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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 659W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00950

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245497**

2.STATE VENDOR OR MEDICAID NO.
(L2) **064742000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAVEN HOMES OF MAPLE PLAIN**
(L4) **1520 WYMAN AVENUE**
(L5) **MAPLE PLAIN, MN** (L6) **55359**

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) **10/01/2004**

6. DATE OF SURVEY **05/12/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(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 :
Kathleen Lucas, Unit Supervisor 05/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 06/20/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1987
(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
Posted 07/07/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/23/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245497
June 20, 2017

Mr. Garrett Bothun, Administrator
Haven Homes of Maple Plain
1520 Wyman Avenue
Maple Plain, MN 55359

Dear Mr. Bothun:

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 May 3, 2017 the above facility is certified for or recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 20, 2017

Mr. Garrett Bothun, Administrator
Haven Homes Of Maple Plain
1520 Wyman Avenue
Maple Plain, MN 55359

RE: Project Number S5497027

Dear Mr. Bothun:

On April 7, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 23, 2017. 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 May 12, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 23, 2017, effective May 3, 2017 and therefore remedies outlined in our letter to you dated April 7, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 659W

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(L3) **HAVEN HOMES OF MAPLE PLAIN**
(L4) **1520 WYMAN AVENUE**
(L5) **MAPLE PLAIN, MN** (L6) **55359**

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) **10/01/2004**

6. DATE OF SURVEY **03/23/2017** (L34)

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

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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

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From (a) :
To (b) :

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Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

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18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(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 :
Carlene Lange, HFE NE II — 04/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/23/2017 (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)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
10/01/1987
(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
Posted 05/23/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 13, 2017

Mr. Garrett Bothun, Administrator
Haven Homes of Maple Plain
1520 Wyman Avenue
Maple Plain, MN 55359

RE: Project Number S5497027

Dear Mr. Bothun:

On March 23, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 May 2, 2017, 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 May 2, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (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 June 23, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 23, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 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
	245497	A. BUILDING _____ B. WING _____	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable 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(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;	F 156		4/7/17

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

Electronically Signed | 04/21/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 156	Continued From page 1 (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(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 as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email),	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(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 3 and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must 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. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) 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.	F 156		

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	245497	A. BUILDING _____ B. WING _____	03/23/2017

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F 156	Continued From page 4 (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) 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/ Medicaid or by the facility's per diem rate.	F 156		

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F 156	Continued From page 5 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform residents and/or their families of the updated Combined Federal and Minnesota State Bill of Rights information. This had the potential to affect 35 of 47 residents who resided in the facility and were admitted prior to 11/28/16.	F 156	The facility timely submits this response and plan of correction pursuant to the federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of deficiency was correctly cited or	

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F 156	Continued From page 6 Findings include: R57 was interviewed on 3/22/17, at 3:43 p.m. and stated she was unaware if she had been given a copy of the updated Bill of Rights. On 3/23/17, at 8:14 a.m. the licensed social worker (LSW)-A was interviewed and stated the updated Bill of Rights had been placed in the admission packets and were given to residents on admission. LSW-A stated she went through the building giving the new Bill of Rights to current residents who were cognitively intact; however, she was unable to remember who had received them, and when they were given; she thought it was sometime in December. LSW-A stated she had not documented who had received the Bill of Rights. LSW-A stated the facility was still in the process of providing the Bill of Rights to responsible parties for cognitively impaired residents, further stating the rights were given at care conferences. LSW-A stated there was no documentation to confirm which responsible parties had received the new rights and which hadn't. LSW-A stated she had no way of knowing who had received the new Bill of Rights. The facility policy Resident Rights-Informing dated 6/00, directed "The resident will be asked to sign the Resident's Bill of Rights form to acknowledge receipt of the Bill of Rights. The resident is given the Bill of Rights document. If the resident has a guardian or conservator, the guardian or conservator will be given the Bill of Rights document."	F 156	factually based and is not to be construed as an admission against interest of the facility, the administrator, or of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Haven Home to ensure all residents are provided the current Combined Federal and State Bill of Rights. 1. Regarding cited resident/s: Resident 57 has been given the updated Combined Federal and Minnesota State Bill of Rights. 2. Actions taken to identify other potential residents having similar occurrences: 35 residents admitted prior to 11/28/16 were affected. All 35 residents or responsible parties were given the New Combined Federal and State Bill of Rights by April 7th, 2017. 3. Measures put in place to ensure deficient practice does not recur: The new Combined Federal and Minnesota State Bill of Rights is in the admission packet and is given to residents upon admission. 4. Effective implementation of actions will be monitored by: The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5. Those responsible to maintain compliance will be: Social Services	

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F 156	Continued From page 7	F 156	Director is responsible for compliance.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 279		5/3/17

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F 279	Continued From page 8 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for pocketing liquids in the mouth for 1 of 3 residents (R59) reviewed for activities of daily living (ADL's). Findings include: R59's Face Sheet identified diagnoses that included a history of cerebral infarction (medical term for a stroke), dysphagia (difficulty swallowing), and dementia. R59's quarterly Minimum Data Set (MDS) dated	F 279	The facility timely submits this response and plan of correction pursuant to the federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of deficiency was correctly cited or factually based and is not to be construed as an admission against interest of the facility, the administrator, or of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same.	

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F 279	Continued From page 9 12/21/16, indicated R59 had moderate cognitive impairment. The MDS further identified R59 was independent with eating with supervision, encouragement or cueing. The MDS further identified R59 had no signs or symptoms of a possible swallowing disorder. R59's care plan dated 12/22/16, identified R59 was at risk related to nutritional status and having dementia instructing staff to "observe for chewing or swallowing difficulty." However, the care plan lacked any identification that R59 pocketed fluids and drooled, and lacked associated interventions. On 3/21/17, at 2:10 p.m. R59 was observed in the activities room. A large wet area was noted on the front of her shirt, and clear liquid was running down and hanging from the left side of her mouth. R59 was observed later that evening, at 6:05 p.m. eating supper. No dysphagia or drooling was observed while R59 ate. On 3/22/17, at 1:02 p.m. R59 was observed sitting in the activities room holding a plastic cup with water. R59 was observed with clear liquid running down the left side of her face. R59 used a Kleenex to wipe the clear liquid away from her mouth. The front of her shirt appeared dry. On 3/23/17, at 9:12 a.m. R59 was observed sitting at the table in the activities room. A small plastic cup with water was sitting in front of her, and she was observed with clear liquid on the left side of her face, which dripped onto her lap. R59 reached forward and grabbed a Kleenex box, and used the tissue to wipe the left side of her face. At 9:25 a.m. activities aide (AA)-A came over to R59 and asked if she wanted to join in the activity. As R59 answered yes, a moderate amount of clear	F 279	It is the policy of Haven Home to ensure all residents are provided services by developing comprehensive care plans. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s: Resident 59's comprehensive care plan was reviewed and revised. Resident re-evaluated by the Speech Pathologist. Interventions of offering resident to wear clothing protector during meals or wipe chin as tolerated for drooling, stay in upright position after meals and to monitor for changes in swallowing habits along with monitoring for increased salivation and coughing related to swallowing. 2. Actions taken to identify other potential residents having similar occurrences: An audit was done of all current residents care plans and was completed on April 21, 2017. This audit reviewed skin and dietary care plans to ensure ongoing/current effective and individualized interventions based on individual resident's needs. 3. Measures put in place to ensure deficient practice does not recur: Education was provided to all staff on 4/19/17 on care plans and providing individualized interventions for each resident. Education was provided to MDS Coordinator regarding current and ongoing individualized care plans and interventions. 4. Effective implementation of actions will be monitored by: The facility will complete 8 audits weekly for 6 weeks. The data collected will be presented to the Quality Assessment and Assurance	

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F 279	Continued From page 10 liquid rolled out of her mouth onto her lap. AA-A went to assist another resident, during which, R59 took a sip from the plastic cup, and held it in her mouth before swallowing. R59 did not appear to have difficulty swallowing the liquid. On 3/23/17, at 9:59 a.m. nursing assistant (NA)-A stated R59 did not have any difficulty swallowing; however, would hold liquids in her mouth, but wasn't sure why she did. NA-A further stated R59's saliva dripped from the left side of her mouth, and she would keep tissue by her on the right side of her wheelchair for it. NA-A reported the drooling didn't bother R59, and when R59 had a wet shirt, the staff would try to change it; however, R59 sometimes refused. On 3/23/17, at 10:14 a.m. AA-A was interviewed and stated R59 kept quite a bit of tissue with her. AA-A stated R59 tended to pocket fluids in the mouth, which would come out when R59 spoke. AA-A stated she would tell R59 "remember to swallow" before she answered questions. AA-A reported R59 had pocketed fluids for as long as she could remember. On 3/23/17, at 10:39 a.m. trained medication aide (TMA)-A stated R59 took her pills well; however, sometimes when R59 took her pills, she would just hold the pills and water in her mouth. TMA-A further stated at times when R59 would open her mouth fluids, like water, would come out. TMA-A reported R59 kept tissues on her, and would try to catch the saliva with them. TMA-A was unaware if R59 had been assessed for pocketing fluids, but stated R59 did just fine at meals and did not pocket fluids then. On 3/23/17, at 10:55 a.m. the director of nursing	F 279	Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5. Those responsible to maintain compliance will be: Director of Nursing is responsible for compliance.	

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F 279	Continued From page 11 (DON) stated R59 had a history of drooling related to a CVA (cerebral vascular accident, commonly known as a stroke), and had been assessed by speech and occupational therapies. The DON further stated the therapies noted the drooling, but ruled out dysphagia. The DON reported the pocketing of fluids was more of a behavior, which had been identified by occupational therapy and this behavior was present during psychology visits. The DON reported R59 always kept a box of tissues with her, and would expect staff to assist her if the drooling was excessive. Furthermore, the DON reported R59 was undergoing a significant change assessment and had had a recent room change, noting that any changes or increased stress could increase R59's symptoms and make it worse. The DON acknowledged the pocketing of fluids and drooling were not addressed in her care plan, further acknowledging it would be hard for new staff to know what to do or to monitor R59's symptoms for a change. The DON stated herself and the dietary department needed to communicate the pocketing of fluids and drooling, and would expect the behaviors to be on the care plan. On 3/23/17, at 1:19 p.m. speech therapist (SP)-A stated R59 was evaluated and did have an occasional wetness with oral secretions; however, due to her history of dementia it wasn't uncommon to aspirate a bit of drool, and R59 was not appropriate for thickened liquids or an altered diet as she did not have difficulty during meals, and saliva wouldn't get thickened anyway. SP-A stated she communicated immediately with nursing whenever she did a swallow evaluation. R59's progress note dated 5/10/16, written by	F 279		

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F 279	Continued From page 12 speech therapy identified a swallow evaluation had been performed. The note indicated R59 had no signs of aspiration during meal and recommended a regular diet. It further noted that per the COTA (certified occupational therapy assistant) R59 sometimes holds water sips in her mouth, and drools a bit, but this behavior was not observed during lunch today. The facility policy Care Plans and Care Conferences dated 6/00, directed all care plans are reviewed, updated, and reviewed, and indicated care plans were reviewed initially on admission, with quarterly care conferences, and at a weekly care plan review.	F 279		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with	F 323		4/20/17

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F 323	Continued From page 13 the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a transfer bar was correctly applied to the bed to prevent the potential for injury for 1 of 1 residents (R23) reviewed for accidents. In addition, the facility failed to ensure transfer bars were assessed to determine a resident's ability to utilize the assistive device safely without supervision for 33 of 47 residents utilizing transfer bars on beds. Findings include: R23's 14 day Minimum Data Set (MDS) dated 2/27/17, identified diagnoses that included chronic obstructive pulmonary disease (COPD) that required oxygen therapy. The MDS also identified R23 had minimal difficulty with hearing, had adequate vision with glasses, and was cognitively intact. The MDS further identified R23 required extensive assistance from staff with bed mobility and transfers, and was not steady while moving from seated to standing position. Further, the MDS identified a bed rail was not used. R23's Care Area Assessment (CAA) dated 2/20/17, indicated R23 was at risk for falls related to diagnoses of COPD and coronary artery disease (CAD). The CAA further indicated R23 required assistance with transfers and activities of daily living (ADLs). The CAA directed staff to follow the care plan.	F 323	The facility timely submits this response and plan of correction pursuant to the federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of deficiency was correctly cited or factually based and is not to be construed as an admission against interest of the facility, the administrator, or of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Haven Home to ensure all residents are provided services free of accident hazards/supervision/devices. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s: Resident 23's transfer bar was tightened 3/21/17. Grab bar assessment completed 3/29/17 which indicates resident has weakness and pain and will benefit from a grab bar on right side. Grab bar does not restrict residents movement or restrict residents freedom to get into or out of bed when desired. Grab bar removed from left side of bed. 2. Actions taken to identify other potential residents having similar occurrences: Safety audits completed on	

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F 323	Continued From page 14 R23's care plan dated 3/15/17, identified R23 was at risk for falls, indicating an intervention of transfer handles on the bed to aid with positioning and bed mobility. R23's progress notes from 2/13/17, to 3/22/17, lacked an assessment for the use of an assuasive device (transfer bar) on the bed. R23's physician orders dated 3/22/17 - 3/31/17, lacked an order for the use of transfer bars. R23's therapy note dated 2/14/17, lacked an assessment for transfer bars. On 3/20/17, at 11:04 a.m. R23's bed was observed to have bilateral transfer bars, with the right bar loose from the bed, bending out 10-15 degrees from the side of the bed. On 3/21/17, at 6:18 p.m. R23 stated he used the bars when getting into bed, and verified he felt the transfer bar was loose, but he had not told staff. On 3/21/17, at 6:57 p.m. nursing assistant (NA)-D was interviewed and denied any concerns with R23's transfer bars. NA-D stated if any concern were identified with the transfer bars, it would be reported to maintenance. On 3/22/17, at 9:37 a.m. NA-E was interviewed and stated R23 used the transfer bars to sit up and reposition in bed, and hold onto when getting into bed, mainly using the transfer bar on the right side. NA-E stated if a transfer bar was noted to be loose, maintenance would be informed. On 3/22/17, at 2:09 p.m. maintenance director (MD) was interviewed and stated R23's right	F 323	all transfer handles. Residents identified with transfer handles/grab bars were assessed with Matrix Grab bar/side rail observation. 3. Measures put in place to ensure deficient practice does not recur: Upon discharge if transfer handles are present, they will be removed. When a resident is admitted they will be assessed for need of transfer handle. Safety audits will be done weekly x 4 weeks 4. Effective implementation of actions will be monitored by: Safety Committee ongoing review. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued 5. Those responsible to maintain compliance will be: Director of Environmental Services and Director of Nursing.	

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HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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F 323	Continued From page 15 transfer bar was tightened the evening of 3/21/17. The MD stated there was no work order placed for this transfer bar prior to staff informing him on 3/21/17. The MD also stated there was no process in place to check transfer bars for correct application. On 3/22/17, at 2:38 p.m. registered nurse (RN)-A and the nurse consultant (NC)-A were interviewed. RN-A stated the use of transfer bars are determined by the nursing judgment and resident preference, with therapy also included in the decision. RN-A further stated the facility did not have a formal assessment to use for transfer bars. RN-A stated after maintenance puts transfer bars on a resident's bed, staff observe the resident use them. NC-A stated the assessment is done by observation, and no formal assessment tool is completed at the facility for the use of transfer bars. On 3/22/17, at 3:20 p.m. physical therapy assistant (PTA) denied any involvement with a transfer bar assessment. On 3/22/17, at 3:32 p.m. physical therapist (PT) was interviewed by telephone and denied being included in an assessment for any resident for the use of transfer bars, indicating this is done by nursing. On 3/22/17, at 4:06 p.m. the director of nursing (DON) was interviewed and stated no formal assessment tool was used to determine if a resident was safe to utilize transfer bars. The DON stated the admitting nurse or nurse manager would observe if a resident was able to turn themselves over in bed, or use the transfer bar to sit up in bed, and would request the	F 323		

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F 323	Continued From page 16 transfer bar be placed on the bed if the resident could utilize it. The DON further stated this informal assessment could be done on admission or any time. The DON stated the therapy department was also included in the assessment. The DON stated that at this point, there was nothing in the form of an assessment or progress note indicating an assessment had been completed. The DON verified 33 residents utilized transfer bars, none with assessments for use. The facility policy titled Side Rails - Assessing for Safety dated 7/14, directed staff to alert the RN if a client has any type of side rail, or similar equipment, and the RN will then evaluate whether the side rail appears to be safe for the client.	F 323		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law)	F 356		4/20/17

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F 356	Continued From page 17 (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the nurse staffing posting was current and posted daily over weekends. This had the potential to affect all 47 residents in the facility. Findings include: On 3/20/17, at 6:51 a.m. the nurse staff posting was observed hanging on the wall behind the	F 356	The facility timely submits this response and plan of correction pursuant to the federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of deficiency was correctly cited or factually based and is not to be construed as an admission against interest of the facility, the administrator, or of any	

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F 356	Continued From page 18 central nurse's station. The nurse staff posting was dated 3/17/17, and had not been changed over the weekend. On the same day, at 8:03 a.m. the nurse staff posting had been changed and was observed with the correct date. On 3/22/17, at 1:06 p.m. the health unit coordinator (HUC)-A was interviewed and stated she was responsible for the nurse staff posting. HUC-A reported she worked Monday through Friday and placed the postings for Saturday and Sunday in a calendar kept at the nurse's station. HUC-A further reported the day shift nurses working weekends were responsible for taking the postings out of the calendar and hanging them up. HUC-A stated the staff postings had been in the calendar but hadn't been posted over the weekend, further stating the postings were no longer a priority. HUC-A stated the weekend postings didn't get posted approximately four times a year. On 3/22/17, at 2:39 p.m. the director of nursing (DON) was interviewed and stated the nurse staff posting for weekends were kept in the calendar at the nurse's station. The DON further stated she had been at the facility on Sunday and hadn't posted it stating "it was off my radar." A policy regarding the nurse staff posting was requested but not provided.	F 356	employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Haven Home to ensure posting of nurse staffing information. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s : Updated nursing staff information posted 3/20/17 at 7:30am. Re-educate nursing staff regarding procedure for updating hours. 2. Actions taken to identify other potential residents having similar occurrences: Current procedure revised to establish practice to ensure that nursing hours are posted in a timely manner. 3. Measures put in place to ensure deficient practice does not recur: Education provided to nursing staff on 4/20/17 on posting of nursing hours with emphasis placed on adherence to the current policy and the importance of it being posted timely and accurate with updated changes in staffing throughout the shift. 4. Effective implementation of actions will be monitored by: The HUC will audit daily x 2 weeks, 3 times a week for 2 week, 2 times a week for 2 weeks. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5. Those responsible to maintain	

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F 356	Continued From page 19	F 356	compliance will be: Director of Nursing will ensure compliance.	
F 431 SS=F	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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.	F 431		4/13/17

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F 431	Continued From page 20 (h) Storage of Drugs and Biologicals. (1) 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. (2) 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a system to ensure the disposition of controlled medications (medications that have a high likelihood of abuse) to prevent diversion, which included the timely destruction of narcotics (controlled pain medication). This had the potential to affect all 47 residents currently residing in the facility. Findings include: On 3/23/17, at 11:24 a.m. the director of nursing (DON) was interviewed and stated when a resident was discharged or passed away, any remaining narcotic medications remained in the locked narcotic box in the medication cart until she was in the facility. The DON stated she and another nurse would then remove the medications from the narcotics box, record the remaining amount in the narcotic log book. The	F 431	The facility timely submits this response and plan of correction pursuant to the federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of deficiency was correctly cited or factually based and is not to be construed as an admission against interest of the facility, the administrator, or of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Haven Home to ensure controlled medications are destroyed in a timely matter and according to policy. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s: Stored	

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F 431	Continued From page 21 DON physically took them into her office and placed them in a locked file cabinet. The DON stated she was the only person in the building with a key to the file cabinet, and the cabinet and her office door were always locked. The DON added if there was ever an issue with the count, the facility would problem solve. The DON further stated, "It's usually just an error". If the facility was unable to find the error, their policy would be to report to the State Agency. On 3/23/17, at 11:45 a.m. the DON was observed to unlock the file cabinet in her office. The large drawer held a large amount of controlled substances including several blister packs of pills and several bottles of liquid medication. The DON indicated she and another nurse destroyed the medications monthly, more often if needed, and stated the process included checking the narcotics log book to ensure the correct amount of medication was destroyed. Each medication was written on the Certificate Of Inventory And Destruction Of Controlled Substances form, which they both signed, and the medications were wasted by flushing into the sewer system. Although the controlled medication were to be destroyed monthly or more often if needed, the DON stated she hadn't reconciled or destroyed any medications since 1/18/17, over two months ago. On 3/23/17, at 2:16 p.m. the DON and nurse consultant were observed reconciling the medications. As they counted each medication, the DON verified the amount listed in the narcotics log book, and the nurse consultant listed each medication on the destruction of controlled substances form. Approximately 20 packages of controlled medications in pill form,	F 431	controlled medications were reconciled and destroyed 3/23/17 with the DON and nurse consultant. 2. Actions taken to identify other potential residents having similar occurrences: All residents who have discontinued narcotics have the potential of being affected by this practice. 3. Measures put in place to ensure deficient practice does not recur: Discontinued controlled medications will be reconciled and destroyed according to policy. 4. Effective implementation of actions will be monitored by: Review with consulting pharmacist. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5. Those responsible to maintain compliance will be: Director of Nursing will ensure compliance.	

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F 431	Continued From page 22 including oxycodone, lorazepam, morphine, alprazolam, hydromorphone, methadone, and tramadol were observed to be counted, removed from the packaging, and put into a basin. In addition, the DON and nurse consultant were observed to count and then empty approximately 27 bottles of liquid controlled medications, including morphine, lorazepam, oxycodone, and hydromorphone, into the same basin. The DON and nurse consultant were observed to flush the medications into the sewer system. On 3/23/17, at 2:59 p.m. the consultant pharmacist (CP) was interviewed and recommended that destruction of controlled substances should be done once a month, if not weekly, depending upon the staffing availability. The CP stated he had never had any problems of diversion with the facility; however, the sooner controlled substances were destroyed the less chance there would be for diversion. The CP was unaware of the overflow of controlled substances in the DON's office. The facility's Disposal/Destruction of Expired or Discontinued Medications policy dated 12/1/07, directed unused portions of controlled medications should be destroyed and how to destroy them, however, it did not give a time period in which this should occur.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		4/20/17

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F 441	Continued From page 23 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 441		

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F 441	Continued From page 24 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures were maintained during incontinence care for 1 of 1 resident (R16) observed for personal cares. Findings include: R16's admission Minimum Data Set (MDS) dated 9/27/16, identified R16 had moderate cognitive impairment, was frequently incontinent of bowel, and was totally dependent on staff for toilet use/incontinence care. On 3/20/17, at 9:19 a.m. nursing assistant (NA)-B and NA-C were observed entering R16's room with a mechanical lift to transfer R16 into bed. R16 was transferred into bed, and was assisted	F 441	The facility timely submits this response and plan of correction pursuant to the federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of deficiency was correctly cited or factually based and is not to be construed as an admission against interest of the facility, the administrator, or of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Haven Home to ensure all residents are free of risk of infection. To assure continued compliance the following plan has been put into place	

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F 441	Continued From page 25 to turn from side to side in bed to remove the lift sling. NA-B and NA-C donned gloves, slid down R16's pants and unfastened his incontinence brief. R16 was noted to be incontinent of a large amount of stool. NA-B encouraged R16 to turn on the left side toward NA-C, and used disposable wipes to clean the stool from R16's buttocks. NA-B tossed the wipes into the garbage. When finished, NA-B removed her gloves, used hand sanitizer and left the room, while NA-C assisted R16 to turn onto his back. NA-C stated, "One cold wipe up the front," and used a disposable wipe to clean the remaining stool. Without removing her gloves, NA-C placed and fastened a clean incontinent brief, and pulled up R16's pants. NA-B returned to the room with clean linen. NA-B and NA-C assisted R16 to turn from side to side, and replaced the draw sheet underneath him with a clean draw sheet. Still without removing her gloves, NA-C covered R16 with a blanket, picked up the soiled draw sheet, and held the soiled draw sheet against her side with her elbow while she tied the garbage bag in the garbage can. Without removing the gloves, NA-C carried the unbagged soiled draw sheet and the garbage bag out of R16's room, using her gloved hand to open the door. Without removing the gloves, NA-C walked in the hallway to the soiled utility room, used her elbow to open the door, lifted the lid on the laundry bin with her gloved hand, and tossed the unbagged soiled draw sheet into the bin. NA-C opened the plastic lid on the large garbage can with her gloved hand and threw the garbage bag into the can. NA-C then removed her gloves and washed her hands. On 3/20/17, at 10:07 a.m. NA-C stated, "Many people have different opinions on this. I don't know when you would be given the opportunity to	F 441	1. Regarding cited resident/s: Immediate education with involved staff. 2. Actions taken to identify other potential residents having similar occurrences: An all staff infection control training was held on 04/19/2017. 3. Measures put in place to ensure deficient practice does not recur: Daily audits 5 a day x 1 week, 10 audits per week x 3 weeks. 4. Effective implementation of actions will be monitored by: Ongoing monitoring of infections logs and trends. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5. Those responsible to maintain compliance will be: Infection Control Preventionist.	

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F 441	Continued From page 26 do so [change gloves], unless my gloves are obviously soiled." NA-C verified she did not remove her gloves after wiping R16's peri area of stool and proceeded to carry unbagged, soiled linen and the garbage out of R16's room, in the hallway, to the utility room. NA-C further stated she would typically take the gloves off and put them in the garbage before leaving a resident's room because, "You're not supposed to leave the room with gloves on," and verified that she did not do that. On 3/23/17, at 2:25 p.m. the director of nursing (DON) was interviewed and stated it was the expectation for staff to remove soiled gloves and sanitize or wash hands after completing incontinence care, and prior to touching surfaces and clean linen; and to remove gloves and wash hands prior to leaving residents' rooms. The DON further stated soiled linen should always be bagged before transporting to the utility room. The facility's policy Handwashing/Hand Hygiene dated 7/14, directed staff to wash hands after removing gloves, and to wash hands or use hand sanitizer between resident cares and whenever direct physical contact with a resident took place. The policy lacked direction regarding appropriate glove use to prevent the spread of infection. A facility policy was requested for the transportation of soiled linen but was not provided.	F 441		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional,	F 465		5/3/17

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F 465	Continued From page 27 sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment in a clean and sanitary manner. This had the potential to effect 46 of 47 residents receiving meals from the kitchen. Findings include: On 3/20/17, at 7:08 a.m. during the initial kitchen tour with the certified dietary manager (CDM), the following were observed: A silver cart with a door utilized for placing beverages and side dishes to take to the dining room to serve to residents was observed to have a yellow substance dried on the front frame, approximately 1 inch x 1/4 inch. The cart also had white crumbs scattered across the bottom of the inside of the cart. A walk-in freezer was observed to have ice condensation across the ceiling, approximately 1 1/2 x 3 feet, dripping on the floor. A black mat was observed on the floor of the freezer, which had scattered white areas from the dripping. A tan trash container with a lid was observed next to the dishwashing area, with brown substance splattered on the front, covering approximately	F 465	The facility timely submits this response and plan of correction pursuant to the federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency does exist or that a statement of deficiency was correctly cited or factually based and is not to be construed as an admission against the interest of the facility, the administrator, or of any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified the same. It is the policy of Haven Homes to ensure all residents are provided a safe, sanitary, and comfortable living environment. To ensure continued compliance, the following plan has been put into place 1. Regarding cited area(s): The silver cart used for placing beverages and side dishes has been cleaned. The walk-in freezer will be defrosted. The trash container next to the dishwasher has been cleaned. All large cookie sheets have been cleaned. All hood vents above the stove have been cleaned. The metal sheet behind the steamer has been cleaned. In the dry storage room, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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F 465	Continued From page 28 half of the front of the trash container. A large deep fryer covered with a large cookie sheet type pan was located to the right of the stove. The pan was observed to have splattered grease dried on to it. The hood vents above the stove was noted to have brown dust clinging to it, with a thick covering on four of six panels to the right, closest to the fryer. A steamer was located to the left of the stove, on top of a convection oven. Behind the steamer, on the wall, there was a metal sheet. This metal had a brown dried grease appearing substance and food particles stuck to it. The dry storage area had shelves, and to the right side under the shelve, onions were stored on the bottom shelf. A large amount of dried onion skin was noted on the floor under the shelf, covering approximately 12 x 12 inches. When interviewed at this time, the CDM verified the findings. The CDM stated the cart is to be cleaned after each use. She further stated maintenance had been working on the condensation in the freezer, but the issue had not been resolved. The CDM verified the trash container was pretty dirty. The CDM stated the pan should be cleaned every day after use, and the fryer was used nearly every day. Regarding the hood vents, the CDM stated maintenance was notified a couple weeks prior to clean, but it had not been completed yet. A company was hired to come out to do a thorough cleaning of the hood vents, and was last out in December or January. The dry storage area was to be cleaned	F 465	dried onion skin has been cleaned off the floor. 2. Actions taken to identify other potential areas in the kitchen having similar occurrences: Cleaning schedules have been revised to address all areas. All areas in the kitchen, dry food storage, and freezer have the potential to exhibit poor sanitation. 3. Measures put in place to ensure deficient practice does not recur: Education will be provided to kitchen staff and environmental services by 05/03/2017 regarding cleaning and sanitation policies and scheduling. 4. Effective implementation of actions will be monitored by: Beginning 04/13/2017, the facility will complete food/kitchen/equipment audits 4x a week for 2 weeks, 3X a week for 2 weeks, 2X a week for 2 weeks, and 1X a week for 2 weeks. The data collected will be presented to the Quality Assessment and Assurance Committee quarterly. At that time the Quality Assessment and Assurance Committee will make the decision/recommendation regarding any follow-up audits needing to be continued. 5. Those responsible to maintain compliance will be: The food service manager or designee will be responsible for ensuring all areas, utensils, and equipment in the kitchen remains clean and sanitary.	

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F 465	Continued From page 29 every day. On 3/22/17, at 12:59 p.m. the CDM stated the hoods were cleaned by maintenance Monday night, but the area behind the stove had not been cleaned yet. On 3/22/17, at 2:09 p.m. the environmental services director (ESD) was interviewed and stated the hood vents above the stove are cleaned by an outside company twice a year, and was last done in November or December. ESD further stated there was no schedule for the maintenance department to clean the hood vents on a routine basis. Regarding the freezer condensation, ESD stated it had been looked at, there was no concern with the freezer temperatures, and the kitchen staff would inform him if there was a concern. The ESD further stated the facility has tried different methods to try to get it to stop dripping. A Maintenance Work Order dated 2/24/17, indicated hood filters needed cleaning. This was signed by CDM on 2/24/17, and maintenance on 3/20/17. Review of the facility Maintenance Schedule from 2/19/17 - 3/12/17, instructed the following: - morning aid to wipe down dishwashing area, and wipe off carts - evening aid wash out garbage can by dishwasher and let dry The facility policy Sanitation dated 11/10/14, directed: - all kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects.	F 465		

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F 465	Continued From page 30 - All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. - Carts may be used to transport food to dining areas and soiled dishes back to the dietary department provided that the compartment is sanitized between the transportation of soiled dishes and food. - Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. - The food services manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.	F 465		

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	245497	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/22/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE** **MAPLE PLAIN, MN 55359**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 22, 2017. At the time of this survey, Haven Homes of Maple Plain was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Haven Homes of Maple Plain is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(000) construction. In 1999, an addition was constructed to the southeast and was determined to be of Type II(000) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is centrally monitored for fire department notification. The facility has a capacity of 52 beds and had a census of 47 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
April 13, 2017

Mr. Garrett Bothun, Administrator
Haven Homes of Maple Plain
1520 Wyman Avenue
Maple Plain, MN 55359

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5497027

Dear Mr. Bothun:

The above facility was surveyed on March 20, 2017 through March 23, 2017 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, Health Regulation 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 Teresa Ament, Unit Supervisor at (218) 302-6151.

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
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
	00950	A. BUILDING: _____ B. WING _____	03/23/2017

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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	2 000		

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2 000	Continued From page 1 attached Minnesota 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 dates, 03/20/2107-03/23/2017 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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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 a comprehensive care plan for pocketing liquids in the mouth for 1 of 3 residents (R59) reviewed for activities of daily living (ADL's). Findings include: R59's Face Sheet identified diagnoses that included a history of cerebral infarction (medical term for a stroke), dysphagia (difficulty swallowing), and dementia. R59's quarterly Minimum Data Set (MDS) dated 12/21/16, indicated R59 had moderate cognitive impairment. The MDS further identified R59 was independent with eating with supervision,	2 560		

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2 560	Continued From page 3	2 560		

encouragement or cueing. The MDS further identified R59 had no signs or symptoms of a possible swallowing disorder.

R59's care plan dated 12/22/16, identified R59 was at risk related to nutritional status and having dementia instructing staff to "observe for chewing or swallowing difficulty." However, the care plan lacked any identification that R59 pocketed fluids and drooled, and lacked associated interventions.

On 3/21/17, at 2:10 p.m. R59 was observed in the activities room. A large wet area was noted on the front of her shirt, and clear liquid was running down and hanging from the left side of her mouth. R59 was observed later that evening, at 6:05 p.m. eating supper. No dysphagia or drooling was observed while R59 ate.

On 3/22/17, at 1:02 p.m. R59 was observed sitting in the activities room holding a plastic cup with water. R59 was observed with clear liquid running down the left side of her face. R59 used a Kleenex to wipe the clear liquid away from her mouth. The front of her shirt appeared dry.

On 3/23/17, at 9:12 a.m. R59 was observed sitting at the table in the activities room. A small plastic cup with water was sitting in front of her, and she was observed with clear liquid on the left side of her face, which dripped onto her lap. R59 reached forward and grabbed a Kleenex box, and used the tissue to wipe the left side of her face. At 9:25 a.m. activities aide (AA)-A came over to R59 and asked if she wanted to join in the activity. As R59 answered yes, a moderate amount of clear liquid rolled out of her mouth onto her lap. AA-A went to assist another resident, during which, R59 took a sip from the plastic cup, and held it in her mouth before swallowing. R59 did not appear

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2 560	Continued From page 4 to have difficulty swallowing the liquid. On 3/23/17, at 9:59 a.m. nursing assistant (NA)-A stated R59 did not have any difficulty swallowing; however, would hold liquids in her mouth, but wasn't sure why she did. NA-A further stated R59's saliva dripped from the left side of her mouth, and she would keep tissue by her on the right side of her wheelchair for it. NA-A reported the drooling didn't bother R59, and when R59 had a wet shirt, the staff would try to change it; however, R59 sometimes refused. On 3/23/17, at 10:14 a.m. AA-A was interviewed and stated R59 kept quite a bit of tissue with her. AA-A stated R59 tended to pocket fluids in the mouth, which would come out when R59 spoke. AA-A stated she would tell R59 "remember to swallow" before she answered questions. AA-A reported R59 had pocketed fluids for as long as she could remember. On 3/23/17, at 10:39 a.m. trained medication aide (TMA)-A stated R59 took her pills well; however, sometimes when R59 took her pills, she would just hold the pills and water in her mouth. TMA-A further stated at times when R59 would open her mouth fluids, like water, would come out. TMA-A reported R59 kept tissues on her, and would try to catch the saliva with them. TMA-A was unaware if R59 had been assessed for pocketing fluids, but stated R59 did just fine at meals and did not pocket fluids then. On 3/23/17, at 10:55 a.m. the director of nursing (DON) stated R59 had a history of drooling related to a CVA (cerebral vascular accident, commonly known as a stroke), and had been assessed by speech and occupational therapies. The DON further stated the therapies noted the	2 560		

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2 560	Continued From page 5	2 560		

drooling, but ruled out dysphagia. The DON reported the pocketing of fluids was more of a behavior, which had been identified by occupational therapy and this behavior was present during psychology visits. The DON reported R59 always kept a box of tissues with her, and would expect staff to assist her if the drooling was excessive. Furthermore, the DON reported R59 was undergoing a significant change assessment and had had a recent room change, noting that any changes or increased stress could increase R59's symptoms and make it worse. The DON acknowledged the pocketing of fluids and drooling were not addressed in her care plan, further acknowledging it would be hard for new staff to know what to do or to monitor R59's symptoms for a change. The DON stated herself and the dietary department needed to communicate the pocketing of fluids and drooling, and would expect the behaviors to be on the care plan.

On 3/23/17, at 1:19 p.m. speech therapist (SP)-A stated R59 was evaluated and did have an occasional wetness with oral secretions; however, due to her history of dementia it wasn't uncommon to aspirate a bit of drool, and R59 was not appropriate for thickened liquids or an altered diet as she did not have difficulty during meals, and saliva wouldn't get thickened anyway. SP-A stated she communicated immediately with nursing whenever she did a swallow evaluation.

R59's progress note dated 5/10/16, written by speech therapy identified a swallow evaluation had been performed. The note indicated R59 had no signs of aspiration during meal and recommended a regular diet. It further noted that per the COTA (certified occupational therapy assistant) R59 sometimes holds water sips in her

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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) COMPLETE DATE
2 560	Continued From page 6 mouth, and drools a bit, but this behavior was not observed during lunch today. The facility policy Care Plans and Care Conferences dated 6/00, directed all care plans are reviewed, updated, and reviewed, and indicated care plans were reviewed initially on admission, with quarterly care conferences, and at a weekly care plan review. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could direct staff to revise the resident's care plan to include appropriate interventions for monitoring non pressure related skin conditions. A monitoring program could be established in order to assure on going and effective care plan interventions based on audits and observations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures were maintained during incontinence care for 1 of 1 resident (R16)	21385		

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21385	Continued From page 7 observed for personal cares. Findings include: R16's admission Minimum Data Set (MDS) dated 9/27/16, identified R16 had moderate cognitive impairment, was frequently incontinent of bowel, and was totally dependent on staff for toilet use/incontinence care. On 3/20/17, at 9:19 a.m. nursing assistant (NA)-B and NA-C were observed entering R16's room with a mechanical lift to transfer R16 into bed. R16 was transferred into bed, and was assisted to turn from side to side in bed to remove the lift sling. NA-B and NA-C donned gloves, slid down R16's pants and unfastened his incontinence brief. R16 was noted to be incontinent of a large amount of stool. NA-B encouraged R16 to turn on the left side toward NA-C, and used disposable wipes to clean the stool from R16's buttocks. NA-B tossed the wipes into the garbage. When finished, NA-B removed her gloves, used hand sanitizer and left the room, while NA-C assisted R16 to turn onto his back. NA-C stated, "One cold wipe up the front," and used a disposable wipe to clean the remaining stool. Without removing her gloves, NA-C placed and fastened a clean incontinent brief, and pulled up R16's pants. NA-B returned to the room with clean linen. NA-B and NA-C assisted R16 to turn from side to side, and replaced the draw sheet underneath him with a clean draw sheet. Still without removing her gloves, NA-C covered R16 with a blanket, picked up the soiled draw sheet, and held the soiled draw sheet against her side with her elbow while she tied the garbage bag in the garbage can. Without removing the gloves, NA-C carried the unbagged soiled draw sheet and the garbage bag out of R16's room, using her gloved hand to open	21385		

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21385	Continued From page 8	21385		

the door. Without removing the gloves, NA-C walked in the hallway to the soiled utility room, used her elbow to open the door, lifted the lid on the laundry bin with her gloved hand, and tossed the unbagged soiled draw sheet into the bin. NA-C opened the plastic lid on the large garbage can with her gloved hand and threw the garbage bag into the can. NA-C then removed her gloves and washed her hands.

On 3/20/17, at 10:07 a.m. NA-C stated, "Many people have different opinions on this. I don't know when you would be given the opportunity to do so [change gloves], unless my gloves are obviously soiled." NA-C verified she did not remove her gloves after wiping R16's peri area of stool and proceeded to carry unbagged, soiled linen and the garbage out of R16's room, in the hallway, to the utility room. NA-C further stated she would typically take the gloves off and put them in the garbage before leaving a resident's room because, "You're not supposed to leave the room with gloves on," and verified that she did not do that.

On 3/23/17, at 2:25 p.m. the director of nursing (DON) was interviewed and stated it was the expectation for staff to remove soiled gloves and sanitize or wash hands after completing incontinence care, and prior to touching surfaces and clean linen; and to remove gloves and wash hands prior to leaving residents' rooms. The DON further stated soiled linen should always be bagged before transporting to the utility room.

The facility's policy Handwashing/Hand Hygiene dated 7/14, directed staff to wash hands after removing gloves, and to wash hands or use hand sanitizer between resident cares and whenever direct physical contact with a resident took place.

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21385	Continued From page 9 The policy lacked direction regarding appropriate glove use to prevent the spread of infection. A facility policy was requested for the transportation of soiled linen but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21385		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed	21630		

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21630	Continued From page 10 according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a system to ensure the disposition of controlled medications (medications that have a high likelihood of abuse) to prevent diversion, which included the timely destruction of narcotics (controlled pain medication). This had the potential to affect all 47 residents currently residing in the facility. Findings include: On 3/23/17, at 11:24 a.m. the director of nursing (DON) was interviewed and stated when a resident was discharged or passed away, any remaining narcotic medications remained in the locked narcotic box in the medication cart until she was in the facility. The DON stated she and another nurse would then remove the medications from the narcotics box, record the remaining amount in the narcotic log book. The DON physically took them into her office and placed them in a locked file cabinet. The DON stated she was the only person in the building with a key to the file cabinet, and the cabinet and her office door were always locked. The DON added if there was ever an issue with the count, the facility would problem solve. The DON further stated, "It's usually just an error". If the facility was	21630		

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21630	Continued From page 11 unable to find the error, their policy would be to report to the State Agency. On 3/23/17, at 11:45 a.m. the DON was observed to unlock the file cabinet in her office. The large drawer held a large amount of controlled substances including several blister packs of pills and several bottles of liquid medication. The DON indicated she and another nurse destroyed the medications monthly, more often if needed, and stated the process included checking the narcotics log book to ensure the correct amount of medication was destroyed. Each medication was written on the Certificate Of Inventory And Destruction Of Controlled Substances form, which they both signed, and the medications were wasted by flushing into the sewer system. Although the controlled medication were to be destroyed monthly or more often if needed, the DON stated she hadn't reconciled or destroyed any medications since 1/18/17, over two months ago. On 3/23/17, at 2:16 p.m. the DON and nurse consultant were observed reconciling the medications. As they counted each medication, the DON verified the amount listed in the narcotics log book, and the nurse consultant listed each medication on the destruction of controlled substances form. Approximately 20 packages of controlled medications in pill form, including oxycodone, lorazepam, morphine, alprazolam, hydromorphone, methadone, and tramadol were observed to be counted, removed from the packaging, and put into a basin. In addition, the DON and nurse consultant were observed to count and then empty approximately 27 bottles of liquid controlled medications, including morphine, lorazepam, oxycodone, and hydromorphone, into the same basin. The DON	21630		

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21630	Continued From page 12 and nurse consultant were observed to flush the medications into the sewer system. On 3/23/17, at 2:59 p.m. the consultant pharmacist (CP) was interviewed and recommended that destruction of controlled substances should be done once a month, if not weekly, depending upon the staffing availability. The CP stated he had never had any problems of diversion with the facility; however, the sooner controlled substances were destroyed the less chance there would be for diversion. The CP was unaware of the overflow of controlled substances in the DON's office. The facility's Disposal/Destruction of Expired or Discontinued Medications policy dated 12/1/07, directed unused portions of controlled medications should be destroyed and how to destroy them, however, it did not give a time period in which this should occur. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to remove expired medications. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.	21665		

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21665	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment in a clean and sanitary manner. This had the potential to effect 46 of 47 residents receiving meals from the kitchen. Findings include: On 3/20/17, at 7:08 a.m. during the initial kitchen tour with the certified dietary manager (CDM), the following were observed: A silver cart with a door utilized for placing beverages and side dishes to take to the dining room to serve to residents was observed to have a yellow substance dried on the front frame, approximately 1 inch x 1/4 inch. The cart also had white crumbs scattered across the bottom of the inside of the cart. A walk-in freezer was observed to have ice condensation across the ceiling, approximately 1 1/2 x 3 feet, dripping on the floor. A black mat was observed on the floor of the freezer, which had scattered white areas from the dripping. A tan trash container with a lid was observed next to the dishwashing area, with brown substance splattered on the front, covering approximately half of the front of the trash container. A large deep fryer covered with a large cookie sheet type pan was located to the right of the stove. The pan was observed to have splattered grease dried on to it.	21665		

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21665	Continued From page 14 The hood vents above the stove was noted to have brown dust clinging to it, with a thick covering on four of six panels to the right, closest to the fryer. A steamer was located to the left of the stove, on top of a convection oven. Behind the steamer, on the wall, there was a metal sheet. This metal had a brown dried grease appearing substance and food particles stuck to it. The dry storage area had shelves, and to the right side under the shelve, onions were stored on the bottom shelf. A large amount of dried onion skin was noted on the floor under the shelf, covering approximately 12 x 12 inches. When interviewed at this time, the CDM verified the findings. The CDM stated the cart is to be cleaned after each use. She further stated maintenance had been working on the condensation in the freezer, but the issue had not been resolved. The CDM verified the trash container was pretty dirty. The CDM stated the pan should be cleaned every day after use, and the fryer was used nearly every day. Regarding the hood vents, the CDM stated maintenance was notified a couple weeks prior to clean, but it had not been completed yet. A company was hired to come out to do a thorough cleaning of the hood vents, and was last out in December or January. The dry storage area was to be cleaned every day. On 3/22/17, at 12:59 p.m. the CDM stated the hoods were cleaned by maintenance Monday night, but the area behind the stove had not been cleaned yet. On 3/22/17, at 2:09 p.m. the environmental services director (ESD) was interviewed and stated the hood vents above the stove are	21665		

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21665	Continued From page 15	21665		

cleaned by an outside company twice a year, and was last done in November or December. ESD further stated there was no schedule for the maintenance department to clean the hood vents on a routine basis. Regarding the freezer condensation, ESD stated it had been looked at, there was no concern with the freezer temperatures, and the kitchen staff would inform him if there was a concern. The ESD further stated the facility has tried different methods to try to get it to stop dripping.

A Maintenance Work Order dated 2/24/17, indicated hood filters needed cleaning. This was signed by CDM on 2/24/17, and maintenance on 3/20/17.

Review of the facility Maintenance Schedule from 2/19/17 - 3/12/17, instructed the following:

- morning aid to wipe down dishwashing area, and wipe off carts
- evening aid wash out garbage can by dishwasher and let dry

The facility policy Sanitation dated 11/10/14, directed:
- all kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects.
- All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions.
- Carts may be used to transport food to dining areas and soiled dishes back to the dietary department provided that the compartment is sanitized between the transportation of soiled

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21665	Continued From page 16 dishes and food. - Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. - The food services manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop, review and/or revise policies and procedures to ensure cleanliness of the kitchen and food storage areas. The maintenance director or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21665		
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	21800		

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21800	Continued From page 17 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: Based on interview and document review, the facility failed to inform residents and/or their families of the updated Combined Federal and Minnesota State Bill of Rights information. This had the potential to affect 35 of 47 residents who resided in the facility and were admitted prior to 11/28/16. Findings include: R57 was interviewed on 3/22/17, at 3:43 p.m. and stated she was unaware if she had been given a copy of the updated Bill of Rights. On 3/23/17, at 8:14 a.m. the licensed social	21800		

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21800	Continued From page 18 worker (LSW)-A was interviewed and stated the updated Bill of Rights had been placed in the admission packets and were given to residents on admission. LSW-A stated she went through the building giving the new Bill of Rights to current residents who were cognitively intact; however, she was unable to remember who had received them, and when they were given; she thought it was sometime in December. LSW-A stated she had not documented who had received the Bill of Rights. LSW-A stated the facility was still in the process of providing the Bill of Rights to responsible parties for cognitively impaired residents, further stating the rights were given at care conferences. LSW-A stated there was no documentation to confirm which responsible parties had received the new rights and which hadn't. LSW-A stated she had no way of knowing who had received the new Bill of Rights. The facility policy Resident Rights-Informing dated 6/00, directed "The resident will be asked to sign the Resident's Bill of Rights form to acknowledge receipt of the Bill of Rights. The resident is given the Bill of Rights document. If the resident has a guardian or conservator, the guardian or conservator will be given the Bill of Rights document." SUGGESTED METHOD OF CORRECTION: The administrator or designee could educate staff on policies and procedures to ensure residents/families recieve updated rights in a timely manner and a receipt of them recieving the rights is kept. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21800		

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