we would look at the program to determine if the behaviors were a result of discomfort, if the exercises were being performed correctly, if the time of day was a factor for refusals or behaviors. DPT-A stated the program should just not be discontinued without attempting to determine why the resident is refusing or displaying behaviors. " We want to look at the reason why and what is going on ...and exhaust all options." DPT-A stated programs can be revised and designed to accommodate the resident and the nursing department should communicate with the physical therapy department with concerns and status of the ROM programs. DPT-A stated, " It ' s a collaborative effort." During an interview on 3/19/15, at 2:00 p.m. director of nursing (DON) stated there was only one nursing note in the medical record regarding refusal by R32 to participate in ROM/exercise program. DON stated, "the program was more than likely discontinued without determining or reevaluating what the cause of behaviors during the program were ...the physician should have been consulted and an assessment should have been completed to attempt root cause analysis and if the resident needed to be referred to physical therapy." According to the facility's plan of correction dated 3/11/15 it read, "...other residents who would benefit from range of motion programs will be assessed for referral in the interdisciplinary care conference schedule. The facility is in the process of developing a restorative nursing	{F 318}		

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{F 318}	Continued From page 17 program...nursing management or designee will be responsible for monitoring by random monthly audits..." The facility provided a random audit to ensure ROM programs were being addressed and completed was performed by the facility between 3/11/15 and 3/18/15; an audit pertaining to R32 had not been performed. The facility provided a range of motion guideline however, the guideline did not include: how the need for ROM services would be identified, when assessment or evaluation would be conducted, when to make outside referrals to physical or occupational therapy, under what circumstances programs would be discontinued, and how to monitor and track progress or decline of the resident who would receive ROM services.	{F 318}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive fall assessment for 2 of 3 residents (R58, R43) reviewed in the sample for falls. Findings included: R58 sustained an unwitnessed fall on 3/15/15 that lead to an emergency room visit to rule out	{F 323}	Tag F323 Accidents Maple Manor Nursing & Rehab, LLC provides an environment as free of accident hazards as is possible and each	4/17/15

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{F 323}	Continued From page 18 hip and/or pelvic fracture. The facility failed to assess/evaluate the fall for root cause analysis and determine and put ongoing interventions in place to prevent or minimize risk for further falls. Facility admission record indicated R58 was admitted to the facility on 11/6/13 and had diagnoses that included but were not limited to dementia, depressive disorder, and history of stroke. R58's quarterly Minimum Data Set (MDS) dated 3/20/15 indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 2, displayed physical, verbal, and other behaviors 1-3 days per week, required extensive assist of two staff members for bed mobility, transfers, toileting, personal hygiene, and required extensive assist of one staff for ambulation. The MDS further indicated R58 was not steady and only able to stabilize with staff assistance with transfers, walking, turning around when standing, and moving from a seated position to a standing position. The MDS also revealed the resident was frequently incontinent of bowel and bladder, had sustained 2 falls since the last assessment period, and was not receiving therapies or nursing restorative program. R58's most recent care plan provided by the facility indicated R58 was at risk for falls related antidepressant medication. The care plan directed staff to use the following interventions to prevent or minimize the risk for falls; on 11/10 /14 care plan was revised to add Dycem in wheel chair to prevent slipping out, on 12/1/14 toileting plan updated to toilet every one hour while awake (later revised on 12/17/14 to prompt every 2 hours while awake, evening to toilet at 10:00 p.m. and nights to toilet at 6:00 a.m., on 1/7/15 care plan was revised to include a perimeter mattress	{F 323}	resident has adequate supervision and assistance devices to prevent avoidable accidents. A comprehensive fall risk assessment is completed on all residents on admission, with a change of condition, and as needed. The care plan identifies risk factors and interventions that are initiated to prevent avoidable falls. If a resident does have a fall, incidents are reviewed in IDT meetings. Referrals are made and interventions are initiated as appropriate. The plan of care is reviewed and revised accordingly. Fall assessments for resident 58 and 43 were completed and referrals made. The policy and procedure for accidents/falls was reviewed. At the Nurses meetings on April 2nd & 3rd 2015 the staff was in-serviced and re-educated on the policy and procedure for fall risk assessments and intervention implementation. The Director of Nursing and/or designee will monitor for compliance for the next 4 weeks. Completion Date: April 17, 2015	

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{F 323}	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 score ....alert 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 resident involved ....all residents that have sustained an injury, or involved in a fall, must have a full set of vital signs taken at the time of incident and every 4 hours for 24 hours after, observe resident closely for change from normal habits that could be an indication there is an injury not noticed or diagnosed during the initial	{F 323}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 20 assessment, resident's care plan should be revised and updated with information pertinent to incident along with interventions, fall risk assessment will be reviewed." The policy also directed staff to perform an investigation as well as implementing immediate interventions.	{F 323}		
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	{F 329}	Tag F329	4/17/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	R 03/20/2015

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{F 329}	Continued From page 21 review, the facility did not ensure adequate side effects monitoring was completed to determine side effects for the use of psychotropic medications for 1 of 5 residents (R68) who received Seroquel an antipsychotic medication. Findings Include: R68 received an antipsychotic medication (Seroquel) and was not monitored for possible side effects. R68's Medication Administration Record (MAR) for 3/1/15 through 3/31/15, listed R68's diagnoses including psychosis, dementia, depression, anxiety state and urinary retention. The MAR also indicated R68 was on Seroquel 12.5 mg every evening; Remeron (antidepressant) 15 mg at bedtime. R68's MAR or treatment sheet for 3/1/15 through 3/31/15 did not include monitoring for side effects for the use of the Seroquel. The care plan dated 1/27/14 indicated R68 was at risk for falls related to psychotropic medication use. Interventions include giving medications per orders. However, side effects of psychotropic medications in relation to falls were not identified and were not specifically planned to be monitored. 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	{F 329}	Unnecessary Drugs Maple Manor Nursing & Rehab, LLC staff assures that each resident□s drug regime is free from unnecessary drugs. The resident□s drug regime is reviewed by the staff, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences. The medication review includes monitoring for unnecessary duplicate therapy. The policies related to completion of the Abnormal Involuntary Movement Scale to assess (AIMS) for adverse effects of antipsychotic medications. AIMS assessments will continue to be done monthly for three months and then every six months. During the consultant pharmacist□s monthly medication audits and the quarterly care planning process, the resident□s medications will continue to be reviewed to assure that the resident is receiving the lowest effective medication dose with appropriate indications and monitoring. Other residents who are prescribed antipsychotic medications will be observed for targeted behaviors and physical side effects and reviewed quarterly as well. Resident number 68 -- The AIMS assessment was completed February 20,	

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{F 329}	Continued From page 22 identify specific side effects of psychotropic medications to be monitored. On 3/19/15 at 10:54 p.m. licensed practical nurse (LPN)-C stated he monitored R68 for targeted behaviors for the use of the Seroquel, not for side effects. LPN-C verified the MAR and treatment administration record (TAR) did not include monitoring of possible side effects for the use of Seroquel. On 3/19/15 at 11:49 a.m. the director of nursing (DON) stated her expectation would be the side effects staff was to monitor for should be included in the specific resident order for the medication, should be monitored for on the MAR and included in the care plan for the resident. The DON verified R68 received an antipsychotic medication (Seroquel) and was not monitored for possible side effects. The facility's Antipsychotic Medication Use policy dated 3/2015 read, "...Nursing staff shall monitor and report any of the following side effect to the Attending Physician: a. Sedation; b. Orthostatic hypotension; c. Lightheadedness; d. Dry mouth; e. Blurred vision; f. Constipation; g. Urinary retention; h. Increased psychotic symptoms (atropine psychosis); i. Extrapyramidal effects; j. Akathisia [Akathisia is a movement disorder characterized by inner restlessness and the inability to sit or stand still]; k. Dystonia [Dystonia is a movement disorder that causes involuntary contractions of your muscles. These contractions result in twisting and repetitive movements.]; l. Tremor [A tremor is an involuntary, somewhat rhythmic, muscle contraction and relaxation involving oscillations or twitching movements of one or more body parts.]; m. Rigidity [Hypokinesia	{F 329}	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 staff will continue to document observed target behaviors and monitor for any physical side effects. The Director of Nurses/designee and the Consultant Pharmacist will continue to monitor for compliance with antipsychotic side effect monitoring, behavior related documentation, and duplicate drug therapy during the routine quarterly record reviews and more often if indicated. Completion date: April 17, 2015	

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{F 329}	Continued From page 23 refers to decreased bodily movement. One of the two categories of movement disorders, hypokinesia is characterized by a partial or complete loss of muscle movement]; n. Akinesia [akinesia /aki·ne·sia/ (a?ki-ne´zhah) absence, poverty, or loss of control of voluntary muscle movements.]; or tardive dyskinesia [Tardive dyskinesia is a mostly irreversible neurological disorder of involuntary movements caused by long-term use of antipsychotic or neuroleptic drugs.] ..."	{F 329}		
{F 431} SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	{F 431}		4/17/15

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{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 unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed store, date when open and discard medications timely. This had the potential to affect the majority of residents who use the medications stored or used in the facility. Findings included: The facilities plan of correction dated 3/11/15 indicated all medication storage areas had been check for outdated and discontinued medications and biologicals and a planned mandatory meeting was held that instructed licensed nurses and trained medication aides the procedures for processing discontinued and outdated medications and biologicals and dating open insulin vials. However, outdated medications and storage concerns were again found. During medication storage review of the north medication room refrigerator on 3/18/15, at 8:15. a.m. an open vial of Fluzone (influenza vaccine) with no open date after being opened and this was observed in the presence of registered nurse (RN)-B. RN-B verified there was not an open date on the vial and indicated it should have had an open date located on the vial. The medication refrigerator also contained Novolog (insulin) flexpen prefilled syringe and a Lantus (insulin)	{F 431}	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 medications 2) accurate labeling and 3) a system of medication records that enables periodic accurate reconciliation and accounting of all controlled medications. The facility utilizes only persons authorized under state requirements to administer medications. Outdated and expired drugs and biologicals are routinely discarded according to accepted practice standards. The policies for storage of medications were reviewed and found appropriate. All medication storage areas were checked for outdated and discontinued medications and biologicals. On a routine basis, a nurse or trained medication aid will be assigned by the Director of Nursing to audit the medication carts for expired	

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{F 431}	Continued From page 25 pen prefilled syringe for R96. During medication storage review of the north wing medication cart on 3/18/15, at 8:20 a.m. an bottle of MAPAP extra strength 500 milligrams (Acetaminophen) had a pharmacy label that indicated the expiration date was December 2014 with a manufacturer's expiration date on the bottle of September 2016. Trained medication assistant (TMA)-A verified mismatched date and explained the medication bottle should have a new label; the bottle was removed from the cart. During mediation storage review of the east/west medication room refrigerator on 3/18/15, at 8:52 a.m. revealed one open vial of Aplisol (tuberculin testing solution) with missing doses with an open date of 1/28/15. TMA-B verified open date on the vial and removed it from the refrigerator. One of two boxes of Aplisol was saturated from the moisture in the refrigerator, the freezer had ice buildup and the temperature outside the freezer read 40 degrees Fahrenheit. During medication storage review of the west medication room cart on 3/18/15, at 9:00 a.m. an open bottle of lantanoprost (eye drops to control progression of glaucoma) with missing doses and with no open date for R110. TMA-B verified no open date on the bottle and explained drops expired 42 days after open date. During medication storage review of the east medication cart on 3/18/15, at 10:40 a.m. revealed two open bottles of lantanoprost with missing doses and with no open dates for R48 and R74. RN-C verified bottles of lantanoprost were open and did not indicate open dates. The Aplisol package insert read, " Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency" and "Failure to store and handle Aplisol as recommended may result in loss of	{F 431}	medication and appropriate dating of insulin vials During the planned mandatory meeting, the licensed nurses and trained medication aides will be instructed on 1) the procedures for processing discontinued and outdated medications and biologicals and 2) dating opened insulin vials. Compliance with dating of insulin vials and disposition of outdated medications/biologicals will be monitored every week for one month by the Director of Nurses/designee and every quarter by the consultant pharmacist. If noncompliance is noted additional monitoring and staff education will be done. Compliance will be reviewed during the March Quality Assessment and Assurance Committee meetings. Completion Date: April 17, 2015	

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{F 431}	Continued From page 26 potency and inaccurate test results." The Latanoprost package insert read, "....once bottle is opened for use, it may be stored at room temperature up 25 C [Celsius] (77 F [Fahrenheit]) for 6 weeks." The facility policy medication storage policy last reviewed February 2015, read, "drugs shall not be kept on hand after the expiration date on the label ...No food items can be stored in the medication refrigerator ... On a weekly basis the night nurse will check both the refrigerator and medication carts for expired medications, remove them and dispose per disposal policy ...and all medications on hand for residents who expire and those medications not sent home with residents at time of discharge shall be immediately withdrawn from stock and either locked away separately or immediately destroyed ..." The policy did not address when to date when opened especially for use of multi-dose vials that have expiration after opening other than insulin.	{F 431}		
{F 441} SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	{F 441}		4/17/15

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{F 441}	Continued From page 27 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a surveillance program to identify resident infections that included trends and analysis of data and failed to educate staff on personal protective equipment (PPE) and isolation precautions for R63 if necessary by the Centers for Disease Control (CDC). Findings included: During an interview on 3/19/15, at 3:11 p.m. the director of nursing (DON) confirmed there was not an infection control log for March 2015 started. The DON also confirmed tracking or trending of infections had not been completed so	{F 441}	Tag F441 Infection Control Maple Manor Nursing & Rehab, LLC has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The infection control program 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be	

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{F 441}	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 garbage bag. During an interview on 3/19/15, at 4:00 p.m. R63 stated he had two different infections in his wound, but could not recall the name of them. R63 stated he had 2 different kinds of IV antibiotics. R67 also had a PICC on the right arm. During an interview on 3/19/15, at 4:01 p.m., LPN-C stated he was not aware of what infection	{F 441}	implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The facility has comprehensive infection control policies and procedures that have been reviewed and revised to more closely reflect the current standards of practice and the state/federal regulations. The policies address the surveillance and investigation of infections and maintenance of accurate and comprehensive records of resident infections. The revised policies and procedures will provide additional guidance to the nursing staff for identifying and reporting symptoms of possible infections and documenting/tracking related symptoms. Comprehensive tracking logs for both resident and staff reporting of infections have been updated to create current data for trending and analysis of potential infection control status and provide for appropriate interventions to prevent cross-contamination to other residents and staff. Personal protective equipment will be provided and directions posted to contact charge nurse for information on precautions. Compliance with facility policies and regulatory requirements will be monitored by the Director of Nurses/designee through record review and audits of the infection control logs and reports for two	

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{F 441}	Continued From page 29 causing bacterium was in R63 ' s wound. LPN-C stated R63 was not on isolation. To the question, " how do you know which PPE to use if you don ' t know what the bacteria were causing infection? " LPN-C stated, he used contact isolation and wore gloves and a mask. LPN-C indicated he was not sure who determined isolation precautions for residents with active infections. During an interview on 3/20/15, at 8:23 a.m. registered nurse (RN)-B stated R63 had MRSA and was not aware what antibiotics were prescribed. RN-B stated R63 had been on isolation precautions and was not aware when residents could come off of isolation. RN-B explained the nurse that did the admission of the resident would put isolation precautions in place if they were needed.	{F 441}	months and randomly thereafter. The results of the infection control surveillance and investigation activities are reviewed monthly as part of the continuous quality improvement program. Compliance will be reviewed during the May quarterly Quality Assessment and Assurance Committee meeting and ongoing. Completion date: April 17, 2015	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245409	A. Building B. Wing 01 - MAIN BUILDING 01	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 Reg. # NFPA 101 LSC K0062	Correction Completed 03/11/2015	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 03/11/2015	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 03/11/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/kfd	04/29/2015	25822	03/21/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/26/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on April ~~29~~ 27, 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
20565 -- S/S: -- MN Rule 4658.0405 Subp. 3 -- Comprehensive Plan Of Care; Use 300.00
20830 -- S/S: -- MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General 350.00
20895 -- S/S: -- MN Rule 4658.0525 Subp. 2.B -- Rehab - Range Of Motion 350.00
20910 -- S/S: -- MN Rule 4658.0525 Subp. 5 A.B -- Rehab - Incontinence 350.00
20920 -- S/S: -- MN Rule 4658.0525 Subp. 6 B -- Rehab - Adls 350.00
21375 -- S/S: -- 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.

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
gary.nederhoff@state.mn.us
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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
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	(Y2) Multiple Construction	(Y3) Date of Revisit
00916	A. Building B. Wing	3/20/2015

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 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
ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **03/11/2015**	ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp.** LSC	Correction Completed **03/11/2015**	ID Prefix **20930** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **03/11/2015**
ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp.** LSC	Correction Completed **03/11/2015**	ID Prefix **21080** Reg. # **MN Rule 4658.0650 Subp.** LSC	Correction Completed **03/11/2015**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **03/11/2015**
ID Prefix **21550** Reg. # **MN Rule 4658.1325 Subp.** LSC	Correction Completed **03/11/2015**	ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp.** LSC	Correction Completed **03/11/2015**	ID Prefix **21800** Reg. # **MN St. Statute144.651 Sub** LSC	Correction Completed **03/11/2015**
ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **03/11/2015**	ID Prefix **21980** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **03/11/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	03/30/2015	15425	03/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/30/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	R 03/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on March, 18, 19 & 20, 2015. During this onsite visit it was determined one or more licensing order had not been corrected. This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 000}		

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{2 560}	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. As evidenced by: Based on observation, interview and document review, the facility failed to develop interventions to address a history of Clostridium difficile (C-diff) and Vancomycin-resistant enterococcus (VRE) to prevent the spread of these infections for 1 of 1 resident (R38) who had chronic C-Diff and VRE. Findings include: R38 had a history of C-Diff and VRE without care plan interventions to prevent the spread to staff and other residents. R38 ' s diagnosis included C-Diff and history of VRE according to facility current admissions face sheet dated 1/9/15. 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.	{2 560}		

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{2 560}	Continued From page 2 Document review of R38's resident care plan dated 1/5/15; revealed R38 had urinary incontinence and colostomy. The care plan directed staff to assist with incontinence care, ostomy care and to record ostomy output every shift. Document review of R38's resident care plan dated 3/19/15 revealed no staff direction related to C-Diff and VRE precautions. Document review of facility treatment sheets dated 3/11/15 to 3/19/15, revealed R38 was to have colostomy output emptied and measured by staff each shift and as needed. Document review of facility bowel movement charting revealed bowel movements (through colostomy) was to be measured each shift. The emptying of the colostomy and assistance with incontinence care had potential to expose R38, staff, or other resident to C-diff and VRE. During interview on 3/20/15, at 8:10 a.m., director of nursing verified the facility had not developed a care plan to address history of C-diff and VRE. Director of nursing verified she was aware the lack of care plan interventions was identified in the initial survey and stated she would not develop care plan directions for a history of diagnosis. Document review of facility Care Plan policy reviewed dated 2/2015, indicated the purpose of the care plan was, " To provide a multi-disciplinary, comprehensive plan of care which provides a working tool that addresses the needs of each resident." Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 560}		

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{2 565}	Continued From page 3	{2 565}		
{2 565}	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. As evidenced by: Based on interview and document review, the facility failed to ensure the plan of care was followed for 2 of 3 residents (R38, R32) reviewed for care plan interventions. Findings include: LACK of OBTAINING WEEKLY WEIGHTS: R38's physician orders dated 3/19/15, revealed orders to check weights Monday, Wednesday, and Friday. Document review of resident care plan dated 3/19/15, revealed a care plan problem of diet, dated 2/17/15, with intervention to weigh Monday, Wednesday, and Friday. Document review of facility treatment sheets dated 3/11/15 to 3/18/15, revealed check weights Monday, Wednesday, and Friday. However, the treatment sheet revealed no weights were identified out of 4 times possible.	{2 565}		

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{2 565}	Continued From page 4 Document review of facility resident vitals/weights monitoring revealed from 3/11/15 to 3/18/15, no weights were identified out of 4 times possible. According to the same monitoring, most recent weight prior to 3/11/15 and was checked on 2/25/15. During interview on 3/20/15, at 8:10 a.m., director of nursing stated the weights for R38 had been discontinued. At 9:05 a.m., director of nursing stated R38 ' s weights were changed by the nurse practitioner on 3/10/15, to check weights per routine. Director of nursing stated facility routine was to check weights weekly. Director of nursing verified staff were to check weights Monday, Wednesday, and Friday, according to the treatment sheet and care plan. Director of nursing verified weights were not checked according to physician orders, treatment sheet, or resident care plan. LACK OF CONSISTENT COLOSTOMY OUTPUT RECORDED: R38 had a physician orders dated 3/19/15, revealed orders to empty colostomy every shift and as needed and document output every shift. The order was dated 1/9/15. Document review of resident care plan dated 3/19/15, revealed a care plan problem of altered elimination. Approaches included to record ostomy output every shift. Document review of facility treatment sheets dated 3/11/15 to 3/18/15, revealed staff directed to empty colostomy every shift and as needed and document output. Document review of treatment sheets for 3/11/15 to 3/18/15, revealed colostomy output was documented 12 out of 24	{2 565}		

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{2 565}	Continued From page 5 possible shifts. Document review of facility bowel movement charting (colostomy) for 3/11/15 to 3/18/15, revealed bowel movement output (colostomy) was documented 17 out of 24 possible shifts. During interview on 3/20/15, 8:10 a.m., director of nursing verified colostomy output was not recorded each shift. Director of nursing stated the facility bowel movement sheets were nursing assistant documentation of bowel movements (colostomy) and treatment sheet was nurse documentation of colostomy output. Director of nursing stated she expected nursing assistants to report colostomy output to the nurse and nurse to document colostomy output on the treatment sheet. Director of nursing verified the facility lacked consistent monitoring of R38 ' s colostomy output. Document review of facility Care Plan policy reviewed dated 2/2015, indicated the purpose of the care plan was, " To provide a multi-disciplinary, comprehensive plan of care which provides a working tool that addresses the needs of each resident. " LACK OF NAIL AND FACIAL HAIR GROOMING: R32's facility admission record indicated R32 had diagnoses that included but was not limited to dementia with Lewy bodies, diabetes, and generalized muscle weakness. 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 current care plan was provided by the facility on 3/18/15 and reviewed. The care plan indicated R32 was extensive assist with activities	{2 565}		

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{2 565}	Continued From page 6 of daily living however, lacked direction to staff when, how, and by whom grooming and hygiene assistance would be provided. The care plan also indicated the R32 could be resistive to cares and directed staff to re-approach R32 at a different time to provide necessary care. During an observation on 3/18/15 at 11:55 a.m., R32 had very long soiled fingernails. Left hand contracture caused finger nails to leave indentations on the palm of the hand. R32 also was not cleanly shaven; had long facial hair above the upper lip and on chin and neck. R32 stated he liked to be shaved daily. During an interview on 3/18/15, at 4:11 p.m., nursing assistant (NA)-A verified R32 ' s long fingernails and had facial hair. NA-A offered R32 a shave and fingernail care however, R32 declined. NA-A explained R32 sometimes became agitated with cares and would refuse. NA-A stated if a resident refused cares a nurse would be notified. During an observation on 3/19/15, at 8:51 a.m. R32 continued to have long soiled nails and had facial hair. R32 ' s nursing notes were reviewed from 3/18/15; notes did not indicate resident had refused cares or further attempts or offers were made to provide hygiene assistance. A facility policy on providing grooming/hygiene assistance was not provided. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 565}		
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on	{2 830}		

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{2 830}	Continued From page 7 individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on observation, interview and record review, the facility failed to meet the assessed grooming needs for 1 of 3 residents (R32) who had soiled fingernails and long facial hairs. Findings included: R32's facility admission record indicated R32 had diagnoses that included but was not limited to dementia with Lewy bodies, diabetes, and generalized muscle weakness. 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 current care plan was provided by the facility on 3/18/15 and reviewed. The care plan indicated R32 was extensive assist with activities of daily living however, lacked direction to staff when, how, and by whom grooming and hygiene assistance would be provided. The care plan also indicated the R32 could be resistive to cares and directed staff to re-approach R32 at a different	{2 830}		

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{2 830}	Continued From page 8 time to provide necessary care. During an observation on 3/18/15 at 11:55 a.m., R32 had very long soiled fingernails. Left hand contracture caused finger nails to leave indentations on the palm of the hand. R32 also was not cleanly shaven; had long facial hair above the upper lip and on chin and neck. R32 stated he liked to be shaved daily. During an interview on 3/18/15, at 4:11 p.m., nursing assistant (NA)-A verified R32 ' s long fingernails and had facial hair. NA-A offered R32 a shave and fingernail care however, R32 declined. NA-A explained R32 sometimes became agitated with cares and would refuse. NA-A stated if a resident refused cares a nurse would be notified. During an observation on 3/19/15, at 8:51 a.m. R32 continued to have long soiled nails and had facial hair. R32's nursing notes were reviewed from 3/18/15; notes did not indicate resident had refused cares or further attempts or offers were made to provide hygiene assistance. A facility policy on providing grooming/hygiene assistance was not provided. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 830}		
{2 895}	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which	{2 895}		

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{2 895}	Continued From page 9 provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on observation, interview, and document review, the facility failed to assess the benefits and risks of continuing ROM (range of motion) services for 1 of 3 residents (R32) reviewed for ROM services. Findings included: R32's facility admission record indicated R32 had diagnoses that included but was not limited to dementia with Lewy bodies, hemiplegia (right side), diabetes, and generalized muscle weakness. R32's quarterly Minimum Data Set (MDS) dated 1/9/15 indicated was moderately cognitively impaired and required extensive assist with activities of daily living that included eating, toileting, transfers, dressing and hygiene. R32 ' s current care plan was provided by the facility on 3/18/15 and reviewed. The care plan indicated R32 was extensive assist with activities of daily living, had the potential for pain related to degenerative joint disease and limited mobility, had a right hand contracture and utilized a splint during the night; R32 did not ambulate, and required a mechanical lift for transfers. The care plan identified R32 had resistive behaviors that included interventions to prevent or minimize behaviors. The care plan also indicated R32 had Parkinson ' s that had been treated with	{2 895}		

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{2 895}	Continued From page 10	{2 895}		

medications. Diagnosis of Parkinson ' s was not indicated on the MDS, physician ' s orders, or the facility ' s disease index report for this resident.
R32 ' s care plan also revealed a range of motion and exercise program had been in place and was discontinued. The care plan read, " Resident refuses and becomes abusive when attempted (even when he has agreed to ROM) to perform maintenance cares with this resident puts the resident and staff in harm ' s way. " The care plan did not indicate a date when ROM or exercise program was discontinued.
The only documentation that indicated R32 displayed disruptive behaviors or refusal of ROM program was entered into a nursing note on 5/2/14; the note read, "Seated bilateral L.E. [lower extremity] exercises, 5 reps [repetitions] daily.-supine exercises 10 x [times] daily. Resident refuses, becomes agitated (hitting, kicking, biting, etc.) continue to encourage.
A referral to physical therapy (PT) or a comprehensive assessment to determine appropriateness of the program that had been in place and/or an assessment to determine ongoing treatment and or interventions to prevent or slow decline of mobility was not found in the medical record. There was no documentation that indicated the physician had been notified or consulted ROM program/exercise program had been discontinued. Furthermore, evidence could not be found in the medical record resident and family members were given education of risk/benefits for continuing or discontinuing ROM/exercise programs.
During an interview on 3/19/15, at 1:29 p.m. physical therapist assistant (PTA)-A stated R32 had not received physical or occupational services for ROM services in the last year nor did nursing make a referral to evaluate for appropriateness of ROM services in the last year.

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{2 895}	Continued From page 11 During an interview on 3/19/15, at 1:34 p.m. doctor of physical therapy (DPT)-A explained if a resident displayed behaviors or nursing had difficulties with residents performing ROM/exercises we would look at the program to determine if the behaviors were a result of discomfort, if the exercises were being performed correctly, if the time of day was a factor for refusals or behaviors. DPT-A stated the program should just not be discontinued without attempting to determine why the resident is refusing or displaying behaviors. " We want to look at the reason why and what is going on ...and exhaust all options." DPT-A stated programs can be revised and designed to accommodate the resident and the nursing department should communicate with the physical therapy department with concerns and status of the ROM programs. DPT-A stated, " It ' s a collaborative effort." During an interview on 3/19/15, at 2:00 p.m. director of nursing (DON) stated there was only one nursing note in the medical record regarding refusal by R32 to participate in ROM/exercise program. DON stated, "the program was more than likely discontinued without determining or reevaluating what the cause of behaviors during the program were ...the physician should have been consulted and an assessment should have been completed to attempt root cause analysis and if the resident needed to be referred to physical therapy." According to the facility's plan of correction dated 3/11/15 it read, "...other residents who would benefit from range of motion programs will be assessed for referral in the interdisciplinary care conference schedule. The facility is in the process of developing a restorative nursing program...nursing management or designee will be responsible for monitoring by random monthly	{2 895}		

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{2 895}	Continued From page 12 audits..." The facility provided a random audit to ensure ROM programs were being addressed and completed was performed by the facility between 3/11/15 and 3/18/15; an audit pertaining to R32 had not been performed. The facility provided a range of motion guideline however, the guideline did not include: how the need for ROM services would be identified, when assessment or evaluation would be conducted, when to make outside referrals to physical or occupational therapy, under what circumstances programs would be discontinued, and how to monitor and track progress or decline of the resident who would receive ROM services. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 895}		
{2 910}	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. 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.	{2 910}		

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{2 910}	Continued From page 13 This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on observation, interview and document review, the facility failed to ensure a comprehensive bladder assessment and an assessment of risks for developing urinary tract infections (UTIs) was completed for 2 of 3 residents (R23 & R70) reviewed with recurrent urinary tract infections and the facility failed to follow physician orders for intermittent catheterizations and failed to monitor, evaluate, and assess urine output for 1 of 1 residents (R70) in the sample with scheduled physician ordered catheterizations. Findings Include: R23's nursing notes and treatment administration record (TAR) were reviewed from 3/11/15-3/19/15. Nursing notes did not indicate indwelling catheter was being monitored for signs and symptoms of infection, integrity of indwelling catheter and urine, and if general maintenance care had been provided. The treatment administration record had two different areas that output had been recorded; the entries of output are inconsistent and were incomplete. The TAR lacked 24 hour totals on all daily entries recorded; 24 hour totals were not assessed. R23's quarterly Minimum Data Set (MDS) dated 3/20/15 indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 13, was dependent on staff for activities of daily living (ADLs) of bed mobility, eating, toilet use, and personal hygiene, had diagnoses that included but was not limited to heart failure, hypertension, diabetes, hemiplegia, and required an indwelling urinary catheter (the facilities	{2 910}		

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{2 910}	Continued From page 14 disease index report indicated R23 had diagnoses of neurogenic bladder). R23's current care plan provided by the facility on 3/19/15 included the direction to care for indwelling catheter that included but not limited to monitor for signs and symptoms of infection (included decreased urine output) related to indwelling catheter, and check and empty urine collection bag every shift, apply leg strap, placement of drainage bag, maintain a closed drainage system, and change catheter per policy. R23's current physician's orders provided by the facility included a 2 liter fluid restriction and measure output every shift, and change catheter every month on the 14th of every month. R23's physician orders and care plan lacked catheter size, retention balloon size, frequency of cleaning maintenance care, and frequency of checking catheter patency integrity. The care plan failed to address risk for infection associated with use of indwelling Foley catheter with associated interventions to minimize risk for infection. R23's medical record did not contain an indwelling catheter assessment. During an interview on 3/19/15, at 9:39 a.m., registered nurse (RN)-A explained routine catheter care (cleaning and maintenance) instructions would be on the TAR and nursing notes would address urine integrity and if the catheter was patent. RN-A stated catheter care (cleaning and maintenance) should be in the care 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 explained aide staff would alert nurses if there was a concern with the catheter. During an interview on 3/19/15, at 9:53 a.m.,	{2 910}		

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{2 910}	Continued From page 15 RN-C explained catheter care entailed; emptying collection bag once per shift, cleaning the collection bag with vinegar if the leg bag is applied, and new catheter was inserted once per month. RN-C stated, "I think they change the collection bag once per week, but I ' m not sure." During an interview on 3/19/15, at 9:58 a.m., nursing assistant (NA)-B explained catheter care entailed; cleaning the collection bag with vinegar and cleaning the tube with every incontinent bowel episode. In response to the question, "How often do you check the tubing for kinks to ensure patency?" NA-B stated the catheter bag was checked at the beginning and end of the shift and with each incontinent episode. During an interview on 3/19/15, at 10:30 a.m. director of nursing (DON) stated output monitoring should have been recorded on the TAR, and the aides should be providing cleaning of catheter. The DON explained she was not familiar with routine checking catheter tubing for patency. Facility policy, physician orders, and the care plan did not instruct staff to clean the collection bag with vinegar, if it should be cleaned, how often it should be cleaned or how often the collection bag should be changed. According to the Centers for Disease Control and Prevention (CDC) article in regards to Guideline for prevention of catheter-associated urinary tract infections 2009." Recommends, "Keep the catheter and collecting tube free from kinking, routine hygiene is appropriate (cleansing of the meatal surface during daily bathing or showering). Routine installation of antiseptic or antimicrobial solutions into urinary drainage bags is not recommended." R70's quarterly Minimum Data Set (MDS) dated 2-10-15 revealed R70 had a BIMS score of 13 indicating intact cognition, required extensive	{2 910}		

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{2 910}	Continued From page 16 assistance to meet personal hygiene needs, required limited assist to meet toileting needs and was intermittently cauterized. R70's record review lacked a comprehensive bowel and bladder assessment and a comprehensive UTI risk assessment even though R70 had a current history of UTIs. R70's current care plan provided by the facility on 3/19/15 indicated R70 occasionally refused cares and gave staff direction to chart refusals. Care plan indicated resident was at risk for fluid volume deficit and directed staff to report no urine output in a shift. Care plan also indicated R70's diagnosis of hypertonic bladder, benign prostatic hyperplasia (enlarged prostate) with obstruction, and required intermittent catheterization and directed staff to perform intermittent catheterization as ordered. The care plan did not include the physicians order to bladder scan if needed first. Signed physician's orders dated 12/19/14 included diagnoses of Parkinson's, dementia with Lewy bodies, hypertonicity (increased tension of the bladder making it more rigid, hampering complete urinating ability) of bladder and benign prostatic hyperplasia (BPH which is an enlargement of the prostate) making it more difficult to pass urine. Signed physician's orders dated 12/19/14 included in and out (I and O) catheterization (Cath) every four hours scheduled, may I and O cath for retention/discomfort as needed (PRN) and "ok to bladder scan prior to I and O and hold cath if scanned amount is less than 200 cubic centimeters (cc).	{2 910}		

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{2 910}	Continued From page 17 R70's treatment administration record (TAR) indicated scheduled I and O cath times were 1:00 a.m., 5:00 a.m., 9 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. However, the documentation to indicate cath was completed was inconsistent. The Maple Manor Bladder Scan Sheets for March 2015 indicated I and O catheterization times and amount of outputs resulting from urinary catheterization. However, the use of the bladder scan was not completed prior to any I & O done. The bladder scan sheet documentation from 3-11-15 to 3-17-15 reflected R70 had I and O cathed a total of 31 times out of 42 opportunities. There were 12 times urine obtained from cathing procedure resulted in amounts 500 cc and above and 8 times collection amounts were 1000 cc and above. At no point during the review from 3-11-15 to 3-17-15 documentation reflected R70 was I and O cathed every four hours per physician's orders or a reason why R70 refused to have it completed. According to an article published by the National Institute of health (NIH Publication No. 14-3195 December 2013) it read, "A normal bladder acts like a reservoir and can hold 1.5 [360 cc] to 2 cups [480 cc] of urine." On 3/18/15 at 3:33 p.m. the director of nursing verified R70's TAR indicated scheduled I and O cath times were 1:00 a.m., 5:00 a.m., 9 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. and verified the documentation to indicate catheterization was completed was inconsistent. The DON stated she expected the staff to let the nurse practitioner know, if R70 was refusing to be cathed and stated the facility should look at adjusting the order if R70 was refusing the be cathed. The	{2 910}		

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{2 910}	Continued From page 18 DON stated it looked like R70 was being catheterized every 8 hours and maybe that would be a more appropriate order for resident. The DON stated there was no documentation in the nurses ' progress notes to say R70 was refusing to being catheterized. The DON stated the comprehensive bowel and bladder assessment and the risk for UTI assessments that were completed for R70 on 2-20-15 were not comprehensive assessments. The DON stated a comprehensive assessment would provide a complete summary of a resident so a person reviewing the record would have a clear picture of the resident and their need for catheterization and why the resident was at risk for UTIs. The DON stated she just made sure the assessments were completed and did not review the assessments to see if they were comprehensive. The DON stated she delegated these assessments to MDS coordinator to complete, but then stated she should have made sure she understood how to complete the comprehensive assessments for Bowel and bladder and at risk for UTI. The DON stated parameters in place for catheterization were not to cath R70 if the bladder scan was less than 200 cc per the physician order and verified the physicians order did not have parameters of when to notify resident 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 nurses they were not aware they could not pull that much urine at a time. The DON stated R70 needed to be assessed for appropriate catheter use and stated we should be looking look at doing something different for R70 if he is making that much urine and the staff cannot keep up with the every four hour schedule, the facility needs to look at this and I	{2 910}		

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{2 910}	Continued From page 19 will bring this forward to the provider for assessment. The DON stated pulling 1000 cc of urine at one time staff could cause hypotension, bladder spasms and stated his bladder should not be that full. The DON stated staff is not assessing the amount of urine being pulled and reporting concerns to the provider for R70. On 3/19/15 at 2:41 p.m. the certified nurse practitioner (CNP)-A stated staff need to cath R70 per his physician order and stated if R70 refused to be cathed they need to report it to the charge nurse and educate the resident and family on the refusals. CNP-A stated she was unaware this was a problem for R70 and stated if he refused to be cathed and was having this high of urine output the facility needed to look at placing a Foley catheter for this resident. CNP-A stated pulling off 1300 cc of urine was a huge amount and stated there would be potential for harm to the resident. CNP-A stated she expected to be notified if R70 refused to be cathed three times in a row or if the staff was pulling off over 750 cc three times in a row and stated this would need to be addressed. CNP-A stated the physician's order should have parameters of when to notify the provider of high urine outputs. On 3/19/15 at 3:09 p.m. licensed practical nurse (LPN)-A stated R70 was cathed two times on his shift. LPN-A stated he bladder scanned R70 depending him on what his urine outputs were and documented the urine output on the sheet (Maple Manor Bladder Scan Sheet). LPN-A stated R70 would often refuse to be bladder scanned and just wanted to be cathed. LPN-A stated he documented R70's urine output in the book and the nurse practitioner could look at it in the book is she wanted to see R70's outputs. LPN-A stated he would fill out an SBAR	{2 910}		

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{2 910}	Continued From page 20 (communication to the provider of a concern) for the nurse practitioner when R70 had urine output below 200 cc. LPN-A stated we are not going to turn in a report on R70's urine outputs weekly as the CNP didn't have time for that. LPN-A verified he would notify the CNP of low urine output anything under 200 cc but stated he has never reported any high urine outputs to the CNP. On 3/20/15 at 9:42 a.m. licensed practical nurse (LPN)-B stated she usually tried to cath R70 twice a day on her shift. LPN-B stated there were five times R70 was cathed for over 1000 cc at one time and three times R70 was cathed for 1000 cc at one time between 3-11-15 and 3-17-15 and the nurse practitioner should have been informed of the high urine output. The facility did not have a policy for in and out catheterization. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 910}		
{2 920}	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to:	{2 920}		

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{2 920}	Continued From page 21 Based on observation, interview, and document review, the facility failed to assess the benefits and risks of continuing ROM (range of motion) services for 1 of 3 residents (R32) reviewed for ROM services. Findings included: R32's facility admission record indicated R32 had diagnoses that included but was not limited to dementia with Lewy bodies, hemiplegia (right side), diabetes, and generalized muscle weakness. R32's quarterly Minimum Data Set (MDS) dated 1/9/15 indicated was moderately cognitively impaired and required extensive assist with activities of daily living that included eating, toileting, transfers, dressing and hygiene. R32 ' s current care plan was provided by the facility on 3/18/15 and reviewed. The care plan indicated R32 was extensive assist with activities of daily living, had the potential for pain related to degenerative joint disease and limited mobility, had a right hand contracture and utilized a splint during the night; R32 did not ambulate, and required a mechanical lift for transfers. The care plan identified R32 had resistive behaviors that included interventions to prevent or minimize behaviors. The care plan also indicated R32 had Parkinson ' s that had been treated with medications. Diagnosis of Parkinson ' s was not indicated on the MDS, physician ' s orders, or the facility ' s disease index report for this resident. R32 ' s care plan also revealed a range of motion and exercise program had been in place and was discontinued. The care plan read, " Resident refuses and becomes abusive when attempted (even when he has agreed to ROM) to perform maintenance cares with this resident puts the resident and staff in harm ' s way. " The care plan did not indicate a date when ROM or exercise program was discontinued.	{2 920}		

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{2 920}	Continued From page 22 The only documentation that indicated R32 displayed disruptive behaviors or refusal of ROM program was entered into a nursing note on 5/2/14; the note read, "Seated bilateral L.E. [lower extremity] exercises, 5 reps [repetitions] daily.-supine exercises 10 x [times] daily. Resident refuses, becomes agitated (hitting, kicking, biting, etc.) continue to encourage. A referral to physical therapy (PT) or a comprehensive assessment to determine appropriateness of the program that had been in place and/or an assessment to determine ongoing treatment and or interventions to prevent or slow decline of mobility was not found in the medical record. There was no documentation that indicated the physician had been notified or consulted ROM program/exercise program had been discontinued. Furthermore, evidence could not be found in the medical record resident and family members were given education of risk/benefits for continuing or discontinuing ROM/exercise programs. During an interview on 3/19/15, at 1:29 p.m. physical therapist assistant (PTA)-A stated R32 had not received physical or occupational services for ROM services in the last year nor did nursing make a referral to evaluate for appropriateness of ROM services in the last year. During an interview on 3/19/15, at 1:34 p.m. doctor of physical therapy (DPT)-A explained if a resident displayed behaviors or nursing had difficulties with residents performing ROM/exercises we would look at the program to determine if the behaviors were a result of discomfort, if the exercises were being performed correctly, if the time of day was a factor for refusals or behaviors. DPT-A stated the program should just not be discontinued without attempting to determine why the resident is refusing or displaying behaviors. " We want to	{2 920}		

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{2 920}	Continued From page 23 look at the reason why and what is going on ...and exhaust all options." DPT-A stated programs can be revised and designed to accommodate the resident and the nursing department should communicate with the physical therapy department with concerns and status of the ROM programs. DPT-A stated, " It ' s a collaborative effort." During an interview on 3/19/15, at 2:00 p.m. director of nursing (DON) stated there was only one nursing note in the medical record regarding refusal by R32 to participate in ROM/exercise program. DON stated, "the program was more than likely discontinued without determining or reevaluating what the cause of behaviors during the program were ...the physician should have been consulted and an assessment should have been completed to attempt root cause analysis and if the resident needed to be referred to physical therapy." According to the facility's plan of correction dated 3/11/15 it read, "...other residents who would benefit from range of motion programs will be assessed for referral in the interdisciplinary care conference schedule. The facility is in the process of developing a restorative nursing program...nursing management or designee will be responsible for monitoring by random monthly audits..." The facility provided a random audit to ensure ROM programs were being addressed and completed was performed by the facility between 3/11/15 and 3/18/15; an audit pertaining to R32 had not been performed. The facility provided a range of motion guideline however, the guideline did not include: how the need for ROM services would be identified, when assessment or evaluation would be conducted, when to make outside referrals to physical or occupational therapy, under what circumstances	{2 920}		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 920}	Continued From page 24 programs would be discontinued, and how to monitor and track progress or decline of the resident who would receive ROM services. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 920}		
{21375}	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Based on observation, interview, and document review, the facility failed to develop a surveillance program to identify resident infections that included trends and analysis of data and failed to educate staff on personal protective equipment (PPE) and isolation precautions if necessary by the Centers for Disease Control (CDC). Findings included: During an interview on 3/19/15, at 3:11 p.m. the director of nursing (DON) confirmed there was not an infection control log for March 2015 started. The DON also confirmed tracking or trending of infections had not been completed so far for March. The DON reported since 3/11/15 there had been two cases of infections one of them was R67 who had an open hand wound infection. DON stated she thought bacterium causing infection in the hand wound was	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21375}	Continued From page 25 methicillin resistant staphylococcus aureus (MRSA) and R67 was on isolation precautions. R67 ' 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). R67 ' 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 R67 ' 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 garbage bag. During an interview on 3/19/15, at 4:00 p.m. R67 stated he had two different infections in his wound, but could not recall the name of them. R67 stated he had 2 different kinds of IV antibiotics. R67 also had a PICC on the right arm. During an interview on 3/19/15, at 4:01 p.m., LPN-C stated he was not aware of what infection causing bacterium was in R67 ' s wound. LPN-C stated R67 was not on isolation. To the question, " how do you know which PPE to use if you don ' t know what the bacteria were causing infection? " LPN-C stated, he used contact isolation and wore gloves and a mask. LPN-C indicated he was not	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21375}	Continued From page 26 sure who determined isolation precautions for residents with active infections. During an interview on 3/20/15, at 8:23 a.m. registered nurse (RN)-B stated R67 had MRSA and was not aware what antibiotics were prescribed. RN-B stated R67 had been on isolation precautions and was not aware when residents could come off of isolation. RN-B explained the nurse that did the admission of the resident would put isolation precautions in place if they were needed. During an interview on 3/20/15, at 8:26 a.m. RN-C stated, "I am not sure what [R67] is being treated for ... [R67] was on isolation when he came back from the hospital." RN-C reported she used gloves when changing the dressing. RN-C also explained the facility policy was to remove isolation precautions after 7 days of being treated with an antibiotic. During an interview on 3/20/15, at 9:38 a.m. LPN-D who was assigned to infection control program reported the bacterium that caused the infection in R67 ' s hand had been MRSA. LPN-D explained she had been put in charge of the infection control program, however did not have the experience, education, or training to oversee the infection control program. LPN-D stated her experience with infection control was limited to data entry and recording of information only. Facility policy surveillance for infection control last reviewed in February 2015 read, " Maple Manor Nursing and Rehab, LLC. Closely monitors all residents who exhibit signs/symptoms of infection through ongoing surveillance and sues a systematic method of collecting, consolidating, and analyzing data discern the frequency and likely cause of given illness and/or even, followed by communication of that information to those who can assist with outcome improvement. Infection prevention begins with ongoing	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21375}	Continued From page 27 surveillance to identify infections that are causing or have the potential to cause an outbreak. " The policy also read, " The surveillance processes determines whether the facility...uses personal protective equipment when indicated. " and " All residents are monitored for the risk of infection and for the presence of actual infections." Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{21375}		
{21535}	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced	{21535}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21535}	Continued From page 28 by: This licensing order was not corrected due to: Based on observation, interview and document review, the facility did not ensure adequate side effects monitoring was completed to determine side effects for the use of psychotropic medications for 1 of 5 residents (R68) who received Seroquel an antipsychotic medication. Findings Include: R68 received an antipsychotic medication (Seroquel) and was not monitored for possible side effects. R68's Medication Administration Record (MAR) for 3/1/15 through 3/31/15, listed R68's diagnoses including psychosis, dementia, depression, anxiety state and urinary retention. The MAR also indicated R68 was on Seroquel 12.5 mg every evening; Remeron (antidepressant) 15 mg at bedtime. R68's MAR or treatment sheet for 3/1/15 through 3/31/15 did not include monitoring for side effects for the use of the Seroquel. The care plan dated 1/27/14 indicated R68 was at risk for falls related to psychotropic medication use. Interventions include giving medications per orders. However, side effects of psychotropic medications in relation to falls were not identified and were not specifically planned to be monitored. 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	{21535}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 3QEK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00916

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/30/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 02/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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.

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	01/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		3/11/15

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

Electronically 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	01/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1	F 156		

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

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

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

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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or a uniform denial letter to be used by skilled nursing facilities upon termination of all Medicare Part A skilled services; and failed to provide appropriate liability notices for 4 of 5 residents (R28, R66, R77 & R88) reviewed for liability notices; and failed to provide two day notice prior to discharge from Medicare services for 2 of 5 residents (R77, R88) reviewed for liability notices. Findings include: INACCURATE SKILLED NURSING FACILITY ADVANCED BENEFICIARY NOTICE:	F 156	Tag F156 Medicare Notices Plan of Correction Maple Manor Nursing and Rehab, LLC routinely informs the resident both orally and in writing in a language that the resident understands of his/her rights and 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 stay. Receipt of such information and any amendments to it are acknowledged in writing. The goal of Maple Manor Nursing and Rehab., LLC is to assure that each	

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F 156	Continued From page 3 R77 and R88 received Advance Beneficiary Notice of Noncoverage. However, the form provided was not for skilled nursing facility use. Also no residents in the sample selected option 1 to have their bill submitted to Medicare for review. Document review of the Advance Beneficiary Notice of Noncoverage (Form CMS-R-131 (03/08)) used by the facility, options selection read, " Option 1. I want the (D) Services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles." According to this option, the facility would bill residents until Medicare made a decision and then would refund any payments made by the resident. Document review of Centers for Medicare and Medicaid Services Advance Beneficiary Notice of Noncoverage, form CMS-R-131, " Skilled nursing facilities (SNF) must use the ABN for items/services expected to be denied under Medicare Part B only. " During interview on 1/28/15, at 2:00 p.m., business office assistant (BOA)-A verified R77 and R88 had received Medicare Part A services, were discharged from Medicare Part A, and remained in the facility. BOA-A verified the Advance Beneficiary Notice of Noncoverage was the only Advance Beneficiary Notice of Noncoverage used by the facility.	F 156	resident knows his/her rights and responsibilities and that the facility communicates this information in a timely for all residents not just residents identified as: 28, 66, 77, 88. The facility notifies the resident/family/representative before Medicare benefits are discontinued and provides the resident/family/representative with a notice of their rights of appeal. The regulations and a facility policies/procedures addressing resident notification non-coverage of Medicare benefits were reviewed and in-serviced with responsible staff on 2/9/2015 and 2/11/2015. The Office Manager and/or designee will be responsible for monitoring compliance. Resident records will be audited for two months to verify completion of required Medicare notification compliance. Completion date:3/11/2015	

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F 156	Continued From page 4 LACK OF SKILLED NURSING FACILITY ADVANCED BENEFICIARY NOTICE: R28 was discharged from Medicare Part A services on 12/5/14, according to R28's Notice of Medicare Non-Coverage, a Medicare liability notice. R28 remained in the facility. The facility failed to provide Skilled Nursing Facility Advance Beneficiary Notice, a Medicare liability notice that would allow R28 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 R28 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. R66 was discharged from Medicare Part A services on 8/25/14, according to R66 ' s Notice of Non-Coverage, a Medicare liability notice. R66 remained in the facility. Document review of the Notice of Medicare Non-Coverage, revealed a telephone voice message was left and the notice 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 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	F 156		

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F 156	Continued From page 5 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 9/22/14, 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. R88 was discharged from Medicare Part A services on 9/29/14, according to R88's Notice of Medicare Non-Coverage, a Medicare liability notice, which was signed by representative on 10/2/14, 4 days after Medicare coverage ended. R88 remained in the facility. There was no evidence of when the resident or family was notified of non-coverage prior to Medicare coverage ending. R88 received Skilled Nursing Advanced Beneficiary Notice, signed by representative on 10/2/14, 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 R88 the required 2 days prior to discharge from Medicare services.	F 156		

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F 156	Continued From page 6 During interview on 1/28/15, at 2:00 p.m., BOA-A verified R28, R66, R77, and R88 had received Medicare Part A services, were discharged from Medicare Part A, and remained in the facility. BOA-A verified the facility lacked evidence of resident or representative notification. BOA-A stated the facility did not have a written policy or procedure for liability notices.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident (R96) was assessed and provided the opportunity to self-administer medications. Findings include: R96 was observed on 1/25/15 at 12:00 p.m. R96 was observed to eat regular meals and was interviewed and she knew foods allowed to eat related to her gastric by-pass, kidney transplant, and diabetes. On 1/30/15 at 9:15 a.m. R96 indicated that she managed her diabetes independently at home and that the blood sugar was stable. R96 ' s admission Minimum Data Set (MDS) dated 12/9/14 indicated R96 had a brief interview of mental status (BIMS) score of 14 out of a possible 15 points or was cognitively intact. The MDS also noted that R96 had no functional range	F 176	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. All residents who request to self-administer medications will be assessed to assure that it is safe to do so. A Physician□s order will be obtained and plan of care will be updated. The appropriateness of self-administration of drugs will be reviewed quarterly, with change of condition, and as needed to ensure continued safety. The policy and procedure regarding self-administration of medications was reviewed and revised. Resident number 96 has been assessed	3/11/15

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F 176	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 that 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 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 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. The director of nursing (DON) was interviewed on 1/30/15 at 10:45 a.m. DON indicated residents would need to be assessed prior to the self-administration of medications.	F 176	by the NP and it was determined that she 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 through observation and record review. Completion Date: March 11, 2015	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		3/11/15

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F 225	Continued From page 8 ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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F 225	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate and immediately report allegations of missing money and physical abuse to the administrator and designated state agency for 2 of 3 residents (R70 & R29) reviewed for vulnerable adult reports. Findings included: R70's quarterly Minimum Data Set (MDS) dated 11/20/14 indicated R70, had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of eleven, and required extensive assist for activities of daily living of dressing, toileting, transfers, and hygiene. During an interview on 1/26/15, at 1:00 p.m. R70 stated approximately $30.00 went missing out of his drawer about 3 months ago. R70 stated he had won the money at bingo. R70 stated he had not kept money in room since the $30.00 was missing and had made it a habit to deposit bingo winnings in his account with the facility. R70 stated staff was notified of the missing $30.00. R70 did recall he had talked to the previous administrator about it. During an interview on 1/28/15, at 8:23 a.m. licensed social worker (SW)-A was notified the R70 had reported missing money to this surveyor and stated she had not been aware money had been taken out of R70's drawer. SW-A stated R70 had never reported anything missing that she was aware of. During an interview on 1/29/15, at 8:12 a.m. SW-A stated R70's family member was just informed of the missing money but has not returned her phone call. Also SW-A said she had not reported the missing money to the designated state agency after being informed of it yesterday	F 225	Tag F225 Report/Investigate Allegations Maple Manor Nursing & Rehab, LLC requires that all alleged resident mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property be 1) reported immediately to the administrator and other appropriate officials and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action is taken. The facility intervenes to prevent further potential abuse while the investigation is in process. Maple Manor Nursing & Rehab, LLC does not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating residents. Any knowledge of actions against an employee which would indicate unfitness for service as a nursing assistant or in other resident care positions are investigated and reported to the State nurse aid registry or licensing authorities. The facility□s vulnerable policies, Adult Incident Reporting and Resident Abuse Prevention Plan, were reviewed and found appropriate. The policy language clearly reflects that the appropriate regulatory/government agencies are to be	

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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 the designated state agency. R29's had a grievance form completed by SW-A indicated an allegation of physical abuse occurred to R29 on 12/5/15. Nursing assistant (NA)-M had reported the incident to the nurse however the allegation was not immediately reported to the administrator nor to the designated state agency (Office of Health Compliance-OHFC). A letter was provided in regards to the allegation of abuse for R29. The letter was written by NA-M who was accused by R29 to have hit her in the face during cares. NA-A wrote, "The second one [reference to an argument] was I was fixing her [R29] pillow and I hold her head up and when I change a different pillow and move my hand I accidentally hit her on her cheek. I apologized to her and told her it was an accident she say it wasn't I did it on purpose and she was going to turn me in." The letter went on to explain NA-M reported the incident to the licensed practical nurse (LPN)-F. During an interview on 1/29/15, at 3:47 p.m. SW-A confirmed the incident was not immediately reported or investigated by LPN-F Facility policy Vulnerable Adult Incident Reporting last revised on 2/6/2013 read, "Facility staff are required to notify the administrator immediately of any vulnerable adult incidents and the federal requirement is that the facility is required to report all reportable incidents to the Minnesota Department of Health electronically immediately of knowledge of an alleged incident." Facility policy Resident Abuse Prevention Plan dated 6/30/2009 read, "The facility will report all alleged violations and all substantiated incidents to the appropriate state agencies", and " In the	F 225	immediately notified (as soon as possible upon the becoming aware of the concerns) of alleged violations involving resident mistreatment, neglect, abuse, misappropriation of resident property. During the planned mandatory meeting, staff will be instructed on 1) the facility□s zero tolerance policy for abuse/neglect/misappropriation of property 2) the residents□ rights to be free from abuse 3) the definition of a vulnerable adult 4) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation of property 5) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 6) timely reporting of incidents 7) the procedures for communicating/documenting resident concerns/incidents and 8) internal reporting of vulnerable adult issues especially those related to missing property. The staff are reeducated on vulnerable adult issues at least every twelve months and vulnerable adult reporting/investigation is addressed as part of the new employee orientation process. Resident number 70 □ After becoming aware of the resident□s report of missing bingo winnings in the amount of $30.00, the social worker immediately investigated the allegation. When interviewed by the social worker, the resident did not recall the incident of missing money. (The resident had previously reported that he	

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F 225	Continued From page 11 event of suspected maltreatment, the needs of the resident will be immediately assessed, and Notify the resident's responsible party as well as physician as soon as possible. "	F 225	had lost the money three months ago.) The resident had not left the facility to play bingo and could not have won $30.00 at facility-sponsored bingo. The social worker interviewed the resident□s wife who verified that it was improbable that the resident had $30.00 in his possession□she stated that she would never let him have that much money in his room. Resident number 29 □ On December 5, 2014, the nursing assistant accidently hit the resident□s cheek when adjusting pillows. The nursing assistant immediately apologized to the resident and reported the incident to the charge nurse. The resident told the nursing assistant that the contact with the cheek was intentional. The resident stated to the nursing assistant that she was going to turn me in. The Interim Director of Nurses reviewed the written statements by the nursing assistant and the charge nurse and counseled them on the facility□s vulnerable adult reporting/investigation policies. The Social Worker interviewed the resident December 8, 2014 at which time the resident reported that nothing happened between herself and the staff member. Future allegations of resident maltreatment or misappropriation of personal property will be reported immediately to the state/county agencies according to facility policy.	

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F 225	Continued From page 12	F 225	Compliance will be monitored by the Social Worker through an audit of the incident reports and reporting time frames for three months. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be discussed during the March Quality Assurance Committee meeting and reviewed during subsequent meetings. Completion date: March 11, 2015	

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F 225	Continued From page 13	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy on reporting missing money and allegations of physical abuse for 2 of 3 (R70, R29) residents reviewed for vulnerable adult. Findings included: R70's quarterly Minimum Data Set (MDS) dated 11/20/14 indicated R70, had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of eleven, and required extensive assist for activities of daily living of dressing, toileting, transfers, and hygiene. During an interview on 1/26/15, at 1:00 p.m. R70 stated approximately $30.00 went missing out of his drawer about 3 months ago. R70 stated he had won the money at bingo. R70 stated he had not kept money in room since the $30.00 was missing and had made it a habit to deposit bingo winnings in his account with the facility. R70 stated staff was notified of the missing $30.00. R70 did recall he had talked to the previous administrator about it.	F 226	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	3/11/15

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

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F 226	Continued From page 14 During an interview on 1/28/15, at 8:23 a.m. licensed social worker (SW)-A was notified the R70 had reported missing money to this surveyor and stated she had not been aware money had been taken out of R70's drawer. SW-A stated R70 had never reported anything missing that she was aware of. During an interview on 1/29/15, at 8:12 a.m. SW-A stated R70's family member was just informed of the missing money but has not returned her phone call. Also SW-A said she had not reported the missing money to the designated state agency after being informed of it yesterday a.m. R29 made an allegation of abuse but it was not immediately reported to the administrator or to the designated state agency. R29's had a grievance form completed by SW-A indicated an allegation of physical abuse occurred to R29. Nursing assistant (NA)-M had reported the incident to the nurse however the allegation was not immediately reported to the administrator nor to the designated state agency (Office of Health Compliance-OHFC). A letter was provided in regards to the allegation of abuse for R29. The letter was written by NA-M who was accused by R29 to have hit her in the face during cares. NA-A wrote, "The second one [reference to an argument] was I was fixing her [R29] pillow and I hold her head up and when I change a different pillow and move my hand I accidentally hit her on her cheek. I apologized to her and told her it was an accident she say it wasn't I did it on purpose and she was going to turn me in." The letter went on to explain NA-M reported the incident to the licensed practical nurse (LPN)-F. During an interview on 1/29/15, at 3:47 p.m. SW-A confirmed the incident was not immediately	F 226	policies and procedures including 1) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 2) timely reporting of incidents 3) the procedures for communicating/documenting resident concerns/incidents and 4) internal reporting of vulnerable adult issues. The staff are reeducated on the facility□s vulnerable adult policies at least every twelve months and vulnerable adult reporting/investigation is addressed as part of the new employee orientation process. Resident number 70 □ After becoming aware of the resident□s report of missing bingo winnings in the amount of $30.00, the social worker immediately investigated the allegation. When interviewed by the social worker, the resident did not recall the incident of missing money. (The resident had previously reported that he had lost the money three months ago.) The resident had not left the facility to play bingo and could not have won $30.00 at facility-sponsored bingo. The social worker interviewed the resident□s wife who verified that it was improbable that the resident had $30.00 in his possession□she stated that she would never let him have that much money in his room. Resident number 29 □ On December 5, 2014, the nursing assistant accidently hit the resident□s cheek when adjusting pillows. The nursing assistant immediately apologized to the resident and reported	

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F 226	Continued From page 15 reported or investigated by LPN-F Facility policy Vulnerable Adult Incident Reporting last revised on 2/6/2013 read, "Facility staff are required to notify the administrator immediately of any vulnerable adult incidents and the federal requirement is that the facility is required to report all reportable incidents to the Minnesota Department of Health electronically immediately of knowledge of an alleged incident." Facility policy Resident Abuse Prevention Plan dated 6/30/2009 read, "The facility will report all alleged violations and all substantiated incidents to the appropriate state agencies", and " In the event of suspected maltreatment, the needs of the resident will be immediately assessed, and Notify the resident's responsible party as well as physician as soon as possible."	F 226	the incident to the charge nurse. The resident told the nursing assistant that the contact with the cheek was intentional. The resident stated to the nursing assistant that she was going to turn me in. The Interim Director of Nurses reviewed the written statements by the nursing assistant and the charge nurse and counseled them on the facility□s vulnerable adult reporting/investigation policies. The Social Worker interviewed the resident December 8, 2014 at which time the resident reported that nothing happened between herself and the staff member. Future allegations of resident maltreatment or misappropriation of personal property will be reported immediately to the state/county agencies according to facility policy. Compliance will be monitored by the Social Worker through an audit of the incident reports and reporting time frames for three months. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be discussed during the March Quality Assurance Committee meeting and reviewed during subsequent meetings. Completion date: March 11, 2015	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		3/11/15

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F 241	Continued From page 16 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote dignity for 10 of 10 residents (R51, R10, R52, R61, R65, R34, R3, R30, R42, and R26) who received assistance to eat there was a folder on the table which was visible to other residents, staff and visitors; failed to allow residents time to eat before cleaning the table of food debris and parked food scraps next to table; and failed to cover urine collection bag to promote dignity for 1 of 1 resident (R68) who was observed with an uncovered urine collection bag with visible urine. Findings include: Residents who received assistance with eating at a table with a folder that said,"Feeder table." R51, R10, R52, R61, R65, R34, R3, R30, R42 were identified by the facility to be assisted to eat at one table in the east/west dining room labeled for residents who needed assistance to eat. One dining room table in the east/west dining room was a folder resting on top of the table which read, "Feeder table." The east/west dining room had one table with a folder which sat upright on the table. The outside of the folder stated "Stays @ Feeder Table" and "Mark after every meal." During dining observations in the east/west dining	F 241	Tag F241 Dignity and Respect of Individuality Maple Manor Nursing & Rehab, LLC promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. During the next mandatory meeting, the nursing staff will be reminded and instructed on the facility□s policy that all residents are to be treated with consideration, respect and full recognition of his/her dignity and individuality and on the residents□ right to dignity and respect during cares and in all activities of daily living, with a focus on a dignified dining experience and covering urinary collection bags. The nursing and dietary staff have been instructed 1) not to place staff information folders identifying residents needing eating assistance and modified consistency diets in a location visible to other residents/visitors 2) to park the bus cart outside the dining room while residents are present 3) to sit next to the resident while assisting them to eat 4) not to deliver a meal tray to a resident who is dependent with eating until a staff member is available to assist them and 5)	

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F 241	Continued From page 17 room on 1/27/15, at 12:10 p.m., five residents were eating positioned at the large table on the south side of the dining room (south table) where residents who needed assistance to eat were observed to sit. A folder was observed upright on the table. The folder was labeled in large letters "Stays @ Feeder Table" and "Mark after every meal." During interview on 1/27/15, at 12:12 p.m., paid feeding assistant (PFA)-A verified the folder on the table was labeled "Stays @ Feeder Table." PFA-A stated the folder contained the list of residents nursing assistants assisted to feed, residents who received thickened liquids, and residents at risk for aspiration. During interview on 1/27/15, at 3:03 p.m., certified dietary manager (CDM)-C stated the folder on the east/west dining room south table labeled "Stays @ Feeder Table" was a folder used by nursing. During interview on 1/27/15, at 3:25 p.m., director of nursing verified the folder sitting on a dining room table labeled "Stays @ Feeder Table" was not appropriate and should not be used. During interview on 1/30/15, at 8:15 a.m., registered nurse-E (RN-E) verified R51, R10, R52, R61, R65, R34, R3, R30, R42 ate at the east/west dining room south table. Document review of facility policy Privacy and Dignity Audit Procedure dated 12/19/06, read, "It is the policy of Maple Manor Health Care & Rehabilitation to provide all residents with privacy and dignity during cares and in activities of daily living."	F 241	to assist residents with eating in a timely manner. The nursing staff were also instructed on the appropriate placement of urinary collection bags and that all urinary collection bags are to be covered when residents are in a common area or in their room and observable from the hallway. Assuring the resident has a dignified dining experience will be monitored by the dietary manager/designee through routine observations of meal service/resident assistance practices for one month and randomly thereafter. Compliance with appropriate placement and covering of urinary collection bags will be monitored by the charge nurse/designee through random observations. If noncompliance is noted additional auditing and staff education will be done. Compliance will be reviewed during the next monthly Quality Assurance and Assessment Committee meeting. Completion Date: March 11, 2015	

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Document review of facility policy Maple Manor Resident's Rights policy dated 3/6/08, read, "All residents at Maple Manor Nursing Home are to be treated with consideration, respect and full recognition of his/her dignity and individuality including privacy in treatment and in care of his/her personal needs."

Residents eating while staff began cleaning the area near them:

During dining observations in the east/west dining room on 1/26/15, at 5:21 p.m., dietary aide (DA)-E pushed a bus cart into the east/west dining room up to a table where a resident was finishing eating her meal. DA-E cleared soiled dishes and placed on the bus cart. DA-D scraped foods into a bucket on the bus cart.

During interview on 1/27/15, at 3:03 p.m., certified dietary manager (CDM)-C stated he expected soiled dishes and foods placed into a garbage container on the bus cart after all residents were finished eating at a table. CDM-C stated the bus cart was not to be in the dining room. CDM-C stated he expected staff cleared off the tables, carried soiled dishes and foods into the hallway and placed on the bus cart.

During observations on 1/30/15, at 1:05 p.m., DA-D was observed to push the bus cart into east/west dining room up to touching the table where five residents in wheelchairs were completing their meal. DA-D began to clear off soiled dishes and placed on the bus cart. DA-D scraped foods into a bucket on the bus cart.

Document review of facility policy Privacy and Dignity Audit Procedure dated 12/19/06, read, "It

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F 241	Continued From page 19 is the policy of Maple Manor Health Care & Rehabilitation to provide all residents with privacy and dignity during cares and in activities of daily living." Document review of facility policy Maple Manor Resident's Rights policy dated 3/6/08, read, "All residents at Maple Manor Nursing Home are to be treated with consideration, respect and full recognition of his/her dignity and individuality including privacy in treatment and in care of his/her personal needs." Staff stood to assist residents to eat and staff went from one resident to another while assisting residents to eat: R26 sat with three other residents at a table and was observed during the noon meal on 1/25/15 at 11:45 a.m. No resident at this table made the attempt to eat independently. Nursing assistant (NA)-F loudly spoke across the table at 11:47 a.m. telling R26 to eat the lunch because it was getting cold. R26 was observed to use her fingers to eat cooked carrots. NA-F told R26 to use your fork twice. At 12:00 p.m. R26 pushed away her plate after eating only carrots. No staff intervened to encourage R26 to eat more of her meal. At 5:09 on 1/26/15 the evening NA-O was observed to be standing while assisting a resident to eat. NA-O then moved to another table and while standing assisted the residents to eat. At 5:12 p.m. it was noted that 2 of the 4 residents sitting at the west table were sleeping in their wheelchair and shortly after this observation NA-O left the dining room. Four minutes later at 5:16 p.m. NA-O returned to the dining room and again stood to assist residents to eat. At 5:18	F 241		

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F 241	Continued From page 20	F 241		

p.m. NA-O moved to the next table and stood while assisting R32 and another resident to eat. Between 5:16 p.m. and 5:29 p.m. the NA-O was observed to walk from one resident to another resident standing while assisting 5 different residents to eat. At 5:20 p.m. NA-O left the dining room stating that she would return tomorrow. No other staff assisted these residents to eat and with food remaining on plates they were moved from the dining room by NA-P and RN-A.

The director of nursing (DON) was interviewed on 1/27/15 at 3:01 p.m. DON indicated her expectations were that staff would sit beside the resident she was helping. DON stated she realized there was a problem with that since everybody needed to be "fed" in the north dining room. DON stated the facility needed to change that.

Lack of covering urine collection bag to promote dignity:

R68 had Foley catheter with urine visible in collection bag that was not covered consistently to promote dignity.

On 1/21/15, at 7:15 a.m. R68's room door was open, R68 was observed lying in bed. R68's indwelling Foley catheter bag was also observed lying flat on top of R68's blanket in bed, on the foot part. The uncovered catheter bag and tubing could be seen from the door, with the bag showing small amount of yellow-colored urine. The exposed part of the catheter tubing was also filled with yellow colored urine. At 7:45 a.m. registered nurse (RN)-C verified R68's catheter bag was on top of bed. At 7:38 a.m. R68's room

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F 241	Continued From page 21 door was open. R68 was still lying in bed. The uncovered catheter bag was still on top of bed, and visible from the hallway. At 8:14 a.m. Nursing assistant (NA)-B was interviewed and confirmed R68's catheter bag was lying on top of bed. At this time NA-B stated nursing assistant's empty the bag every shift and must have been placed by the night shift on top of R68's bed. Also NA-B stated the catheter bag should always be hanging below R68. NA-B added, the urine bag should be placed in a blue bag and hooked "here " (pointing to a loop-like attachment on bed frame). R68's Admissions Face Sheet printed on 1/29/15, indicated R68 had diagnoses including psychosis, dementia, depression, anxiety state and urinary retention. The Physician's Orders Sheet (POS) dated 11/1/14 indicated R68's urinary drainage bag should be kept below bladder level to prevent reflux, maintain a closed drainage system. The POS further indicated bag "to be kept in cloth (blue canvass) bag to prevent infection and provide dignity." R68's care plan dated 10/20/14 indicated R68 required indwelling Foley catheter due to urinary retention. Also drainage bag to be kept in a blue canvass bag to prevent infection and "provide dignity." The facility's Catheter Care Policy dated 7/9/09, directed staff to secure bag on side of bed frame, not to allow bag to touch the floor, to keep the bag below level of bladder at all times and to be inside a blue dignity bag.	F 241		
F 246	483.15(e)(1) REASONABLE ACCOMMODATION	F 246		3/11/15

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F 246 SS=D	Continued From page 22 OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure call light was in reach for 1 of 1 resident (R17) dependent on staff for meeting cares. Findings include: R17 was observed at 7:46 a.m. on 1/26/2015 to be lying in bed, awake and the call light cord was located on the foot part of the bed which was slightly lower than the body part. The call light was not within R17's reach if he needed assistance from staff. At 8:00 a.m. registered nurse (RN)-C verified R17's call light was not within R17's reach and that the call light was tied under and around R17's foot board of the bed. RN-C was observed to pull the call light around the foot board then placed it within reach on R17's left side. The admission record, indicated R17 was admitted on 8/13/07 with diagnoses to include late effects of cerebrovascular disease, calculus in urethra, diabetes mellitus, hemiplegia/hemiparesis (paralysis on half of the body), and depressive disorder.	F 246	Tag F246 Accommodation of Needs It is the policy of Maple Manor Nursing & Rehab, LLC to make reasonable accommodations to meet the needs and preferences of each individual resident except when the health and safety of an individual or other resident would be endangered. It is the policy of Maple Manor Nursing & Rehab, LLC that all residents have call lights within reach when they are unattended in their room or bathroom. Call lights are available with several types of controls to help accommodate individual resident abilities. Staff members frequently check on residents who are unable to use their call lights. During the next planned mandatory education meeting, all nursing staff will be instructed on the facility policy requiring that residents have a call device accessible when in their room and bathroom The Director of Nursing/designee will randomly observe for proper call light	

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F 246	Continued From page 23 The quarterly Minimum Data Set (MDS) dated 11/5/14, indicated R17 had moderate cognitive impairment; and R17 was totally dependent on staff for most activities of daily living to include dressing, and positioning in bed. However, the MDS did not address activity preferences. R17's care plan dated 6/6/14 indicated R17 had self-care deficits. Interventions included two staff to assist with mobility in bed, dressing and grooming and to place call light within R17's reach. On 1/29/15, at 2:35 p.m. the director of nursing stated she expected staff to put call lights in a place residents can reach.	F 246	placement for one month. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the April Quality Assessment and Assurance Committee meeting. Completion Date: March 11, 2015	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		3/11/15

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F 278	Continued From page 24 $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure the quarterly Minimum Data Set (MDS) was coded accurately for 1 of 1 resident (R68) reviewed for urinary catheter use. Findings include: R68's quarterly Minimum Data Set (MDS) (an assessment) dated 12/30/14, indicated R68 was on intermittent catheterization. The MDS did not mark R68 to have an indwelling Foley catheter. R68's care plan dated 10/20/14 indicated R68 required indwelling Foley catheter due to urinary retention. The Physician's Orders Sheet (POS) dated 11/1/14, indicated a doctor's order was made on 10/23/14, which read "UCI with 14 French cath [catheter]" and directed staff to change catheter (14French) every 24th of the month and as needed. The POS further indicated R68 had diagnoses including psychosis, dementia, depression, anxiety state and urinary retention. During interview on 1/28/15, at 7:45 a.m.,	F 278	Tag F278 Assessment Accuracy Maple Manor Nursing & Rehab, LLC conducts and coordinates each resident assessment through participation of the interdisciplinary care team. The facility completes resident assessments according to CMS guidelines as outlined in the User□s Manual for the Resident Assessment Instrument. It is the goal of Maple Manor & Rehab, LLC to have an accurate assessment of all residents to ensure that their needs and preferences are met. Each interdisciplinary team member signs to certify the accuracy of the portion of the assessment they complete. A registered nurse signs to certify that the assessment is complete. The Minimum Data Set (MDS) assessment for resident number 68 has been modified to reflect the user of an indwelling urinary catheter. The Director of Nursing and/designee will monitor compliance with accurate MDS coding of urinary catheter use through	

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F 278	Continued From page 25 registered nurse (RN)-C was not sure what "UCI" meant but confirmed R69 had an indwelling Foley catheter placed on 10/23/14 and was being changed every month. On 1/29/15, at 2:28 p.m. registered nurse (RN)-E stated R68 had been on intermittent catheterization from 8/2014 until it was discontinued on10/2014. RN-E verified the most recent quarterly MDS dated 12/30/14 indicated R68 was on intermittent catheterization, and did not reflect the accurate status of R68 having an indwelling Foley catheter. RN-E did not give an explanation why the MDS was not marked to show R68 had an indwelling Foley catheter.	F 278	random audits for the next 4 weeks. If noncompliance is noted additional auditing and staff training will be done. Completion Date: March 11, 2015	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		3/11/15

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F 279	Continued From page 26 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop interventions to address a history of having Clostridium difficile (C-diff) and Vancomycin-resistant enterococcus (VRE) to prevent the spread of these infections for 1 of 1 resident (R38) who had chronic C-Diff and VRE; failed to develop specific renal dialysis interventions for 1 of 1 resident (R62) with renal dialysis. Findings include: R38 had a history of having C-Diff and the care plan lacked information to prevent the spread to staff and other residents. The hospital discharge summary dated 12/16/14 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 12/30/14 indicated R38 had recent c-diff infection. The hospital discharge summary dated 1/9/15 indicated R38 had asymptomatic (a disease is considered asymptomatic if 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	F 279	Tag F279 Comprehensive Care Plans It is the policy of Maple Manor Nursing & Rehab, LLC to develop a multi-disciplinary, comprehensive plan of care which provides a working tool that addresses the needs of each resident. Care plans reflect medical conditions, level of socialization skills, and whether the resident may be vulnerable to abuse. The care plan describes services will assist the resident in attaining or maintaining the highest practicable level of physical, mental and psychosocial well-being. The comprehensive care plan is completed by the Interdisciplinary Team by day 21 of a resident□s stay. The resident/family/legal representative participate in the development, review, and goals of the plan of care. The interdisciplinary care team reviews the resident□s plan of care at least every 90 days and with changes in condition. Based on a full clinical nursing assessment of a resident□s cognitive status and physical and social needs, a temporary care plan is implemented on admission The temporary care plan addresses infections including C-Diff and VRE as well as other conditions that may require special staff direction to safely meet the residents□ needs. Resident number 38 does not currently	

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F 279	Continued From page 27 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 indicated the purpose of the multi-disciplinary comprehensive plan of care what to provide a working tool for staff. R62 received dialysis services and renal diet without care plan interventions for renal diet. R62 was admitted to the facility on 11/21/14, with diagnosis that included end stage renal disease and dialysis, according to admissions face sheet. Document review of physician orders dated 11/21/14, revealed physician orders for hemodialysis on Tuesdays and Saturdays and renal diet. Document review of facility care area assessment (CAA) dated 12/4/14, identified R62 nutrition triggered to care plan for therapeutic diet and was	F 279	have active C-Diff or VRE infections but does have a history of the same. This resident does not currently require a private room for medical reasons. Standard precautions are used when caring for all residents according CDC guidelines. Implementation of contact precautions also follows the CDC guidelines and is initiated with any resident who has an active diagnosis that may affect the safety of other residents as well as staff. Resident number 82 receives a renal diet. The care plan has been revised and updated to reflect this diet order. The DON/designee will perform random audits for two months to ensure care plans are updated, current, and appropriate. Completion Date: March 11, 2015	

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F 279	Continued From page 28 offered a renal diet. Document review of R62's resident care plan printed 1/28/15, revealed no care plan for renal diet. Document review of dietary notes dated 1/21/15, revealed R62 received renal diet related to diagnosis and attended dialysis on Tuesday and Saturday. During interview on 1/28/15, at 9:10 a.m., registered dietician verified R62 received renal diet, communicates with dialysis dietician, received dialysis Tuesdays and Saturdays, and packed lunch to go with R62 to dialysis. During interview on 1/30/15, at 8:00 a.m., director of nursing verified R62's care plan lacked identification and interventions for renal diet restriction.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280		3/11/15

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F 280	Continued From page 29 each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure revision of the dietary care plan for 1 of 3 residents (R38) reviewed with a dietary meal change. Findings include: R38 was observed during the evening meal on 1/26/15 from 5:20 p.m. to 6:11 p.m. R38 was eating independently but ate only 25% of her meal. At 6:11 p.m. R38 stated that she was on a fluid restriction and was not sure what foods she could eat. She said she had breaded food for both noon meal and supper. R38's admission Minimum Data Set dated 12/22/14 indicated she had a brief interview of mental status (BIMS) score of 10 out of a possible 15 or was moderately cognitively impaired. The MDS indicated R38 was independent with eating and was not on a therapeutic diet. Review of the hospital discharge summaries dated 12/16/14, 12/30/14, and 1/9/15 listed diagnoses that included: cardiac concerns, electrolyte imbalance, chronic anemia, and colostomy. The physician orders noted on the hospital discharge summary dated 12/16/14 was for a general diet and physician orders on 12/30/13, was for a general low residual diet. The physician orders noted on the hospital discharge summary	F 280	Tag F280 It is the policy of Maple Manor Nursing & Rehab, LLC to develop a multi-disciplinary, comprehensive plan of care which provides a working tool that addresses the needs of each resident. Care plans reflect medical conditions, level of socialization skills, and whether the resident may be vulnerable to abuse. The comprehensive care plan is completed by the interdisciplinary team by day 21 of a residents stay. Care planning needs are reviewed and revised as a resident□s conditions warrant. The resident/family/legal representative participate in the development, review, and goals of the plan of care. The interdisciplinary care team updates care plans for residents every 90-days, with change of condition, and/or as needed. Resident number 38 is on a regular diet with no fluid restrictions and is able to choose her preferred menus choices. The care plan was reviewed and revised accordingly. The Food Service Director and the consultant Registered Dietitian counseled with the resident several times regarding her previous diet restrictions. The resident□s diet order and food preferences will continue to be discussed during her care conferences that are held every 90 days and with significant	

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F 280	Continued From page 30 dated 1/9/15 listed a diet of 1500 to 2000 mg sodium, low cholesterol, and low fat. R38 ' s care plan provided 1/27/15 was reviewed. On 12/22/14 a problem of "Diet: [R38] is at risk r/t [related to] her need for extra calories to aid in healing." The interventions directed a general diet with regular textures and Boost supplement. The care plan also had a problem dated 1/12/15 of "Diet: [R38] is at risk r/t her medical dx [diagnosis] with need for a therapeutic diet and fluid restriction." The interventions noted a no added salt diet and a 2000 cc fluid restriction. Neither of the care plan problems identified the exact diet ordered by the physician 1/9/15. The director of nursing (DON) was interviewed on 1/28/15 at 4:25 p.m. DON indicated the diet listed on the care plan was written by dietary staff. The certified dietary manager (CDM) was interviewed on 1/29/15 at 9:20 a.m. CDM stated he had not revised the care plan to reflect the doctors prescribed orders on 1/9/15.	F 280	changes in condition changes. The Food Service Director has reviewed all care plans to ensure that the prescribed diet is accurately reflected. The Food Service Director/designee will audit the care plans during the routine 90-day reviews to assure accuracy of diet restrictions. If noncompliance is noted additional auditing and staff training will be done. Completion Date: March 11, 2015	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services as directed on each residents care plan for 2 of 5	F 282	Tag F282 Services by Qualified Person/Per Care Plan	3/11/15

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F 282	Continued From page 31 residents (R3, R88) for assistance with eating; for 2 of 3 residents (R88 & R31) assessed to need assistance with personal care; and failed to ensure 2 of 2 resident (R45 & R38) with daily weights to assess health status change; 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; and failed to provide adaptive scoop plate as directed in the care plan for 1 of 1 resident (R32) assessed to need scoop plate to eat independently. Findings include: Lack of assistance with eating: R3 did not receive assistance with eating according to care plan interventions. R3's care plan dated 3/19/13, identified problem 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. R3's 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. R3 was observed on 1/28/15, at 9:45 a.m., and was in wheelchair in the east/west dining room at a large table designated by the facility for residents who needed assistance to eat. Also at this time registered nurse (RN)-C was assisting	F 282	Maple Manor Nursing & Rehab, LLC develops an interdisciplinary plan of care for each resident based on a comprehensive assessment of the resident□s needs and preferences. The nursing staff are made aware of each resident□s plan of care and services are routinely provided that meet professional standards and supports the highest practicable level of function and well-being. The procedures for communicating the residents' care needs to the direct care staff were reviewed and found appropriate. During a mandatory training meeting, the nursing staff were instructed that the resident care plans must be followed and that job performance expectations include being aware of and following the care plan. In reference to the residents□ dining experience: The direct care staff have been instructed to refer to the unit assistance care guides for direction on assisting residents with eating. The eating assistance required by residents number 3 and 88 were reviewed with the certified nursing assistants. Providing adequate and timely assistance was stressed. In reference to personal care provided to the residents: The direct care staff have been instructed to refer to the unit assistance care guides for direction on meeting the residents□ needs for assistance with personal care/hygiene needs. The nursing assistants were reminded to pay particular attention to cleaning eyeglasses, removal of facial hair, and cleaning/cutting fingernails. The	

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F 282	Continued From page 32 R3 to eat. At 9:52 a.m., RN-C left R3 at the table alone. R3 still had plate of food and beverages and made no attempt to eat independently. At 10:00 a.m. R3 was noted to be asleep and no assistance with eating was offered or provided. At 10:12 a.m., nursing assistant (NA)-D sat to assist R3 with meal. R3 had no assistance with eating from 9:52 a.m. to 10:12 a.m. a total of 20 minutes. R3 was admitted 3/19/13, with diagnosis that included paralysis agitans and dementia with Lewy Bodies, according to physician orders printed 1/29/15. The facility identified R3 on the annual Minimum Data Set (MDS), an assessment dated 12/8/14, to have short and long term memory problems, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene, and received a mechanically altered diet. Care Plan policy dated 1/19/12, read, "Purpose: To provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident During interview on 1/29/15, at 9:00 a.m., Director of nursing stated she expected staff to follow the care plan and to provide R3 with assistance for meals. R88 did not receive assistance with eating according to care plan interventions. R88's care plan dated 9/10/14, identified problem	F 282	grooming needs of residents number 31 and 88 were reviewed. In reference to obtaining daily weights: The licensed and certified nursing staff have been instructed to refer to the physician□s orders and unit assistance care guides for direction on the frequency of resident□s weights. The importance of obtaining daily weights as instructed on the care guides was reinforced with the certified nursing assistants. The need to assure timely weights, monitor weight changes, and report weight changes as the physician directs were reviewed with the licensed nurses. The physician□s order for daily weights and reporting of weight gain for resident number 45 were discussed with the nursing staff. In reference to monitoring fluid intake, colostomy output and weights for resident number 38: The nursing staff has been instructed on the need to follow the physician□s orders for monitoring intake, output and weights for resident number 38. The facility□s monitoring and documentation procedures were discussed as part of the staff instruction/education process. In reference to the indwelling catheter and placement of the urine collection bag for resident number 68: The licensed and certified nursing staff were instructed on the facility policy and standards of practice for decreasing the risk of urinary tract infections for residents with indwelling catheters. The need for proper securement of the collection bag and keeping the collection bag below the level	

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F 282	Continued From page 33 of at risk for decline in nutritional status due to need for mechanically altered food related to poor dentation, due to open areas with increased need for nutritional support, due to abnormal labs, due to need for assistance with meals, due to decreased cognition. Approaches dated 9/10/14 included assist as needed and as resident allows with food/fluid. Approaches dated 9/22/14 included pureed diet with thin liquids. Approaches dated 9/23/14, included house supplement two times daily. Approaches dated 9/29/14 included alternate bites with sips, watch for swallow and give next bite/sip to maintain pace and uncovered cups ok when being assisted. R88 was observed on 1/27/15, at 11:18 a.m., R88 was in wheelchair located in the east/west dining room. R88 was placed at a table designated by the facility as being for residents who need assistance to eat. Also at this time R88 appeared to be asleep and had a meal of pureed carrots, quiche, and mashed potatoes and four adaptive cups of beverages with lids were on the table directly in front of R88. From 11:18 a.m., to 11:50 a.m. (total of 32 minutes) R88 remained asleep and no staff assisted her to eat or encourage her to eat her meal. At 11:50 a.m., trained medication assistant (TMA)-A, aroused R88 and then placed food on a spoon and handed to R88, who immediately dropped the spoon into her lap then TMA-A left the table. At 11:54 a.m., paid feeding assistant (PFA)-A assisted another resident at same table, handed R88 glass of chocolate milk and PFA-A continues to assist R88 to eat between assisting another resident to eat. R88 was admitted to the facility 8/26/14, with	F 282	of the resident□s bladder was reinforced. The bladder management plan of care for resident number 68 was reviewed with the staff. In reference to resident meal time preferences and need for adaptive equipment for resident number 32: The nursing and dietary staff were instructed on the resident□s preference for double portions at breakfast and the need for a scoop plate to facilitate independence in eating. The need to reference the physician□s orders, care plan, resident care guides and/or the dining room tray card for diet instructions was reinforced with the nursing and dietary staff. Compliance with care plans addressing catheter care, assistance with personal cares, obtaining weights, reporting of weight changes, monitoring intake/output will be monitored by the Director of Nursing/designee through random observation and record review for one month. The Food Service Director will monitor for staff compliance with care plans specifying serving portions and adaptive eating equipment/utensils through random observations for one month. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed at the next Quality Assessment and Assurance Committee meeting. Completion Date: March 11, 2015	

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F 282	Continued From page 34	F 282		

diagnosis that included dementia with Lewy Bodies and paralysis agitans according to resident diagnosis codes printed 1/30/15.

The facility identified R88 on the quarterly Minimum Data Set (MDS), an assessment dated 11/23/14, to have short term memory problem, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene, and received a mechanically altered diet.

R88 was again observed during breakfast on 1/28/15, at 9:37 a.m., R88 in wheelchair at the same table as the evening meal yesterday. R88 was observed asleep with plate of cooked cereal and scrambled eggs, applesauce, magic cup, and beverages set before her. At 9:41 a.m. (four minutes without assistance to eat meal) TMA-A sat next to R88 to only administer medication. At 9:42 a.m., registered nurse (RN)-C sat next to R88 and began to assist her to eat. At 9:45 a.m., RN-C asked if R88 wanted juice and handed the cup to R88 who took the cup. At 9:47 a.m., RN-C handed R88 a spoon of cooked cereal and R88 took and ate the food. At 9:52 a.m., RN-C left R88 and the table. R88 still had plate of food and beverages in front of R88 and made no attempt to feed self. From 9:52 a.m. until 10:12 a.m. (20 minutes interval) R88 did not have staff assistance to eat or encouragement from staff to eat until NA-D sat with R88 and begin to assist R88 to eat. Interview at that time, NA-D verified the cooked cereal was cold and had not been warmed before serving it to R88. At 10:17 a.m., NA-D assisted R88 with a drink of juice and then went to reheat cold cereal.

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Care Plan policy dated 1/19/12, read, "Purpose: To provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident

During interview on 1/29/15, at 9:00 a.m., Director of nursing stated she expected staff to follow the care plan for R88.

Lack of providing personal cares according to care plan:

R88 had long facial hair and long soiled finger nails which were not trimmed nor cleaned according to R88 ' s care plan.

R88's care plan dated 9/4/14, identified problem of needed assistance with activities of daily living, transfer and ambulation related to dementia and decreased endurance and mobility. Approaches included assist of one staff with wheel chair mobility, dressing, personal hygiene, is assisted with meals, set up for meals and required assistance when sleepy.

R88 was observed on 1/26/15, at 2:58 p.m., R88 was observed with long facial hairs while lying in bed. On 1/28/15, at 9:37 a.m., R88 sat in wheelchair at south table in east/west dining room. R88 was observed to have long, soiled finger nails and facial hair unshaven.

R88 was admitted to the facility 8/26/14, with diagnosis that included dementia with Lewy Bodies and paralysis agitans according to resident diagnosis codes printed 1/30/15.

The facility identified R88 on the quarterly Minimum Data Set (MDS), an assessment dated

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11/23/14, to have short term memory problem, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene, and received a mechanically altered diet.

During interview on 1/28/15, at 10:10 a.m., nursing assistant (NA)-D stated they had assisted R88 with morning cares. NA-D verified had not provided facial hair removal or nail care. NA-D stated residents are shaved with morning cares and nail care was done in the evenings. Also at 10:12 a.m., NA-D verified R88 had long soiled finger nails and long facial hairs.

During interview on 1/28/15, at 11:15 a.m., registered nurse (RN)-F verified the long facial hair and long soiled finger nails for R88. RN-F stated she expected facial hair shaved on bath day and as needed. RN-F sated she expected manicures were done weekly and on bath days. She verified R88 received bath on Fridays and this day was Wednesday morning.

The Care Plan policy dated 1/19/12, read, "Purpose: To provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident."

The AM Cares policy dated 8/31/04, read, " Procedure: 2.The mouth nails, and hair are to be cared for in the same manner as for a complete bath."

The CARE OF NAILS policy dated 3/12/08, read, "1. Keep clean and well manicured."

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F 282	Continued From page 37 During interview on 1/29/15, at 9:00 a.m., Director of nursing stated she expected staff to follow the care plan and to provide R88 with assistance for meals and personal care. R31 was observed on 1/25/2015 at 2:06 p.m., on 1/26/15 at 1:31 p.m., 1/27/15 at 8:57 a.m. R31 had dark brown/black debris underneath fingernails and eye glasses were extremely dirty and had tape on both bows of the glasses. R31's care plan indicated resident was one assist with grooming. According to an interview on 1/30/15, RN-A stated fingernail care and cleaning glasses were included in the grooming category. R31's quarterly Minimum Data Set (MDS) dated 10/30/14 indicated the resident had severe cognitive impairment and was dependent on staff for activities of daily living including toileting, dressing, hygiene, and eating. Physician's visit progress note dated 1/15/15 included diagnoses of advanced dementia and primary open angle glaucoma. The policy Care of Nails read, "Keep clean and well-manicured." Lack of daily weights as directed in the care plan: R45 was not weighed daily according to physician orders and care plan interventions. R45's care plan dated 12/11/14, identified problem of at risk for complications due to use of cardiac medications related to cerebral vascular accident, peripheral vascular disease, hypertension, dyslipidemia, and congestive heart failure. Care plan approaches directed weights and vital signs as per orders and or policy. R45's care plan dated 1/8/15 identified problem at risk related to medical diagnosis and need for therapeutic diet. Care plan approaches directed	F 282		

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F 282	Continued From page 38 staff monitor and record weights as ordered. Physician orders dated 12/10/14, revealed physician orders for daily weights due to congestive heart failure; and physician orders dated 12/12/14, for daily weight, notify nurse practitioner with weight gain over 3 pounds in one day or 5 pounds from baseline, admit weight 220 pounds (#). R45 was admitted to the facility on 12/10/14, with diagnosis that included congestive heart failure, according to physician orders dated 12/10/14; diabetes mellitus, cerebral vascular accident, and peripheral vascular disease, according to the admission minimum data set (MDS) dated 12/16/14; and right below knee amputation 12/5/14, according to hospital discharge summary dated 12/26/14. Document review of facility record of weights for R45 showed weights were done 9 times out of 35 days from 12/12/14 to 1/26/15 as follows: 12/12/14--252 pounds expected weight loss after surgery 12/16/14--250.4 pounds Hospitalized -- 12/21/14 and returned to facility on 12/26/14 12/27/14-239 pounds 1/10/15--243.7 pounds 1/21/15--228.5 pounds 1/22/15--229.3 pounds 1/23/15-230 pounds 1/24/15--232.2 pounds 1/26/15-231 pounds Also the facility did not report a three day weight	F 282		

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gain due to not doing weights daily nor did the report the five pound weight gain from base line of 220 pounds or when R45 weighed 225 pounds or more. By 1/26/15 R45 weighed 231 or 11 pounds over base line weight.

Document review of hospital dismissal summary dated 12/26/14, revealed R45 was hospitalized 12/21/14 and discharged from the hospital on 12/26/14, for diagnosis of pontine infarction (stroke) secondary to acute basilar thromboembolism (blood clot).

During interview on 1/29/15, at 5:00 p.m., registered nurse (RN)-A verified the lack of daily weights as physician ordered. RN-A verified lack of evidence of nurse practitioner notification of weight gain over 3 pounds between 12/27/14 and 1/10/15, a gain of 4.7 pounds

During interview on 1/30/15, at 9:30 a.m., RN-F stated she expected R45 to be weighed daily. RN-F verified daily weights were on the nursing assignment sheet and on the Evening Weight Charting-West list for daily weights.

The Care Plan policy dated 1/19/12, read, "Purpose: To provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident."

Policy for Weighing Residents dated 6/7/13, read, "It is the policy of Maple Manor to ensure that residents are weighed and a weight record is kept on each resident and monitored routinely." "Residents will be weighed thereafter as ordered by the physician, but at least monthly."
R38 lacked provision of services in accordance

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F 282	Continued From page 40 with the plan of care on the treatment record and as ordered by the physician. R38's treatment record indicated staff was to monitor fluid intake because of a fluid restriction, monitor colostomy output, and monitor weight daily. The treatment record, intake record, or intake and output record did not have documentation related to fluid intake, colostomy output or daily weights nor was any provided when requested. During an interview on 1/28/15 at 8:00 a.m. the clinical manager (RN)-A and the director of nursing stated they were aware that this was not being done as ordered by the physician. Lack of following care plan to prevent urinary tract infections were not provided: R68's care plan interventions and services in regards to the Foley catheter were not followed by staff. On 1/21/15, at 7:15 a.m. R68's room door was open, R68 was observed lying in bed. R68's indwelling Foley catheter bag was also observed lying flat on top of R68's blanket of his bed. At 7:45 a.m. registered nurse (RN)-C observed R68's catheter bag was placed directly on top of R68's bed linens. RN-C was asked if the urine bag was to be placed on top of the bed linens and RN-C stated, "Yes." On asking how much urine was in the collection bag RN-C was observed to hold the urine bag and raised it to her eye level and verified there was about 75 milliliters of urine collected in bag. As RN-C was holding the bag up, the bag's drain (rubber emptying spout) was observed to have been clamped, however, it was not placed in the designated bag pouch but	F 282		

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uncovered and sticking out as it was not secured in the collection bags spout holder. RN-C then placed the urine bag back on top of the bed with the drain spout in direct contact with the linens on the bed. At 7:38 a.m. on 1/21/15 R68's room door was open and R68 was still lying in bed with the collection bag still on top of the bed linens. At 8:14 a.m. Nursing assistant (NA)-B was interviewed and confirmed R68's catheter bag was lying directly on top of R68's bed linen. NA-B stated nursing assistants empty the bag every shift and must have been placed on the bed by the night shift when they left this morning. NA-B stated the catheter bag should always be hanging below R68. NA-B added, urine bag should be placed in a blue cloth cover and hooked "here" (pointing to a loop-like attachment on bed frame). NA-B then moved bag from bed.

R68's care plan dated 10/20/14 indicated R68 required indwelling Foley catheter due to urinary retention. The care plan directed staff to keep drainage bag below bladder level to prevent reflux and to maintain a closed drainage system.

R68's Admissions Face Sheet printed on 1/29/15, indicated R68 had diagnoses including psychosis, dementia, depression, anxiety state and urinary retention.

The Physician's Orders Sheet (POS) dated 11/1/14 indicated R68's urinary drainage bag should be kept below bladder level to prevent reflux, maintain a closed drainage system. The POS further indicated bag "to be kept in cloth (blue canvass) bag to prevent infection and provide dignity."

The facility's Catheter Care Policy dated 7/9/09,

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F 282	Continued From page 42 directed staff to secure bag on side of bed frame, not to allow bag to touch the floor, to keep the bag below level of bladder at all times and to be inside a blue dignity bag. The American Nurses Association (ANA) adopted the guidelines provided by the Centers for Disease Control (CDC, 2009) to prevent catheter 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. R32 was observed during breakfast meal on 1/27/15 at 8:40 a.m. and on 1/28/15 at 8:50 a.m. revealed R32 did not receive double sized food portions and did not receive a scoop plate (a plate with high edges) according to the care plan. R32's care plan dated 1/16/15 read, "has had a significant weight loss ...is offered double portions at breakfast with extras on tray for other meals ...8/13/14 provide a scoop plate at all meals, provide shallow bowls if unable to use scoop plate." 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 dining room tray card (card used to communicate dietary information to staff) included the instruction to give double portions at	F 282		

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F 282	Continued From page 43 breakfast and provide a scoop plate. During an interview on 1/30/15, at 10:30 a.m. certified dietary manager (CDM) verified resident did not receive double portions and stated the resident was supposed to have a scoop plate.	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 5 of 39 residents (R100, R71, R45, R38, and R39) had ongoing services and treatments as ordered by the physician to monitor for significant health status changes so they could be reported timely to the physician for interventions; and failed to maintain an agreement with the dialysis provider for 1 of 1 resident (R62) currently receiving end stage dialysis services. Findings include: Lack of monitoring health status for changes due to congestive heart failure (CHF): R100 was admitted to the facility on 1/13/15 according to the admission form however, the staff failed to monitor, assess, and evaluate fluid intake for dehydration, renal failure, and fluid	F 309	Tag F309 Quality of Care Maple Manor Nursing & Rehab, LLC provides the necessary care and services 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 health changes are reported to the physician in a timely manner. The facility□s policies addressing weight, fluid intake monitoring, and monitoring/reporting condition changes were reviewed. According to policy, residents are weighed monthly and more often as order by the physician. Weights	3/11/15

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F 309	Continued From page 44 overload for R100 who had a new diagnoses of congestive heart failure, had a newly prescribed diuretic, and had a fluid restriction of 1500 cubic centimeters (cc). R100's hospital discharge summary dated 1/13/15 indicated R100 was cognitively intact and included the diagnoses of acute congestive heart failure, acute hypoxemic respiratory failure, acute kidney injury on chronic kidney disease, and hypokalemia (high serum potassium). According to this summary the diagnoses of congestive heart failure was new and was started on Lasix (diuretic). A physician's visit note from hematology dated 1/19/15 indicated R100 had been hospitalized in the past few months for a urinary tract infection with dehydration. R100's physician orders included Hydrochlorothiazide (diuretic) 12.5 milligrams (mg) by mouth every day, Lasix 40 mg by mouth every other day, potassium chloride 20 milli-equals (mEq) by mouth every day while on Lasix, daily weights, and 1.5 liter (L) fluid restriction. R100's care plan dated 1/22/15 indicated R100 was cognitively impaired, was independent with activities of daily living (dressing, hygiene, transfers, toileting, and eating). Care plan indicated R100 was at risk for electrolyte imbalance related to diuretics and fluid restriction; directed staff of fluid restriction, daily weights, and monitor for dehydration. R100's fluid intake was recorded on the intake and output form. Fluid intake and output forms were dated from 1/19/15 through 1/28/15. However, no fluid intake monitoring forms for dates 1/13/15 to 1/18/15 were found in the medical record or provided when requested. The forms provided were reviewed and several had	F 309	are reported to the charge nurse for needed follow up and documented in the medical record. A scale that accommodates wheelchairs was recently purchased. According to policy, dietary and nursing staff document intake and output for residents as ordered by the physician. The amounts are totaled every 24 hours and documented in the medical record. According to policy, residents are monitored for condition changes including those related to congestive heart failure. The physician/nurse practitioner is to be notified as necessary regarding the resident response to the current medical and nursing plan of care. During the planned mandatory meeting, the certified nursing assistants and licensed nurses will be reinstructed on the facility□s policies for 1) monitoring and documenting fluid intake for residents on a fluid restricted diet 2) monitoring and documenting output for residents with a colostomy 3) obtaining and documenting daily weights 4) reporting significant weight gain/loss to the physician 4) monitoring residents who are at risk for condition changes requiring immediate interventions such as symptoms of worsening congestive heart failure and 5) use of the new wheelchair scale. Resident number 100 □ The resident□s condition improved and she was discharged from the facility February 17, 2015. Resident number 71 □ The resident died at the facility November 19, 2014. The findings were reviewed as part of the	

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F 309	Continued From page 45 not been completed. According to the documentation R100 had no fluid intake on 1/19/15, 1/20/15, 1/21/15, 1/22/15, and 1/28/15. On 1/23/15 documentation indicated a total intake of 220 ccs (cubic centimeters) , on 1/24/15 total intake documented was 120 ccs, on 1/25/15 total intake documented was 60cc's and on 1/27/15 total intake documented was 30 cc. None of the forms had a 24 hour totals calculated to determine if they met or exceeded fluid limit. No further documentation pertaining to monitoring, assessing, and evaluating of fluid status was located in the medical record or provided when requested. During an interview on 1/26/15, at 1:25 p.m. R100 stated she did not receive the fluids she wanted between meals; and explained the fluid restriction. R100 was unable to report how much fluid she had consumed so far that day; and explained nurses kept track of that. Observation revealed no water pitcher or water glass at bedside. During an observation on 1/28/15, at 7:48 a.m. R100 had 240 ccs of milk, 240 cc of water, and 140 cc of orange juice. During an interview on 1/28/15, at 7:44 a.m. licensed practical nurse (LPN)-D explained that dietary gave certain fluid amounts to R100 and then R100 told the nurses how much she consumed. The amounts should then be recorded on the fluid intake sheet. LPN-D was then shown the fluid intake sheet and verified it had not been completed. During an interview on 1/28/15, at 7:54 a.m. registered nurse (RN)-A stated fluid was divided up between dietary and nursing. No one is monitoring or evaluating fluid intake anymore. RN-A confirmed no further documentation had been completed for R100 ' s fluid intake.	F 309	facility□s continuous quality improvement process. Resident number 45 □ The Nurse Practitioner and the Director of Nurses reassessed the resident□s condition February 23, 2015. Daily weights were discontinued. The care plan was updated accordingly. Resident number 38 □ The Nurse Practitioner and the Director of Nurses reassessed the resident□s condition February 23, 2015. The fluid restriction diet was discontinued. The resident is to receive a general diet and be weighed three times per week. The staff has been reminded to monitor/document colostomy function and output. The care plan has been updated accordingly. Resident number 39 - The Nurse Practitioner and the Director of Nurses reassessed the resident□s condition February 23, 2015. An order was written to discontinue the fluid restriction and daily weights. The care plan was updated accordingly. Resident number 62 □ A contract with the provider of the resident□s dialysis services has been written and is awaiting authorized signatures. A copy of the signed contract will be filed in the resident□s medical record. The Director of Nursing/designee will perform random audits through observation and record review for one month to ensure weights have been obtained as ordered, fluid intake has been appropriately monitored/documented for residents on fluid restricted diets, output is being tracked for residents with	

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F 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 intakes...any 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 for daily living that required cues and supervision, no or unknown weight loss or weight gain, and was not on a diuretic (medication to reduce fluid). R71's hospital History and Physical dated 10/30/14, indicated diagnoses of hypoxemic respiratory failure resolved, secondary to chronic diastolic heart failure, acute systolic heart failure, newly diagnosed, paroxysmal atrial fibrillation, severe depression status post eleven sessions of	F 309	colostomies, and weight changes are being communicated to the physician/nurse practitioner as ordered. Completion Date: March 11, 2015	

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electroconvulsive therapy. The History and Physical revealed R71 was hospitalized secondary to failure to thrive and was moved from the cardiac service and transferred to an inpatient psychiatric unit for management of severe depression. It also indicated his weight was 162 lbs. on 10/27/14. R71's hospital discharge orders dated 10/30/14 indicated he received Lopressor 12.5 milligrams (mg) for hypertension. The discharge orders for continuing care instructed, "daily weights required for: Congestive heart failure."

R71's signed physician orders dated 10/31/14 read, "daily weights PMs [evenings], Update NP [nurse practitioner] with weight gains of > [greater than] 3 lbs [pounds] in a day or 5 lbs from baseline weight. Baseline weight 162.1 lbs [pounds]." Physician orders dated 11/7/14 read, "...Lasix 10 mg [milligram] by mouth daily, weigh daily update provider for weight gains 3 # [pounds] or more in one day and 5 # [pounds] or more total. Update provider with fluid status (weights, edema, lungs) on 11/11 [11/11/14] ..." and physician orders dated 11/11/14 read, " Bilateral lower extremity wraps for edema."

R71's care plan dated 11/6/14 identified a problem of at risk for complications of cardiac medications related to hypertension, atrial fibrillation and hyperlipidemia. The plan instructed staff to notify his medical practitioner of any signs of complications of antihypertensives (drugs used to lower blood pressure) including hypo/hypertension.

Review of the facilities Weights and Vitals Summary entered into R71 ' s medical record on the computer revealed the following weights:

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F 309	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 11/9/14 107 lbs 11/10/14 127 lbs 11/13/14 132 lbs 11/16/14 155 lbs 11/18/14 155 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 [atrial 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 edema ...PHYSICAL EXAMINATION:..Lungs: Diminished breath sounds bibasilar, otherwise clear to auscultation. Respiration unlabored ...Extremities: +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 nursing home is 163# [pounds] (11/2/14), up from 162.1# [pounds]. Daily weights have not been	F 309		

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completed and I will ask nursing to ensure that these are obtained. I am going to add a low dose of Lasix 10 mg [milligrams] by mouth daily and use TED stocking for compression. Recheck CBC [complete blood count], Lytes/Cr [electrolytes/creatinine to test kidney function] on 11/11. Nursing to update me with fluid status (weights, edema, lungs, ect [sic].) at that time ..."

R71's interdisciplinary progress notes were reviewed from 10/31/14 to 11/3/14 and 11/8/14 to 11/10/14 and revealed no documentation related to monitoring of daily weights, edema in extremities or lung sounds to determine if fluid was accumulating and heart was not able to function to remove fluid.

On 1/29/15 at 12:12 p.m. registered nurse (RN)-E R71 had physician orders for daily weights related to diagnosis of congestive heart failure. RN-E verified the facility did not complete daily weights for R71 per the physician orders.

On 1/29/15 at 2:09 p.m. the director of nursing (DON) stated she would have expected staff to follow the physician orders for daily weights and reporting to the NP (nurse practitioner) for the parameters identified.

Even though R71 had symptoms of lower extremity edema, the facility failed to consistently monitor R71 for symptoms of CHF (CHF is Heart failure that does not mean the heart has stopped working. Rather, it means that the heart's pumping power is weaker than normal. With heart failure, blood moves through the heart and body at a slower rate, and pressure in the heart increases. As a result, the heart cannot pump enough oxygen and nutrients to meet the body's

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needs. The chambers of the heart may respond by stretching to hold more blood to pump through the body or by becoming stiff and thickened. This helps to keep the blood moving, but the heart muscle walls may eventually weaken and become unable to pump as efficiently. As a result, the kidneys may respond by causing the body to retain fluid (water) and salt. If fluid builds up in the arms, legs, ankles, feet, lungs, or other organs, the body becomes congested, and congestive heart failure is the term used to describe the condition.)
R45 was not weighed daily nor had ongoing assessment for control of CHF.

R45 was admitted to the facility on 12/10/14, with diagnosis that included congestive heart failure, according to physician orders dated 12/10/14; diabetes mellitus, cerebral vascular accident, and peripheral vascular disease, according to the admission MDS dated 12/16/14; and right below knee amputation 12/5/14, according to hospital discharge summary dated 12/26/14.

Document review of physician orders dated 12/10/14, revealed physician orders for daily weights for congestive heart failure; and physician orders dated 12/12/14, for daily weight, notify nurse practitioner with weight gain over 3 pounds in one day or 5 pounds from baseline, admit weight 220# with right pylon cast.

Document review of hospital dismissal summary dated 12/26/14, revealed R45 was hospitalized 12/21/14 and discharged from the hospital on 12/26/14, for diagnosis of pontine infarction secondary to acute basilar thromboembolism.

Document review of Dietary Nutritional

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F 309	Continued From page 51 Assessment dated 12/17/14, identified weight of 243 pounds (#), diet of no sugar added, and summary included at risk due to diet, multiple medications, abnormal lab values, stage 2 pressure ulcer, 9% weight loss in 3 months, some weight loss may be related to right below knee amputation, current weight taken with right cast, and staff to monitor weights. Document review of dietary progress note dated 12/31/14, revealed weight of 233 pounds which reflected weight loss of 6.8% in 11 days, nursing notified of need to know if were taken with prosthesis on or off, independent in eating, and staff to monitor weights. R45's care plan dated 12/11/14, identified problem of R45 at risk for complications of use of cardiac medications related to cerebral vascular accident, peripheral vascular disease, hypertension, dyslipidemia, and congestive heart failure. Care plan approaches directed weights and vital signs as per orders and or policy. Resident care plan dated 1/8/15 identified problem as risk related to medical diagnosis and need for therapeutic diet. Care plan approaches directed staff monitor and record weights as ordered. Document review of facility record of weights for R45 revealed the following weights 12/12/14 to 1/26/15: 12/12/14--252 pounds expected weight loss after surgery 12/16/14--250.4 pounds Hospitalized -- 12/21/14 and returned to facility on 12/26/14	F 309		

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F 309	Continued From page 52 12/27/14-239 pounds 1/10/15--243.7 pounds 1/21/15--228.5 pounds 1/22/15--229.3 pounds 1/23/15-230 pounds 1/24/15--232.2 pounds 1/26/15-231 pounds Although physician orders dated 12/10/14, were for weights to be checked daily, the first weight was taken on 12/12/14, or 2 after the order, and then 11 and 14 days apart. Although physician orders dated 12/12/14, were for notification of nurse practitioner of weight gain over 3 pounds in one day, the staff did not notify the nurse practitioner of weight gain of 4.7 pounds between 12/27/14 and 1/10/15, the only weights taken in that period of time. Although physician orders dated 12/12/14, were for notification of the nurse practitioner of 5 pounds from baseline, admit weight 220 #, the staff did not notify the nurse practitioner of 12/12/14 weight of 252 pounds, a 30 pound gain from the 220 pounds baseline. During interview on 1/29/15, at 5:00 p.m., registered nurse (RN)-A verified the lack of daily weights as physician ordered, lack of evidence of nurse practitioner notification of weight gain over 3 pounds between 12/27/14 and 1/10/15, a gain of 4.7 pounds, and stated the facility had no other weights available. During interview on 1/30/15, at 9:00 a.m., nurse practitioner (NP)-G verified the physician orders dated 12/10/14 for daily weights, and 12/12/14 for	F 309		

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nurse practitioner notification of 3 pound weight gain. NP-G stated she expected the facility to notify the nurse practitioner of weight gain as ordered and expected daily weights as ordered, due to congestive heart failure and edema. NP-G verified orders dated 12/12/14 were current physician orders. NP-G verified there was no documentation of nurse practitioner notified of weights or weight gain. NP-G verified the lack of physician ordered daily weights.

During interview on 1/30/15, at 9:15 a.m., nursing assistant (NA)-E stated R45 was to be weighed daily, according to the nursing assistant assignment sheet but has not been done.

During interview on 1/30/15, at 9:30 a.m., registered nurse (RN)-F stated she expected R45 to be weighed daily and verified daily weights were not completed on the nursing assignment sheet and on the Evening Weight Charting-West list for daily weights.

The Policy for Weighing Residents dated 6/7/13, read, "It is the policy of Maple Manor to ensure that residents are weighed and a weight record is kept on each resident and monitored routinely." "Residents will be weighed thereafter as ordered by the physician, but at least monthly."
R38 lacked monitoring or a new colostomy, fluid restrictions, and daily weight

R38 was admitted to the facility from the hospital on 12/16/14. The hospital discharge summary noted R38 had a perforated colon that resulted in a colostomy. Hospital dismissal summary dated 12/30/14 indicated the resident had been readmitted to the hospital with acute respiratory failure. The hospital discharge summary dated

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F 309	Continued From page 54 1/9/15 noted R38 had experienced volume depletion and hyponatremia. Physician orders of 1/9/15 and the facility treatment record indicated 2 liter fluid restriction and report weight increase of 2 to 3 pounds in one day or increase of 5 pounds over baseline weight. Increased swelling, bloating, fatigue, weakness, shortness of breath, difficulty breathing, especially with activity and at night. The intake and output forms for 1/14/15 through 1/25/15 were reviewed. The forms noted fluid intake, voiding and bowel movement could be documented. The documentation was sporadic and not totaled for the day. Nursing assistant (NA) Entry Report was reviewed for 12/16/14 through 1/26/15. The report allowed for documentation of meal intake, bladder and bowel output. The documentation was inconsistent, had no daily totals of intake, no fluid intake or urine or colostomy output recorded. The treatment record for R38 from 1/9/15 through 1/30/15 was reviewed. The colostomy was to empty each shift and the output documented. However, it was not completed for 2 of 3 shifts making 24 hour total impossible to determine. The treatment record noted heart failure prevention: report weight increase of 2 to 3 pounds in one day or increase of 5 pounds over baseline weight. Increased swelling, bloating, fatigue, weakness, shortness of breath, difficulty breathing, esp. with activity and at night. No documentation was noted on the treatment record. Review of the weight record for 1/9/15 through 1/26/15 did not indicate the resident was weighed daily.	F 309		

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The clinical manager (RN)-A and the director of nursing (DON) was interviewed on 1/28/15 at 8:00 a.m. They both indicated the nursing assistant was responsible to document intake and output and that nursing and dietary were to review the totals. They both were aware that this was not being done consistently. They stated they were aware that R38 had been hospitalized for hypovolemia (decreased blood volume.) Also stated they were aware that weights were not being monitored as ordered by the doctor.

During an interview on 1/28/15 at 9:40 a.m. RN-A stated staff were to monitoring for signs and symptoms of fluid retention on the treatment sheet and that should be signed and documented if done. Any change in status was to be documented for the nurse practitioner and also placed in the interdisciplinary team notes. RN-A said this was not being done.

R39's face sheet identified that R39 was admitted on 1/7/2015.

The dismissal summary from the hospital dated 1/7/15 identified R39 had diagnoses to include mild dementia, chronic left ventricular diastolic heart failure, atrial fibrillation, hypertension, history of transient ischemic attack (TIA), diabetes mellitus, type 2 with diabetic proliferative retinopathy, anxiety and depression, and history of probable Bonnet Syndrome (a condition among people who have lost their sight. It causes visual hallucinations).

The admission MDS dated 1/14/15 indicated that R39 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated cognitively intact. R39 required extensive assist with bed

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mobility, transfers and dressing, supervision with walking in room and corridor, supervision with toilet use, and limited assist with eating and personal hygiene.

R39's current physician orders dated 1/29/15 identified that R39 received Lasix (diuretic) 40 mg twice a day for diastolic heart failure, Lisinopril 10 mg every day for hypertension/congested heart failure, a diet order of diabetic, no added salt, mechanical soft with ground meat, 2000 ml (milliliters) fluid restriction and staff were directed to obtain daily weights on evenings. The dismissal summary dated 1/7/15 from the hospital recommended that respiratory and fluid status with daily weights to determine if modifications to diuretic regimen are needed.

R39's care plan dated 1/12/15 indicated R39 had a problem related to taking multiple cardiac medications related to processes including cardiovascular accident history, hypertension and congested heart failure. The problem dated 1/16/15 titled Diet indicated R39 was at risk related to medical diagnosis with need for a therapeutic diet and mechanical texture modifications and she is legally blind. R39 has a 2 liter fluid restriction. R39 was to maintain weight of 155 pounds (#) + or - thru next 90 days. Approaches included staff to monitor and record weights as ordered.

The physician visit on 1/14/15 indicated that nursing staff were to monitor daily weights. Continue metoprolol (treat chest pain), digoxin (heart medication), Lasix (diuretic) and Lisinopril (lower blood pressure).

R39's weights were reviewed from the day of

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F 309	Continued From page 57 admission, 1/7/15, through 1/29/15. Out of the 23 days, 10 days of weights were missing with 4 days of weights missing between 1/7/15 and 1/22/15. During an interview with the registered nurse (RN)-A on 1/19/15 at 3:58 p.m., RN-A stated that they had staffing issues and the weights he gave me were all they had for R39. Policy for Weighing Residents, dated 6/07/15 instructed staff to: Upon admission, all residents will be weighed within 3 days to obtain an initial weight. Residents will be weighed thereafter as ordered by the physician. At the weekly dietary meeting the director of nursing will bring the list of residents who have doctor ordered specific weights and the team will review/audit the residents who have lost weights for further interventions. Lack of renal dialysis agreement to assure quality services were provided to residents: R62 received dialysis services from the clinic providing End Stage Renal Disease services without an agreement between the facility and clinic to provide dialysis services. R62 was admitted to the facility 11/21/14, with diagnosis that included end stage renal disease and renal dialysis according to the admission face sheet. Document review of physician orders dated 11/21/14; revealed R62 was to receive hemodialysis on Tuesdays and Saturdays. During interview on 1/28/15, at 4:20 p.m., the administrator verified the facility did not have a contract or an agreement with the dialysis	F 309		

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F 309	Continued From page 58 provider where R62 received dialysis. No policy was received after being requested.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 5 residents (R3, R88) in the sample dependent on staff for assistance, received assistance with eating, and 2 of 3 residents (R88, R31) in the sample dependent on staff for personal care, received assistance with personal cares. Findings include: LACK OF ASSIST WITH EATING: R3 did not receive assistance with eating according to care plan interventions. During observations on 1/28/15, at 9:45 a.m., R3 was in wheelchair located in the east/west dining room. R3 was placed at a table designated by staff for residents who needed assistance to eat. Also at that time, registered nurse (RN)-C was assisting R3 to eat. At 9:52 a.m., RN-C left the table. R3 still had plate of food and beverages in front of R3 with no attempt to feed self. At 10:00	F 312	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 oral 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 providing resident services as outlined in the	3/11/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 59 a.m., R3 was asleep with f hard-boiled egg, small powdered donut, 1 slice toast cut into half, and 4 glasses beverages in front of R3, and no staff assistance given. From 10:00 a.m. until nursing assistant (NA)-D sat and assisted R3 to complete her meal starting at 10:12 a.m. or twelve minutes without assistance to eat meal or cueing. R3 was admitted 3/19/13, with diagnosis that included paralysis agitans and dementia with Lewy Bodies, according to physician orders printed 1/29/15. The facility identified R3 on the annual Minimum Data Set (MDS), an assessment dated 12/8/14, to have short and long term memory problems, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene, and received a mechanically altered diet. Document review of the annual Nutritional assessment dated 12/16/14; identified R3 independently ate with difficulty chewing, no difficulty swallowing, received general diet with soft textures and thin liquids, and no significant weight changes. R3's care plan dated 3/19/13, identified problem 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	F 312	individualized plan of care. Providing care for residents who are dependent in eating and/or require assistance with daily hygiene needs will be stressed. The Director of Nursing/designee will perform random audits for one month to ensure that personal hygiene and eating needs are being met for those residents requiring assistance. Completion Date: March 11, 2015	

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	245409	A. BUILDING _____ B. WING _____	01/30/2015

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F 312	Continued From page 60 eating pureed diet. During interview on 1/29/15, at 9:00 a.m., director of nursing stated she expected staff to follow the care plan and to provide R3 with assistance for meals. Director of nursing stated she was aware of the lack of staff in the east/west dining room. R88 did not receive assistance with eating according to care plan interventions. During observations on 1/27/15, at 11:18 a.m., R88 was in wheelchair located at the table designated for residents who needed assistance with eating in the east/west dining. During observations at that time, a plate of pureed carrots, quiche, and mashed potatoes and four adaptive cups of beverages with lids were on the table directly in front of R88, who was noted to have her eyes closed. From 11:18 a.m., to 11:50 a.m. (32 minutes) R88 eyes were closed and no staff assisted her to eat nor encouraged her to eat. At 11:50 a.m., trained medication assistant (TMA)-A sat beside R88, placed food on a spoon and handed to R88, R88 immediately dropped the spoon of food onto her lap, TMA-A left R88 following this incident. At 11:54 a.m., feeding assistant (FA)-A assisted another resident at R88 ' s table, then FA-A handed R88 glass of chocolate milk and continued to assist R88 until 12:08 p.m. and during this time FA-A would stand to assist R88 at times as FA-A was also assisting another resident to eat. During interview on 1/27/15, at 12:12 p.m., FA-A stated R88 received pureed foods and any staff could assist R88 to eat. FA-A stated R88 had good days and sometimes would eat independently and other days needed assist with	F 312		

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F 312	Continued From page 61 eating. R88 was admitted to the facility 8/26/14, with diagnosis that included dementia with Lewy Bodies and paralysis agitans according to resident diagnosis codes printed 1/30/15. The facility identified R88 on the quarterly MDS, an assessment dated 11/23/14, to have short term memory problem, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene, and received a mechanically altered diet. R88's care plan dated 9/10/14, identified problem of at risk for decline in nutritional status due to need for mechanically altered food related to poor dentation, due to open areas with increased need for nutritional support, due to abnormal labs, due to need for assistance with meals, due to decreased cognition. Approaches dated 9/10/14 included assist as needed and as resident allows with food/fluid. Approaches dated 9/22/14 included pureed diet with thin liquids. Approaches dated 9/23/14, included house supplement two times daily. Approaches dated 9/29/14 included alternate bites with sips, watch for swallow and give next bite/sip to maintain pace and uncovered cups ok when being assisted. During interview on 1/28/15, at 9:15 a.m., registered dietician (RD)-I and surveyor read RD-I's notes on 1/26/15, which identified weight loss of 8.5% in 2 months, some weight loss may be decreased edema, pureed diet, eating skills are dependent, per nursing staff R88 lethargic during meals and staff to assist resident as	F 312		

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F 312	Continued From page 62 resident allowed. During a second meal observation on 1/28/15, at 9:37 a.m., R88 sat in wheelchair located at the table designated by staff for residents who need assistance to eat located in the east/west dining room. R88 was observed with eyes closed with plate of cooked cereal and scrambled eggs, applesauce, magic cup, and beverages in 2 adaptive cups with lids. At 9:41 a.m., TMA-A sat to administer medication to R88 then left after taken. At 9:42 a.m., RN-C sat next to R88 and began to assist her to eat until 9:52 a.m., when RN-C left R88. R88 still had food and beverages in front of her and made no attempt to eat independently. From 9:52 a.m. to 10:12 a.m. (20 minutes) R88 had eyes closed and no staff assistance or cueing to eat was given. NA-D sat and assisted R88 to complete her meal starting at 10:12 a.m. During interview on 1/29/15, at 9:00 a.m., Director of nursing stated she expected staff to follow the care plan and to provide R88 with assistance for meals and personal cares. Director of nursing stated she was aware of the lack of staff in the east/west dining room. The Care Plan policy dated 1/19/12, read, "Purpose: To provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident." LACK of PERSONAL CARES: R88 had long facial hair and long soiled finger nails without assistance with personal cares according to care plan interventions.	F 312		

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F 312	Continued From page 63	F 312		

During observations on 1/26/15, at 2:58 p.m., R88 had visible long facial hairs while lying bed. On 1/28/15, at 9:37 a.m., R88 sat in wheelchair located at south table in east/west dining room with several other residents who ate meal in this dining room and again had long, soiled finger nails and long facial hair.

R88 was admitted to the facility 8/26/14, with diagnosis that included dementia with Lewy Bodies and paralysis agitans according to resident diagnosis codes printed 1/30/15.

The facility identified R88 on the quarterly MDS, an assessment dated 11/23/14, to have short term memory problem, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene.

R88's care plan dated 9/4/14, identified problem of needed assistance with activities of daily living, transfer and ambulation related to dementia and decreased endurance and mobility. Approaches included assist of one staff with wheel chair mobility, dressing, and personal hygiene.

During interview on 1/28/15, at 10:10 a.m., NA-D stated had assisted R88 with morning cares. NA-D verified had not provided shave or nail care. NA-D stated residents are shaved with morning cares and nail care was done in the evenings.

During interview on 1/28/15, at 11:15 a.m., RN-F verified the long facial hair and long soiled finger nails. RN-F stated she expected facial hair shaved on bath day and as needed. RN-F stated

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F 312	Continued From page 64	F 312		

she expected manicures were done weekly and on bath days. Also RN-F said R88 received bath on Fridays and Wednesdays (today) in the morning.

During interview on 1/29/15, at 9:00 a.m., director of nursing Director of nursing stated she expected staff to follow the care plan and to provide R88 with assistance for nail and facial hair removal care.
R31 did not receive nail cares and eye glasses were not cleaned to promote clear vision when worn:
Observations made on 1/25/2015 at 2:06 p.m., on 1/26/15 at 1:31 p.m., 1/27/15 at 8:57 a.m revealed R31 had dark brown/black debris underneath fingernails and eye glasses were extremely dirty and had tape on both bows of the glasses.
R31's quarterly MDS dated 10/30/14 indicated R31 had severe cognitive impairment and was dependent on staff for activities of daily living including toileting, dressing, hygiene, and eating.
Physician's visit progress note dated 1/15/15 included diagnoses of advanced dementia and primary open angle glaucoma.
R31's care plan indicated resident was one assist with grooming.
According to an interview on 1/30/15, RN-A stated fingernail care and cleaning glasses were to be completed for R31 as they are considered part of " grooming " as noted in R31's care plan.
The AM Cares policy dated 8/31/04, read, "1. Partial baths are given when complete baths are omitted." Procedure: "2. The mouth, nails, and hair are to be cared for in the same manner as for a complete bath."

The CARE OF NAILS policy dated 3/12/08, read,

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F 312	Continued From page 65 "1. Keep clean and well manicured."	F 312		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comprehensive bladder assessments and an assessment of risks for developing and monitoring of symptoms for urinary tract infections (UTIs) for 7 of 8 residents (R16, R6, R70, R30, R69, R96, R38) reviewed with recurrent urinary tract infections; the facility failed to prevent urinary tract infections and the spread of infections to other residents due to staff not following sound infection practices regarding Foley Catheter care and equipment used for 1 of 1 resident (R68) with an indwelling Foley catheter; and the facility failed to follow physician orders for intermittent catheterizations and failed to monitor, evaluate, and assess urine output for 1 of 1 residents (R70) in the sample with intermittent cauterizations. Findings include:	F 315	Tag F315 Urinary Incontinence Maple Manor Nursing & Rehab, LLC ensures that a resident does not have an indwelling catheter placed unless the resident□s clinical condition demonstrates that catheterization is necessary; and that 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. Residents with or without a catheter receive appropriate care and services to prevent infections to extent possible. According to the updated facility policy, a bladder assessment is completed for each resident on admission, quarterly, with a change of condition, and as needed. Residents with risk factors for	3/11/15

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F 315	Continued From page 66 R16 lacked identification of signs and symptoms of the urinary tract infection (UTI) and lacked a bladder assessment and assessment of UTI risk. R16 was noted on the infection control (IC) logs to have a UTI on 10/17/14. Review of the interdisciplinary team notes (IDT) of 10/8/14 to 10/21/14 noted no signs or symptoms of a UTI documented. The quarterly Minimum Data Set (MDS) dated 10/29/14 indicated a brief interview of mental status (BIMS) score of 12 or moderately cognitively impaired, that R16 required extensive to total assist to meet toileting and personal hygiene needs, and that R16 was frequently incontinent. The care plan dated 9/13/11 noted R16 had functional incontinence. The care plan did not indicate R16 was at risk for UTIs. Registered nurse (RN)-E stated on 1/30/15 at 12:45 p.m. that R16 did not have a completed bladder assessment. R6 lacked identification of symptoms of a UTI and lacked a UTI risk assessment. R6 was noted on the IC log to have a UTI on 10/27/14 and 12/10/14. Review of the IDT notes for this time period noted no signs and symptoms of infections listed. The quarterly MDS dated 12/26/14 was reviewed. R6 had a BIMS score of 13 or cognitively intact, required extensive to total assistance to meet toileting and personal hygiene needs, had a neurogenic bladder and obstructive uropathy, and	F 315	urinary tract infections will have this documented in the progress notes and in the plan of care. According to facility policy, the physician/nurse practitioner is notified when a resident is exhibiting urinary tract symptoms. The nursing staff document urinary tract symptoms, notification of the physician/nurse practitioner, and any medical/nursing interventions. Follow up on the effectiveness of the treatments/interventions is documented. According to facility policy, when a resident requires intermittent in and out catheterization or has an indwelling catheter, the output is documented in the medical record. Indwelling catheters are hung/placed below the level of the bladder and off of the floor with the tubing arranged to avoid kinking or pulling. All catheter bags are placed in a pouch cover. A bladder scan is performed prior to/after an in and out catheterization with perameters ordered by the physician/nurse practitioner. The results of the scan and the output are documented in the medical record. When a resident refuses to be catheterized, the refusal is documented in the medical record. At the planned mandatory meetings, the nursing assistants will be reinstructed on placement of the urine collection bags, covering the bags to maintain resident dignity, and documenting output. The licensed nurses will be instructed on the facility□s policy and procedures for completing bladder assessments, assessing the resident□s risk of urinary	

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F 315	Continued From page 67 was intermittently catheterized. R6's care plan printed 12/28/15 noted an indwelling suprapubic catheter and a history of recurrent UTIs resulting in frequent hospitalization. The care plan did not have interventions based on a comprehensive bladder assessment had been completed. No UTI risk assessment was found or provided by facility when requested. R70 lacked identification of symptoms of a UTI and lacked a UTI risk assessment R70 was noted on the IC log to have a UTI on 9/29/14. The IDT notes were reviewed and no documentation of signs and symptoms of the infection were found. The quarterly MDS dated 11/20/14 indicated R70 had a BIMS score of 11 or moderately cognitively impaired, required extensive assistance to meet toileting and personal hygiene needs, and was intermittently cauterized. Again no bladder assessment or UTI risk assessment was found or provided when requested for R70. R30 lacked identification of symptoms of a UTI and lacked a UTI risk assessment. R30 was noted on the IC log to have a UTI on 10/15/14, 11/7/14, and 11/29/14. The IDT notes were reviewed and lacked identification of signs and symptoms of UTI. The annual MDS dated 11/6/14 noted R30 had	F 315	tract infections, documenting the resident□s urinary tract symptoms prior to calling the physician/nurse practitioner, monitoring/documenting follow up on the effectiveness of nursing/medical interventions, following the physician□s orders for intermittent catheterization intervals, and notifying the physician of large residual amounts. Resident number 16 □ The resident□s bladder function (has indwelling suprapubic catheter due to a neurogenic bladder) was reassessed by a registered nurse including an assessment of the resident□s risk of urinary tract infections. The care plan has been reviewed and revised accordingly. Resident number 6 □ The resident□s bladder function (has indwelling suprapubic catheter due to a neurogenic bladder) was reassessed by a registered nurse including an assessment of the resident□s risk of urinary tract infections. The care plan has been reviewed and revised accordingly. Resident number 70 □ The resident□s bladder function was reassessed by a registered nurse including an assessment of the resident□s risk of urinary tract infections. The care plan has been reviewed and revised accordingly. Resident number 30 □ The resident□s bladder function (has obstructive uropathy) was reassessed by a registered nurse including an assessment of the resident□s risk of urinary tract infections. The care plan has been reviewed and revised accordingly. Resident number 69 □ The resident□s	

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F 315	Continued From page 68 memory impairment, was intermittently cauterized, had obstructive uropathy, and had total dependence on staff to meet toileting and personal hygiene needs. R30 had a care plan dated 12/15/11 that listed a problem of at risk for UTI related to staph bacteremia, but did not indicate an assessment related to clinical, functional or environmental risk factors had been completed. Two bladder assessments were found in the medical record dated 11/6/14 and 1/28/15. However, neither assessment evaluated R30's UTI risk. R69 lacked identification of symptoms of the UTI and lacked a bladder and UTI risk assessment. R69 was noted on the IC log to have a UTI on 10/7/14, 10/31/14, 11/9/14, 11/18/14. The IDT notes were reviewed and lacked identification of signs and symptoms of UTI. The 30-day PPS MDS dated 12/15/14 was reviewed. The MDS indicated R69's short term and long term memory were intact, that R69 required extensive assist with toileting and personal hygiene, and that R69 had experienced a UTI in the past 30 days. No bladder or UTI risk assessment was found in the record. RN-E stated on 1/30/15 at 12:45 p.m. that R69 did not have a completed bladder assessment. R96 lacked a bladder assessment and a UTI risk assessment R96 was admitted on 12/2/14. The hospital dismissal summary dated 12/2/14 noted R96 had	F 315	bladder function was assessed by a registered nurse February 20, 2015. The assessment addressed the resident□s risk of urinary tract infections. The care plan has been reviewed and revised accordingly. Resident number 96 □ The resident□s bladder function was assessed by a registered nurse February 20, 2015. The assessment addressed the resident□s risk of urinary tract infections. The care plan has been reviewed and revised accordingly. Resident number 38 □ The resident□s bladder function was assessed by a registered nurse February 20, 2015. The assessment addressed the resident□s risk of urinary tract infections. The care plan has been reviewed and revised accordingly. Resident number 68 □ The staff have been reinstructed on keeping the urine collection bag below the level of the bladder and to cover the bag whenever the resident is in a common area or in the room and visible from the hallway. The care plan was reviewed and updated. Resident number 70 □ The physician□s orders for intermittent catheterization and bladder scans were reviewed with the licensed nurses. Documentation of the catheterizations and bladder scans was also addressed. The care plan was reviewed and updated. The Director of Nursing/designee will perform random audits through observation and record review for one month to ensure catheterization protocol is followed, that residents with symptoms	

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F 315	Continued From page 69 chronic UTI and was on suppression Bactrim (antibiotic). 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. RN-E stated on 1/30/15 at 12:45 p.m. that R96 did not have a completed bladder assessment. R38 lacked a bladder assessment and a UTI risk assessment. R38 was admitted with a UTI 12/16/14. The admission MDS dated 12/22/14 indicated R38 had BIMS score of 10 or moderately cognitively impaired, required extensive to total assistance to meet toileting and personal hygiene needs, had an ostomy, and had experienced a urinary tract infection during the previous 30 days, and was always incontinent. No bladder or UTI risk assessments were found in the record. RN-E stated on 1/30/15 at 12:45 p.m. that R38 did not have a completed bladder assessment. On 1/27/15 at 2:00 p.m. UTI policies were provided by the director of nursing. The policies included 1) Chronic Urinary Tract Infection Policy dated 5/2/12 and 2) Prevention of UTI's at Risk Residents dated 4/3/12. The policies did not direct staff to evaluate the risk for developing UTIs and did not include signs and symptoms of UTIs and what/when to document. The policies did not direct a comprehensive nursing	F 315	of urinary tract infection have appropriate documentation and follow up, and that bladder assessments are completed as scheduled. Completion Date: March 11, 2015	

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F 315	Continued From page 70	F 315		

assessment that included contributing factors or comorbidities related to medical conditions, cognitive function, medications, physical function or the environment

RN-A was interviewed on 1/28/15 at 9:40 a.m. RN-A stated he had a form that listed the criteria for infections, but that no policy related to the form had been developed. RN-A stated nursing was to document the criteria for infections observed in the nursing notes.

On 1/28/15 at 10:10 a.m. RN-A and the director of nursing (DON) were interviewed. They indicated the facility did not have a list of infection or UTI criteria available to staff to use and document from. They stated the facility did not have a policy/procedure on the management of urinary tract infections.

On 1/30/15 at 9:30 a.m. the DON indicated the bladder assessment did not include a UTI risk assessment and that staff were not expected to do a narrative note related to UTI risk.
R68's Foley catheter care did not promote sound infection control practices when handling the draining tubing and collection bag nor was the collection bag placed to prevent the spread of infection or prevent a urinary tract infection.

On 1/21/15, at 7:15 a.m. R68's room door was open, R68 was observed lying in bed. R68's indwelling Foley catheter bag was also observed lying flat on top of R68's blanket of his bed. At 7:45 a.m. registered nurse (RN)-C observed R68's catheter bag was placed directly on top of R68's bed linens. RN-C was asked if the urine bag was to be placed on top of the bed linens and RN-C stated, "Yes." On asking how much urine

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was in the collection bag RN-C was observed to hold the urine bag and raised it to her eye level and verified there was about 75 milliliters of urine collected in bag. As RN-C was holding the bag up, the bag's drain (rubber emptying spout) was observed to have been clamped, however, it was not placed in the designated bag pouch but uncovered and sticking out as it was not secured in the collection bags spout holder. RN-C then placed the urine bag back on top of the bed with the drain spout in direct contact with the linens on the bed. At 7:38 a.m. on 1/21/15 R68's room door was open and R68 was still lying in bed with the collection bag still on top of the bed linens. At 8:14 a.m. Nursing assistant (NA)-B was interviewed and confirmed R68's catheter bag was lying directly on top of R68's bed linen. NA-B stated nursing assistants empty the bag every shift and must have been placed on the bed by the night shift when they left this morning. NA-B stated the catheter bag should always be hanging below R68. NA-B added, urine bag should be placed in a blue cloth cover and hooked "here" (pointing to a loop-like attachment on bed frame). NA-B then moved bag from bed.

R68's Admissions Face Sheet printed on 1/29/15, indicated R68 had diagnoses including psychosis, dementia, depression, anxiety state and urinary retention.

The Physician's Orders Sheet (POS) dated 11/1/14 indicated R68's urinary drainage bag should be kept below bladder level to prevent reflux, maintain a closed drainage system. The POS further indicated bag "to be kept in cloth (blue canvass) bag to prevent infection and provide dignity."

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R68's care plan dated 10/20/14 indicated R68 required indwelling Foley catheter due to urinary retention. The care plan directed staff to keep drainage bag below bladder level to prevent reflux and to maintain a closed drainage system.

The facility's Catheter Care Policy dated 7/9/09, directed staff to secure bag on side of bed frame, not to allow bag to touch the floor, to keep the bag below level of bladder at all times and to be inside a blue dignity bag.

The American Nurses Association (ANA) adopted the guidelines provided by the Centers for Disease Control (CDC, 2009) to prevent catheter 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.
R70 lacked every four hour catheterization to prevent urinary tract infections and bladder problems.

On 12/8/14 R70 filed a grievance with the facility that pertained to staff not catheterizing him every four hours as ordered by the physician and bladder scans had not been performed prior to catheterization. Grievance indicated R70 went six hours without being catheterized; which lead to the removal of 1000 milliliters (ml) of urine.

R70's quarterly Minimum Data Set (MDS) dated 11/20/14 indicated R70 required intermittent urinary catheterization, had moderate cognitive impairment with a Brief Interview for Mental

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Status (BIMS) score of eleven, and required extensive assist for activities of daily living of dressing, toileting, transfers, and hygiene.

R70's current care plan provided by the facility on 1/28/15 indicated R70 occasionally refused cares and gave staff direction to chart refusals. Care plan indicated resident was at risk for fluid volume deficit and directed staff to report no urine output in a shift. Care plan also indicated R70's diagnosis of hypertonic bladder, benign prostatic hyperplasia (enlarged prostate) with obstruction, and required intermittent catheterization and directed staff to perform intermittent catheterization as ordered. The care plan lacked size and type of urinary intermittent catheter (straight versus coude catheter is a curved catheter tip for easy insertion for people with obstruction in the urethra) to use. The care plan did not include the physicians order to bladder scan if needed first.

Signed physician's orders dated 12/19/14 included diagnoses of Parkinson's, dementia with Lewy bodies, hypertonicity (increased tension of the bladder making it more rigid, hampering complete urinating ability) of bladder and benign prostatic hyperplasia (BPH which is an enlargement of the prostate) making it more difficult to pass urine.

Signed physician's orders dated 12/19/14 included in and out (I and O) catheterization (Cath) every four hours scheduled, may I and O cath for retention/discomfort as needed (PRN) and "ok to bladder scan prior to I and O and hold cath if scanned amount is less than 200 cubic centimeters (cc). However, the physician orders lacked size and type of catheter to use for R70 as

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F 315	Continued From page 74 the size matters to promote comfort and prevent tissue damage when catheterizing. R70's treatment administration record (TAR) indicated scheduled I and O cath times were 1:00 a.m., 5:00 a.m., 9 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. However, the documentation to indicate cath was completed was inconsistent; outputs were not recorded except intermittently during the scheduled 9:00 p.m. treatment time. The Maple Manor Bladder Scan Sheets for November, December 2014 and January 2015 indicated I and O catheterization times and amount of outputs resulting from urinary catheterization. However, the use of the bladder 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 by the National Institute of health (NIH Publication No. 14-3195 December 2013) it read, "A normal bladder acts like a reservoir and can hold 1.5 [360 cc] to 2 cups [480 cc] of urine." During an interview on 01/30/15, at 1:57 p.m. licensed practical nurse (LPN)-C explained resident often refused to be cathed or had been at an activity. LPN-C stated refusals would be	F 315		

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F 315	Continued From page 75 indicated on the bladder scan sheet or on the TAR. These documents were reviewed and found to be inconclusive if R70 had refused or unavailable or if the nurse had not completed for other reasons. During an interview on 1/30/15, at 11:30 a.m. director of nursing (DON) stated, "They should be documenting why the cath is not getting done as ordered." The facility did not have a policy for in and out catheterization.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess the benefits or risk to continue range of motion (ROM) services for 1 of 2 residents (R31) reviewed for range of motion. Findings included: R31 had ROM services discontinued by nursing and was not reassessed for a maintenance range of motion services to maintain functionality of	F 318	F-318 Range of Motion R31 was evaluated by therapies and set-up for a passive ROM program as tolerated. Therapies in-serviced staff to appropriate ROM specific to this resident. Other residents who would benefit from a range of motion program will be assessed for referral in the interdisciplinary care conference schedule. The facility is in the	3/11/15

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F 318	Continued From page 76 joints, prevent complications, or slow progression of range of motion impairment in the shoulders and lower extremities. Physician ' s visit note dated 1/15/15 included diagnoses of major depressive disorder, degenerative arthritis in shoulders, hands, and knees, and osteopenia. R31's quarterly Minimum Data Set (MDS) dated 10/30/14 indicated the resident had severe cognitive impairment and was dependent on staff for activities of daily living including toileting, dressing, hygiene, and eating. R31 required a mechanical lift for transfers. On 1/26/2015 at 12:25 p.m. R31 was observed sitting in her wheel chair located in the dining room. NA-C stated she usually eats good during breakfast and very sleepy during lunch period and eats one really good meal a day. During an interview on 1/26/15 at 12:06 p.m. licensed practical nurse (LPN)-B stated R31 had limited range of motion in neck, shoulders, and hips and R31 did not use orthotics and did not have a range of motion (ROM) program in place. R31's care plan indicated the range of motion program was discontinued on 12/31/2013. Nursing progress note dated 1/16/14 read, "maintenance cares- passive range of motion, stretches discontinued 1/29/14- resident is comfort cares [resident does not wish for heroic medical interventions to prolong life] " . Progress note lacked assessment, evaluation, and plan.	F 318	process of developing a restorative nursing program which will enhance assessment and treatment for prevention of decreased ROM as well as provide therapy directed restorative programs. Nursing management or designee will be responsible for monitoring by random monthly audits and a nurse manager will be assigned to be program manager. Completion Plan Date: 3/11/15	

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F 318	Continued From page 77 No further assessment for need of range of motion program was found in the medical record since program was discontinued. During an interview on 1/28/15, at 1:43 p.m., LPN-D stated " we tried to do range of motion in the past and we continue to reposition her " . LPN-D indicated when the R31 ate independently active range of motion was being performed. LPN-D had no further examples of how active or passive range of motion had been provided. During an interview on 1/28/15, at 2:05 p.m. registered nurse (RN)-A stated " according to the aide care plan, maintenance is not being provided. " During another interview on 1/29/15 RN-A stated they were not aware of documentation that indicated R31 ' s program was discontinued related to pain or refusal of services. During an interview on 1/29/15, at 8:27 a.m. physical therapy assistant (PTA)-J stated, " Sometimes we would recommend passive range of motion if it ' s not going to cause pain. Providing passive range of motion could ease the burden of care. " PTA-J explained typically programs are reassessed prior to discontinuing completely and would recommend evaluating need and appropriateness for programs on a quarterly basis. PTA-J recommended R31 being evaluated by physical therapy for a maintenance program. During an interview on 1/29/15, at 9:12 a.m. nursing assistant (NA)-K stated R31 did not receive passive range or motion at this time and thought R31 would allow and tolerate receiving ROM services without any difficulty.	F 318		

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F 318	Continued From page 78 During an interview on 1/30/15 at 10:00 a.m. nurse practitioner (NP) stated, " I think she [R31] would definitely benefit from a passive range of motion program. "	F 318		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure medication administration via gastric tube was followed for 1 of 1 resident (R69) observed for medication administration through gastric tube.	F 322	Tag F322 Naso-Gastric Tubes Maple Manor Nursing & Rehab, LLC ensures that residents who are fed by a	3/11/15

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F 322	Continued From page 79 Findings include: R69's Admissions Face Sheet (AFS) indicated that R69 was admitted to facility on 6/13/13. The Diagnosis section of the AFS listed R69's diagnoses to include late effects of cerebrovascular disease; dysphasia (impaired ability to communicate due to brain injury or damage); chronic kidney disease; hypertension and prostate problems. The physician's orders dated 1/1/15, read, "Flush meds [medications] with 60 cc [cubic centimeters] H2O before and after and 5 cc H2O [water] between meds." On 1/29/15, at 8:08 a.m., R69 was observed to have an ongoing feeding through the gastric tube (g-tube). R69 gave permission for surveyor to observe registered nurse (RN)-D administer medications through R69's g-tube. RN-D was observed to stop the ongoing tube feeding, and then secured the tip of the tubing in the intravenous (IV) pole. RN-D immediately took the Asepto syringe (a trademark for a large bulb-fitted, blunt-tipped syringe), drew the first medication from a mini plastic medication cup, pushed it through the g-tube, then stopped however; RN-D did not flush the g-tube with 60 cc water before the initial medication was administered to flush the food from the tubing. On 1/29/15, at 8:12 a.m. RN-D verified she did not flush the g-tube with water before giving the first medication. The facility's Procedure for the Administration of Medication via a Percutaneous Endoscopic Gastrostomy (PEG) Tube policy dated 7/24/08,	F 322	naso-gastric/gastrostomy tube receive the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers, and to restore, if possible, normal eating skills. The standard policy and procedure for administering medications through a feeding tube is to mix medications with 10-15ml of water after crushing then flushing the tubing with 30ml of water. After the medication is instilled the tube is again flushed with 30ml of water. Other specified amounts of water for flushing may be ordered at the NP/MD discretion. The policy and procedure for administering medications through a gastrostomy tube has been reviewed and revised. At the next Nurses meeting staff will be in-serviced on the policy and procedure for administering medications through a gastrostomy tube. The Director of Nursing and/or designee will be responsible for monitoring compliance by random audits for the next 4 weeks. Completion Date: March 11, 2015	

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F 322	Continued From page 80 directed staff to follow the "standard procedure" in giving medication through gastrostomy tube to include flushing with 30 milliliters (ml) of water before and then 30 ml of water after medication administration. The physician specifically ordered 60 cc vs. 30 cc per policy.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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 cognitively 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.	F 323	Tag F323 Accidents Maple Manor Nursing & Rehab, LLC provides an environment as free of accident hazards as is possible and each resident has adequate supervision and assistance devices to prevent avoidable accidents. A comprehensive fall risk assessment is completed on all residents on admission, with a change of condition, and as needed. The care plan identifies risk factors and interventions that are initiated to prevent avoidable falls. If a resident does have a fall, referrals are made and intervention initiated as appropriate. The	3/11/15

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F 323	Continued From page 81 On 1/25/15 at 2:20 p.m. R96 was observed sitting on the bed with ice packs on both legs. R96 stated that she had broken both legs in a fall at home about 11 week ago. On 1/25/15 at 2:07 p.m. licensed practical nurse (LPN)-B stated R96 had fallen on 1/1/15 (after admission to facility) but sustained no injuries. The interdisciplinary team notes (IDT) dated 1/1/15 indicated R96 had been lowered to floor during a transfer because she had weak knees and received no injury. The clinical manager registered nurse (RN)-A documented no problems identified on the IDT notes. R96 ' s are plan had a problem dated 12/16/14 of fall risk, related to need for assistance. The care plan directed to assist R96 with mobility as needed and to use a mechanical lift, but lacked other individualized interventions to reduce or prevent falls for R96. No fall risk assessment identifying contributing factors or comorbidities related to medical conditions, cognitive function, medications, physical function or the environment that could contribute to R96's risk for falls was found or provided by the staff when requested for R96. On 1/29/15 at 5:00 p.m. RN-A was interviewed and stated no fall risk assessment could be located for R96. No policy/procedure was provided when requested.	F 323	plan of care is reviewed and revised accordingly. The fall risk assessment for resident 96 has been completed. The policy and procedure for accidents/falls was reviewed and revised. At the next Nurses meeting staff will be in-serviced on the policy and procedure for fall risk assessments and intervention implementation. The Director of Nursing and/or designee will monitor for compliance by random audits for the next 4 weeks. Completion Date: March 11, 2015	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive	F 325		3/11/15

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F 325	Continued From page 82 assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accurate and ongoing nutritional reassessments and consistent and accurate weights were provided to determine and monitor for weight loss for 3 of 4 residents (R38, R96, and R32) in the sample reviewed for nutrition concerns. Findings include: R38 lacked the correct diet and monitoring of intake and also lacked ongoing monitoring for significant weight loss and nutritional assessment for needs. R38 was observed on 1/26/15 at 5:20 p.m. eating independently. She left the table at 5:35 p.m. and had eaten less than 25% of the meal. R38 was interviewed on 1/26/15 at 6:11 p.m. and she was on a fluid restriction and was sure she had dietary restrictions, but needed to talk to a dietician to find out what the restrictions were. R38 was admitted to the facility from the hospital on 12/16/14 according to the hospital discharge	F 325	F-325 Maintain Nutritional Status Unless Unavoidable Maple Manor is developing the process for communicating and evaluating intakes for resident meal consumption that is being recorded by dietary staff, and will incorporate fluid monitoring for residents identified for restrictions. Residents (R38, R96, R32) have been assessed and will be referred to the Dietician for further interventions. The daily log sheets will be returned after the day□s final meal to the CDM for identification of residents consuming less than 50% or not meeting fluid guidelines per physician order. The facility has purchased a wheel chair scale to better monitor weights as ordered. Residents who trigger for low meal consumption will be referred to the Dietician for weekly review and recommendation of enhanced monitoring of nutritional needs and physician ordered weights. The CDM and Dietician will be responsible	

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F 325	Continued From page 83 summary which noted R38 had a perforated colon that resulted in a colostomy and had a prescribed diet of general diet. Hospital dismissal summary dated 12/30/14 indicated the resident had been readmitted to the hospital with acute respiratory failure, hyponatremia, hypophosphatemia, hypomagnesaemia and chronic anemia. The diet prescribed was general with low residual. The hospital discharge summary dated 1/9/15 noted R38 had experienced volume depletion and hyponatremia. The prescribed diet was changed to 1500-2000 milligrams (ml) sodium, low cholesterol, and low fat. The physician orders of 12/30/14 noted continue to monitor weights, blood pressures, and pulse. However, an admission weight was not obtained. The hospital weight of 12/28/14 was 161 pound and the weight on the temporary care plan dated 1/9/15 showed a weight of 141 pounds, or 20 pound (12%) weight loss. The registered dietician completed an assessment on 12/17/14 that indicated a regular diet and to monitor initial intake. Weight loss not expected. Ideal body weight 135-165 pounds and current weight 162 pounds. The 12/24/14 dietary care area assessment noted general diet, boost nutritional supplement twice a day for extra calories and a weight of 163 pounds. On 1/25/15 a readmission nutritional assessment was completed by the certified dietary manager (CDM) and included a no added salt diet with any other changes. R38 weight was 139 pounds and	F 325	for evaluating intakes and communicating concerns to nursing and physicians for the interventions to nutritional concerns. Random monthly audits will be conducted by Administration or designee for system implementation and compliance. Completion Date: 3/11/15	

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noted no significant weight changes (significant loss is calculated as 14% weight loss in one month.)

The dietary tray care noted a fluid restriction and a no added salt diet. The tray card did not include the physician orders (1/9/15 hospital discharge) of 1500-2000 mg sodium, low fat, low cholesterol.

Physician order of 1/14/15 noted staff were to administer 2 ounces of dietary supplement 2.0 at medication pass due to weight loss, stage II wound, and meal intake of less than 50%. The physician order of 12/13/14 also included boost (240 cc) twice a day. The facility continued to document that they were offering both the 2.0 and boost, but the medication administration record did not indicate the percentage of these two supplements taken by R38. Licensed practical nurse (LPN)-D was interviewed on 1/29/15 at 9:25 a.m. and stated the boost had been changed to Ensure (2.0) so R38 would receive the Ensure during the medication pass. On 1/29/15 at 10:10 a.m. registered nurse (RN)-A was interviewed regarding documentation of nutritional supplement intake and stated that nursing only documented if R38 refused the supplement and not the amount taken during the medication pass.

The meal intake for 12/16/14 through 1/26/15 was reviewed and the intake was documented sporadically this was found for the fluid intake monitoring for 1/14/15 to 1/26/15. Also none of the daily intake was totaled to determine if intake was adequate for R38.

R38 ' s care plan printed 1/27/15 was reviewed and included a diet plan dated 12/22/14 with an

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intervention of general diet. Care plan dated 1/12/15 included intervention of no added salt diet and a 2000 cc (cubic centimeter) fluid restriction. During an interview on 1/2/15 at 4:25 p.m. the director of nursing (DON) verified the care plan had two conflicting orders for R38's diet.

Clinical manager (RN-A) and director of nursing were interviewed on 1/28/15 at 8:00 a.m. They both stated the nursing assistant was responsible to document the intake and that nursing and dietary were to review the totals. They stated they were aware that this was not being done at this time. They both were aware the weights were not being done as ordered.

The certified dietary manage (CDM) was interviewed on 1/28/15 at 8:10 a.m. CDM stated that R38 was not on his list of residents that he was to be watching weight on. CDM stated he would look only at the weights that were in the computer system and that he was aware that the weights were not being done. CDM would have the registered dietician (RD) assess new admissions, annual reassessments, and any resident with a significant weight loss.

The RD was interviewed on 1/28/15 at 8:35 a.m. and stated she was aware that taking of weights were an issue in the facility. RD stated that R38 received a cardiac diet which was a low sodium diet only. RD stated she would see admissions and annual reassessment residents and did look at weight listings with each visit to see if there was any resident she should see. RD stated she was aware that intake was not being monitored and she was unsure of the accuracy for weights being taken by staff as they varied.

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During an interview with CDM on 1/29/15 at 940 a.m. CDM stated the average diet served was 4 to 6 grams (4000 to 6000 mg) sodium and verified that exceeded R38's recommended 1500-2000 milligrams of sodium. During an interview on 1/29/15 at 10:20 a.m. CDM stated the general diet was not considered to be low fat/low cholesterol. CDM stated R38 would be served the regular diet but no added salt from salt shaker is given.

Cook (C)-A was interviewed on 1/30/15 at 7:55 a.m. and said that a no added salt diet meant the resident was not served sausage or bacon, but that everything else would be ok to serve. At this time C-C stated that at breakfast every resident would be served the same thing with no change to foods offered no matter what restrictions they may have. On 1/30/15 at 8:10 a.m. C-B stated that residents on a no added salt diet received the same as the other residents just no sausage or bacon.

R96 lacked the correct diet also lacked consistent monitoring of intake and also lacked ongoing monitoring of interventions to prevent further weight loss having had a significant weight loss and nutritional assessment for needs.

R96 was observed to eat lunch in her room on 1/25/15. She had received a regular meal with regular portions. R96 stated that she was to receive smaller portions because she had had a gastric bypass. R96 was observed on 1/26/15 at 5:15 p.m. stating that she had been weighed today had had lost about 10 pounds since admission. On 1/27/15 at 8:30 a.m. R96 was eating Canadian bacon and waffles for breakfast.

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R96 was interviewed on 1/26/15 at 11:50 a.m. She stated that she was tired of canned fruit since she gets it at every meal. She stated she had had a gastric by-pass and should receive smaller portions. Today she had a full portion meal serving and ate less than 50% of the meal. Review of the diet card on her tray did not noted small portions. During an interview on 1/30/15 at 9:15 a.m. R96 stated that last night she had scalloped potatoes with ham, creamed cucumbers and something else (bread). R96 said that was a lot of carbs (carbohydrates) with high calories and has been having high blood sugar readings from the increase in carbohydrates compared to when she lived at home.

The hospital dismissal summary dated 12/2/14 and day of admission to the home identified R96 had diagnoses of post renal transplant, hyperlipidemia, hypertension, hypothyroidism, and anemia. Orders for continuing care read, "Diabetes Management, check blood sugars twice daily. Diabetic diet."

R96's Insulin Flow Sheet from 1/1/15 through 1/30/15 was reviewed. Readings for morning blood glucose ranged from 81 to 154; the range of noon blood glucose readings was 118 to 301, the afternoon blood glucose ranged from 113 to 388, and the bedtime glucose range from 96 to 288. On 1/20/15 the physician ordered sliding scale insulin.
American diabetes recommends blood sugars range as follows:
Fasting (before meals; upon waking):70-130 mg/dL (3.9-7.2 mmol/L)
Postprandial (1-2 hours after the start of a meal): greater than 180 mg/dL (10.0 mmol/L) which may

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be higher depending on each resident and doctor. The RD completed a nutritional assessment on 12/3/14. The assessment listed a diagnosis history of gastric bypass, history of a kidney transplant, but not of diabetes. The assessment listed no laboratory values, listed an ideal body weight of 117 to 143 pounds, but no estimated calorie or carbohydrate need. The assessment did identify the resident received insulin for control of blood sugars. The assessment indicated the resident would eat small amounts related to a gastric bypass, but did not indicate the need for a diabetic diet. The nutritional assessment listed the weight at 146 pounds (the same as the hospital discharge summary dated 12/2/14).

The dietary care area assessment dated 12/15/14 noted the resident received a therapeutic diet and was offered a diabetic no sugar added diet per physician order.

The certified nursing assistants (CAN) Entry Report provided by the facility was reviewed for food intake from 12/3/14 through 1/26/14. R96 ' s intake of food was documented sporadically and not completely.

R96's admission weight documented on the weight form read, "157 pounds." At the surveyor request the resident was weighed on 1/26/15 and had a weight of 147 pounds or a weight loss of 10 pounds or 6.4% from 12/2/14 to 1/26/15.

R96's Care plan dated 12/15/14 indicated the need for a therapeutic diet and had interventions of offered a diabetic no added sugar diet.

RN-A was interviewed on 1/27/15 at 8:20 a.m.

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He stated that admission weight were being deferred for a couple weeks since residents admitted from hospitals frequently had a fluid overload and therefore showed a weight loss. He stated he did not know why the weights were not done monthly or as ordered by the physician.

RN-A and DON were interviewed on 1/28/15 at 8:00 a.m. Both stated that nursing assistants were to record food intake and that nursing was to review the total consumed. When asked about consistent weights being taken both RN-A and DON said they were aware of lack of weights being completed for residents.

The RD was interviewed on 1/28/15 at 8:35 a.m. She stated she was aware that taking and recording weights was an ongoing problem as they were not done as required. She stated that it was nursing's responsibility to obtain the correct information on the diets and inform dietary if changes were needed. The RD was again interviewed on 1/28/15 and was aware R96 had gastric bypass to reduce weight and the treatment consisted of small frequent meals offered vs. larger three meals per day. RD felt that weight loss was expected but that she did not know R96 lost any weight since admission.

The nurse practitioner (NP)-A was interviewed on 1/30/15 at 9:00 a.m. NP-A stated a regular diet was not appropriate for R96. The resident had been complaining of high blood sugars in the afternoon and would complain about the closeness of the breakfast and lunch meal. But no change was done to accommodate R96 ' s need for smaller more frequent meals.

The facility policy dated 6/7/13 regarding

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weighting of residents was reviewed and read, "It is the policy of Maple Manor to ensure that residents are weighed and a weight record is kept on each resident and monitored routinely." Residents are to be weighed within 3 days of admission and thereafter as ordered by the physician, but at least monthly.

R32 had a weight loss of 9.6 pounds in thirty days, declined in eating meals, however, no reassessment was completed to assess weight loss and determine interventions to prevent more weight loss.

R32's quarterly Minimum Data Set (MDS) dated 1/9/15 indicated was moderately cognitively impaired with diagnoses of dementia, always incontinent of bowel, and required extensive assist with activities of daily living (eating, toileting, transfers, dressing and hygiene).
R32's physician's note dated 12/16/14 included the diagnoses of Lewy body dementia, diabetes mellitus, and constipation.
R32's most recent care plan provided by the facility on 1/27/15 included R32 has had a significant weight loss, had a mechanically altered diet with soft textures and nectar thickened liquids. Care plan instructed staff to bring R32 to the dining room and sit at supervised table and is assisted to eat as needed and staff to prompt in proper technique of swallowing per speech therapy (ST) recommendations. The care plan also instructed staff to provide a scoop plate at all meals or a shallow bowl if unable to use a scoop plate and provide double portions at meal times.
R32's physician orders dated 12/16/14 included the following medication orders to treat constipation: Senna-S tablet 2 tabs by mouth three times daily (original order date of 4/16/08),

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F 325	Continued From page 91 Miralax 17 grams by mouth two times daily (original order date of 4/30/09), and Sorbitol 70% solution 30 milliliters (ml) by mouth one time daily (original order dater of 1/21/09). Physician's orders also included Seroquel 25 milligrams (mg) by mouth at noon and 37.5 mg at 6:00 p.m. R32's dietary assessment progress notes were reviewed: note on 8/5/14 indicated R32 was independent with eating, weight is stable, no difficulty with swallowing or chewing, and does not eat a lot for lunch or dinner. Note on 9/3/14 indicated R32 switched from regular texture foods to mechanically soft and nectar thickened liquids related to coughing during meals and staff were to monitor intake. Note from 10/24/14 indicated R32 eats 50-75% of meal, had difficulty chewing and swallowing, had a 4.8% weight loss in the last 30 days or 9.5 pounds, and R32 was offered pudding at lunch and supper for weight gain. Dietary assessment note written on 11/19/14 indicated R32 had a weight loss of 7.3% in 6 months and read, "However, resident has a brace on foot and weight may/may not include brace, staff to monitor weight, intake, notify certified dietary manager, registered dietician." Dietary assessment note written on 1/16/15 indicated intake was 50-75% of food at meals and noted an overall weight loss of 20.6 pounds or 10.3% of body weight in 180 days. Dietary assessments lacked a comprehensive assessment and evaluation of weight loss and failed to address interventions that would maintain or regain weight. R32's meal intake documentation from 1/1/15 through 1/26/15 did not show meal intake for 32 meals. Based on documented meal intake R32 consumed an average of 51-75% of breakfast meal, 51-75% of noon meal, and 26-50% for evening meal. Calories consumed or what had	F 325		

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been consumed for meals was not tracked.
Physician visit note dated 8/14/14 identified one of R32's behaviors as "refuses meals"
Physician visit note dated 10/28/14 (visit after dietary assessment had identified a 9.5 pound weight loss in 30 days) had no mention of the weight loss and read " No other active new challenge "
Physician visit note dated 12/16/14 indicated R32's appetite was fair, however listed "refuses meals" under behaviors. The note had no mention of the 7.3% weight loss in 6 months.
R32 was treated by speech therapy from 8/5/14 through 9/6/14 for recommendations for change in texture of diet related difficulty masticating food and improving ability to swallow fluids safely. On discharge R32 speech therapy indicated resident required verbal cues from staff for safe swallowing and R32 would not regain swallowing function.
R32's dining room tray card (card used to communicate dietary information to staff) included the instruction to give double portions at breakfast and provide a scoop plate.
During observation of evening meal at 5:00 p.m. on 1/26/15. Nursing assistant (NA)-O was assisting residents at tables to eat. When NA-0 was not assisting R32, he sat with arms folded in lap until NA-0 gave another bite of food. Toward the end of the meal at 5:38 p.m. R32 took a bite of pudding independently. This was the only bite of food R32 took independently throughout the meal. When R32 was moved from the dining table, 75% of food remained on the plate. NA-O did not ask R32 if he was done eating just moved R32 from table.
During an observation on 1/28/15 at 8:50 a.m. R32 was brought out to breakfast and was served single sized portions. No scoop plate or shallow

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bowl was used during 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 until he was given a bite of hot cereal. FA-A did not give verbal cues on use swallowing technique to promote ease of swallowing. R32 did not attempt to eat independently during the meal.
During an interview on 1/27/15, at 2:19 p.m. NA-N explained R32 required assistance with eating. NA-N stated, "He does not require any adaptive equipment or special dining needs."
During an interview on 1/27/15, at 2:23 p.m. NA-O stated, " Sometimes he eats and sometimes he doesn't, somebody needs to sit next to him the entire time during the whole meal."
During an interview on 1/27/15, at 2:25 p.m. licensed practical nurse (LPN)-D stated, "75% of the time he needs to be fed. Aide staff should be sitting in close proximity ..."
During an interview on 1/27/15, at 2:30 p.m. certified dietary manager (CDM) explained R32 received double portions at breakfast because he ate more at breakfast. CDM also explained he averaged the range of meal intakes from the nursing assistant documentation, and there was not a mechanism that identified exactly how much or what a resident consumed. The CDM stated the resident had not been on a dietary supplement yet and nursing had not been involved in addressing need for dietary supplements. CDM stated R32 has had a weight loss because of reduced food intake; however no determination had been assessed to determine why he was losing weight.
During an interview on 1/27/15, at 3:01 p.m. director of nursing (DON) explained her expectation would be someone should be sitting

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F 325	Continued From page 94 next to R32 during the entire meal to ensure that he is eating and swallowing correctly. DON further explained when there is a decline or change of condition, nursing should confer with the nurse practitioner, try to identify the root cause (medication, environment, need for assistants, food texture versus disease process), and possibly get speech therapy involved. During an interview on 1/28/15, at 7:35 a.m. registered dietician (RD) stated, "R32 has not been evaluated from a dietary standpoint if he needs more assistance at meals and environment has not been evaluated." During an interview on 1/28/15, at 9:22 a.m. speech therapist (SP)-M stated, "When we saw him he would eat only 25% of his food then allowed staff to feed him up to 75%." SP-M said she was not aware R32 had weight loss and a referral had not been made for her to reevaluate his swallowing/eating status.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		3/11/15

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F 329	Continued From page 95 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure adequate side effects monitoring was completed or other like assessment tool to determine side effects for the use of psychotropic medications for 1 of 5 residents (R68) who received Seroquel and antipsychotic medication; failed to ensure an ongoing bowel assessment for use of three bowel medications or a current physicians justification as to why they are necessary for 1 of 5 residents (R32) reviewed for unnecessary medications. Findings include: R68 received an antipsychotic medication (Seroquel) and was not monitored for possible side effects. On 1/28/15, at 8:14 a.m. R68 was observed in room and seated calmly in wheelchair. R68 did not protest when nursing assistant (NA)-B suggested to braid R68's hair. R68 had a firm handshake with surveyor and R68 stated, "Thank you" pleasantly to compliment about looking nice with the braided hair. R68 smiled as NA-B pushed R68 out from room toward the dining	F 329	Tag F329 Unnecessary Drugs Maple Manor Nursing & Rehab, LLC staff assures that each resident□s drug regime is free from unnecessary drugs. The resident□s drug regime is reviewed by the staff, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences. The medication review includes monitoring for unnecessary duplicate therapy. The policies related to completion of the Abnormal Involuntary Movement Scale to assess (AIMS) for adverse effects of antipsychotic medications and for the use of bowel preparations were reviewed and found appropriate. AIMS assessments will continue to be done monthly for three months and then every six months; the bowel management plan of care will	

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F 329	Continued From page 96 room for breakfast. On 1/28/15 at 1:49 p.m. NA-C was asked if she saw R68 have unwanted behaviors and NA-C said she had not observed R68 manifesting negative behaviors or delusions or hallucinations. On 1/28/15 at 1:52 p.m. NA-B stated she would redirect any resident manifesting a behavior but denied having observed any delusions or hallucinations from R68. NA-C was not aware R68 was being monitored for delusions or hallucinations. On 1/28/15 at 2:08 p.m. registered nurse (RN)-C enumerated R68's target behaviors as "angry, yelling, making noise, does not like everybody." RN-C stated nurses will document in the progress notes when target behaviors and/or possible side effects of medications occur, otherwise no documentation was needed. RN-C stated that nurses do not check orthostatic blood pressures even with the use of anti-psychotic medications if there was no doctor's order. RN-C did not mention about R68's hallucinations and delusions being monitored. On 1/28/15 at 4:02 p.m. RN-A stated R68's target behaviors include making accusations, also had "delusions about staff who were doing catheterization on [R68] were a bunch of lesbians trying to take advantage of [R68]." RN-A verified the specific target behaviors he mentioned were not written in behavior monitoring sheet. RN-A stated nurses will chart if the behaviors occur. When asked if side effects of psychotropic medications were being monitored, RN-A replied, "Probably not because they said no need to monitor." When asked who " They" were, RN-A	F 329	continue to be routinely reviewed by the interdisciplinary care team, pharmacist and physician with updates by the medical practitioner as indicated. During mandatory meetings, the nursing staff were instructed on 1) the need to follow the facility policy on assessing for side effects of antipsychotic medications 2) the importance of documenting observed target behaviors 3) the need for ongoing physician justification for use of multiple laxatives and 3) the importance of tracking and documenting the resident□s bowel function. During the consultant pharmacist□s monthly medication audits and the quarterly care planning process, the resident□s medications will continue to be reviewed to assure that the resident is receiving the lowest effective medication dose with appropriate indications and monitoring. Resident number 32 -- The nurse practitioner reassessed the resident□s bowel function on February 19, 2015. 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 the new regime is ineffective. The care plan has been reviewed and updated. 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	

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F 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. The care plan dated 1/27/14 indicated R68 was at risk for falls related to psychotropic medication use. Interventions include giving medications per orders. However, side effects of psychotropic medications in relation to falls were not identified and were not specifically planned to be monitored. 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. On 1/29/15, at 1:25 p.m. the consultant pharmacist (CP) stated his expectations that side	F 329	target behaviors justifying use of Seroquel and to reflect monitoring for side effects. The nursing assistants will continue to document observed target behaviors. The Director of Nurses/designee and the Consultant Pharmacist will continue to monitor for compliance with antipsychotic side effect monitoring, behavior related documentation, and duplicate drug therapy during the routine quarterly record reviews and more often if indicated. Completion date: March 11, 2015	

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F 329	Continued From page 98 effects of any medications should be monitored. CP agreed orthostatic blood pressure and AIMS should be completed to determine if side effects developed while on anti-psychotic medications. On 1/29/15 at 1:28 p.m. RN-E stated they were unable to locate an AIMS assessment. At 1:43 p.m. the director of nursing (DON) verified there was no record on file to show AIMS was completed for R68 within the last year even though the resident had received the antipsychotic medication. The facility's Use of Psychotherapeutic Medications policy dated 4/11/08, directed staff to monitor drugs for side effects daily, to include monitoring for gait disorders, movement disorders, signs of hypotension, and cholinergic effects such as dry mouth and urinary retention. The policy further directed staff to assess for baseline AIMS and to do reassessment every three months for the use of antipsychotic medications. R32 received three bowel medications and there was no physician justification for need of three bowel medications and exceeded recommended dose of Miralax. R32's physician's note dated 12/16/14 included the diagnoses of Lewy body dementia, diabetes mellitus, and constipation. R32's physician orders dated 12/16/14 included the following medication orders to treat constipation: Senna-S tablet 2 tabs by mouth three times daily (original order date of 4/16/08), Miralax 17 grams by mouth two times daily (original order date of 4/30/09), and Sorbitol 70% solution 30 milliliters (ml) by mouth one time daily (original order dater of 1/21/09). The dose of Miralax ordered exceeds the daily	F 329		

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F 329	Continued From page 99 recommended dose according to the manufacturers label that indicated the adult daily dose was 17 grams vs. double ordered by doctor. The directions indicated not to use more than 7 days and instructed not to take more than 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 different formats; paper flow sheet and electronic medical record. Documentation was found to be inconsistent between the two formats. Documentation revealed R32 routinely had more than one BM daily. The electronic form of documentation lacked consistency (soft, formed, hard, etc.) and size (small, medium or large) of BMs and the paper flow chart lacked consistency of BMs. This lack of information would make it difficult to determine if the medication was affective or was too much as R32 went daily. The last physician ' s assessment and evaluation that justified the need for three medications for bowel regime (polypharmacy) medication was last addressed on April 30, 2009. The documentation read, " ...does not tolerate suppositories ...and will become angry at times ....does have very large bowel movements with suppositories and if not given he may not have a bowel movement for up to 5 or 6 days. Physician progress notes reviewed did not indicate rationale for prescribing more than manufacturer's daily Miralax recommended dose. R32's quarterly Minimum Data Set (MDS) dated 1/9/15 indicated was moderately cognitively impaired with diagnoses of dementia, always incontinent of bowel, and required extensive	F 329		

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F 329	Continued From page 100 assist with activities of daily living (toileting, transfers, dressing and hygiene). R32's care plan did not address constipation or history of constipation or non-pharmacological interventions to promote bowel movements such as increased fluids, adding roughage to diet, increased activity, maintaining routine daily bowel habits, use of toilet or commode, etc. During an interview on 1/27/15, at 2:05 p.m. registered nurse (RN)-A indicated he was not aware of specific reasons why R32 had 3 different bowel medications. RN-A also did not know why the dose of Miralax was higher than recommended. RN-A stated he was not aware of an assessment or physicians recent justified for use of the three bowel medications. During an interview on 1/27/15, at 3:34 p.m. consulting pharmacist (CP) stated if a resident has a diagnoses that required more than a recommended dose of medication it should be care planned and the physician to address or note the reasons for the increased amount and then monitor routinely. During an interview on 1/30/15, at 9:30 a.m. nurse practitioner (NP) stated, "[R32 ' s] bowel medication should be looked at and reduced." After informing NP of R32 ' s three bowel medication and daily bowel movements.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;	F 334		3/11/15

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F 334	Continued From page 101 (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; (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 resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (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 indicated, at a minimum, the following: (A) That the resident or resident's legal	F 334		

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F 334	Continued From page 102 representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an influenza policy that directed staff to ask residents and provide residents with influenza vaccine after October 2014. This had the potential to affect all 69 residents in the facility. Findings include: The facility policy Influenza Prevention and Outbreak Management Policy dated 1/14/13 was reviewed. The policy identified that in September the facility would obtain a creatinine clearance of all residents, provided annual influenza education, obtain permission forms from resident/families related to influenza vaccination. In October the facility would obtain the influenza vaccine and proceed to have staff members and residents vaccinated. The policy then proceeded	F 334	Tag F334 Influenza and pneumococcal immunizations Maple Manor Nursing & Rehab, LLC offers each resident education regarding benefits and potential side effects of the influenza immunization. Each resident is offered the influenza vaccine October 1 through May 31 annually unless contraindicated or have already received it. All residents are offered the current education and the influenza vaccine from 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 record. The policy and procedure for	

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F 334	Continued From page 103 to outbreak management. The policy/procedure lacked direction to staff related to how to re-educate each resident or guardian on the risk/benefits for any resident refusing to be vaccinated, and documenting that education; lacked direction related to questions residents admitted after October if they had received the vaccination elsewhere for the year; and lacked direction to provide the vaccination to newly admitted residents after October 2014. The director of nursing (DON) was interviewed on 1/28/15 at 11:25 a.m. related to the influenza vaccine. She verified the policy did not address provision of the influenza vaccination after October. DON stated the vaccination could be given after October, but that the policy needed to be rewritten.	F 334	administration of the influenza vaccine was reviewed and revised. At the next Nurses meeting staff will be in-serviced on the policy and procedure for influenza vaccination. The Director of Nursing and/or designee will monitor for compliance by random audits for the next 4 weeks. Completion Date: March 11, 2015	
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.	F 353		3/11/15

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F 353	Continued From page 104 Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This 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. Findings include: SEE F241: On 1/25/15 during the noon meal (11:45 a.m.) R26 was seated with several other residents and only nursing assistant (NA)-F was seated helping another resident to eat. At the same time NA-F would speak loudly across the tale for other residents to eat. None of these residents did eat independently and waited long periods of time for assistance to eat. On 1/26/15 at 5:09 p.m. the supper meal, NA-O was assisting five dependent residents to eat and these five residents were seated at two different tables. NA-O was observed to stand while giving one resident a bit of food then moving to another table giving that resident a bit of food then would be repeating this process until NA-O left the dining room and did not return. A short time later NA-F and registered nurse (RN)-A moved the residents from the table and neither NA-F or RN-A attempted to assist the five residents to complete their meal. Also staff stated they were short staffed as evidenced by depended residents being assisted to eat in a continuous period of	F 353	F-353 Sufficient 24-HR Nursing Staff per Care Plans Maple Manor is committed to provide qualified/sufficient staff to provide for our resident needs per their care plan. We identified a systems problem that is being corrected through scheduling and synchronization of defined patient care roles. We have analyzed interdepartmental work-flow enhancements which will provide better accountability and understanding of how each department is related to the success of the next. The framework of the initial changes restructured the shift start times and overlap for transition in the morning. The break schedule was moved to provide more attention preceding meals and accountability during a dignified dining experience. Staff have been educated that our residents who cannot speak for themselves are equally deserving of quality uninterrupted care inclusive of assistive dining in a dignified maner. In addition, we will be adding a restorative nursing program to provide for increased quality of life within the care implementation system. The plan is a	

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F 353	Continued From page 105 time as staff went from resident to resident giving a few bites then moving on to the next resident or staff not assisting residents for periods up to 20 minutes and food was cool by the time staff assisted the residents to eat.; failed to allow residents time to eat before cleaning the table of food debris and had parked the BUS cart with food scraps next to table where residents were still eating; and failed to cover a urine collection bag to promote dignity for 1 of 1 resident (R68) who was observed with an uncovered urine collection bag with urine set on bed and visible to other residents, staff, and visitors. SEE F282 & F312: Based on observation, interview, and document review, the facility failed to provide services as directed on each residents care plan for 2 of 5 residents (R3, R88) for assistance with eating as R3 waited over 20 minutes for staff to assist her to eat and R88 waited during noon meal on 1/27/15 for 32 minutes at one meal before staff assisted her to eat while having her food set in front of her the entire time and waited at breakfast on 1/28/15 for 20 minutes for staff to return to help her finish eating. During interview on 1/29/15, at 9:00 a.m., director of nursing stated she expected staff to follow the care plan and to provide R3 & R88 with assistance for meals. Director of nursing stated she was aware of the lack of staff in the east/west 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 all 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 Resident (R45 & R38) who had orders for daily weights were not consistently done and during a staff	F 353	work in progress and will adapt to the changing needs of our resident population. All department managers have been educated to the system design changes and will assist in monitoring the success in our goal of dignity, adaptability, and overall quality of life. Administration and each designee is responsible for the ongoing success and evaluation of the program. Completion Plan Date: 3/11/15	

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F 353	Continued From page 106 interview it was learned it was because they were short staffed. Also R38 was to have fluids 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. SEE F309: Based on observation, interview and document review, the facility failed to ensure 5 of 39 residents (R100, R71, R45, R38, and R39) had ongoing services and treatments as ordered by the physician to monitor for significant health status changes so they could be reported timely to the physician for interventions as R100 had congestive heart failure and ongoing monitoring of fluid intake was not completed, nor was respirations, lung sounds, monitoring of edema, blood pressure or heart rate monitored closely in order to determine current regimen of medications was affective or acute health changes needed to be responded to by the doctor timely. R71 also had congestive heart failure and did not receive ordered daily weights nor lung sounds, respirations, blood pressure, edema, etc. R45 also had congestive heart failure and lacked physician ordered daily weights, monitoring of lung sounds, worsening of edema of legs, etc. R38 had a new colostomy, and lacked doctor ordered daily weights, monitoring of a fluid restriction, and ongoing assessment of colostomy healing and bowel function. R39 lacked daily weights per doctor ' s order due to congestive heart failure and ongoing monitoring of lung sounds, monitoring for edema and fluid overload. During an interview with the registered nurse (RN)-A on 1/19/15 at 3:58 p.m., RN-A stated that	F 353		

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F 353	Continued From page 107	F 353		

they had staffing issues and the weights he gave me were all they had for R39.

SEE F315: Based on observation, interview and document review, the facility failed to ensure comprehensive bladder assessments and an assessment of risks for developing and monitoring of symptoms for urinary tract infections (UTIs) for 7 of 8 residents (R16, R6, R70, R30, R69, R96, R38) reviewed with recurrent urinary tract infections; the facility failed to prevent urinary tract infections and the spread of infections to other residents due to staff not following sound infection practices regarding Foley Catheter care and equipment used for 1 of 1 resident (R68) with an indwelling Foley catheter; and the facility failed to follow physician orders for intermittent cauterization and failed to monitor, evaluate, and assess urine output for 1 of 1 residents (R70) in the sample with intermittent catheterizations. R70 had physicians order for every four hour catheterization which was not consistently provided.

The director of nursing was interviewed on 1/28/15 at 4:15 p.m. she stated she felt the facility provided adequate staffing numbers. She stated that she did not work on the floor providing direct resident cares. DON said that ideal staffing would be 7 nursing assistants and 3 licensed nurses and 2 trained medication aides each day shift and each evening shift along with administrative nursing staff.

The clinical nurse manager (RN-A) was interviewed on 1/29/15 at 8:05 a.m. He stated he was aware that residents had complained about the lack of staffing levels.

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F 369	Continued From page 108	F 369		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents 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 loss ...is 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 proper technique of swallowing per speech	F 369	F-369 Assistive Devises- Eating Equipment Resident R32 was assessed for adaptive equipment and is now utilizing a scoop plate. Other residents in need of adaptive equipment for dining will be screened on admission, with any significant change and reviewed within the interdisciplinary care conference schedule. The CDM will be responsible for ongoing compliance and Administration or designee will conduct random audits. Completion Date: 3/11/15	3/11/15

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F 369	Continued From page 109 therapy ....8/13/14 provide a scoop plate at all meals, provide shallow bowls if unable to use scoop plate." R32's dining room tray card (card used to communicate dietary information to staff) included the instruction to give double portions at breakfast and provide a scoop plate. During an interview on 1/30/15, at 10:30 a.m. certified dietary manager (CDM) verified resident did not receive double portions and stated the resident was supposed to have a scoop plate.	F 369		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, during the kitchen tour the facility failed to identify when refrigerated foods have expired and should be removed from service and to remove fresh foods that appear they have lost their freshness. This had the potential to affect most residents in the facility. Findings include: The initial kitchen tour on 1/25/15, at 10:11 a.m.	F 371	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 or	3/11/15

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F 371	Continued From page 110 was guided by head cook (HC)-A. Observation of the walk in cooler revealed an open bag of romaine lettuce with several brown pieces of lettuce. The bag had a "use by date" of 1/24/15. The head cook verified the lettuce was out of date and stated, "We throw out food that is past the used by date" and then proceeded to toss the lettuce. Observation further revealed 2 bags of liquid pasteurized eggs that were not labeled or dated in a reach in cooler. The Head cook verified the absence of date and label and commented the bags should be dated and labeled. Facility policy General Food preparation and Handling read, "Food in broken packages or swollen cans, or food with abnormal appearance or odor will not be served." Facility policy Food Storage read, "Food should be dated as it is place on the shelves, date marking to indicate the date or day by which a ready to eat, potentially hazardous food should be consumed, sold or discarded will be visible on high risk foods ....all foods should be covered, labeled, and dated."	F 371	designee is responsible for weekly audits to assure food is safely stored. Completion Date: 3/11/15	
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).	F 373		3/11/15

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F 373	Continued From page 111 In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.	F 373		

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F 373	Continued From page 112 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 3 residents (R88, R68, R66) reviewed for assistance with eating, were comprehensively assessed to be safely assisted to eat with the help of paid feeding assistant (PFA)-A. Findings include: PFA-A assisted R88, R68, R66 with eating although the facility had not assessed these three residents to be safe to have PFA-A help them all eat. R88 was assisted to eat by PFA-A without assessment as safe to be assisted. R88 was admitted to the facility 8/26/14, with diagnosis that included dementia with Lewy Bodies and paralysis agitans according to resident diagnosis codes printed 1/30/15. The facility identified R88 on the quarterly Minimum Data Set (MDS), an assessment dated 11/23/14, to have short term memory problem, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene, and received a mechanically altered diet.	F 373	Tag F373 Feeding Assistants Plan of Correction The goal of Maple Manor Nursing and Rehab, LLC. Is to ensure not only the safety of R66, R88, and R68 but for all residents in the facility that require assistance with feeding. Maple Manor Nursing and Rehab, LLC is assesses residents who require assistance with 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 reviewed. Those residents who were assessed to be free of aspiration and choking risk were evaluated as safe to be aided by a trained feeding assistant. A list of these residents was made available to the trained feeding assistant and placed in a binder along with the resident assessments. This is available for review and is updated as needed. At the next CNA/Nurses meeting, the staff will be instructed on the policies and procedures for assisting residents with eating. The Director of Nursing and/or designee	

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F 373	Continued From page 113 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. R88 ' s care plan dated 9/10/14, identified problem of at risk for decline in nutritional status due to need for mechanically altered food related to poor dentation, due to open areas with increased need for nutritional support, due to abnormal labs, due to need for assistance with meals, due to decreased cognition. Approaches dated 9/10/14 included assist as needed and as resident allows with food/fluid. Approaches dated 9/22/14 included pureed diet with thin liquids. Approaches dated 9/23/14, included house supplement two times daily. Approaches dated 9/29/14 included alternate bites with sips, watch for swallow and give next bite/sip to maintain pace and uncovered cups ok when being assisted. During observations on 1/27/15, at 11:18 a.m., R88 was in wheelchair in the east/west dining room positioned at the large table on the south side of the dining room (south table) where residents who needed assistance to eat were observed to sit. During observations at that time, a plate of pureed carrots, quiche, and mashed potatoes and four adaptive cups of beverages with lids were on the table directly in front of R88, who was asleep. At 11:54 a.m., PFA-A assisted	F 373	will be responsible for monitoring compliance by random audits for the next 4 weeks to ensure that these policies/procedures are being followed. Completion date: March 11, 2015	

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F 373	Continued From page 114	F 373		

another resident at same table, then handed R88 glass of chocolate milk. At 12:06 p.m., PFA-A stood to assist R88 to eat one bite of food after another until R88 was finished eating.

During interview on 1/27/15, at 12:12 p.m., PFA-A verified had assisted R88 to eat. PFA-A stated R88 received pureed foods and any staff could assist R88 to eat. PFA-A stated R88 had good days when R88 ate independently, and other days needed assist with eating.

During interview on 1/29/15, at 9:00 a.m., director of nursing verified R88 had not been assessed to be assisted to eat by PFA.

R68 was assisted to eat by PFA-A without assessment as safe to be assisted.

R68 was admitted 4/17/13 with diagnosis that included dementia, psychosis, depression, and anxiety, according to physician orders printed 1/29/15.

R68's quarterly MDS dated 1/5/15 revealed R68 was independent in eating, no difficulty chewing or swallowing, received regular diet.

R68's care plan dated 4/17/13, revealed problem of at nutritional risk related to pneumonia, decreased cognition, and potential for dehydration. Approaches read, "I want staff to assist with any tray prep." Care plan problem of self care deficit dated 4/18/13, read R68 was independent with eating after set up.

During observations on 1/27/15, at 11:18 a.m., PFA-A was observed to assist R68 with bites of food. At 12:06 p.m., PFA-A continued to assist

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F 373	Continued From page 115 R68 eat and finish her meal at 12:12 p.m. On 1/28/15, at 8:37 a.m., PFA-A was observed to assist R68 eat her breakfast meal. R66 was assisted to eat by PFA-A without assessment as safe to be assisted. R66 was admitted 12/7/12, with diagnosis that included dementia and chronic airway obstruction according to physician orders printed 1/29/15. Document review of physician orders dated 11/14/14, revealed orders for general diet. R66's annual nutrition assessment dated 12/3/14 revealed R66 feeds self, staff assist with set up, and no difficulty chewing or swallowing. R66's care plan dated 12/3/14, identified problem of nutritional risk related to need for staff assist with set up and supervision with reminders to eat. Approaches included offered a general diet and staff assist with tray prep. Care plan problem dated 12/18/12, identified self care deficit and approaches included needed limited assist with eating at times. During observations on 1/28/15, at 7:30 a.m., PFA-A was observed to help R66 eat bites of food and completed her meal with PFA-A ' s help. Document review of the facility Resident List for Feeding During Meal Time, identified residents the PFA could assist, however, R88, R68, and R66 were not on the list. During interview on 1/27/15, at 3:25 p.m., director of nursing verified the undated Resident list for	F 373		

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F 373	Continued From page 116 Feeding During Meal Time was the list of residents who had been assessed to be assisted to eat by a PFA in which R88, R68, R66 were not included on this list. During interview on 1/29/15, at 9:40 a.m., director of nursing verified the facility did not have assessments to determine R88, R68, and R66 were safe to be assisted to eat by paid feeding assistant. Document review of facility Policy for Training Paid Feeding Assistants dated 8/17/10, read, "g.) A trained feeder [employee who has taken the PFA course] can not feed any resident with a complicated feeding problem such as someone with: 1. Recurrent lung aspirations, 2. Difficulty swallowing, 3. Professional Nurses do feeding tubes, 4. Requires thickened liquids. This list is an example, not exclusive. The above residents would have to be fed by nurses or nurse aides. h.) Initial Assessment of resident will be made by 1. Dismissal Summary from hospital, 2. Day of admission PM [p.m.] charge nurse fills out General Maintenance form. 3. PM Clinical Manager audits form to make sure it's completed 4. PM Clinical Manager uses this information to decide who needs to be fed and by Whom (ex. CNA [certified nursing assistant] versus Trained Feeding Assistant)."	F 373		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		3/11/15

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F 428	Continued From page 117 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication irregularities identified by the consultant pharmacist were addressed in a timely manner for 3 of 3 residents (R39, R68 and R32) reviewed for unnecessary medications. Findings include: R39's face sheet identified that R39 was admitted on 1/7/2015 and R39 received Seroquel an antipsychotic daily without having a base line side effects assessment completed per the pharmacist recommendation. The dismissal summary from the hospital dated 1/7/15 identified R39 had diagnoses to include mild dementia, chronic left ventricular diastolic heart failure, atrial fibrillation, hypertension, history of transient ischemic attack (TIA), diabetes mellitus, type 2 with diabetic proliferative retinopathy, anxiety and depression and history of probable Bonnet Syndrome (a condition among people who have lost their sight. It causes visual hallucinations). The admission Minimum Data Set (MDS) dated 1/14/15 indicated that R39 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated cognitively intact.	F 428	Tag F428 Drug Regimen Review The goal of Maple Manor Nursing & Rehab, LLC is to maintain the resident□s highest practicable level of functioning and prevent or minimize adverse consequences related to medication therapy. The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist. The pharmacist reports irregularities to the attending physician and the director of nursing, and these reports are acted upon. The Director of Nursing and Consultant Pharmacist discussed the facility□s procedures for tracking target behaviors, assessing adverse effects for antipsychotic medications, use of bowel medications, and tracking bowel function. 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 audit for appropriate indications justifying	

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F 428	Continued From page 118 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 R39 should have had an AIMS completed before the first MDS assessment (which was completed on 1/14/15). 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. A policy titled AIMS, dated 6/3/03, instructed staff	F 428	psychotropic medications, monitoring for adverse effects of antipsychotic medications, and duplicate drug therapy. 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. 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. 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 the new regime is ineffective. The care	

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F 428	Continued From page 119 that an AIMS form would be filled out on new and re-admissions for any resident on the following: (1) anti-psychotic medication. R68 received an antipsychotic medication (Seroquel) and was not monitored for possible side effects. On 1/28/15, at 8:14 a.m. R68 was observed in room and seated calmly in wheelchair. R68 did not protest when nursing assistant (NA)-B suggested to braid R68's hair. R68 had a firm handshake with surveyor and R68 stated, "Thank you" pleasantly to compliment about looking nice with the braided hair. R68 smiled as NA-B pushed R68 out from room toward the dining room for breakfast. On 1/28/15 at 1:49 p.m. NA-C was asked if she saw R68 have unwanted behaviors and NA-C said she had not observed R68 manifesting negative behaviors or delusions or hallucinations. On 1/28/15 at 1:52 p.m. NA-B stated she would redirect any resident manifesting a behavior but denied having observed any delusions or hallucinations from R68. NA-C was not aware R68 was being monitored for delusions or hallucinations. On 1/28/15 at 2:08 p.m. registered nurse (RN)-C enumerated R68's target behaviors as "angry, yelling, making noise, does not like everybody." RN-C stated nurses will document in the progress notes when target behaviors and/or possible side effects of medications occur, otherwise no documentation was needed. RN-C stated that nurses do not check orthostatic blood pressures even with the use of anti-psychotic medications if there was no doctor's order. RN-C did not	F 428	plan has been reviewed and updated. To monitor compliance, for one month the Director of Nursing/designee will audit records for 1) timely monitoring of adverse effects for antipsychotic medications and 2) care planning for and tracking of target behaviors justifying psychotropic use. The consultant pharmacist will continue to routinely monitor records for identification of target behaviors justifying antipsychotic use, monitoring of adverse effects of antipsychotic medications, and duplicate drug therapy. Compliance will be reviewed during the June quarterly Quality Assessment and Assurance meeting and ongoing. The Director of Nurses/designee and the Consultant Pharmacist will continue to monitor for compliance with antipsychotic side effect monitoring, behavior related documentation, and duplicate drug therapy during the routine quarterly record reviews and more often if indicated. Completion Date: March 11, 2015	

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F 428	Continued From page 120	F 428		

mention about R68's hallucinations and delusions being monitored.

On 1/28/15 at 4:02 p.m. RN-A stated R68's target behaviors include making accusations, also had "delusions about staff who were doing catheterization on [R68] were a bunch of lesbians trying to take advantage of [R68]." RN-A verified the specific target behaviors he mentioned were not written in behavior monitoring sheet. RN-A stated nurses will chart if the behaviors occur. When asked if side effects of psychotropic medications were being monitored, RN-A replied, "Probably not because they said no need to monitor." When asked who " They" were, RN-A 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.

The care plan dated 1/27/14 indicated R68 was at risk for falls related to psychotropic medication use. Interventions include giving medications per orders. However, side effects of psychotropic medications in relation to falls were not identified

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F 428	Continued From page 121 and were not specifically planned to be monitored. 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. On 1/29/15, at 1:25 p.m. the consultant pharmacist (CP) stated his expectations that side effects of any medications should be monitored. CP agreed orthostatic blood pressure and AIMS should be completed to determine if side effects developed while on anti-psychotic medications. On 1/29/15 at 1:28 p.m. RN-E stated they were unable to locate an AIMS assessment. At 1:43 p.m. the director of nursing (DON) verified there was no record on file to show AIMS was completed for R68 within the last year even though the resident had received the antipsychotic medication. The facility's Use of Psychotherapeutic Medications policy dated 4/11/08, directed staff to monitor drugs for side effects daily, to include monitoring for gait disorders, movement disorders, signs of hypotension, and cholinergic effects such as dry mouth and urinary retention. The policy further directed staff to assess for baseline AIMS and to do reassessment every three months for the use of antipsychotic medications. R32 received three bowel medications and there	F 428		

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was no physician justification for need of three bowel medications and exceeded recommended dose of Miralax.
R32's physician's note dated 12/16/14 included the diagnoses of Lewy body dementia, diabetes mellitus, and constipation.
R32's physician orders dated 12/16/14 included the following medication orders to treat constipation: Senna-S tablet 2 tabs by mouth three times daily (original order date of 4/16/08), Miralax 17 grams by mouth two times daily (original order date of 4/30/09), and Sorbitol 70% solution 30 milliliters (ml) by mouth one time daily (original order dater of 1/21/09).
The dose of Miralax ordered exceeds the daily recommended dose according to the manufacturers label that indicated the adult daily dose was 17 grams vs. double ordered by doctor. The directions indicated not to use more than 7 days and instructed not to take more than 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 different formats; paper flow sheet and electronic medical record. Documentation was found to be inconsistent between the two formats. Documentation revealed R32 routinely had more than one BM daily. The electronic form of documentation lacked consistency (soft, formed, hard, etc.) and size (small, medium or large) of BMs and the paper flow chart lacked consistency of BMs. This lack of information would make it difficult to determine if the medication was affective or was too much as R32 went daily.
The last physician ' s assessment and evaluation

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F 428	Continued From page 123 that justified the need for three medications for bowel regime (polypharmacy) medication was last addressed on April 30, 2009. The documentation read, " ...does not tolerate suppositories ...and will become angry at times ....does have very large bowel movements with suppositories and if not given he may not have a bowel movement for up to 5 or 6 days. Physician progress notes reviewed did not indicate rationale for prescribing more than manufacturer's daily Miralax recommended dose. R32's quarterly Minimum Data Set (MDS) dated 1/9/15 indicated was moderately cognitively impaired with diagnoses of dementia, always incontinent of bowel, and required extensive assist with activities of daily living (toileting, transfers, dressing and hygiene). R32's care plan did not address constipation or history of constipation or non-pharmacological interventions to promote bowel movements such as increased fluids, adding roughage to diet, increased activity, maintaining routine daily bowel habits, use of toilet or commode, etc. During an interview on 1/27/15, at 2:05 p.m. registered nurse (RN)-A indicated he was not aware of specific reasons why R32 had 3 different bowel medications. RN-A also did not know why the dose of Miralax was higher than recommended. RN-A stated he was not aware of an assessment or physicians recent justified for use of the three bowel medications. During an interview on 1/27/15, at 3:34 p.m. consulting pharmacist (CP) stated if a resident has a diagnoses that required more than a recommended dose of medication it should be care planned and the physician to address or note the reasons for the increased amount and then monitor routinely. During an interview on 1/30/15, at 9:30 a.m.	F 428		

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F 428	Continued From page 124 nurse practitioner (NP) stated, "[R32 ' s] bowel medication should be looked at and reduced." After informing NP of R32 ' s three bowel medication and daily bowel movements.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of 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 unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		3/11/15

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F 431	Continued From page 125 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure expired medications were removed from 1 of 2 medication rooms located on the East/West Medication Room and from 3 of 3 medications carts; in addition the facility did not ensure insulin was dated when when opened to determine expiration date for 1 of 1 resident (R63). Findings include: On 1/28/15, at 2:28 p.m. the East/West medication storage room was inspected and several expired medications were observed that included the following: R1's half full bottle of Antacid expired on 8/2014; R69's half full bottle of Bisacodyl (laxative) 5 mg tablets labeled with two expiration dates. The pharmacy label indicated expiration date as 6/2014 while the manufacturer's label indicated expiration date as 6/2015. RN-C stated the facility would go by the pharmacy label of 6/2014. On 1/29/15, at 9:36 a.m. the East medication cart contained R15's Lacrilube eye ointment. The eye ointment expired on 12/2014 On 1/29/15, at 9:49 a.m. the West medication cart contained a facility stock of Geri-lanta (antacid) that expired on 11/2014. On 1/29/15, at 2:15 p.m. the North Medication cart contained R5's half full bottle of Senna (stool	F 431	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 medications 2) accurate labeling and 3) a system of medication records that enables periodic accurate reconciliation and accounting of all controlled medications. The facility utilizes only persons authorized under state requirements to administer medications. Outdated and expired drugs and biologicals are routinely discarded according to accepted practice standards. The policies for storage of medications were reviewed and found appropriate. All medication storage areas were checked for outdated and discontinued medications and biologicals. On a routine basis, a nurse or trained medication aid will be assigned by the Director of Nursing to audit the medication carts for expired medication and appropriate dating of insulin vials During the planned mandatory meeting, the licensed nurses and trained medication aides will be instructed on 1) the procedures for processing	

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F 431	Continued From page 126 softener) that expired 10/2013; R44's unopened bottle of Nitrostat 0.4 milligram (mg) that expired on 2/2014. On 1/28/15, at 2:45 p.m. during inspection of the North/South medication refrigerator, R63's Lantus insulin was observed to have been opened but did not have a date it was opened as it expires in 30 days from opening for use. The Physician's Orders Sheet (POS) dated 1/29/15 indicated R63 had diabetes with renal manifestations. The POS further indicated R63 was to be given Lantus 20 units by sub-cutaneous injection daily at noon. During interview on 1/28/15, at 2:28 p.m., registered nurse (RN)-C stated all nurses were responsible in making sure that medications in store for use were not expired. On 1/29/15, at 2:15 p.m. licensed practical nurse (LPN)-D and nursing assistant (NA)-K stated the expired medications should have been removed from carts and discarded. On 1/29/15, at 1:25 p.m. the consultant pharmacist stated as safety precaution, expired medications should be removed from medication storage rooms and carts and time sensitive medications such as insulins must be labeled when opened. An undated policy on Medication Storage in the Facility provided that outdated medications are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from pharmacy if a current order exists. The policy further gave directions for staff to monitor medication storage quarterly.	F 431	discontinued and outdated medications and biologicals and 2) dating opened insulin vials. Compliance with dating of insulin vials and disposition of outdated medications/biologicals will be monitored every two weeks for one month by the Director of Nurses/designee and every quarter by the consultant pharmacist. If noncompliance is noted additional monitoring and staff education will be done. Compliance will be reviewed during the March Quality Assessment and Assurance Committee meetings. Completion Date: March 11, 2015	

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F 431	Continued From page 127 The facility's Policy on Stocking Regular Insulin dated 7/12/04, indicated once a bottle of insulin has been opened, the bottle needs to be dated, and the bottle will expire 30 days from that date.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441		3/11/15

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F 441	Continued From page 128 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop policy and procedures to direct infection control practices related to urinary tract infections identification (UTI) and failed to maintain an infection control program that included ongoing surveillance and timely analyzing and trending of data. Five of Five residents (R16, R6, R70, R30, and R69) were reviewed for having urinary tract infection/s (UTIs). The lack of policy, procedure and an effective infection preventions and control program has the potential to affect all 69 residents currently living in the facility. Findings include: LACK OF UTI SYMPTOMS IDENTIFIED: R16, R6, R70, R30, R69 were identified by the facility as having facility acquired urinary tract infections (UTI) but lacked identification of symptoms: R16 was noted on the infection control (IC) logs to have a urinary tract infection (UTI) on 10/17/14. Review of the interdisciplinary team notes (IDT) of 10/8/14 to 10/21/14 noted no signs or symptoms of a UTI documented. R6 was noted on the IC log to have a UTI on 10/27/14 and 12/10/14. Review of the IDT notes	F 441	Tag F441 Infection Control Maple Manor Nursing & Rehab, LLC has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The infection control program 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control. The facility has comprehensive infection control policies and procedures that are in the process of being reviewed and revised to more closely reflect the current standards of practice and the state/federal regulations. The policies address the surveillance and investigation of infections and maintenance of accurate and comprehensive records of resident infections. The revised policies and procedures will provide additional	

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F 441	Continued From page 129 for this time period noted no signs and symptoms of infections listed. R70 was noted on the IC log to have a UTI on 9/29/14. The IDT notes were reviewed and no documentation of signs and symptoms of the infection were found. R30 was noted on the IC log to have a UTI on 10/15/14, 11/7/14, and 11/29/14. The IDT notes were reviewed and lacked identification of signs and symptoms of UTI. R69 was noted on the IC log to have a UTI on 10/7/14, 10/31/14, 11/9/14, and 11/18/14. The IDT notes were reviewed and lacked identification of signs and symptoms of UTI. On 1/27/15 at 2:00 p.m. UTI policies were provided by the director of nursing. The policies included 1) Chronic Urinary Tract Infection Policy dated 5/2/12 and 2) Prevention of UTIs at Risk Residents dated 4/3/12. The policies did not direct staff to evaluate the risk for developing UTIs and did not include signs and symptoms of UTIs and what/when to document. Registered nurse (RN)-A was interviewed on 1/28/15 at 9:40 a.m. RN-A stated he had a form that listed the criteria for infections, but that no policy/directions related to completing the form had been developed. RN-A stated nursing was to document the criteria for infections observed in the nursing notes. On 1/28/15 at 10:10 a.m. RN-A and the director of nursing (DON) were interviewed. They both indicated the facility did not have a list of infection or UTI criteria available to staff to use and	F 441	guidance to the nursing staff for identifying and reporting symptoms of possible infections and documenting/tracking related symptoms. The licensed nurse assigned the responsibility to oversee the review and implementation of the policies and procedures has been counseled on timely completion of the tracking logs. A reference guide will be provided to the nurses to assist in identifying symptoms/conditions that may be indicative of a urinary tract infection that need reporting to the physician/nurse practitioner. During the planned mandatory meetings, the licensed staff will be instructed on the policies and procedures for identifying urinary tract symptoms that may indicate an infection and when it is appropriate to report the symptoms to the physician/nurse practitioner. The need for documentation of symptoms of infection and follow up after an antibiotic is prescribed will be addressed. The results of the record reviews for residents number 16, 6, 70, 30, and 69 will be shared with the staff for teaching purposes. Compliance with facility policies and regulatory requirements will be monitored by the Director of Nurses/designee through record review and audits of the infection control logs and reports for two months and randomly thereafter. The results of the infection control surveillance	

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	245409	A. BUILDING _____ B. WING _____	01/30/2015

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F 441	Continued From page 130 document from as a tool. They stated the facility did not have a policy/procedure on the management of urinary tract infections. LACK OF ANALYSIS AND SURVEILLANCE OF INFECTIONS TO PREVENT THE SPREAD OF INFECTION: 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 provided when LPN-C had just completed the record keeping on 1/26/15 at 6:30 p.m. Also LPN-C said she had not started to complete the January 1 to 26, 2015 infection log. On 1/29/15 at 5:00 p.m. the director of nursing indicated LPN -C had been designated as the Infections preventionist (This person will serves as coordinator of the infection preventions and control program). DON continued to say there was no analysis of information related to infections completed.	F 441	and investigation activities are reviewed monthly as part of the continuous quality improvement program. Compliance will be reviewed during the March quarterly Quality Assessment and Assurance Committee meeting and ongoing. Completion date: March 11, 2015	

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F 466	Continued From page 131	F 466		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure potable and non-potable water needs for resident use in the facility were estimated should loss of normal water supply occur. This had the potential to affect all 69 current residents of the facility, as well as staff and visitors. Findings include: Although the facility had an emergency water supply procedure, the procedure lacked a process for calculating estimated water required for residents and staff use. Review of the facility Emergency Water Supply procedure revised dated 4/29/05, read, "In the event of a complete loss of water for the facility due to a local disaster or a broken water main requiring prolonged repair, the facility has an agreement with a bulk hauler to transport portable water to the facility." The procedure identified maintenance would secure from storage and distribute labeled 7 gallon containers as follows: Two to west wing, two to east wing, two to north wing, one to dietary, and each wing will have a container labeled drinking and another labeled	F 466	F-466 Policy & Procedure to Ensure Water Availability The policy and procedure have been updated to include estimated water required for resident and staff use on a per day basis. The supplier has confirmed mobile service of potable water on a daily basis during emergency interruption to include a minimum of 1 gallon per resident and sufficient water for staff to provide food preparation and basic care needs. Completed: 3/11/15	3/11/15

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F 466	Continued From page 132 personal needs. Nursing to purchase 20 gallons of bottled water for drinking, dietary to purchase 60 gallons of bottled water for cooking and drinking, and a bulk tank to deliver 6000 gallons per day for cleaning and toilets. The emergency water procedure lacked a procedure for calculating estimated water required for residents and staff use per day. During interview on 1/27/15, at 2:45 p.m., administrator verified the facility emergency water supply procedure lacked a system for calculating estimated water required for residents and staff use. He stated the facility emergency water supply was the facility policy for emergency water supply.	F 466		

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	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Maple Manor Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Maple Manor Nursing Home is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction, with a partial basement. In 1974, addition was constructed and was determined to be of Type II(111) construction, with a full basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 81 beds and had a	K 000		

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K 000	Continued From page 2 census of 70 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.5 and 9.7, 1998 NFPA 25, sections 2-3.2 and 2-4.1.4. This deficient practice could affect all 15 out of 70 residents. Findings include: On facility tour between 12:30 PM and 2:30 PM on 01/26/2015, observation revealed that the following was found: 1. Basement - sprinkler riser gauge has not been calibrated or replaced with-in the last 5 years 2. Basement - spare sprinkler head box does not contained 2 of each type of sprinkler heads in the facility	K 062	In reference to K62 1. Basement -spare sprinkler head box does not contain 2 of each type of sprinkler head 2. Basement -Sprinkler riser Gauge is over 5 years. Plan of Correction In reference to Basement spare Sprinkler heads not in the box Maintenance Director contacted Summit Fire facility contractor and asked them to go through whole facility to make sure we have 2 of each sprinkler heads that our located in place in box by 2-26-2015. In reference to sprinkler riser Gauge over 5 years. Maintenance Supervisor contacted Summit Fire and set up the 5 year	3/11/15

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K 062	Continued From page 3 These deficient practices were confirmed by the Facility Maintenance Director (JT) and Administrator (KS) at the time of discovery.	K 062	inspection and Annual inspection to take 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 just moved our annual inspection date from May to February. The Maintenance Supervisor also created a 5 year sprinkler check on tels Schedule. Documentation is attached to this report showing 5 year check added to preventive maintenance plan on Tels. When sprinkler work is completed Maintenance Supervisor will email pictures and contractor check sheets to Gary Schroeder, Mn state fire inspector.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 70 residents.	K 144	In reference to k144 the weekly generator check not being inspected on 6/15/2014 was missed Plan of Correction; The facility on 6/15/2014 did not have a computer based scheduled program at	3/11/15

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K 144	Continued From page 4 Findings include: On facility tour between 12:30 PM and 2:30 PM on 01/26/2015, documentation review of the weekly inspection logs for the natural gas emergency generator revealed, that the emergency generator weekly inspection logs from January 2014 to January 2015, indicated that the week of 06/15/14 was missed. This deficient practice was confirmed by the Facility Maintenance Director (JT) and Administrator (KS) at the time of discovery.	K 144	the time which shows and documents all the checks each week, monthly, annually, bi annually and 5 years if necessary. The Maintenance Supervisor has in-serviced all staff on how to use tels and create logs. Tels also has a icon on the schedule showing it is a life Safety Code item therefore takes priority to be completed and on time. The maintenance Supervisor also has in-serviced his assistant and maintenance staff complete these scheduled items on time and document someone is on vacation. Maintenance Supervisor has attached signed in service forms to this document.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 9.1.2, 1999 NFPA 70, and 2007 Minnesota State Fire Code 605.7. The deficient practice could affect 2 out of 70 residents. Findings include: On facility tour between 12:30 PM and 2:30 PM on 01/26/2015, observation revealed, that the following items were found: 1. In resident room # 12, power cord going to	K 147	K147 1. In resident room 12 power- cord going to wall light was exposed. The wall light cord plug was fixed. Maintenance Supervisor is working with Administration, Don, safety committee and all staff to in-service staff to report frayed cords or any potential hazard that could jeopardize safety of others. This in service is expected to be completed on or before 2-26-2015 or earlier and documentation will be emailed to Gary	3/11/15

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K 147	Continued From page 5 wall light has exposed wiring 2. Basement - medical records room ceiling lights have been modified from the original listing and is not properly wired These deficient practices were confirmed by the Facility Maintenance Director (JT) and Administrator (KS) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147	Schroeder Mn State fire inspector. 2. In Medical Records room ceiling lights are not properly wired Plan of Correction On February 5 2015 Winkels Electric a Rochester Mn electric Contractor completed work. Before and after pictures and completed Maple Manor work order is attached for documentation.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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,

Kamala Fiske-Downing

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING: _____ B. WING _____	01/30/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000		

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On January 25, 26, 27, 28, 29 & 30, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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	00916	A. BUILDING: _____ B. WING _____	01/30/2015

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop interventions to address a history of having Clostridium difficile (C-diff) and Vancomycin-resistant enterococcus (VRE) to prevent the spread of these infections for 1 of 1 resident (R38) who had chronic C-Diff and VRE; failed to develop specific renal dialysis interventions for 1 of 1 resident (R62) with renal dialysis. Findings include: R38 had a history of having C-Diff and the care plan lacked information to prevent the spread to staff and other residents. The hospital discharge summary dated 12/16/14	2 560	See Federal Regulation responses	3/11/15

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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 12/30/14 indicated R38 had recent c-diff infection. The hospital discharge summary dated 1/9/15 indicated R38 had asymptomatic (a disease is considered asymptomatic if 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 indicated the purpose of the multi-disciplinary

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2 560	Continued From page 4 comprehensive plan of care what to provide a working tool for staff. R62 received dialysis services and renal diet without care plan interventions for renal diet. R62 was admitted to the facility on 11/21/14, with diagnosis that included end stage renal disease and dialysis, according to admissions face sheet. Document review of physician orders dated 11/21/14, revealed physician orders for hemodialysis on Tuesdays and Saturdays and renal diet. Document review of facility care area assessment (CAA) dated 12/4/14, identified R62 nutrition triggered to care plan for therapeutic diet and was offered a renal diet. Document review of R62's resident care plan printed 1/28/15, revealed no care plan for renal diet. Document review of dietary notes dated 1/21/15, revealed R62 received renal diet related to diagnosis and attended dialysis on Tuesday and Saturday. During interview on 1/28/15, at 9:10 a.m., registered dietician verified R62 received renal diet, communicates with dialysis dietician, received dialysis Tuesdays and Saturdays, and packed lunch to go with R62 to dialysis. During interview on 1/30/15, at 8:00 a.m., director of nursing verified R62's care plan lacked identification and interventions for renal diet restriction. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff on components needed for care planning, and then perform audits to ensure	2 560		

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2 560	Continued From page 5 compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services as directed on each residents care plan for 2 of 5 residents (R3, R88) for assistance with eating; for 2 of 3 residents (R88 & R31) assessed to need assistance with personal care; and failed to ensure 2 of 2 resident (R45 & R38) with daily weights to assess health status change; 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; and failed to provide adaptive scoop plate as directed in the care plan for 1 of 1 resident (R32) assessed to need scoop plate to eat independently. Findings include: Lack of assistance with eating: R3 did not receive assistance with eating	2 565	See Federal Regulation responses	3/11/15

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2 565	Continued From page 6 according to care plan interventions. R3's care plan dated 3/19/13, identified problem 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. R3's 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. R3 was observed on 1/28/15, at 9:45 a.m., and was in wheelchair in the east/west dining room at a large table designated by the facility for residents who needed assistance to eat. Also at this time registered nurse (RN)-C was assisting R3 to eat. At 9:52 a.m., RN-C left R3 at the table alone. R3 still had plate of food and beverages and made no attempt to eat independently. At 10:00 a.m. R3 was noted to be asleep and no assistance with eating was offered or provided. At 10:12 a.m., nursing assistant (NA)-D sat to assist R3 with meal. R3 had no assistance with eating from 9:52 a.m. to 10:12 a.m. a total of 20 minutes. R3 was admitted 3/19/13, with diagnosis that included paralysis agitans and dementia with Lewy Bodies, according to physician orders printed 1/29/15. The facility identified R3 on the annual Minimum Data Set (MDS), an assessment dated 12/8/14, to have short and long term memory problems, moderately impaired decision making, total dependence on 2 staff for activities of daily living,	2 565		

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2 565	Continued From page 7 total dependence on 1 staff for eating and personal hygiene, and received a mechanically altered diet. Care Plan policy dated 1/19/12, read, "Purpose: To provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident During interview on 1/29/15, at 9:00 a.m., Director of nursing stated she expected staff to follow the care plan and to provide R3 with assistance for meals. R88 did not receive assistance with eating according to care plan interventions. R88's care plan dated 9/10/14, identified problem of at risk for decline in nutritional status due to need for mechanically altered food related to poor dentation, due to open areas with increased need for nutritional support, due to abnormal labs, due to need for assistance with meals, due to decreased cognition. Approaches dated 9/10/14 included assist as needed and as resident allows with food/fluid. Approaches dated 9/22/14 included pureed diet with thin liquids. Approaches dated 9/23/14, included house supplement two times daily. Approaches dated 9/29/14 included alternate bites with sips, watch for swallow and give next bite/sip to maintain pace and uncovered cups ok when being assisted. R88 was observed on 1/27/15, at 11:18 a.m., R88 was in wheelchair located in the east/west dining room. R88 was placed at a table designated by the facility as being for residents who need assistance to eat. Also at this time R88 appeared	2 565		

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2 565	Continued From page 8 to be asleep and had a meal of pureed carrots, quiche, and mashed potatoes and four adaptive cups of beverages with lids were on the table directly in front of R88. From 11:18 a.m., to 11:50 a.m. (total of 32 minutes) R88 remained asleep and no staff assisted her to eat or encourage her to eat her meal. At 11:50 a.m., trained medication assistant (TMA)-A, aroused R88 and then placed food on a spoon and handed to R88, who immediately dropped the spoon into her lap then TMA-A left the table. At 11:54 a.m., paid feeding assistant (PFA)-A assisted another resident at same table, handed R88 glass of chocolate milk and PFA-A continues to assist R88 to eat between assisting another resident to eat. R88 was admitted to the facility 8/26/14, with diagnosis that included dementia with Lewy Bodies and paralysis agitans according to resident diagnosis codes printed 1/30/15. The facility identified R88 on the quarterly Minimum Data Set (MDS), an assessment dated 11/23/14, to have short term memory problem, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene, and received a mechanically altered diet. R88 was again observed during breakfast on 1/28/15, at 9:37 a.m., R88 in wheelchair at the same table as the evening meal yesterday. R88 was observed asleep with plate of cooked cereal and scrambled eggs, applesauce, magic cup, and beverages set before her. At 9:41 a.m. (four minutes without assistance to eat meal) TMA-A sat next to R88 to only administer medication. At 9:42 a.m., registered nurse (RN)-C sat next to	2 565		

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2 565	Continued From page 9 R88 and began to assist her to eat. At 9:45 a.m., RN-C asked if R88 wanted juice and handed the cup to R88 who took the cup. At 9:47 a.m., RN-C handed R88 a spoon of cooked cereal and R88 took and ate the food. At 9:52 a.m., RN-C left R88 and the table. R88 still had plate of food and beverages in front of R88 and made no attempt to feed self. From 9:52 a.m. until 10:12 a.m. (20 minutes interval) R88 did not have staff assistance to eat or encouragement from staff to eat until NA-D sat with R88 and begin to assist R88 to eat. Interview at that time, NA-D verified the cooked cereal was cold and had not been warmed before serving it to R88. At 10:17 a.m., NA-D assisted R88 with a drink of juice and then went to reheat cold cereal. Care Plan policy dated 1/19/12, read, "Purpose: To provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident During interview on 1/29/15, at 9:00 a.m., Director of nursing stated she expected staff to follow the care plan for R88. Lack of providing personal cares according to care plan: R88 had long facial hair and long soiled finger nails which were not trimmed nor cleaned according to R88 ' s care plan. R88's care plan dated 9/4/14, identified problem of needed assistance with activities of daily living, transfer and ambulation related to dementia and decreased endurance and mobility. Approaches included assist of one staff with wheel chair mobility, dressing, personal hygiene, is assisted with meals, set up for meals and required	2 565		

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2 565	Continued From page 10 assistance when sleepy. R88 was observed on 1/26/15, at 2:58 p.m., R88 was observed with long facial hairs while lying in bed. On 1/28/15, at 9:37 a.m., R88 sat in wheelchair at south table in east/west dining room. R88 was observed to have long, soiled finger nails and facial hair unshaven. R88 was admitted to the facility 8/26/14, with diagnosis that included dementia with Lewy Bodies and paralysis agitans according to resident diagnosis codes printed 1/30/15. The facility identified R88 on the quarterly Minimum Data Set (MDS), an assessment dated 11/23/14, to have short term memory problem, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene, and received a mechanically altered diet. During interview on 1/28/15, at 10:10 a.m., nursing assistant (NA)-D stated they had assisted R88 with morning cares. NA-D verified had not provided facial hair removal or nail care. NA-D stated residents are shaved with morning cares and nail care was done in the evenings. Also at 10:12 a.m., NA-D verified R88 had long soiled finger nails and long facial hairs. During interview on 1/28/15, at 11:15 a.m., registered nurse (RN)-F verified the long facial hair and long soiled finger nails for R88. RN-F stated she expected facial hair shaved on bath day and as needed. RN-F sated she expected manicures were done weekly and on bath days. She verified R88 received bath on Fridays and this day was Wednesday morning.	2 565		

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2 565	Continued From page 11 The Care Plan policy dated 1/19/12, read, "Purpose: To provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident." The AM Cares policy dated 8/31/04, read, " Procedure: 2.The mouth nails, and hair are to be cared for in the same manner as for a complete bath." The CARE OF NAILS policy dated 3/12/08, read, "1. Keep clean and well manicured." During interview on 1/29/15, at 9:00 a.m., Director of nursing stated she expected staff to follow the care plan and to provide R88 with assistance for meals and personal care. R31 was observed on 1/25/2015 at 2:06 p.m., on 1/26/15 at 1:31 p.m., 1/27/15 at 8:57 a.m. R31 had dark brown/black debris underneath fingernails and eye glasses were extremely dirty and had tape on both bows of the glasses. R31's care plan indicated resident was one assist with grooming. According to an interview on 1/30/15, RN-A stated fingernail care and cleaning glasses were included in the grooming category. R31's quarterly Minimum Data Set (MDS) dated 10/30/14 indicated the resident had severe cognitive impairment and was dependent on staff for activities of daily living including toileting, dressing, hygiene, and eating. Physician's visit progress note dated 1/15/15 included diagnoses of advanced dementia and primary open angle glaucoma. The policy Care of Nails read, "Keep clean and well-manicured." Lack of daily weights as directed in the care plan:	2 565		

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2 565	Continued From page 12 R45 was not weighed daily according to physician orders and care plan interventions. R45's care plan dated 12/11/14, identified problem of at risk for complications due to use of cardiac medications related to cerebral vascular accident, peripheral vascular disease, hypertension, dyslipidemia, and congestive heart failure. Care plan approaches directed weights and vital signs as per orders and or policy. R45's care plan dated 1/8/15 identified problem at risk related to medical diagnosis and need for therapeutic diet. Care plan approaches directed staff monitor and record weights as ordered. Physician orders dated 12/10/14, revealed physician orders for daily weights due to congestive heart failure; and physician orders dated 12/12/14, for daily weight, notify nurse practitioner with weight gain over 3 pounds in one day or 5 pounds from baseline, admit weight 220 pounds (#). R45 was admitted to the facility on 12/10/14, with diagnosis that included congestive heart failure, according to physician orders dated 12/10/14; diabetes mellitus, cerebral vascular accident, and peripheral vascular disease, according to the admission minimum data set (MDS) dated 12/16/14; and right below knee amputation 12/5/14, according to hospital discharge summary dated 12/26/14. Document review of facility record of weights for R45 showed weights were done 9 times out of 35 days from 12/12/14 to 1/26/15 as follows: 12/12/14--252 pounds expected weight loss after surgery	2 565		

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2 565	Continued From page 13 12/16/14--250.4 pounds Hospitalized -- 12/21/14 and returned to facility on 12/26/14 12/27/14-239 pounds 1/10/15--243.7 pounds 1/21/15--228.5 pounds 1/22/15--229.3 pounds 1/23/15-230 pounds 1/24/15--232.2 pounds 1/26/15-231 pounds Also the facility did not report a three day weight gain due to not doing weights daily nor did the report the five pound weight gain from base line of 220 pounds or when R45 weighed 225 pounds or more. By 1/26/15 R45 weighed 231 or 11 pounds over base line weight. Document review of hospital dismissal summary dated 12/26/14, revealed R45 was hospitalized 12/21/14 and discharged from the hospital on 12/26/14, for diagnosis of pontine infarction (stroke) secondary to acute basilar thromboembolism (blood clot). During interview on 1/29/15, at 5:00 p.m., registered nurse (RN)-A verified the lack of daily weights as physician ordered. RN-A verified lack of evidence of nurse practitioner notification of weight gain over 3 pounds between 12/27/14 and 1/10/15, a gain of 4.7 pounds During interview on 1/30/15, at 9:30 a.m., RN-F stated she expected R45 to be weighed daily. RN-F verified daily weights were on the nursing assignment sheet and on the Evening Weight Charting-West list for daily weights. The Care Plan policy dated 1/19/12, read,	2 565		

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2 565	Continued From page 14 "Purpose: To provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident." Policy for Weighing Residents dated 6/7/13, read, "It is the policy of Maple Manor to ensure that residents are weighed and a weight record is kept on each resident and monitored routinely." "Residents will be weighed thereafter as ordered by the physician, but at least monthly." R38 lacked provision of services in accordance with the plan of care on the treatment record and as ordered by the physician. R38's treatment record indicated staff was to monitor fluid intake because of a fluid restriction, monitor colostomy output, and monitor weight daily. The treatment record, intake record, or intake and output record did not have documentation related to fluid intake, colostomy output or daily weights nor was any provided when requested. During an interview on 1/28/15 at 8:00 a.m. the clinical manager (RN)-A and the director of nursing stated they were aware that this was not being done as ordered by the physician. Lack of following care plan to prevent urinary tract infections were not provided: R68's care plan interventions and services in regards to the Foley catheter were not followed by staff. On 1/21/15, at 7:15 a.m. R68's room door was open, R68 was observed lying in bed. R68's indwelling Foley catheter bag was also observed	2 565		

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	00916	A. BUILDING: _____ B. WING _____	01/30/2015

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2 565	Continued From page 15 lying flat on top of R68's blanket of his bed. At 7:45 a.m. registered nurse (RN)-C observed R68's catheter bag was placed directly on top of R68's bed linens. RN-C was asked if the urine bag was to be placed on top of the bed linens and RN-C stated, "Yes." On asking how much urine was in the collection bag RN-C was observed to hold the urine bag and raised it to her eye level and verified there was about 75 milliliters of urine collected in bag. As RN-C was holding the bag up, the bag's drain (rubber emptying spout) was observed to have been clamped, however, it was not placed in the designated bag pouch but uncovered and sticking out as it was not secured in the collection bags spout holder. RN-C then placed the urine bag back on top of the bed with the drain spout in direct contact with the linens on the bed. At 7:38 a.m. on 1/21/15 R68's room door was open and R68 was still lying in bed with the collection bag still on top of the bed linens. At 8:14 a.m. Nursing assistant (NA)-B was interviewed and confirmed R68's catheter bag was lying directly on top of R68's bed linen. NA-B stated nursing assistants empty the bag every shift and must have been placed on the bed by the night shift when they left this morning. NA-B stated the catheter bag should always be hanging below R68. NA-B added, urine bag should be placed in a blue cloth cover and hooked "here" (pointing to a loop-like attachment on bed frame). NA-B then moved bag from bed. R68's care plan dated 10/20/14 indicated R68 required indwelling Foley catheter due to urinary retention. The care plan directed staff to keep drainage bag below bladder level to prevent reflux and to maintain a closed drainage system. R68's Admissions Face Sheet printed on 1/29/15, indicated R68 had diagnoses including psychosis,	2 565		

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2 565	Continued From page 16 dementia, depression, anxiety state and urinary retention. The Physician's Orders Sheet (POS) dated 11/1/14 indicated R68's urinary drainage bag should be kept below bladder level to prevent reflux, maintain a closed drainage system. The POS further indicated bag "to be kept in cloth (blue canvass) bag to prevent infection and provide dignity." The facility's Catheter Care Policy dated 7/9/09, directed staff to secure bag on side of bed frame, not to allow bag to touch the floor, to keep the bag below level of bladder at all times and to be inside a blue dignity bag. The American Nurses Association (ANA) adopted the guidelines provided by the Centers for Disease Control (CDC, 2009) to prevent catheter 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. R32 was observed during breakfast meal on 1/27/15 at 8:40 a.m. and on 1/28/15 at 8:50 a.m. revealed R32 did not receive double sized food portions and did not receive a scoop plate (a plate with high edges) according to the care plan. R32's care plan dated 1/16/15 read, "has had a significant weight loss ...is offered double portions at breakfast with extras on tray for other meals ...8/13/14 provide a scoop plate at all meals, provide shallow bowls if unable to use scoop plate."	2 565		

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2 565	Continued From page 17 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 dining room tray card (card used to communicate dietary information to staff) included the instruction to give double portions at breakfast and provide a scoop plate. During an interview on 1/30/15, at 10:30 a.m. certified dietary manager (CDM) verified resident did not receive double portions and stated the resident was supposed to have a scoop plate. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of	2 570		3/11/15

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2 570	Continued From page 18 the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure revision of the dietary care plan for 1 of 3 residents (R38) reviewed with a dietary meal change. Findings include: R38 was observed during the evening meal on 1/26/15 from 5:20 p.m. to 6:11 p.m. R38 was eating independently but ate only 25% of her meal. At 6:11 p.m. R38 stated that she was on a fluid restriction and was not sure what foods she could eat. She said she had breaded food for both noon meal and supper. R38's admission Minimum Data Set dated 12/22/14 indicated she had a brief interview of mental status (BIMS) score of 10 out of a possible 15 or was moderately cognitively impaired. The MDS indicated R38 was independent with eating and was not on a therapeutic diet. Review of the hospital discharge summaries dated 12/16/14, 12/30/14, and 1/9/15 listed diagnoses that included: cardiac concerns, electrolyte imbalance, chronic anemia, and colostomy. The physician orders noted on the hospital discharge summary dated 12/16/14 was for a general diet and physician orders on 12/30/13, was for a general low residual diet. The physician orders noted on the hospital discharge summary dated 1/9/15 listed a diet of 1500 to 2000 mg sodium, low cholesterol, and low fat.	2 570	See Federal Regulation responses	

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2 570	Continued From page 19 R38 ' s care plan provided 1/27/15 was reviewed. On 12/22/14 a problem of "Diet: [R38] is at risk r/t [related to] her need for extra calories to aid in healing." The interventions directed a general diet with regular textures and Boost supplement. The care plan also had a problem dated 1/12/15 of "Diet: [R38] is at risk r/t her medical dx [diagnosis] with need for a therapeutic diet and fluid restriction." The interventions noted a no added salt diet and a 2000 cc fluid restriction. Neither of the care plan problems identified the exact diet ordered by the physician 1/9/15. The director of nursing (DON) was interviewed on 1/28/15 at 4:25 p.m. DON indicated the diet listed on the care plan was written by dietary staff. The certified dietary manager (CDM) was interviewed on 1/29/15 at 9:20 a.m. CDM stated he had not revised the care plan to reflect the doctors prescribed orders on 1/9/15. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff related to the need to evaluate and update care plans and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the	2 800		3/11/15

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2 800	Continued From page 20 residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. 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. Findings include: SEE F241: On 1/25/15 during the noon meal (11:45 a.m.) R26 was seated with several other residents and only nursing assistant (NA)-F was seated helping another resident to eat. At the same time NA-F would speak loudly across the tale for other residents to eat. None of these residents did eat independently and waited long periods of time for assistance to eat. On 1/26/15 at 5:09 p.m. the supper meal, NA-O was assisting five dependent residents to eat and these five residents were seated at two different tables. NA-O was observed to stand while giving one resident a bit of food then moving to another table giving that resident a bit of food then would be repeating this process until NA-O left the dining room and did not return. A short time later NA-F and registered nurse (RN)-A moved the residents from the table and neither NA-F or RN-A attempted to assist the five residents to complete their meal. Also staff stated they were short staffed as evidenced by depended residents being assisted to eat in a continuous period of time as staff went from resident to resident giving	2 800	See Federal Regulation responses	

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2 800	Continued From page 21 a few bites then moving on to the next resident or staff not assisting residents for periods up to 20 minutes and food was cool by the time staff assisted the residents to eat.; failed to allow residents time to eat before cleaning the table of food debris and had parked the BUS cart with food scraps next to table where residents were still eating; and failed to cover a urine collection bag to promote dignity for 1 of 1 resident (R68) who was observed with an uncovered urine collection bag with urine set on bed and visible to other residents, staff, and visitors. SEE F282 & F312: Based on observation, interview, and document review, the facility failed to provide services as directed on each residents care plan for 2 of 5 residents (R3, R88) for assistance with eating as R3 waited over 20 minutes for staff to assist her to eat and R88 waited during noon meal on 1/27/15 for 32 minutes at one meal before staff assisted her to eat while having her food set in front of her the entire time and waited at breakfast on 1/28/15 for 20 minutes for staff to return to help her finish eating. During interview on 1/29/15, at 9:00 a.m., director of nursing stated she expected staff to follow the care plan and to provide R3 & R88 with assistance for meals. Director of nursing stated she was aware of the lack of staff in the east/west 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 all 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 Resident (R45 & R38) who had orders for daily weights were not consistently done and during a staff interview it was learned it was because they were short staffed. Also R38 was to have fluids	2 800		

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2 800	Continued From page 22 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. SEE F309: Based on observation, interview and document review, the facility failed to ensure 5 of 39 residents (R100, R71, R45, R38, and R39) had ongoing services and treatments as ordered by the physician to monitor for significant health status changes so they could be reported timely to the physician for interventions as R100 had congestive heart failure and ongoing monitoring of fluid intake was not completed, nor was respirations, lung sounds, monitoring of edema, blood pressure or heart rate monitored closely in order to determine current regimen of medications was affective or acute health changes needed to be responded to by the doctor timely. R71 also had congestive heart failure and did not receive ordered daily weights nor lung sounds, respirations, blood pressure, edema, etc. R45 also had congestive heart failure and lacked physician ordered daily weights, monitoring of lung sounds, worsening of edema of legs, etc. R38 had a new colostomy, and lacked doctor ordered daily weights, monitoring of a fluid restriction, and ongoing assessment of colostomy healing and bowel function. R39 lacked daily weights per doctor ' s order due to congestive heart failure and ongoing monitoring of lung sounds, monitoring for edema and fluid overload. During an interview with the registered nurse (RN)-A on 1/19/15 at 3:58 p.m., RN-A stated that they had staffing issues and the weights he gave me were all they had for R39.	2 800		

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2 800	Continued From page 23 SEE F315: Based on observation, interview and document review, the facility failed to ensure comprehensive bladder assessments and an assessment of risks for developing and monitoring of symptoms for urinary tract infections (UTIs) for 7 of 8 residents (R16, R6, R70, R30, R69, R96, R38) reviewed with recurrent urinary tract infections; the facility failed to prevent urinary tract infections and the spread of infections to other residents due to staff not following sound infection practices regarding Foley Catheter care and equipment used for 1 of 1 resident (R68) with an indwelling Foley catheter; and the facility failed to follow physician orders for intermittent cauterization and failed to monitor, evaluate, and assess urine output for 1 of 1 residents (R70) in the sample with intermittent catheterizations. R70 had physicians order for every four hour catheterization which was not consistently provided. The director of nursing was interviewed on 1/28/15 at 4:15 p.m. she stated she felt the facility provided adequate staffing numbers. She stated that she did not work on the floor providing direct resident cares. DON said that ideal staffing would be 7 nursing assistants and 3 licensed nurses and 2 trained medication aides each day shift and each evening shift along with administrative nursing staff. The clinical nurse manager (RN-A) was interviewed on 1/29/15 at 8:05 a.m. He stated he was aware that residents had complained about the lack of staffing levels. SUGGESTED METHOD OF CORRECTION: The administrator or director of nursing could evaluate current resident care needs and determine staffing needs based on these needs.	2 800		

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2 800	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 5 of 39 residents (R100, R71, R45, R38, and R39) had ongoing services and treatments as ordered by the physician to monitor for significant health status changes so they could be reported timely to the physician for interventions; and failed to maintain an agreement with the dialysis provider for 1 of 1 resident (R62) currently receiving end stage dialysis services. Findings include: Lack of monitoring health status for changes due to congestive heart failure (CHF): R100 was admitted to the facility on 1/13/15	2 830	See Federal Regulation responses	3/11/15

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2 830	Continued From page 25 according to the admission form however, the staff failed to monitor, assess, and evaluate fluid intake for dehydration, renal failure, and fluid overload for R100 who had a new diagnoses of congestive heart failure, had a newly prescribed diuretic, and had a fluid restriction of 1500 cubic centimeters (cc). R100's hospital discharge summary dated 1/13/15 indicated R100 was cognitively intact and included the diagnoses of acute congestive heart failure, acute hypoxemic respiratory failure, acute kidney injury on chronic kidney disease, and hypokalemia (high serum potassium). According to this summary the diagnoses of congestive heart failure was new and was started on Lasix (diuretic). A physician's visit note from hematology dated 1/19/15 indicated R100 had been hospitalized in the past few months for a urinary tract infection with dehydration. R100's physician orders included Hydrochlorothiazide (diuretic) 12.5 milligrams (mg) by mouth every day, Lasix 40 mg by mouth every other day, potassium chloride 20 milli-equals (mEq) by mouth every day while on Lasix, daily weights, and 1.5 liter (L) fluid restriction. R100's care plan dated 1/22/15 indicated R100 was cognitively impaired, was independent with activities of daily living (dressing, hygiene, transfers, toileting, and eating). Care plan indicated R100 was at risk for electrolyte imbalance related to diuretics and fluid restriction; directed staff of fluid restriction, daily weights, and monitor for dehydration. R100's fluid intake was recorded on the intake and output form. Fluid intake and output forms were dated from 1/19/15 through 1/28/15. However, no fluid intake monitoring forms for dates 1/13/15 to 1/18/15 were found in the	2 830		

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2 830	Continued From page 26 medical record or provided when requested. The forms provided were reviewed and several had not been completed. According to the documentation R100 had no fluid intake on 1/19/15, 1/20/15, 1/21/15, 1/22/15, and 1/28/15. On 1/23/15 documentation indicated a total intake of 220 ccs (cubic centimeters) , on 1/24/15 total intake documented was 120 ccs, on 1/25/15 total intake documented was 60 cc and on 1/27/15 total intake documented was 30 cc. None of the forms had a 24 hour totals calculated to determine if they met or exceeded fluid limit. No further documentation pertaining to monitoring, assessing, and evaluating of fluid status was located in the medical record or provided when requested. During an interview on 1/26/15, at 1:25 p.m. R100 stated she did not receive the fluids she wanted between meals; and explained the fluid restriction. R100 was unable to report how much fluid she had consumed so far that day; and explained nurses kept track of that. Observation revealed no water pitcher or water glass at bedside. During an observation on 1/28/15, at 7:48 a.m. R100 had 240 ccs of milk, 240 cc of water, and 140 cc of orange juice. During an interview on 1/28/15, at 7:44 a.m. licensed practical nurse (LPN)-D explained that dietary gave certain fluid amounts to R100 and then R100 told the nurses how much she consumed. The amounts should then be recorded on the fluid intake sheet. LPN-D was then shown the fluid intake sheet and verified it had not been completed. During an interview on 1/28/15, at 7:54 a.m. registered nurse (RN)-A stated fluid was divided up between dietary and nursing. No one is monitoring or evaluating fluid intake anymore. RN-A confirmed no further documentation had	2 830		

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

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2 830	Continued From page 27 been completed for R100 ' s fluid intake. 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 intakes...any 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 for daily living that required cues and supervision, no or unknown weight loss or weight gain, and was not on a diuretic (medication to reduce fluid). R71's hospital History and Physical dated 10/30/14, indicated diagnoses of hypoxemic respiratory failure resolved, secondary to chronic diastolic heart failure, acute systolic heart failure, newly diagnosed, paroxysmal atrial fibrillation,	2 830		

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2 830	Continued From page 28 severe depression status post eleven sessions of electroconvulsive therapy. The History and Physical revealed R71 was hospitalized secondary to failure to thrive and was moved from the cardiac service and transferred to an inpatient psychiatric unit for management of severe depression. It also indicated his weight was 162 lbs. on 10/27/14. R71's hospital discharge orders dated 10/30/14 indicated he received Lopressor 12.5 milligrams (mg) for hypertension. The discharge orders for continuing care instructed, "daily weights required for: Congestive heart failure." R71's signed physician orders dated 10/31/14 read, "daily weights PMs [evenings], Update NP [nurse practitioner] with weight gains of > [greater than] 3 lbs [pounds] in a day or 5 lbs from baseline weight. Baseline weight 162.1 lbs [pounds]." Physician orders dated 11/7/14 read, "...Lasix 10 mg [milligram] by mouth daily, weigh daily update provider for weight gains 3 # [pounds] or more in one day and 5 # [pounds] or more total. Update provider with fluid status (weights, edema, lungs) on 11/11 [11/11/14] ..." and physician orders dated 11/11/14 read, " Bilateral lower extremity wraps for edema." R71's care plan dated 11/6/14 identified a problem of at risk for complications of cardiac medications related to hypertension, atrial fibrillation and hyperlipidemia. The plan instructed staff to notify his medical practitioner of any signs of complications of antihypertensives (drugs used to lower blood pressure) including hypo/hypertension. Review of the facilities Weights and Vitals Summary entered into R71 ' s medical record on the computer revealed the following weights:	2 830		

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2 830	Continued From page 29 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 11/9/14 107 lbs 11/10/14 127 lbs 11/13/14 132 lbs 11/16/14 155 lbs 11/18/14 155 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 [atrial 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 edema ...PHYSICAL EXAMINATION:..Lungs: Diminished breath sounds bibasilar, otherwise clear to auscultation. Respiration unlabored ...Extremities: +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 nursing home is 163# [pounds] (11/2/14), up from 162.1# [pounds]. Daily weights have not been completed and I will ask nursing to ensure that	2 830		

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2 830	Continued From page 30	2 830		

these are obtained. I am going to add a low dose of Lasix 10 mg [milligrams] by mouth daily and use TED stocking for compression. Recheck CBC [complete blood count], Lytes/Cr [electrolytes/creatinine to test kidney function] on 11/11. Nursing to update me with fluid status (weights, edema, lungs, ect [sic].) at that time ..."

R71's interdisciplinary progress notes were reviewed from 10/31/14 to 11/3/14 and 11/8/14 to 11/10/14 and revealed no documentation related to monitoring of daily weights, edema in extremities or lung sounds to determine if fluid was accumulating and heart was not able to function to remove fluid.

On 1/29/15 at 12:12 p.m. registered nurse (RN)-E R71 had physician orders for daily weights related to diagnosis of congestive heart failure. RN-E verified the facility did not complete daily weights for R71 per the physician orders.

On 1/29/15 at 2:09 p.m. the director of nursing (DON) stated she would have expected staff to follow the physician orders for daily weights and reporting to the NP (nurse practitioner) for the parameters identified.

Even though R71 had symptoms of lower extremity edema, the facility failed to consistently monitor R71 for symptoms of CHF (CHF is Heart failure does not mean the heart has stopped working. Rather, it means that the heart's pumping power is weaker than normal. With heart failure, blood moves through the heart and body at a slower rate, and pressure in the heart increases. As a result, the heart cannot pump enough oxygen and nutrients to meet the body's needs. The chambers of the heart may respond by stretching to hold more blood to pump through

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2 830	Continued From page 31 the body or by becoming stiff and thickened. This helps to keep the blood moving, but the heart muscle walls may eventually weaken and become unable to pump as efficiently. As a result, the kidneys may respond by causing the body to retain fluid (water) and salt. If fluid builds up in the arms, legs, ankles, feet, lungs, or other organs, the body becomes congested, and congestive heart failure is the term used to describe the condition.) R45 was not weighed daily nor had ongoing assessment for control of CHF. R45 was admitted to the facility on 12/10/14, with diagnosis that included congestive heart failure, according to physician orders dated 12/10/14; diabetes mellitus, cerebral vascular accident, and peripheral vascular disease, according to the admission MDS dated 12/16/14; and right below knee amputation 12/5/14, according to hospital discharge summary dated 12/26/14. Document review of physician orders dated 12/10/14, revealed physician orders for daily weights for congestive heart failure; and physician orders dated 12/12/14, for daily weight, notify nurse practitioner with weight gain over 3 pounds in one day or 5 pounds from baseline, admit weight 220# with right pylon cast. Document review of hospital dismissal summary dated 12/26/14, revealed R45 was hospitalized 12/21/14 and discharged from the hospital on 12/26/14, for diagnosis of pontine infarction secondary to acute basilar thromboembolism. Document review of Dietary Nutritional Assessment dated 12/17/14, identified weight of 243 pounds (#), diet of no sugar added, and	2 830		

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2 830	Continued From page 32 summary included at risk due to diet, multiple medications, abnormal lab values, stage 2 pressure ulcer, 9% weight loss in 3 months, some weight loss may be related to right below knee amputation, current weight taken with right cast, and staff to monitor weights. Document review of dietary progress note dated 12/31/14, revealed weight of 233 pounds which reflected weight loss of 6.8% in 11 days, nursing notified of need to know if were taken with prosthesis on or off, independent in eating, and staff to monitor weights. R45's care plan dated 12/11/14, identified problem of R45 at risk for complications of use of cardiac medications related to cerebral vascular accident, peripheral vascular disease, hypertension, dyslipidemia, and congestive heart failure. Care plan approaches directed weights and vital signs as per orders and or policy. Resident care plan dated 1/8/15 identified problem as risk related to medical diagnosis and need for therapeutic diet. Care plan approaches directed staff monitor and record weights as ordered. Document review of facility record of weights for R45 revealed the following weights 12/12/14 to 1/26/15: 12/12/14--252 pounds expected weight loss after surgery 12/16/14--250.4 pounds Hospitalized -- 12/21/14 and returned to facility on 12/26/14 12/27/14-239 pounds 1/10/15--243.7 pounds 1/21/15--228.5 pounds	2 830		

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2 830	Continued From page 33 1/22/15--229.3 pounds 1/23/15-230 pounds 1/24/15--232.2 pounds 1/26/15-231 pounds Although physician orders dated 12/10/14, were for weights to be checked daily, the first weight was taken on 12/12/14, or 2 after the order, and then 11 and 14 days apart. Although physician orders dated 12/12/14, were for notification of nurse practitioner of weight gain over 3 pounds in one day, the staff did not notify the nurse practitioner of weight gain of 4.7 pounds between 12/27/14 and 1/10/15, the only weights taken in that period of time. Although physician orders dated 12/12/14, were for notification of the nurse practitioner of 5 pounds from baseline, admit weight 220 #, the staff did not notify the nurse practitioner of 12/12/14 weight of 252 pounds, a 30 pound gain from the 220 pounds baseline. During interview on 1/29/15, at 5:00 p.m., registered nurse (RN)-A verified the lack of daily weights as physician ordered, lack of evidence of nurse practitioner notification of weight gain over 3 pounds between 12/27/14 and 1/10/15, a gain of 4.7 pounds, and stated the facility had no other weights available. During interview on 1/30/15, at 9:00 a.m., nurse practitioner (NP)-G verified the physician orders dated 12/10/14 for daily weights, and 12/12/14 for nurse practitioner notification of 3 pound weight gain. NP-G stated she expected the facility to notify the nurse practitioner of weight gain as ordered and expected daily weights as ordered,	2 830		

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2 830	Continued From page 34 due to congestive heart failure and edema. NP-G verified orders dated 12/12/14 were current physician orders. NP-G verified there was no documentation of nurse practitioner notified of weights or weight gain. NP-G verified the lack of physician ordered daily weights. During interview on 1/30/15, at 9:15 a.m., nursing assistant (NA)-E stated R45 was to be weighed daily, according to the nursing assistant assignment sheet but has not been done. During interview on 1/30/15, at 9:30 a.m., registered nurse (RN)-F stated she expected R45 to be weighed daily and verified daily weights were not completed on the nursing assignment sheet and on the Evening Weight Charting-West list for daily weights. The Policy for Weighing Residents dated 6/7/13, read, "It is the policy of Maple Manor to ensure that residents are weighed and a weight record is kept on each resident and monitored routinely." "Residents will be weighed thereafter as ordered by the physician, but at least monthly." R39's face sheet identified that R39 was admitted on 1/7/2015. The dismissal summary from the hospital dated 1/7/15 identified R39 had diagnoses to include mild dementia, chronic left ventricular diastolic heart failure, atrial fibrillation, hypertension, history of transient ischemic attack (TIA), diabetes mellitus, type 2 with diabetic proliferative retinopathy, anxiety and depression, and history of probable Bonnet Syndrome (a condition among people who have lost their sight. It causes visual hallucinations).	2 830		

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2 830	Continued From page 35 The admission MDS dated 1/14/15 indicated that R39 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated cognitively intact. R39 required extensive assist with bed mobility, transfers and dressing, supervision with walking in room and corridor, supervision with toilet use, and limited assist with eating and personal hygiene. R39's current physician orders dated 1/29/15 identified that R39 received Lasix (diuretic) 40 mg twice a day for diastolic heart failure, Lisinopril 10 mg every day for hypertension/congested heart failure, a diet order of diabetic, no added salt, mechanical soft with ground meat, 2000 ml (milliliters) fluid restriction and staff were directed to obtain daily weights on evenings. The dismissal summary dated 1/7/15 from the hospital recommended that respiratory and fluid status with daily weights to determine if modifications to diuretic regimen are needed. R39's care plan dated 1/12/15 indicated R39 had a problem related to taking multiple cardiac medications related to processes including cardiovascular accident history, hypertension and congested heart failure. The problem dated 1/16/15 titled Diet indicated R39 was at risk related to medical diagnosis with need for a therapeutic diet and mechanical texture modifications and she is legally blind. R39 has a 2 liter fluid restriction. R39 was to maintain weight of 155 pounds (#) + or - thru next 90 days. Approaches included staff to monitor and record weights as ordered. The physician visit on 1/14/15 indicated that nursing staff were to monitor daily weights. Continue metoprolol (treat chest pain), digoxin (heart medication), Lasix (diuretic) and Lisinopril	2 830		

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2 830	Continued From page 36 (lower blood pressure). R39's weights were reviewed from the day of admission, 1/7/15, through 1/29/15. Out of the 23 days, 10 days of weights were missing with 4 days of weights missing between 1/7/15 and 1/22/15. During an interview with the registered nurse (RN)-A on 1/19/15 at 3:58 p.m., RN-A stated that they had staffing issues and the weights he gave me were all they had for R39. Policy for Weighing Residents, dated 6/07/15 instructed staff to: Upon admission, all residents will be weighed within 3 days to obtain an initial weight. Residents will be weighed thereafter as ordered by the physician. At the weekly dietary meeting the director of nursing will bring the list of residents who have doctor ordered specific weights and the team will review/audit the residents who have lost weights for further interventions. Lack of renal dialysis agreement to assure quality services were provided to residents: R62 received dialysis services from the clinic providing End Stage Renal Disease services without an agreement between the facility and clinic to provide dialysis services. R62 was admitted to the facility 11/21/14, with diagnosis that included end stage renal disease and renal dialysis according to the admission face sheet. Document review of physician orders dated 11/21/14; revealed R62 was to receive hemodialysis on Tuesdays and Saturdays. During interview on 1/28/15, at 4:20 p.m., the	2 830		

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2 830	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 cognitively 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. On 1/25/15 at 2:20 p.m. R96 was observed sitting on the bed with ice packs on both legs. R96 stated that she had broken both legs in a fall at home about 11 week ago. On 1/25/15 at 2:07 p.m. licensed practical nurse (LPN)-B stated R96 had fallen on 1/1/15 (after admission to facility) but sustained no injuries. The interdisciplinary team notes (IDT) dated 1/1/15 indicated R96 had been lowered to floor during a transfer because she had weak knees and received no injury. The clinical manager registered nurse (RN)-A documented no problems identified on the IDT notes. R96 ' s are plan had a problem dated 12/16/14 of	2 830		

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2 830	Continued From page 38 fall risk, related to need for assistance. The care plan directed to assist R96 with mobility as needed and to use a mechanical lift, but lacked other individualized interventions to reduce or prevent falls for R96. No fall risk assessment identifying contributing factors or comorbidities related to medical conditions, cognitive function, medications, physical function or the environment that could contribute to R96's risk for falls was found or provided by the staff when requested for R96. On 1/29/15 at 5:00 p.m. RN-A was interviewed and stated no fall risk assessment could be located for R96. No policy/procedure was provided when requested. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to comprehensively assess and implement interventions to ensure residents are provided care in a manner to promote their highest well-being. A monitoring program could be established in order to assure ongoing assessment and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days. ALSO: Based on observation, interview and document review, the facility did not ensure medication administration via gastric tube was followed for 1 of 1 resident (R69) observed for medication administration through gastric tube.	2 830		

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2 830	Continued From page 39 Findings include: R69's Admissions Face Sheet (AFS) indicated that R69 was admitted to facility on 6/13/13. The Diagnosis section of the AFS listed R69's diagnoses to include late effects of cerebrovascular disease; dysphasia (impaired ability to communicate due to brain injury or damage); chronic kidney disease; hypertension and prostate problems. The physician's orders dated 1/1/15, read, "Flush meds [medications] with 60 cc [cubic centimeters] H2O before and after and 5 cc H2O [water] between meds." On 1/29/15, at 8:08 a.m., R69 was observed to have an ongoing feeding through the gastric tube (g-tube). R69 gave permission for surveyor to observe registered nurse (RN)-D administer medications through R69's g-tube. RN-D was observed to stop the ongoing tube feeding, and then secured the tip of the tubing in the intravenous (IV) pole. RN-D immediately took the Asepto syringe (a trademark for a large bulb-fitted, blunt-tipped syringe), drew the first medication from a mini plastic medication cup, pushed it through the g-tube, then stopped however; RN-D did not flush the g-tube with 60 cc water before the initial medication was administered to flush the food from the tubing. On 1/29/15, at 8:12 a.m. RN-D verified she did not flush the g-tube with water before giving the first medication. The facility's Procedure for the Administration of Medication via a Percutaneous Endoscopic Gastrostomy (PEG) Tube policy dated 7/24/08, directed staff to follow the "standard procedure" in	2 830		

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2 830	Continued From page 40 giving medication through gastrostomy tube to include flushing with 30 milliliters (ml) of water before and then 30 ml of water after medication administration. The physician specifically ordered 60 cc vs. 30 cc per policy. SUGGESTED METHOD OF CORRECTION: The DON can inservice all staff responsible for tube feedings medication administration to use accepted current practices. Also to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess the benefits or risk to continue range of motion (ROM) services for 1 of 2 residents (R31) reviewed for range of	2 895	See Federal Regulation responses	3/11/15

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	00916	A. BUILDING: _____ B. WING _____	01/30/2015

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2 895	Continued From page 41 motion. Findings included: R31 had ROM services discontinued by nursing and was not reassessed for a maintenance range of motion services to maintain functionality of joints, prevent complications, or slow progression of range of motion impairment in the shoulders and lower extremities. Physician ' s visit note dated 1/15/15 included diagnoses of major depressive disorder, degenerative arthritis in shoulders, hands, and knees, and osteopenia. R31's quarterly Minimum Data Set (MDS) dated 10/30/14 indicated the resident had severe cognitive impairment and was dependent on staff for activities of daily living including toileting, dressing, hygiene, and eating. R31 required a mechanical lift for transfers. On 1/26/2015 at 12:25 p.m. R31 was observed sitting in her wheel chair located in the dining room. NA-C stated she usually eats good during breakfast and very sleepy during lunch period and eats one really good meal a day. During an interview on 1/26/15 at 12:06 p.m. licensed practical nurse (LPN)-B stated R31 had limited range of motion in neck, shoulders, and hips and R31 did not use orthotics and did not have a range of motion (ROM) program in place. R31's care plan indicated the range of motion program was discontinued on 12/31/2013. Nursing progress note dated 1/16/14 read,	2 895		

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2 895	Continued From page 42 "maintenance cares- passive range of motion, stretches discontinued 1/29/14- resident is comfort cares [resident does not wish for heroic medical interventions to prolong life] " . Progress note lacked assessment, evaluation, and plan. No further assessment for need of range of motion program was found in the medical record since program was discontinued. During an interview on 1/28/15, at 1:43 p.m., LPN-D stated " we tried to do range of motion in the past and we continue to reposition her " . LPN-D indicated when the R31 ate independently active range of motion was being performed. LPN-D had no further examples of how active or passive range of motion had been provided. During an interview on 1/28/15, at 2:05 p.m. registered nurse (RN)-A stated " according to the aide care plan, maintenance is not being provided. " During another interview on 1/29/15 RN-A stated they were not aware of documentation that indicated R31 ' s program was discontinued related to pain or refusal of services. During an interview on 1/29/15, at 8:27 a.m. physical therapy assistant (PTA)-J stated, " Sometimes we would recommend passive range of motion if it ' s not going to cause pain. Providing passive range of motion could ease the burden of care. " PTA-J explained typically programs are reassessed prior to discontinuing completely and would recommend evaluating need and appropriateness for programs on a quarterly basis. PTA-J recommended R31 being evaluated by physical therapy for a maintenance program.	2 895		

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2 895	Continued From page 43 During an interview on 1/29/15, at 9:12 a.m. nursing assistant (NA)-K stated R31 did not receive passive range or motion at this time and thought R31 would allow and tolerate receiving ROM services without any difficulty. During an interview on 1/30/15 at 10:00 a.m. nurse practitioner (NP) stated, " I think she [R31] would definitely benefit from a passive range of motion program. " SUGGESTED METHOD FOR CORRECTION: The DON, director of therapy or designee(s) could review and revise as necessary the policies and procedures regarding implementing and maintaining proper range of motion care. The DON, director of therapy or designee(s) could provide an in-service for all appropriate staff on providing treatment per each resident's plan of care. The DON, director of therapy or designee(s) could monitor to assure residents receive proper range of motion treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and	2 910		3/11/15

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2 910	Continued From page 44 B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comprehensive bladder assessments and an assessment of risks for developing and monitoring of symptoms for urinary tract infections (UTIs) for 7 of 8 residents (R16, R6, R70, R30, R69, R96, R38) reviewed with recurrent urinary tract infections; the facility failed to prevent urinary tract infections and the spread of infections to other residents due to staff not following sound infection practices regarding Foley Catheter care and equipment used for 1 of 1 resident (R68) with an indwelling Foley catheter; and the facility failed to follow physician orders for intermittent catheterizations and failed to monitor, evaluate, and assess urine output for 1 of 1 residents (R70) in the sample with intermittent cauterizations. Findings include: R16 lacked identification of signs and symptoms of the urinary tract infection (UTI) and lacked a bladder assessment and assessment of UTI risk. R16 was noted on the infection control (IC) logs to have a UTI on 10/17/14. Review of the interdisciplinary team notes (IDT) of 10/8/14 to 10/21/14 noted no signs or symptoms of a UTI documented.	2 910	See Federal Regulation responses	

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2 910	Continued From page 45 The quarterly Minimum Data Set (MDS) dated 10/29/14 indicated a brief interview of mental status (BIMS) score of 12 or moderately cognitively impaired, that R16 required extensive to total assist to meet toileting and personal hygiene needs, and that R16 was frequently incontinent. The care plan dated 9/13/11 noted R16 had functional incontinence. The care plan did not indicate R16 was at risk for UTIs. Registered nurse (RN)-E stated on 1/30/15 at 12:45 p.m. that R16 did not have a completed bladder assessment. R6 lacked identification of symptoms of a UTI and lacked a UTI risk assessment. R6 was noted on the IC log to have a UTI on 10/27/14 and 12/10/14. Review of the IDT notes for this time period noted no signs and symptoms of infections listed. The quarterly MDS dated 12/26/14 was reviewed. R6 had a BIMS score of 13 or cognitively intact, required extensive to total assistance to meet toileting and personal hygiene needs, had a neurogenic bladder and obstructive uropathy, and was intermittently catheterized. R6's care plan printed 12/28/15 noted an indwelling suprapubic catheter and a history of recurrent UTIs resulting in frequent hospitalization. The care plan did not have interventions based on a comprehensive bladder assessment had been completed. No UTI risk assessment was found or provided by facility when requested.	2 910		

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2 910	Continued From page 46 R70 lacked identification of symptoms of a UTI and lacked a UTI risk assessment R70 was noted on the IC log to have a UTI on 9/29/14. The IDT notes were reviewed and no documentation of signs and symptoms of the infection were found. The quarterly MDS dated 11/20/14 indicated R70 had a BIMS score of 11 or moderately cognitively impaired, required extensive assistance to meet toileting and personal hygiene needs, and was intermittently cauterized. Again no bladder assessment or UTI risk assessment was found or provided when requested for R70. R30 lacked identification of symptoms of a UTI and lacked a UTI risk assessment. R30 was noted on the IC log to have a UTI on 10/15/14, 11/7/14, and 11/29/14. The IDT notes were reviewed and lacked identification of signs and symptoms of UTI. The annual MDS dated 11/6/14 noted R30 had memory impairment, was intermittently cauterized, had obstructive uropathy, and had total dependence on staff to meet toileting and personal hygiene needs. R30 had a care plan dated 12/15/11 that listed a problem of at risk for UTI related to staph bacteremia, but did not indicate an assessment related to clinical, functional or environmental risk factors had been completed. Two bladder assessments were found in the medical record dated 11/6/14 and 1/28/15.	2 910		

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2 910	Continued From page 47 However, neither assessment evaluated R30's UTI risk. R69 lacked identification of symptoms of the UTI and lacked a bladder and UTI risk assessment. R69 was noted on the IC log to have a UTI on 10/7/14, 10/31/14, 11/9/14, 11/18/14. The IDT notes were reviewed and lacked identification of signs and symptoms of UTI. The 30-day PPS MDS dated 12/15/14 was reviewed. The MDS indicated R69's short term and long term memory were intact, that R69 required extensive assist with toileting and personal hygiene, and that R69 had experienced a UTI in the past 30 days. No bladder or UTI risk assessment was found in the record. RN-E stated on 1/30/15 at 12:45 p.m. that R69 did not have a completed bladder assessment. R96 lacked a bladder assessment and a UTI risk assessment R96 was admitted on 12/2/14. The hospital dismissal summary dated 12/2/14 noted R96 had chronic UTI and was on suppression Bactrim (antibiotic). 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. RN-E stated on 1/30/15 at 12:45 p.m. that R96 did not have a completed bladder assessment.	2 910		

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2 910	Continued From page 48 R38 lacked a bladder assessment and a UTI risk assessment. R38 was admitted with a UTI 12/16/14. The admission MDS dated 12/22/14 indicated R38 had BIMS score of 10 or moderately cognitively impaired, required extensive to total assistance to meet toileting and personal hygiene needs, had an ostomy, and had experienced a urinary tract infection during the previous 30 days, and was always incontinent. No bladder or UTI risk assessments were found in the record. RN-E stated on 1/30/15 at 12:45 p.m. that R38 did not have a completed bladder assessment. On 1/27/15 at 2:00 p.m. UTI policies were provided by the director of nursing. The policies included 1) Chronic Urinary Tract Infection Policy dated 5/2/12 and 2) Prevention of UTI's at Risk Residents dated 4/3/12. The policies did not direct staff to evaluate the risk for developing UTIs and did not include signs and symptoms of UTIs and what/when to document. The policies did not direct a comprehensive nursing assessment that included contributing factors or comorbidities related to medical conditions, cognitive function, medications, physical function or the environment RN-A was interviewed on 1/28/15 at 9:40 a.m. RN-A stated he had a form that listed the criteria for infections, but that no policy related to the form had been developed. RN-A stated nursing was to document the criteria for infections observed in the nursing notes. On 1/28/15 at 10:10 a.m. RN-A and the director of nursing (DON) were interviewed. They indicated	2 910		

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2 910	Continued From page 49 the facility did not have a list of infection or UTI criteria available to staff to use and document from. They stated the facility did not have a policy/procedure on the management of urinary tract infections. On 1/30/15 at 9:30 a.m. the DON indicated the bladder assessment did not include a UTI risk assessment and that staff were not expected to do a narrative note related to UTI risk. R68's Foley catheter care did not promote sound infection control practices when handling the draining tubing and collection bag nor was the collection bag placed to prevent the spread of infection or prevent a urinary tract infection. On 1/21/15, at 7:15 a.m. R68's room door was open, R68 was observed lying in bed. R68's indwelling Foley catheter bag was also observed lying flat on top of R68's blanket of his bed. At 7:45 a.m. registered nurse (RN)-C observed R68's catheter bag was placed directly on top of R68's bed linens. RN-C was asked if the urine bag was to be placed on top of the bed linens and RN-C stated, "Yes." On asking how much urine was in the collection bag RN-C was observed to hold the urine bag and raised it to her eye level and verified there was about 75 milliliters of urine collected in bag. As RN-C was holding the bag up, the bag's drain (rubber emptying spout) was observed to have been clamped, however, it was not placed in the designated bag pouch but uncovered and sticking out as it was not secured in the collection bags spout holder. RN-C then placed the urine bag back on top of the bed with the drain spout in direct contact with the linens on the bed. At 7:38 a.m. on 1/21/15 R68's room door was open and R68 was still lying in bed with the collection bag still on top of the bed linens. At	2 910		

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2 910	Continued From page 50 8:14 a.m. Nursing assistant (NA)-B was interviewed and confirmed R68's catheter bag was lying directly on top of R68's bed linen. NA-B stated nursing assistants empty the bag every shift and must have been placed on the bed by the night shift when they left this morning. NA-B stated the catheter bag should always be hanging below R68. NA-B added, urine bag should be placed in a blue cloth cover and hooked "here" (pointing to a loop-like attachment on bed frame). NA-B then moved bag from bed. R68's Admissions Face Sheet printed on 1/29/15, indicated R68 had diagnoses including psychosis, dementia, depression, anxiety state and urinary retention. The Physician's Orders Sheet (POS) dated 11/1/14 indicated R68's urinary drainage bag should be kept below bladder level to prevent reflux, maintain a closed drainage system. The POS further indicated bag "to be kept in cloth (blue canvass) bag to prevent infection and provide dignity." R68's care plan dated 10/20/14 indicated R68 required indwelling Foley catheter due to urinary retention. The care plan directed staff to keep drainage bag below bladder level to prevent reflux and to maintain a closed drainage system. The facility's Catheter Care Policy dated 7/9/09, directed staff to secure bag on side of bed frame, not to allow bag to touch the floor, to keep the bag below level of bladder at all times and to be inside a blue dignity bag. The American Nurses Association (ANA) adopted the guidelines provided by the Centers for Disease Control (CDC, 2009) to prevent catheter	2 910		

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2 910	Continued From page 51 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. R70 lacked every four hour catheterization to prevent urinary tract infections and bladder problems. On 12/8/14 R70 filed a grievance with the facility that pertained to staff not catheterizing him every four hours as ordered by the physician and bladder scans had not been performed prior to catheterization. Grievance indicated R70 went six hours without being catheterized; which lead to the removal of 1000 milliliters (ml) of urine. R70's quarterly Minimum Data Set (MDS) dated 11/20/14 indicated R70 required intermittent urinary catheterization, had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of eleven, and required extensive assist for activities of daily living of dressing, toileting, transfers, and hygiene. R70's current care plan provided by the facility on 1/28/15 indicated R70 occasionally refused cares and gave staff direction to chart refusals. Care plan indicated resident was at risk for fluid volume deficit and directed staff to report no urine output in a shift. Care plan also indicated R70's diagnosis of hypertonic bladder, benign prostatic hyperplasia (enlarged prostate) with obstruction, and required intermittent catheterization and directed staff to perform intermittent catheterization as ordered. The care plan lacked	2 910		

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2 910	Continued From page 52 size and type of urinary intermittent catheter (straight versus coude catheter is a curved catheter tip for easy insertion for people with obstruction in the urethra) to use. The care plan did not include the physicians order to bladder scan if needed first. Signed physician's orders dated 12/19/14 included diagnoses of Parkinson's, dementia with Lewy bodies, hypertonicity (increased tension of the bladder making it more rigid, hampering complete urinating ability) of bladder and benign prostatic hyperplasia (BPH which is an enlargement of the prostate) making it more difficult to pass urine. Signed physician's orders dated 12/19/14 included in and out (I and O) catheterization (Cath) every four hours scheduled, may I and O cath for retention/discomfort as needed (PRN) and "ok to bladder scan prior to I and O and hold cath if scanned amount is less than 200 cubic centimeters (cc). However, the physician orders lacked size and type of catheter to use for R70 as the size matters to promote comfort and prevent tissue damage when catheterizing. R70's treatment administration record (TAR) indicated scheduled I and O cath times were 1:00 a.m., 5:00 a.m., 9 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m. However, the documentation to indicate cath was completed was inconsistent; outputs were not recorded except intermittently during the scheduled 9:00 p.m. treatment time. The Maple Manor Bladder Scan Sheets for November, December 2014 and January 2015 indicated I and O catheterization times and amount of outputs resulting from urinary catheterization. However, the use of the bladder	2 910		

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2 910	Continued From page 53 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 by the National Institute of health (NIH Publication No. 14-3195 December 2013) it read, "A normal bladder acts like a reservoir and can hold 1.5 [360 cc] to 2 cups [480 cc] of urine." During an interview on 01/30/15, at 1:57 p.m. licensed practical nurse (LPN)-C explained resident often refused to be cathed or had been at an activity. LPN-C stated refusals would be indicated on the bladder scan sheet or on the TAR. These documents were reviewed and found to be inconclusive if R70 had refused or unavailable or if the nurse had not completed for other reasons. During an interview on 1/30/15, at 11:30 a.m. director of nursing (DON) stated, "They should be documenting why the cath is not getting done as ordered." The facility did not have a policy for in and out catheterization. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all employees responsible for preventing urinary	2 910		

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2 910	Continued From page 54 tract infections on the need to assess and develop interventions to prevent urinary tract infections. The director of nursing could inservice all employees responsible to follow physician orders for intermittent cauterization and audit for compliance. The director of nursing could inservice all employees responsible for monitoring, evaluating and assessing urine output and audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 5 residents (R3, R88) in the sample dependent on staff for assistance, received assistance with eating, and 2 of 3 residents (R88, R31) in the sample dependent on staff for personal care, received assistance with personal cares. Findings include: LACK OF ASSIST WITH EATING: R3 did not receive assistance with eating	2 920	See Federal Regulation responses	3/11/15

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2 920	Continued From page 55 according to care plan interventions. During observations on 1/28/15, at 9:45 a.m., R3 was in wheelchair located in the east/west dining room. R3 was placed at a table designated by staff for residents who needed assistance to eat. Also at that time, registered nurse (RN)-C was assisting R3 to eat. At 9:52 a.m., RN-C left the table. R3 still had plate of food and beverages in front of R3 with no attempt to feed self. At 10:00 a.m., R3 was asleep with f hard-boiled egg, small powdered donut, 1 slice toast cut into half, and 4 glasses beverages in front of R3, and no staff assistance given. From 10:00 a.m. until nursing assistant (NA)-D sat and assisted R3 to complete her meal starting at 10:12 a.m. or twelve minutes without assistance to eat meal or cueing. R3 was admitted 3/19/13, with diagnosis that included paralysis agitans and dementia with Lewy Bodies, according to physician orders printed 1/29/15. The facility identified R3 on the annual Minimum Data Set (MDS), an assessment dated 12/8/14, to have short and long term memory problems, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene, and received a mechanically altered diet. Document review of the annual Nutritional assessment dated 12/16/14; identified R3 independently ate with difficulty chewing, no difficulty swallowing, received general diet with soft textures and thin liquids, and no significant weight changes. R3's care plan dated 3/19/13, identified problem	2 920		

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2 920	Continued From page 56 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. During interview on 1/29/15, at 9:00 a.m., director of nursing stated she expected staff to follow the care plan and to provide R3 with assistance for meals. Director of nursing stated she was aware of the lack of staff in the east/west dining room. R88 did not receive assistance with eating according to care plan interventions. During observations on 1/27/15, at 11:18 a.m., R88 was in wheelchair located at the table designated for residents who needed assistance with eating in the east/west dining. During observations at that time, a plate of pureed carrots, quiche, and mashed potatoes and four adaptive cups of beverages with lids were on the table directly in front of R88, who was noted to have her eyes closed. From 11:18 a.m., to 11:50 a.m. (32 minutes) R88 eyes were closed and no staff assisted her to eat nor encouraged her to eat. At 11:50 a.m., trained medication assistant (TMA)-A sat beside R88, placed food on a spoon and handed to R88, R88 immediately dropped the spoon of food onto her lap, TMA-A left R88 following this incident. At 11:54 a.m., feeding assistant (FA)-A assisted another resident at R88 ' s table, then FA-A handed R88 glass of chocolate milk and continued to assist R88 until 12:08 p.m. and during this time FA-A would stand	2 920		

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2 920	Continued From page 57 to assist R88 at times as FA-A was also assisting another resident to eat. During interview on 1/27/15, at 12:12 p.m., FA-A stated R88 received pureed foods and any staff could assist R88 to eat. FA-A stated R88 had good days and sometimes would eat independently and other days needed assist with eating. R88 was admitted to the facility 8/26/14, with diagnosis that included dementia with Lewy Bodies and paralysis agitans according to resident diagnosis codes printed 1/30/15. The facility identified R88 on the quarterly MDS, an assessment dated 11/23/14, to have short term memory problem, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene, and received a mechanically altered diet. R88's care plan dated 9/10/14, identified problem of at risk for decline in nutritional status due to need for mechanically altered food related to poor dentation, due to open areas with increased need for nutritional support, due to abnormal labs, due to need for assistance with meals, due to decreased cognition. Approaches dated 9/10/14 included assist as needed and as resident allows with food/fluid. Approaches dated 9/22/14 included pureed diet with thin liquids. Approaches dated 9/23/14, included house supplement two times daily. Approaches dated 9/29/14 included alternate bites with sips, watch for swallow and give next bite/sip to maintain pace and uncovered cups ok when being assisted.	2 920		

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2 920	Continued From page 58 During interview on 1/28/15, at 9:15 a.m., registered dietician (RD)-I and surveyor read RD-I's notes on 1/26/15, which identified weight loss of 8.5% in 2 months, some weight loss may be decreased edema, pureed diet, eating skills are dependent, per nursing staff R88 lethargic during meals and staff to assist resident as resident allowed. During a second meal observation on 1/28/15, at 9:37 a.m., R88 sat in wheelchair located at the table designated by staff for residents who need assistance to eat located in the east/west dining room. R88 was observed with eyes closed with plate of cooked cereal and scrambled eggs, applesauce, magic cup, and beverages in 2 adaptive cups with lids. At 9:41 a.m., TMA-A sat to administer medication to R88 then left after taken. At 9:42 a.m., RN-C sat next to R88 and began to assist her to eat until 9:52 a.m., when RN-C left R88. R88 still had food and beverages in front of her and made no attempt to eat independently. From 9:52 a.m. to 10:12 a.m. (20 minutes) R88 had eyes closed and no staff assistance or cueing to eat was given. NA-D sat and assisted R88 to complete her meal starting at 10:12 a.m. During interview on 1/29/15, at 9:00 a.m., Director of nursing stated she expected staff to follow the care plan and to provide R88 with assistance for meals and personal cares. Director of nursing stated she was aware of the lack of staff in the east/west dining room. The Care Plan policy dated 1/19/12, read, "Purpose: To provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident."	2 920		

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2 920	Continued From page 59 LACK of PERSONAL CARES: R88 had long facial hair and long soiled finger nails without assistance with personal cares according to care plan interventions. During observations on 1/26/15, at 2:58 p.m., R88 had visible long facial hairs while lying bed. On 1/28/15, at 9:37 a.m., R88 sat in wheelchair located at south table in east/west dining room with several other residents who ate meal in this dining room and again had long, soiled finger nails and long facial hair. R88 was admitted to the facility 8/26/14, with diagnosis that included dementia with Lewy Bodies and paralysis agitans according to resident diagnosis codes printed 1/30/15. The facility identified R88 on the quarterly MDS, an assessment dated 11/23/14, to have short term memory problem, moderately impaired decision making, total dependence on 2 staff for activities of daily living, total dependence on 1 staff for eating and personal hygiene. R88's care plan dated 9/4/14, identified problem of needed assistance with activities of daily living, transfer and ambulation related to dementia and decreased endurance and mobility. Approaches included assist of one staff with wheel chair mobility, dressing, and personal hygiene. During interview on 1/28/15, at 10:10 a.m., NA-D stated had assisted R88 with morning cares. NA-D verified had not provided shave or nail care. NA-D stated residents are shaved with morning cares and nail care was done in the evenings.	2 920		

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2 920	Continued From page 60 During interview on 1/28/15, at 11:15 a.m., RN-F verified the long facial hair and long soiled finger nails. RN-F stated she expected facial hair shaved on bath day and as needed. RN-F stated she expected manicures were done weekly and on bath days. Also RN-F said R88 received bath on Fridays and Wednesdays (today) in the morning. During interview on 1/29/15, at 9:00 a.m., director of nursing Director of nursing stated she expected staff to follow the care plan and to provide R88 with assistance for nail and facial hair removal care. R31 did not receive nail cares and eye glasses were not cleaned to promote clear vision when worn: Observations made on 1/25/2015 at 2:06 p.m., on 1/26/15 at 1:31 p.m., 1/27/15 at 8:57 a.m revealed R31 had dark brown/black debris underneath fingernails and eye glasses were extremely dirty and had tape on both bows of the glasses. R31's quarterly MDS dated 10/30/14 indicated R31 had severe cognitive impairment and was dependent on staff for activities of daily living including toileting, dressing, hygiene, and eating. Physician's visit progress note dated 1/15/15 included diagnoses of advanced dementia and primary open angle glaucoma. R31's care plan indicated resident was one assist with grooming. According to an interview on 1/30/15, RN-A stated fingernail care and cleaning glasses were to be completed for R31 as they are considered part of " grooming " as noted in R31's care plan. The AM Cares policy dated 8/31/04, read, "1. Partial baths are given when complete baths are	2 920		

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2 920	Continued From page 61 omitted." Procedure: "2. The mouth, nails, and hair are to be cared for in the same manner as for a complete bath." The CARE OF NAILS policy dated 3/12/08, read, "1. Keep clean and well manicured." SUGGESTED METHOD OF CORRECTION: The director of nursing could monitor personal cares provided to residents to determine resident/staffing needs, educate staff, and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 920		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure medication	2 930	See Federal Regulation responses	3/11/15

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2 930	Continued From page 62 administration via gastric tube was followed for 1 of 1 resident (R69) observed for medication administration through gastric tube. Findings include: R69's Admissions Face Sheet (AFS) indicated that R69 was admitted to facility on 6/13/13. The Diagnosis section of the AFS listed R69's diagnoses to include late effects of cerebrovascular disease; dysphasia (impaired ability to communicate due to brain injury or damage); chronic kidney disease; hypertension and prostate problems. The physician's orders dated 1/1/15, read, "Flush meds [medications] with 60 cc [cubic centimeters] H2O before and after and 5 cc H2O [water] between meds." On 1/29/15, at 8:08 a.m., R69 was observed to have an ongoing feeding through the gastric tube (g-tube). R69 gave permission for surveyor to observe registered nurse (RN)-D administer medications through R69's g-tube. RN-D was observed to stop the ongoing tube feeding, and then secured the tip of the tubing in the intravenous (IV) pole. RN-D immediately took the Asepto syringe (a trademark for a large bulb-fitted, blunt-tipped syringe), drew the first medication from a mini plastic medication cup, pushed it through the g-tube, then stopped however; RN-D did not flush the g-tube with 60 cc water before the initial medication was administered to flush the food from the tubing. On 1/29/15, at 8:12 a.m. RN-D verified she did not flush the g-tube with water before giving the first medication.	2 930		

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2 930	Continued From page 63 The facility's Procedure for the Administration of Medication via a Percutaneous Endoscopic Gastrostomy (PEG) Tube policy dated 7/24/08, directed staff to follow the "standard procedure" in giving medication through gastrostomy tube to include flushing with 30 milliliters (ml) of water before and then 30 ml of water after medication administration. The physician specifically ordered 60 cc vs. 30 cc per policy. SUGGESTED METHOD OF CORRECTION: The DON can inservice all staff responsible for tube feedings medication administration to use accepted current practices. Also to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accurate and ongoing nutritional reassessments and consistent and accurate weights were provided to determine and monitor for weight loss for 3 of 4 residents	2 965	See Federal Regulation responses	3/11/15

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2 965	Continued From page 64 (R38, R96, and R32) in the sample reviewed for nutrition concerns. Findings include: R38 lacked the correct diet and monitoring of intake and also lacked ongoing monitoring for significant weight loss and nutritional assessment for needs. R38 was observed on 1/26/15 at 5:20 p.m. eating independently. She left the table at 5:35 p.m. and had eaten less than 25% of the meal. R38 was interviewed on 1/26/15 at 6:11 p.m. and she was on a fluid restriction and was sure she had dietary restrictions, but needed to talk to a dietician to find out what the restrictions were. R38 was admitted to the facility from the hospital on 12/16/14 according to the hospital discharge summary which noted R38 had a perforated colon that resulted in a colostomy and had a prescribed diet of general diet. Hospital dismissal summary dated 12/30/14 indicated the resident had been readmitted to the hospital with acute respiratory failure, hyponatremia, hypophosphatemia, hypomagnesaemia and chronic anemia. The diet prescribed was general with low residual. The hospital discharge summary dated 1/9/15 noted R38 had experienced volume depletion and hyponatremia. The prescribed diet was changed to 1500-2000 milligrams (ml) sodium, low cholesterol, and low fat. The physician orders of 12/30/14 noted continue to monitor weights, blood pressures, and pulse. However, an admission weight was not obtained. The hospital weight of 12/28/14 was 161 pound	2 965		

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2 965	Continued From page 65 and the weight on the temporary care plan dated 1/9/15 showed a weight of 141 pounds, or 20 pound (12%) weight loss. The registered dietician completed an assessment on 12/17/14 that indicated a regular diet and to monitor initial intake. Weight loss not expected. Ideal body weight 135-165 pounds and current weight 162 pounds. The 12/24/14 dietary care area assessment noted general diet, boost nutritional supplement twice a day for extra calories and a weight of 163 pounds. On 1/25/15 a readmission nutritional assessment was completed by the certified dietary manager (CDM) and included a no added salt diet with any other changes. R38 weight was 139 pounds and noted no significant weight changes (significant loss is calculated as 14% weight loss in one month.) The dietary tray care noted a fluid restriction and a no added salt diet. The tray card did not include the physician orders (1/9/15 hospital discharge) of 1500-2000 mg sodium, low fat, low cholesterol. Physician order of 1/14/15 noted staff were to administer 2 ounces of dietary supplement 2.0 at medication pass due to weight loss, stage II wound, and meal intake of less than 50%. The physician order of 12/13/14 also included boost (240 cc) twice a day. The facility continued to document that they were offering both the 2.0 and boost, but the medication administration record did not indicate the percentage of these two supplements taken by R38. Licensed practical nurse (LPN)-D was interviewed on 1/29/15 at	2 965		

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2 965	Continued From page 66 9:25 a.m. and stated the boost had been changed to Ensure (2.0) so R38 would receive the Ensure during the medication pass. On 1/29/15 at 10:10 a.m. registered nurse (RN)-A was interviewed regarding documentation of nutritional supplement intake and stated that nursing only documented if R38 refused the supplement and not the amount taken during the medication pass. The meal intake for 12/16/14 through 1/26/15 was reviewed and the intake was documented sporadically this was found for the fluid intake monitoring for 1/14/15 to 1/26/15. Also none of the daily intake was totaled to determine if intake was adequate for R38. R38 ' s care plan printed 1/27/15 was reviewed and included a diet plan dated 12/22/14 with an intervention of general diet. Care plan dated 1/12/15 included intervention of no added salt diet and a 2000 cc (cubic centimeter) fluid restriction. During an interview on 1/2/15 at 4:25 p.m. the director of nursing (DON) verified the care plan had two conflicting orders for R38's diet. Clinical manager (RN-A) and director of nursing were interviewed on 1/28/15 at 8:00 a.m. They both stated the nursing assistant was responsible to document the intake and that nursing and dietary were to review the totals. They stated they were aware that this was not being done at this time. They both were aware the weights were not being done as ordered. The certified dietary manage (CDM) was interviewed on 1/28/15 at 8:10 a.m. CDM stated that R38 was not on his list of residents that he was to be watching weight on. CDM stated he would look only at the weights that were in the computer system and that he was aware that the	2 965		

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	00916	A. BUILDING: _____ B. WING _____	01/30/2015

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2 965	Continued From page 67 weights were not being done. CDM would have the registered dietician (RD) assess new admissions, annual reassessments, and any resident with a significant weight loss. The RD was interviewed on 1/28/15 at 8:35 a.m. and stated she was aware that taking of weights were an issue in the facility. RD stated that R38 received a cardiac diet which was a low sodium diet only. RD stated she would see admissions and annual reassessment residents and did look at weight listings with each visit to see if there was any resident she should see. RD stated she was aware that intake was not being monitored and she was unsure of the accuracy for weights being taken by staff as they varied. During an interview with CDM on 1/29/15 at 940 a.m. CDM stated the average diet served was 4 to 6 grams (4000 to 6000 mg) sodium and verified that exceeded R38's recommended 1500-2000 milligrams of sodium. During an interview on 1/29/15 at 10:20 a.m. CDM stated the general diet was not considered to be low fat/low cholesterol. CDM stated R38 would be served the regular diet but no added salt from salt shaker is given. Cook (C)-A was interviewed on 1/30/15 at 7:55 a.m. and said that a no added salt diet meant the resident was not served sausage or bacon, but that everything else would be ok to serve. At this time C-C stated that at breakfast every resident would be served the same thing with no change to foods offered no matter what restrictions they may have. On 1/30/15 at 8:10 a.m. C-B stated that residents on a no added salt diet received the same as the other residents just no sausage or bacon.	2 965		

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2 965	Continued From page 68 R96 lacked the correct diet also lacked consistent monitoring of intake and also lacked ongoing monitoring of interventions to prevent further weight loss having had a significant weight loss and nutritional assessment for needs. R96 was observed to eat lunch in her room on 1/25/15. She had received a regular meal with regular portions. R96 stated that she was to receive smaller portions because she had had a gastric bypass. R96 was observed on 1/26/15 at 5:15 p.m. stating that she had been weighed today had had lost about 10 pounds since admission. On 1/27/15 at 8:30 a.m. R96 was eating Canadian bacon and waffles for breakfast. R96 was interviewed on 1/26/15 at 11:50 a.m. She stated that she was tired of canned fruit since she gets it at every meal. She stated she had had a gastric by-pass and should receive smaller portions. Today she had a full portion meal serving and ate less than 50% of the meal. Review of the diet card on her tray did not noted small portions. During an interview on 1/30/15 at 9:15 a.m. R96 stated that last night she had scalloped potatoes with ham, creamed cucumbers and something else (bread). R96 said that was a lot of carbs (carbohydrates) with high calories and has been having high blood sugar readings from the increase in carbohydrates compared to when she lived at home. The hospital dismissal summary dated 12/2/14 and day of admission to the home identified R96 had diagnoses of post renal transplant, hyperlipidemia, hypertension, hypothyroidism, and anemia. Orders for continuing care read, "Diabetes Management, check blood sugars twice daily. Diabetic diet."	2 965		

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2 965	Continued From page 69 R96 ' s Insulin Flow Sheet from 1/1/15 through 1/30/15 was reviewed. Readings for morning blood glucose ranged from 81 to 154; the range of noon blood glucose readings was 118 to 301, the afternoon blood glucose ranged from 113 to 388, and the bedtime glucose range from 96 to 288. On 1/20/15 the physician ordered sliding scale insulin. American diabetes recommends blood sugars range as follows: Fasting (before meals; upon waking):70-130 mg/dL (3.9-7.2 mmol/L) Postprandial (1-2 hours after the start of a meal): greater than 180 mg/dL (10.0 mmol/L) which may be higher depending on each resident and doctor. The RD completed a nutritional assessment on 12/3/14. The assessment listed a diagnosis history of gastric bypass, history of a kidney transplant, but not of diabetes. The assessment listed no laboratory values, listed an ideal body weight of 117 to 143 pounds, but no estimated calorie or carbohydrate need. The assessment did identify the resident received insulin for control of blood sugars. The assessment indicated the resident would eat small amounts related to a gastric bypass, but did not indicate the need for a diabetic diet. The nutritional assessment listed the weight at 146 pounds (the same as the hospital discharge summary dated 12/2/14). The dietary care area assessment dated 12/15/14 noted the resident received a therapeutic diet and was offered a diabetic no sugar added diet per physician order. The certified nursing assistants (CAN) Entry Report provided by the facility was reviewed for	2 965		

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2 965	Continued From page 70 food intake from 12/3/14 through 1/26/14. R96 ' s intake of food was documented sporadically and not completely. R96 ' s admission weight documented on the weight form read, " 157 pounds. " At the surveyor request the resident was weighed on 1/26/15 and had a weight of 147 pounds or a weight loss of 10 pounds or 6.4% from 12/2/14 to 1/26/15. R96 ' s Care plan dated 12/15/14 indicated the need for a therapeutic diet and had interventions of offered a diabetic no added sugar diet. RN-A was interviewed on 1/27/15 at 8:20 a.m. He stated that admission weight were being deferred for a couple weeks since residents admitted from hospitals frequently had a fluid overload and therefore showed a weight loss. He stated he did not know why the weights were not done monthly or as ordered by the physician. RN-A and DON were interviewed on 1/28/15 at 8:00 a.m. Both stated that nursing assistants were to record food intake and that nursing was to review the total consumed. When asked about consistent weights being taken both RN-A and DON said they were aware of lack of weights being completed for residents. The RD was interviewed on 1/28/15 at 8:35 a.m. She stated she was aware that taking and recording weights was an ongoing problem as they were not done as required. She stated that it was nursing's responsibility to obtain the correct information on the diets and inform dietary if changes were needed. The RD was again interviewed on 1/28/15 and was aware R96 had gastric bypass to reduce weight and the	2 965		

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2 965	Continued From page 71 treatment consisted of small frequent meals offered vs. larger three meals per day. RD felt that weight loss was expected but that she did not know R96 lost any weight since admission. The nurse practitioner (NP)-A was interviewed on 1/30/15 at 9:00 a.m. NP-A stated a regular diet was not appropriate for R96. The resident had been complaining of high blood sugars in the afternoon and would complain about the closeness of the breakfast and lunch meal. But no change was done to accommodate R96 ' s need for smaller more frequent meals. The facility policy dated 6/7/13 regarding weighting of residents was reviewed and read, "It is the policy of Maple Manor to ensure that residents are weighed and a weight record is kept on each resident and monitored routinely." Residents are to be weighed within 3 days of admission and thereafter as ordered by the physician, but at least monthly. R32 had a weight loss of 9.6 pounds in thirty days, declined in eating meals, however, no reassessment was completed to assess weight loss and determine interventions to prevent more weight loss. R32's quarterly Minimum Data Set (MDS) dated 1/9/15 indicated was moderately cognitively impaired with diagnoses of dementia, always incontinent of bowel, and required extensive assist with activities of daily living (eating, toileting, transfers, dressing and hygiene). R32's physician's note dated 12/16/14 included the diagnoses of Lewy body dementia, diabetes mellitus, and constipation. R32's most recent care plan provided by the facility on 1/27/15 included R32 has had a	2 965		

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2 965	Continued From page 72	2 965		

significant weight loss, had a mechanically altered diet with soft textures and nectar thickened liquids. Care plan instructed staff to bring R32 to the dining room and sit at supervised table and is assisted to eat as needed and staff to prompt in proper technique of swallowing per speech therapy (ST) recommendations. The care plan also instructed staff to provide a scoop plate at all meals or a shallow bowl if unable to use a scoop plate and provide double portions at meal times.
R32's physician orders dated 12/16/14 included the following medication orders to treat constipation: Senna-S tablet 2 tabs by mouth three times daily (original order date of 4/16/08), Miralax 17 grams by mouth two times daily (original order date of 4/30/09), and Sorbitol 70% solution 30 milliliters (ml) by mouth one time daily (original order dater of 1/21/09). Physician's orders also included Seroquel 25 milligrams (mg) by mouth at noon and 37.5 mg at 6:00 p.m.
R32's dietary assessment progress notes were reviewed: note on 8/5/14 indicated R32 was independent with eating, weight is stable, no difficulty with swallowing or chewing, and does not eat a lot for lunch or dinner. Note on 9/3/14 indicated R32 switched from regular texture foods to mechanically soft and nectar thickened liquids related to coughing during meals and staff were to monitor intake. Note from 10/24/14 indicated R32 eats 50-75% of meal, had difficulty chewing and swallowing, had a 4.8% weight loss in the last 30 days or 9.5 pounds, and R32 was offered pudding at lunch and supper for weight gain.
Dietary assessment note written on 11/19/14 indicated R32 had a weight loss of 7.3% in 6 months and read, "However, resident has a brace on foot and weight may/may not include brace, staff to monitor weight, intake, notify certified dietary manager, registered dietician."
Dietary assessment note written on 1/16/15

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2 965	Continued From page 73 indicated intake was 50-75% of food at meals and noted an overall weight loss of 20.6 pounds or 10.3% of body weight in 180 days. Dietary assessments lacked a comprehensive assessment and evaluation of weight loss and failed to address interventions that would maintain or regain weight. R32's meal intake documentation from 1/1/15 through 1/26/15 did not show meal intake for 32 meals. Based on documented meal intake R32 consumed an average of 51-75% of breakfast meal, 51-75% of noon meal, and 26-50% for evening meal. Calories consumed or what had been consumed for meals was not tracked. Physician visit note dated 8/14/14 identified one of R32's behaviors as "refuses meals." Physician visit note dated 10/28/14 (visit after dietary assessment had identified a 9.5 pound weight loss in 30 days) had no mention of the weight loss and read " No other active new challenge " Physician visit note dated 12/16/14 indicated R32 ' s appetite was fair, however listed " refuses meals " under behaviors. The note had no mention of the 7.3% weight loss in 6 months. R32 was treated by speech therapy from 8/5/14 through 9/6/14 for recommendations for change in texture of diet related difficulty masticating food and improving ability to swallow fluids safely. On discharge R32 speech therapy indicated resident required verbal cues from staff for safe swallowing and R32 would not regain swallowing function. R32's dining room tray card (card used to communicate dietary information to staff) included the instruction to give double portions at breakfast and provide a scoop plate. During observation of evening meal at 5:00 p.m. on 1/26/15. Nursing assistant (NA)-O was assisting residents at tables to eat. When NA-0	2 965		

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2 965	Continued From page 74 was not assisting R32, he sat with arms folded in lap until NA-0 gave another bite of food. Toward the end of the meal at 5:38 p.m. R32 took a bite of pudding independently. This was the only bite of food R32 took independently throughout the meal. When R32 was moved from the dining table, 75% of food remained on the plate. NA-O did not ask R32 if he was done eating just moved R32 from table. During an observation on 1/28/15 at 8:50 a.m. R32 was brought out to breakfast and was served single sized portions. No scoop plate or shallow bowl was used during 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 until he was given a bite of hot cereal. FA-A did not give verbal cues on use swallowing technique to promote ease of swallowing. R32 did not attempt to eat independently during the meal. During an interview on 1/27/15, at 2:19 p.m. NA-N explained R32 required assistance with eating. NA-N stated, "He does not require any adaptive equipment or special dining needs." During an interview on 1/27/15, at 2:23 p.m. NA-O stated, " Sometimes he eats and sometimes he doesn't, somebody needs to sit next to him the entire time during the whole meal." During an interview on 1/27/15, at 2:25 p.m. licensed practical nurse (LPN)-D stated, "75% of the time he needs to be fed. Aide staff should be sitting in close proximity ..." During an interview on 1/27/15, at 2:30 p.m. certified dietary manager (CDM) explained R32 received double portions at breakfast because he ate more at breakfast. CDM also explained he averaged the range of meal intakes from the nursing assistant documentation, and there was not a mechanism that identified exactly how much	2 965		

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2 965	Continued From page 75 or what a resident consumed. The CDM stated the resident had not been on a dietary supplement yet and nursing had not been involved in addressing need for dietary supplements. CDM stated R32 has had a weight loss because of reduced food intake; however no determination had been assessed to determine why he was losing weight. During an interview on 1/27/15, at 3:01 p.m. director of nursing (DON) explained her expectation would be someone should be sitting next to R32 during the entire meal to ensure that he is eating and swallowing correctly. DON further explained when there is a decline or change of condition, nursing should confer with the nurse practitioner, try to identify the root cause (medication, environment, need for assistants, food texture versus disease process), and possibly get speech therapy involved. During an interview on 1/28/15, at 7:35 a.m. registered dietician (RD) stated, "R32 has not been evaluated from a dietary standpoint if he needs more assistance at meals and environment has not been evaluated." During an interview on 1/28/15, at 9:22 a.m. speech therapist (SP)-M stated, "When we saw him he would eat only 25% of his food then allowed staff to feed him up to 75%." SP-M said she was not aware R32 had weight loss and a referral had not been made for her to reevaluate his swallowing/eating status. SUGGESTED METHOD OF CORRECTION: The RD and director of nursing could review current policies and procedures regarding residents who experienced weight loss to ensure their nutritional needs met and the changes in weight are recognized in a timely manner. The RD or director of nursing could complete audits to ensure the correct diet was being provided and monitoring of food intake was being completed	2 965		

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2 965	Continued From page 76 and staff education could be done. The results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21080	MN Rule 4658.0650 Subp. 1 Food Supplies; Clean,free from spoilage Subpart 1. Food. All food must be clean, wholesome, free from spoilage, free from adulteration and misbranding, and safe for human consumption. Canned or preserved food which has been processed in a place other than a commercial food-processing establishment is prohibited for use by nursing homes. This MN Requirement is not met as evidenced by: Based on observation and interview, during the kitchen tour the facility failed to identify when refrigerated foods have expired and should be removed from service and to remove fresh foods that appear they have lost their freshness. This had the potential to affect most residents in the facility. Findings include: The initial kitchen tour on 1/25/15, at 10:11 a.m. was guided by head cook (HC)-A. Observation of the walk in cooler revealed an open bag of romaine lettuce with several brown pieces of lettuce. The bag had a "use by date" of 1/24/15. The head cook verified the lettuce was out of date and stated, "We throw out food that is past the used by date" and then proceeded to toss the	21080	See Federal Regulation responses	3/11/15

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21080	Continued From page 77 lettuce. Observation further revealed 2 bags of liquid pasteurized eggs that were not labeled or dated in a reach in cooler. The Head cook verified the absence of date and label and commented the bags should be dated and labeled. Facility policy General Food preparation and Handling read, "Food in broken packages or swollen cans, or food with abnormal appearance or odor will not be served." Facility policy Food Storage read, "Food should be dated as it is place on the shelves, date marking to indicate the date or day by which a ready to eat, potentially hazardous food should be consumed, sold or discarded will be visible on high risk foods ....all foods should be covered, labeled, and dated." SUGGESTED METHOD OF CORRECTION: The dietary manager or designee (s) could develop and implement policies and procedures, train staff, assure food is stored in am manner to reduce spoilage and to ensure food is discarded by the best used date. Develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21080		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		3/11/15

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21375	Continued From page 78 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to develop policy and procedures to direct infection control practices related to urinary tract infections identification (UTI) and failed to maintain an infection control program that included ongoing surveillance and timely analyzing and trending of data. Five of Five residents (R16, R6, R70, R30, and R69) were reviewed for having urinary tract infection/s (UTIs). The lack of policy, procedure and an effective infection preventions and control program has the potential to affect all 69 residents currently living in the facility. Findings include: LACK OF UTI SYMPTOMS IDENTIFIED: R16, R6, R70, R30, R69 were identified by the facility as having facility acquired urinary tract infections (UTI) but lacked identification of symptoms: R16 was noted on the infection control (IC) logs to have a urinary tract infection (UTI) on 10/17/14. Review of the interdisciplinary team notes (IDT) of 10/8/14 to 10/21/14 noted no signs or symptoms of a UTI documented. R6 was noted on the IC log to have a UTI on 10/27/14 and 12/10/14. Review of the IDT notes for this time period noted no signs and symptoms of infections listed. R70 was noted on the IC log to have a UTI on 9/29/14. The IDT notes were reviewed and no documentation of signs and symptoms of the	21375	See Federal Regulation responses	

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21375	Continued From page 79 infection were found. R30 was noted on the IC log to have a UTI on 10/15/14, 11/7/14, and 11/29/14. The IDT notes were reviewed and lacked identification of signs and symptoms of UTI. R69 was noted on the IC log to have a UTI on 10/7/14, 10/31/14, 11/9/14, and 11/18/14. The IDT notes were reviewed and lacked identification of signs and symptoms of UTI. On 1/27/15 at 2:00 p.m. UTI policies were provided by the director of nursing. The policies included 1) Chronic Urinary Tract Infection Policy dated 5/2/12 and 2) Prevention of UTIs at Risk Residents dated 4/3/12. The policies did not direct staff to evaluate the risk for developing UTIs and did not include signs and symptoms of UTIs and what/when to document. Registered nurse (RN)-A was interviewed on 1/28/15 at 9:40 a.m. RN-A stated he had a form that listed the criteria for infections, but that no policy/directions related to completing the form had been developed. RN-A stated nursing was to document the criteria for infections observed in the nursing notes. On 1/28/15 at 10:10 a.m. RN-A and the director of nursing (DON) were interviewed. They both indicated the facility did not have a list of infection or UTI criteria available to staff to use and document from as a tool. They stated the facility did not have a policy/procedure on the management of urinary tract infections. LACK OF ANALYSIS AND SURVEILLANCE OF INFECTIONS TO PREVENT THE SPREAD OF INFECTION:	21375		

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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 provided when LPN-C had just completed the record keeping on 1/26/15 at 6:30 p.m. Also LPN-C said she had not started to complete the January 1 to 26, 2015 infection log. On 1/29/15 at 5:00 p.m. the director of nursing indicated LPN -C had been designated as the Infections preventionist (This person will serves as coordinator of the infection preventions and control program). DON continued to say there was no analysis of information related to infections completed. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service employees responsible for infection control program to include tracking, evaluating, interventions to prevent the spread of infection. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		

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21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		3/11/15

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21530	Continued From page 82 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication irregularities identified by the consultant pharmacist were addressed in a timely manner for 3 of 3 residents (R39, R68 and R32) reviewed for unnecessary medications. Findings include: R39's face sheet identified that R39 was admitted on 1/7/2015 and R39 received Seroquel an antipsychotic daily without having a base line side effects assessment completed per the pharmacist recommendation. The dismissal summary from the hospital dated 1/7/15 identified R39 had diagnoses to include mild dementia, chronic left ventricular diastolic heart failure, atrial fibrillation, hypertension, history of transient ischemic attack (TIA), diabetes mellitus, type 2 with diabetic proliferative retinopathy, anxiety and depression and history of probable Bonnet Syndrome (a condition among people who have lost their sight. It causes visual hallucinations). The admission Minimum Data Set (MDS) dated 1/14/15 indicated that R39 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated cognitively intact. 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).	21530	See Federal Regulation responses	

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21530	Continued From page 83 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 R39 should have had an AIMS completed before the first MDS assessment (which was completed on 1/14/15). 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. A policy titled AIMS, dated 6/3/03, instructed staff that an AIMS form would be filled out on new and re-admissions for any resident on the following: (1) anti-psychotic medication. R68 received an antipsychotic medication (Seroquel) and was not monitored for possible side effects.	21530		

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21530	Continued From page 84 On 1/28/15, at 8:14 a.m. R68 was observed in room and seated calmly in wheelchair. R68 did not protest when nursing assistant (NA)-B suggested to braid R68's hair. R68 had a firm handshake with surveyor and R68 stated, "Thank you" pleasantly to compliment about looking nice with the braided hair. R68 smiled as NA-B pushed R68 out from room toward the dining room for breakfast. On 1/28/15 at 1:49 p.m. NA-C was asked if she saw R68 have unwanted behaviors and NA-C said she had not observed R68 manifesting negative behaviors or delusions or hallucinations. On 1/28/15 at 1:52 p.m. NA-B stated she would redirect any resident manifesting a behavior but denied having observed any delusions or hallucinations from R68. NA-C was not aware R68 was being monitored for delusions or hallucinations. On 1/28/15 at 2:08 p.m. registered nurse (RN)-C enumerated R68's target behaviors as "angry, yelling, making noise, does not like everybody." RN-C stated nurses will document in the progress notes when target behaviors and/or possible side effects of medications occur, otherwise no documentation was needed. RN-C stated that nurses do not check orthostatic blood pressures even with the use of anti-psychotic medications if there was no doctor's order. RN-C did not mention about R68's hallucinations and delusions being monitored. On 1/28/15 at 4:02 p.m. RN-A stated R68's target behaviors include making accusations, also had "delusions about staff who were doing catheterization on [R68] were a bunch of lesbians	21530		

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trying to take advantage of [R68]." RN-A verified the specific target behaviors he mentioned were not written in behavior monitoring sheet. RN-A stated nurses will chart if the behaviors occur. When asked if side effects of psychotropic medications were being monitored, RN-A replied, "Probably not because they said no need to monitor." When asked who " They" were, RN-A 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.

The care plan dated 1/27/14 indicated R68 was at risk for falls related to psychotropic medication use. Interventions include giving medications per orders. However, side effects of psychotropic medications in relation to falls were not identified and were not specifically planned to be monitored.

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

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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.

On 1/29/15, at 1:25 p.m. the consultant pharmacist (CP) stated his expectations that side effects of any medications should be monitored. CP agreed orthostatic blood pressure and AIMS should be completed to determine if side effects developed while on anti-psychotic medications.

On 1/29/15 at 1:28 p.m. RN-E stated they were unable to locate an AIMS assessment. At 1:43 p.m. the director of nursing (DON) verified there was no record on file to show AIMS was completed for R68 within the last year even though the resident had received the antipsychotic medication.

The facility's Use of Psychotherapeutic Medications policy dated 4/11/08, directed staff to monitor drugs for side effects daily, to include monitoring for gait disorders, movement disorders, signs of hypotension, and cholinergic effects such as dry mouth and urinary retention. The policy further directed staff to assess for baseline AIMS and to do reassessment every three months for the use of antipsychotic medications.

R32 received three bowel medications and there was no physician justification for need of three bowel medications and exceeded recommended dose of Miralax.
R32's physician's note dated 12/16/14 included the diagnoses of Lewy body dementia, diabetes mellitus, and constipation.
R32's physician orders dated 12/16/14 included the following medication orders to treat

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21530	Continued From page 87 constipation: Senna-S tablet 2 tabs by mouth three times daily (original order date of 4/16/08), Miralax 17 grams by mouth two times daily (original order date of 4/30/09), and Sorbitol 70% solution 30 milliliters (ml) by mouth one time daily (original order dater of 1/21/09). The dose of Miralax ordered exceeds the daily recommended dose according to the manufacturers label that indicated the adult daily dose was 17 grams vs. double ordered by doctor. The directions indicated not to use more than 7 days and instructed not to take more than 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 different formats; paper flow sheet and electronic medical record. Documentation was found to be inconsistent between the two formats. Documentation revealed R32 routinely had more than one BM daily. The electronic form of documentation lacked consistency (soft, formed, hard, etc.) and size (small, medium or large) of BMs and the paper flow chart lacked consistency of BMs. This lack of information would make it difficult to determine if the medication was affective or was too much as R32 went daily. The last physician ' s assessment and evaluation that justified the need for three medications for bowel regime (polypharmacy) medication was last addressed on April 30, 2009. The documentation read, " ...does not tolerate suppositories ...and will become angry at times ....does have very large bowel movements with suppositories and if not given he may not have a bowel movement for up to 5 or 6 days. Physician progress notes reviewed did not indicate rationale	21530		

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21530	Continued From page 88 for prescribing more than manufacturer's daily Miralax recommended dose. R32's quarterly Minimum Data Set (MDS) dated 1/9/15 indicated was moderately cognitively impaired with diagnoses of dementia, always incontinent of bowel, and required extensive assist with activities of daily living (toileting, transfers, dressing and hygiene). R32's care plan did not address constipation or history of constipation or non-pharmacological interventions to promote bowel movements such as increased fluids, adding roughage to diet, increased activity, maintaining routine daily bowel habits, use of toilet or commode, etc. During an interview on 1/27/15, at 2:05 p.m. registered nurse (RN)-A indicated he was not aware of specific reasons why R32 had 3 different bowel medications. RN-A also did not know why the dose of Miralax was higher than recommended. RN-A stated he was not aware of an assessment or physicians recent justified for use of the three bowel medications. During an interview on 1/27/15, at 3:34 p.m. consulting pharmacist (CP) stated if a resident has a diagnoses that required more than a recommended dose of medication it should be care planned and the physician to address or note the reasons for the increased amount and then monitor routinely. During an interview on 1/30/15, at 9:30 a.m. nurse practitioner (NP) stated, "[R32 ' s] bowel medication should be looked at and reduced." After informing NP of R32 ' s three bowel medication and daily bowel movements. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage and for follow-up on pharmacist recommendations. Staff could be	21530		

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21530	Continued From page 89 educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21535	See Federal Regulation responses	3/11/15

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21535	Continued From page 90 review, the facility did not ensure adequate side effects monitoring was completed or other like assessment tool to determine side effects for the use of psychotropic medications for 1 of 5 residents (R68) who received Seroquel and antipsychotic medication; failed to ensure an ongoing bowel assessment for use of three bowel medications or a current physicians justification as to why they are necessary for 1 of 5 residents (R32) reviewed for unnecessary medications. Findings include: R68 received an antipsychotic medication (Seroquel) and was not monitored for possible side effects. On 1/28/15, at 8:14 a.m. R68 was observed in room and seated calmly in wheelchair. R68 did not protest when nursing assistant (NA)-B suggested to braid R68's hair. R68 had a firm handshake with surveyor and R68 stated, "Thank you" pleasantly to compliment about looking nice with the braided hair. R68 smiled as NA-B pushed R68 out from room toward the dining room for breakfast. On 1/28/15 at 1:49 p.m. NA-C was asked if she saw R68 have unwanted behaviors and NA-C said she had not observed R68 manifesting negative behaviors or delusions or hallucinations. On 1/28/15 at 1:52 p.m. NA-B stated she would redirect any resident manifesting a behavior but denied having observed any delusions or hallucinations from R68. NA-C was not aware R68 was being monitored for delusions or hallucinations. On 1/28/15 at 2:08 p.m. registered nurse (RN)-C	21535		

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enumerated R68's target behaviors as "angry, yelling, making noise, does not like everybody." RN-C stated nurses will document in the progress notes when target behaviors and/or possible side effects of medications occur, otherwise no documentation was needed. RN-C stated that nurses do not check orthostatic blood pressures even with the use of anti-psychotic medications if there was no doctor's order. RN-C did not mention about R68's hallucinations and delusions being monitored.

On 1/28/15 at 4:02 p.m. RN-A stated R68's target behaviors include making accusations, also had "delusions about staff who were doing catheterization on [R68] were a bunch of lesbians trying to take advantage of [R68]." RN-A verified the specific target behaviors he mentioned were not written in behavior monitoring sheet. RN-A stated nurses will chart if the behaviors occur. When asked if side effects of psychotropic medications were being monitored, RN-A replied, "Probably not because they said no need to monitor." When asked who " They" were, RN-A 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

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21535	Continued From page 92 12.5 mg every afternoon; Remeron (antidepressant) 15 mg during hours of sleep. The care plan dated 1/27/14 indicated R68 was at risk for falls related to psychotropic medication use. Interventions include giving medications per orders. However, side effects of psychotropic medications in relation to falls were not identified and were not specifically planned to be monitored. 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. On 1/29/15, at 1:25 p.m. the consultant pharmacist (CP) stated his expectations that side effects of any medications should be monitored. CP agreed orthostatic blood pressure and AIMS should be completed to determine if side effects developed while on anti-psychotic medications. On 1/29/15 at 1:28 p.m. RN-E stated they were unable to locate an AIMS assessment. At 1:43 p.m. the director of nursing (DON) verified there was no record on file to show AIMS was completed for R68 within the last year even though the resident had received the antipsychotic medication. The facility's Use of Psychotherapeutic Medications policy dated 4/11/08, directed staff to monitor drugs for side effects daily, to include monitoring for gait disorders, movement	21535		

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disorders, signs of hypotension, and cholinergic effects such as dry mouth and urinary retention. The policy further directed staff to assess for baseline AIMS and to do reassessment every three months for the use of antipsychotic medications.

R32 received three bowel medications and there was no physician justification for need of three bowel medications and exceeded recommended dose of Miralax.
R32's physician's note dated 12/16/14 included the diagnoses of Lewy body dementia, diabetes mellitus, and constipation.
R32's physician orders dated 12/16/14 included the following medication orders to treat constipation: Senna-S tablet 2 tabs by mouth three times daily (original order date of 4/16/08), Miralax 17 grams by mouth two times daily (original order date of 4/30/09), and Sorbitol 70% solution 30 milliliters (ml) by mouth one time daily (original order dater of 1/21/09).
The dose of Miralax ordered exceeds the daily recommended dose according to the manufacturers label that indicated the adult daily dose was 17 grams vs. double ordered by doctor. The directions indicated not to use more than 7 days and instructed not to take more than 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 different formats; paper flow sheet and electronic medical record. Documentation was found to be inconsistent between the two formats. Documentation revealed R32 routinely had more than one BM daily. The electronic form of documentation lacked consistency (soft,

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21535	Continued From page 94 formed, hard, etc.) and size (small, medium or large) of BMs and the paper flow chart lacked consistency of BMs. This lack of information would make it difficult to determine if the medication was affective or was too much as R32 went daily. The last physician ' s assessment and evaluation that justified the need for three medications for bowel regime (polypharmacy) medication was last addressed on April 30, 2009. The documentation read, " ...does not tolerate suppositories ...and will become angry at times ....does have very large bowel movements with suppositories and if not given he may not have a bowel movement for up to 5 or 6 days. Physician progress notes reviewed did not indicate rationale for prescribing more than manufacturer's daily Miralax recommended dose. R32's quarterly Minimum Data Set (MDS) dated 1/9/15 indicated was moderately cognitively impaired with diagnoses of dementia, always incontinent of bowel, and required extensive assist with activities of daily living (toileting, transfers, dressing and hygiene). R32's care plan did not address constipation or history of constipation or non-pharmacological interventions to promote bowel movements such as increased fluids, adding roughage to diet, increased activity, maintaining routine daily bowel habits, use of toilet or commode, etc. During an interview on 1/27/15, at 2:05 p.m. registered nurse (RN)-A indicated he was not aware of specific reasons why R32 had 3 different bowel medications. RN-A also did not know why the dose of Miralax was higher than recommended. RN-A stated he was not aware of an assessment or physicians recent justified for use of the three bowel medications. During an interview on 1/27/15, at 3:34 p.m. consulting pharmacist (CP) stated if a resident	21535		

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21535	Continued From page 95 has a diagnoses that required more than a recommended dose of medication it should be care planned and the physician to address or note the reasons for the increased amount and then monitor routinely. During an interview on 1/30/15, at 9:30 a.m. nurse practitioner (NP) stated, "[R32 ' s] bowel medication should be looked at and reduced." After informing NP of R32 ' s three bowel medication and daily bowel movements. SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written under this licensing order. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure expired medications were removed from 1 of 2 medication rooms located on the East/West Medication Room and from 3 of 3 medications carts; in addition the facility did not ensure insulin was dated when when opened to determine expiration date for 1 of 1 resident (R63).	21550	See Federal Regulation responses	3/11/15

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21550	Continued From page 96 Findings include: On 1/28/15, at 2:28 p.m. the East/West medication storage room was inspected and several expired medications were observed that included the following: R1's half full bottle of Antacid expired on 8/2014; R69's half full bottle of Bisacodyl (laxative) 5 mg tablets labeled with two expiration dates. The pharmacy label indicated expiration date as 6/2014 while the manufacturer's label indicated expiration date as 6/2015. RN-C stated the facility would go by the pharmacy label of 6/2014. On 1/29/15, at 9:36 a.m. the East medication cart contained R15's Lacrilube eye ointment. The eye ointment expired on 12/2014 On 1/29/15, at 9:49 a.m. the West medication cart contained a facility stock of Geri-lanta (antacid) that expired on 11/2014. On 1/29/15, at 2:15 p.m. the North Medication cart contained R5's half full bottle of Senna (stool softener) that expired 10/2013; R44's unopened bottle of Nitrostat 0.4 milligram (mg) that expired on 2/2014. On 1/28/15, at 2:45 p.m. during inspection of the North/South medication refrigerator, R63's Lantus insulin was observed to have been opened but did not have a date it was opened as it expires in 30 days from opening for use. The Physician's Orders Sheet (POS) dated 1/29/15 indicated R63 had diabetes with renal manifestations. The POS further indicated R63 was to be given Lantus 20 units by sub-cutaneous injection daily at noon. During interview on 1/28/15, at 2:28 p.m.,	21550		

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21550	Continued From page 97 registered nurse (RN)-C stated all nurses were responsible in making sure that medications in store for use were not expired. On 1/29/15, at 2:15 p.m. licensed practical nurse (LPN)-D and nursing assistant (NA)-K stated the expired medications should have been removed from carts and discarded. On 1/29/15, at 1:25 p.m. the consultant pharmacist stated as safety precaution, expired medications should be removed from medication storage rooms and carts and time sensitive medications such as insulins must be labeled when opened. An undated policy on Medication Storage in the Facility provided that outdated medications are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from pharmacy if a current order exists. The policy further gave directions for staff to monitor medication storage quarterly. The facility's Policy on Stocking Regular Insulin dated 7/12/04, indicated once a bottle of insulin has been opened, the bottle needs to be dated, and the bottle will expire 30 days from that date. SUGGESTED METHOD OF CORRECTION: The director of nursing and or pharmacist can educate all staff responsible for medicaiton storage to remove outdated medications to prevent unwanted use by resident/s. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		

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21565	Continued From page 98	21565		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident (R96) was assessed and provided the opportunity to self-administer medications. Findings include: R96 was observed on 1/25/15 at 12:00 p.m. R96 was observed to eat regular meals and was interviewed and she knew foods allowed to eat related to her gastric by-pass, kidney transplant, and diabetes. On 1/30/15 at 9:15 a.m. R96 indicated that she managed her diabetes independently at home and that the blood sugar was stable. R96 ' s admission Minimum Data Set (MDS) dated 12/9/14 indicated R96 had a brief interview of mental status (BIMS) score of 14 out of a possible 15 points or was cognitively intact. The MDS also noted that R96 had no functional range 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 that nursing did not have a lock box so she could not keep her insulin supplies in her room for	21565	See Federal Regulation responses	3/11/15

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21565	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 insulin 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. The director of nursing (DON) was interviewed on 1/30/15 at 10:45 a.m. DON indicated residents would need to be assessed prior to the self-administration of medications. SUGGESTED METHOD OF CORRECTION: The director of nurses could inservice staff regarding the process for determination of resident capability to safely self-administer medications and provided the opportunity to self-administer medications. An audit could be conducted to identify and assess residents who have the capability to participate in self-administration. This could be part of the quality assurance plan. TIME PERIOD FOR CORRECTION: Twenty One	21565		

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21565	Continued From page 100 (21) days.	21565		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by:	21800		3/11/15

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21800	Continued From page 101 Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or a uniform denial letter to be used by skilled nursing facilities upon termination of all Medicare Part A skilled services; and failed to provide appropriate liability notices for 4 of 5 residents (R28, R66, R77 & R88) reviewed for liability notices; and failed to provide two day notice prior to discharge from Medicare services for 2 of 5 residents (R77, R88) reviewed for liability notices. Findings include: INACCURATE SKILLED NURSING FACILITY ADVANCED BENEFICIARY NOTICE: R77 and R88 received Advance Beneficiary Notice of Noncoverage. However, the form provided was not for skilled nursing facility use. Also no residents in the sample selected option 1 to have their bill submitted to Medicare for review. Document review of the Advance Beneficiary Notice of Noncoverage (Form CMS-R-131 (03/08)) used by the facility, options selection read, " Option 1. I want the (D) Services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles." According to this option, the facility would bill residents until Medicare made a decision and then would refund any payments made by the resident.	21800	See Federal Regulation responses	

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21800	Continued From page 102 Document review of Centers for Medicare and Medicaid Services Advance Beneficiary Notice of Noncoverage, form CMS-R-131, " Skilled nursing facilities (SNF) must use the ABN for items/services expected to be denied under Medicare Part B only. " During interview on 1/28/15, at 2:00 p.m., business office assistant (BOA)-A verified R77 and R88 had received Medicare Part A services, were discharged from Medicare Part A, and remained in the facility. BOA-A verified the Advance Beneficiary Notice of Noncoverage was the only Advance Beneficiary Notice of Noncoverage used by the facility. LACK OF SKILLED NURSING FACILITY ADVANCED BENEFICIARY NOTICE: R28 was discharged from Medicare Part A services on 12/5/14, according to R28's Notice of Medicare Non-Coverage, a Medicare liability notice. R28 remained in the facility. The facility failed to provide Skilled Nursing Facility Advance Beneficiary Notice, a Medicare liability notice that would allow R28 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 R28 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. R66 was discharged from Medicare Part A services on 8/25/14, according to R66 ' s Notice of Non-Coverage, a Medicare liability notice. R66 remained in the facility. Document review of the Notice of Medicare Non-Coverage, revealed a telephone voice message was left and the notice	21800		

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21800	Continued From page 103 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 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 9/22/14, 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. R88 was discharged from Medicare Part A	21800		

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21800	Continued From page 104 services on 9/29/14, according to R88's Notice of Medicare Non-Coverage, a Medicare liability notice, which was signed by representative on 10/2/14, 4 days after Medicare coverage ended. R88 remained in the facility. There was no evidence of when the resident or family was notified of non-coverage prior to Medicare coverage ending. R88 received Skilled Nursing Advanced Beneficiary Notice, signed by representative on 10/2/14, 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 R88 the required 2 days prior to discharge from Medicare services. During interview on 1/28/15, at 2:00 p.m., BOA-A verified R28, R66, R77, and R88 had received Medicare Part A services, were discharged from Medicare Part A, and remained in the facility. BOA-A verified the facility lacked evidence of resident or representative notification. BOA-A stated the facility did not have a written policy or procedure for liability notices. SUGGESTED METHOD OF CORRECTION: The administrator could review and revise policies and procedures to ensure staff provide the appropriate liability notices at the end of Medicare services and to ensure resident rights are acted upon. The administrator could educate all appropriate staff to provide the liability notices. The administrator could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights	21805		3/11/15

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	00916	A. BUILDING: _____ B. WING _____	01/30/2015

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21805	Continued From page 105 Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote dignity for 10 of 10 residents (R51, R10, R52, R61, R65, R34, R3, R30, R42, and R26) who received assistance to eat there was a folder on the table which was visible to other residents, staff and visitors; failed to allow residents time to eat before cleaning the table of food debris and parked food scraps next to table; and failed to cover urine collection bag to promote dignity for 1 of 1 resident (R68) who was observed with an uncovered urine collection bag with visible urine. Findings include: Residents who received assistance with eating at a table with a folder that said,"Feeder table." R51, R10, R52, R61, R65, R34, R3, R30, R42 were identified by the facility to be assisted to eat at one table in the east/west dining room labeled for residents who needed assistance to eat. One dining room table in the east/west dining room was a folder resting on top of the table which read, "Feeder table." The east/west dining room had one table with a folder which sat upright on the table. The outside of the folder stated "Stays @ Feeder Table" and "Mark after every meal."	21805	See Federal Regulation responses	

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21805	Continued From page 106 During dining observations in the east/west dining room on 1/27/15, at 12:10 p.m., five residents were eating positioned at the large table on the south side of the dining room (south table) where residents who needed assistance to eat were observed to sit. A folder was observed upright on the table. The folder was labeled in large letters "Stays @ Feeder Table" and "Mark after every meal." During interview on 1/27/15, at 12:12 p.m., paid feeding assistant (PFA)-A verified the folder on the table was labeled "Stays @ Feeder Table." PFA-A stated the folder contained the list of residents nursing assistants assisted to feed, residents who received thickened liquids, and residents at risk for aspiration. During interview on 1/27/15, at 3:03 p.m., certified dietary manager (CDM)-C stated the folder on the east/west dining room south table labeled "Stays @ Feeder Table" was a folder used by nursing. During interview on 1/27/15, at 3:25 p.m., director of nursing verified the folder sitting on a dining room table labeled "Stays @ Feeder Table" was not appropriate and should not be used. During interview on 1/30/15, at 8:15 a.m., registered nurse-E (RN-E) verified R51, R10, R52, R61, R65, R34, R3, R30, R42 ate at the east/west dining room south table. Document review of facility policy Privacy and Dignity Audit Procedure dated 12/19/06, read, "It is the policy of Maple Manor Health Care & Rehabilitation to provide all residents with privacy and dignity during cares and in activities of daily living."	21805		

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21805	Continued From page 107 Document review of facility policy Maple Manor Resident's Rights policy dated 3/6/08, read, "All residents at Maple Manor Nursing Home are to be treated with consideration, respect and full recognition of his/her dignity and individuality including privacy in treatment and in care of his/her personal needs." Residents eating while staff began cleaning the area near them: During dining observations in the east/west dining room on 1/26/15, at 5:21 p.m., dietary aide (DA)-E pushed a bus cart into the east/west dining room up to a table where a resident was finishing eating her meal. DA-E cleared soiled dishes and placed on the bus cart. DA-D scraped foods into a bucket on the bus cart. During interview on 1/27/15, at 3:03 p.m., certified dietary manager (CDM)-C stated he expected soiled dishes and foods placed into a garbage container on the bus cart after all residents were finished eating at a table. CDM-C stated the bus cart was not to be in the dining room. CDM-C stated he expected staff cleared off the tables, carried soiled dishes and foods into the hallway and placed on the bus cart. During observations on 1/30/15, at 1:05 p.m., DA-D was observed to push the bus cart into east/west dining room up to touching the table where five residents in wheelchairs were completing their meal. DA-D began to clear off soiled dishes and placed on the bus cart. DA-D scraped foods into a bucket on the bus cart. Document review of facility policy Privacy and Dignity Audit Procedure dated 12/19/06, read, "It is the policy of Maple Manor Health Care &	21805		

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Rehabilitation to provide all residents with privacy and dignity during cares and in activities of daily living."

Document review of facility policy Maple Manor Resident's Rights policy dated 3/6/08, read, "All residents at Maple Manor Nursing Home are to be treated with consideration, respect and full recognition of his/her dignity and individuality including privacy in treatment and in care of his/her personal needs."

Staff stood to assist residents to eat and staff went from one resident to another while assisting residents to eat:

R26 sat with three other residents at a table and was observed during the noon meal on 1/25/15 at 11:45 a.m. No resident at this table made the attempt to eat independently. Nursing assistant (NA)-F loudly spoke across the table at 11:47 a.m. telling R26 to eat the lunch because it was getting cold. R26 was observed to use her fingers to eat cooked carrots. NA-F told R26 to use your fork twice. At 12:00 p.m. R26 pushed away her plate after eating only carrots. No staff intervened to encourage R26 to eat more of her meal.

At 5:09 on 1/26/15 the evening NA-O was observed to be standing while assisting a resident to eat. NA-O then moved to another table and while standing assisted the residents to eat. At 5:12 p.m. it was noted that 2 of the 4 residents sitting at the west table were sleeping in their wheelchair and shortly after this observation NA-O left the dining room. Four minutes later at 5:16 p.m. NA-O returned to the dining room and again stood to assist residents to eat. At 5:18 p.m. NA-O moved to the next table and stood

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while assisting R32 and another resident to eat. Between 5:16 p.m. and 5:29 p.m. the NA-O was observed to walk from one resident to another resident standing while assisting 5 different residents to eat. At 5:20 p.m. NA-O left the dining room stating that she would return tomorrow. No other staff assisted these residents to eat and with food remaining on plates they were moved from the dining room by NA-P and RN-A.

The director of nursing (DON) was interviewed on 1/27/15 at 3:01 p.m. DON indicated her expectations were that staff would sit beside the resident she was helping. DON stated she realized there was a problem with that since everybody needed to be fed in the north dining room. DON stated the facility needed to change that.

Lack of covering urine collection bag to promote dignity:

R68 had Foley catheter with urine visible in collection bag that was not covered consistently to promote dignity.

On 1/21/15, at 7:15 a.m. R68's room door was open, R68 was observed lying in bed. R68's indwelling Foley catheter bag was also observed lying flat on top of R68's blanket in bed, on the foot part. The uncovered catheter bag and tubing could be seen from the door, with the bag showing small amount of yellow-colored urine. The exposed part of the catheter tubing was also filled with yellow colored urine. At 7:45 a.m. registered nurse (RN)-C verified R68's catheter bag was on top of bed. At 7:38 a.m. R68's room door was open. R68 was still lying in bed. The uncovered catheter bag was still on top of bed, and visible from the hallway. At 8:14 a.m. Nursing

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21805	Continued From page 110 assistant (NA)-B was interviewed and confirmed R68's catheter bag was lying on top of bed. At this time NA-B stated nursing assistant's empty the bag every shift and must have been placed by the night shift on top of R68's bed. Also NA-B stated the catheter bag should always be hanging below R68. NA-B added, the urine bag should be placed in a blue bag and hooked "here " (pointing to a loop-like attachment on bed frame). R68's Admissions Face Sheet printed on 1/29/15, indicated R68 had diagnoses including psychosis, dementia, depression, anxiety state and urinary retention. The Physician's Orders Sheet (POS) dated 11/1/14 indicated R68's urinary drainage bag should be kept below bladder level to prevent reflux, maintain a closed drainage system. The POS further indicated bag "to be kept in cloth (blue canvass) bag to prevent infection and provide dignity." R68's care plan dated 10/20/14 indicated R68 required indwelling Foley catheter due to urinary retention. Also drainage bag to be kept in a blue canvass bag to prevent infection and "provide dignity." The facility's Catheter Care Policy dated 7/9/09, directed staff to secure bag on side of bed frame, not to allow bag to touch the floor, to keep the bag below level of bladder at all times and to be inside a blue dignity bag. SUGGESTED METHOD OF CORRECTION: The administrator, director or nursing or designee could provide staff education related to dignified dining services and monitor for compliance	21805		

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21805	Continued From page 111 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21805		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	21980		3/11/15

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21980	Continued From page 112 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to investigate and immediately report allegations of missing money and physical abuse to the administrator and designated state agency for 2 of 3 residents (R70 & R29) reviewed for vulnerable adult reports. Findings included: R70's quarterly Minimum Data Set (MDS) dated 11/20/14 indicated R70, had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of eleven, and required extensive assist for activities of daily living of dressing, toileting, transfers, and hygiene. During an interview on 1/26/15, at 1:00 p.m. R70 stated approximately $30.00 went missing out of his drawer about 3 months ago. R70 stated he had won the money at bingo. R70 stated he had not kept money in room since the $30.00 was missing and had made it a habit to deposit bingo winnings in his account with the facility. R70 stated staff was notified of the missing $30.00.	21980	See Federal Regulation responses	

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21980	Continued From page 113 R70 did recall he had talked to the previous administrator about it. During an interview on 1/28/15, at 8:23 a.m. licensed social worker (SW)-A was notified the R70 had reported missing money to this surveyor and stated she had not been aware money had been taken out of R70's drawer. SW-A stated R70 had never reported anything missing that she was aware of. During an interview on 1/29/15, at 8:12 a.m. SW-A stated R70's family member was just informed of the missing money but has not returned her phone call. Also SW-A said she had not reported the missing money to the designated state agency after being informed of it yesterday a.m. R29 made an allegation of abuse but it was not immediately reported to the administrator or to the designated state agency. R29's had a grievance form completed by SW-A indicated an allegation of physical abuse occurred to R29 on 12/5/15. Nursing assistant (NA)-M had reported the incident to the nurse however the allegation was not immediately reported to the administrator nor to the designated state agency (Office of Health Compliance-OHFC). A letter was provided in regards to the allegation of abuse for R29. The letter was written by NA-M who was accused by R29 to have hit her in the face during cares. NA-A wrote, "The second one [reference to an argument] was I was fixing her [R29] pillow and I hold her head up and when I change a different pillow and move my hand I accidentally hit her on her cheek. I apologized to her and told her it was an accident she say it wasn't I did it on purpose and she was going to turn me in." The letter went on to explain NA-M reported the incident to the licensed practical nurse (LPN)-F. During an interview on 1/29/15, at 3:47 p.m.	21980		

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21980	Continued From page 114 SW-A confirmed the incident was not immediately reported or investigated by LPN-F Facility policy Vulnerable Adult Incident Reporting last revised on 2/6/2013 read, "Facility staff are required to notify the administrator immediately of any vulnerable adult incidents and the federal requirement is that the facility is required to report all reportable incidents to the Minnesota Department of Health electronically immediately of knowledge of an alleged incident." Facility policy Resident Abuse Prevention Plan dated 6/30/2009 read, "The facility will report all alleged violations and all substantiated incidents to the appropriate state agencies", and " In the event of suspected maltreatment, the needs of the resident will be immediately assessed, and Notify the resident's responsible party as well as physician as soon as possible. " SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to immediately reporting suspected abuse to the designated state agency/common entry point. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21980		