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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8D5X

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 **07/07/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
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 :
Brenda Fischer, Unit Supervisor 07/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 07/15/2016 (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 07/29/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/06/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245497
July 15, 2016

Mr. Garrett Bothun, Administrator
Haven Homes of Maple Plain
1520 Wyman Avenue
Maple Plain, Minnesota 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 June 13, 2016 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
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

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 15, 2016

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

RE: Project Number S5497026

Dear Mr. Bothun:

On May 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 5, 2016. 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 July 7, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 6, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 5, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 5, 2016, effective June 13, 2016 and therefore remedies outlined in our letter to you dated May 19, 2016, 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
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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245497 Y1	A. Building B. Wing Y2	7/7/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed
LSC	06/13/2016	LSC	06/13/2016	LSC	06/13/2016
ID Prefix F0329	Correction	ID Prefix F0373	Correction	ID Prefix F0425	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.35(h)	Completed	Reg. # 483.60(a),(b)	Completed
LSC	06/13/2016	LSC	06/13/2016	LSC	06/13/2016
ID Prefix F0428	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.60(c)	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	06/13/2016	LSC	06/13/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 07/15/2016	SIGNATURE OF SURVEYOR 35575	DATE 07/07/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
5/5/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245497	A. Building 01 - MAIN BUILDING 01 B. Wing	6/6/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 06/02/2016	ID Prefix Reg. # NFPA 101 LSC K0066	Correction Completed 06/02/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/KJ	**DATE** 07/15/2016	**SIGNATURE OF SURVEYOR** 37009	**DATE** 06/06/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 5/3/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8D5X

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: **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 **05/05/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
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:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Michelle Koch, HFE NE II — 06/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/30/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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 07/06/2016 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
May 19, 2016

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

RE: Project Number S5497026

Dear Mr. Bothun:

On May 5, 2016, 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:

Pam Kerssen, RN, APM
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 308-2129
Fax: (218) 308-2122

and

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if

your facility has not achieved substantial compliance by June 14, 2016, 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 June 14, 2016 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 August 5, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 5, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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 _____	05/05/2016

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's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the plan of care was followed for 1 of 2 residents (R39) reviewed for assistance with shaving. Findings include: R39's annual Minimum Data Set (MDS) dated 3/30/16, indicated the resident had severe cognitive impairment, needed assistance with daily hygiene, and did not display rejection of cares/behaviors.	F 282	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	6/13/16

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

Electronically Signed | 05/26/2016

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

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F 282	Continued From page 1 R39's current care plan dated 3/31/16, indicated he had an alteration in ADL's (activities of daily living) due to the diagnoses of Parkinson's disease and dementia. R39's care plan directed one person to assist with daily hygiene and was to be shaved every morning. On 5/2/16 at 4:58 p.m., R39 was observed with long white hairs approximately 1/4' (inch) long under the bridge of his nose and along the upper lip. During observation on 5/4/16, at 6:57 a.m. nursing assistant (NA)-F assisted R39 with morning cares. While in the bathroom, NA-F brushed R39's teeth and assisted him to wash his face before walking back to wheelchair. Once in wheelchair, NA-F left R39's room. Continuous observation was performed on until later that morning at 8:51 a.m. when R39 was brought to the dining room for breakfast. No further daily hygiene care were performed. R39 had not been offered shaving. On the same day at 12:58 p.m., R39 was observed in the dining room with the same white hairs on upper lip. New stubble approximately 1/8' long appeared on his face and cheeks. During interview on 5/4/16 at 1:46 p.m., NA-F stated that R39 got shaved on shower days and did not know what day or time it was done. NA-F also stated that R39 sometimes refused and had not been shaven this morning.	F 282	the same. It is the policy of Haven Homes to ensure all residents are provided services by qualified individuals in accordance with their established plan of care. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s: Resident 39 has been shaved. Care plan/NA/R care guide has been updated to encourage resident to allow assistance with shaving on a daily basis. Shaving audits on resident 39 will be conducted periodically as facility does NA/R care audits to ensure shaving is completed in accordance with the resident plan of care. 2. Actions taken to identify other potential residents having similar occurrences: Residents identified as having potential to be affected by area cited are any residents who require staff assistance with shaving. 3. Measures put in place to ensure deficient practice does not recur: Education was provided to care related staff by June 10, 2016 on providing interventions and following the resident care plan/NA/R care guide. Resident care plan and NA/R care guide was updated to reflect the residents ADL interventions. MDS□s will be completed upon admission, quarterly, and with significant change in condition to include interventions needed to ensure resident receives necessary assistance with ADL□S 4. Effective implementation of actions will be monitored by: The facility will complete	

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F 282	Continued From page 2	F 282	five NA/R care observations weekly for 3 months. 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 Acting Director of Nursing is responsible for compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide residents with dementia specific nutritional interventions for 1 of 1 residents (R43) reviewed with progressive dementia. Findings include: R43's minimum data set (MDS), dated 3/15/16, identified R43 as having a severe cognitive impairment and listed diagnoses of Alzheimer's Dementia and Anxiety Disorder. R43's MDS further identified that she needed a mechanically	F 309	It is the policy of Haven Home to ensure all residents receive the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s: Resident 43 is now offered a hand to hold or object to hold while staff are assisting with dining as a dementia focused intervention. Care plan/NA/R care guide has been updated to encourage resident to hold a hand or	6/13/16

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F 309	Continued From page 3 altered diet and extensive assistance with meals. R43's care area assessment (CAA), also dated 3/15/16, identified R43 as having impaired communication related to the diagnosis of Alzheimer's and directed staff to "anticipate needs and continue with plan of care." The nutritional status CAA identified R43 as being fed by staff and had varied intakes. Although weight and BMI (body mass index) had remained stable over the last quarter, the nutritional status CAA stated R43 "has had a decline of 11.5% [body weight] in the last 175 days." On 5/4/16, from 8:44 a.m. to 9:06 a.m., registered nurse (RN)-D was observed assisting R43 with eating in the dining room. RN-D was seated between and slightly behind R43 and another resident. In front of R43 was breakfast consisting of scrambled eggs, pureed toast, and cream of wheat. RN-D attempted to feed R43 two spoonfuls of cereal and one spoonful of eggs. When offered, R43 turned her head away or used left hand to push spoonfuls of food away. After refusals, RN-D would turn and assist other resident and then attempt to feed R43 again. R43 ate only a few bites during observation. RN-D did not converse with R43 during observation, only spoke with R43 to offer food. On 5/4/16, from 9:35 a.m. to 9:53 a.m., RN-A was observed sitting between R43 and another resident, assisting R43 with the same breakfast. RN-A was observed lightly holding R43's left hand and conversing with R43 about horses. RN-A faced R43 when offering her a bite of food. R43 was observed eating more and did not attempt to turn her head or push food away with her left hand. R43 ate approximately 3/4 of the eggs, 1/2	F 309	object to allow assistance with dining. Dining audits on resident 43 will be conducted periodically as facility does dining audits to ensure meal interventions are completed in accordance with the resident plan of care. 2. Actions taken to identify other potential residents having similar occurrences: All residents have the potential to require dining interventions to attain or maintain the highest practicable physical, mental and psychosocial well-being. 3. Measures put in place to ensure deficient practice does not recur: Education was provided to care related staff by June 10, 2016 on providing interventions and following the resident care plan/NA/R care guide. Resident care plan and NA/R care guide was updated to reflect the residents dining interventions. MDS□s will be completed upon admission, quarterly, and with significant change in condition to include interventions needed to attain or maintain the highest practicable physical, mental and psychosocial well-being 4. Effective implementation of actions will be monitored by: The facility will complete three CMS QIS Dining observation audits weekly for 3 months. 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 309	Continued From page 4 the pureed toast, and a few bites of cereal. On 5/4/16, at 9:22 a.m., R43's family member (F)-A was interviewed regarding R43's nutritional status. F-A stated some days some of the staff can get her to eat, other can't. On 5/4/16, at 12:09 p.m., RN-A stated RN-D assisted R43 with eating if extra help was needed. RN-A stated R43 responded to interventions such as holding hands, talking about garage sales or horses, and trying to reapproach her after offering food. RN-A also stated staff was aware of these interventions through training and R43's care plan. However, RN-A was unable to find the interventions on the care plan. On 5/4/16, at 12:41 p.m., the assistant director of nursing (ADON) assisted R43 with eating lunch. The ADON's hand was lightly on top of R43's left hand and she faced R43 while explaining the food to her. R43 made no attempt to push food away with left hand and was observed eating pureed coleslaw. On 5/4/16, at 2:14 p.m., the ADON stated R43 responded to interventions such as making her laugh. The ADON stated the interventions should be in the care plan, and could also be in the communication book. The ADON was unable to find any interventions in the communication book and was unsure if they were in the care plan. The ADON stated she had been told about the interventions for R43. The ADON stated the nursing assistants were encouraged to verbally update one another, however; the paper care sheets carried by the nursing assistants were developed from the care plan.	F 309	compliance will be: The Acting Director of Nursing is responsible for compliance.	

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F 309	Continued From page 5 An untitled nursing assistant sheet, dated 5/4/16, did not list any intervention for R43 related to nutrition or dementia care. R43's care plan, dated 3/17/16, included the diagnoses of alteration in ADL (activities of daily living) and directed staff to assist with eating. A risk for behaviors and rejection of care directed staff to approach R43 calmly and explain tasks. The risk for nutritional deficit directed staff to position R43 to minimize the feeling of being watched. The care plan did not contain interventions related to dementia care and nutrition to assist in minimizing the risk for a deficit.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal grooming was provided for 2 of 3 residents (R22, R39) reviewed for activities of daily living (ADLs) and who was dependent on staff for care. Findings include: R22's annual Minimum Data Set (MDS) dated 4/10/16, identified R22 had intact cognition and	F 312	It is the policy of Haven Homes to ensure grooming assistance is provided to all residents who are dependent on staff for assistance. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s: Resident 22 has had his nails trimmed. Resident 39 has been shaved. Resident 39□s Care plan/NA/R care guide has been updated	6/13/16

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F 312	Continued From page 6 required extensive assistance with personal hygiene. During observation on 5/2/16, at 2:29 p.m. R22 was seated in his room watching television. R22 had long fingernails on both hands, with several nails having a dark colored substance underneath. R22 stated the nursing staff cuts his nails because he was unable to do it himself, and he would like them trimmed and cleaned. "This has to be done." On 5/3/16, at 9:40 a.m. and 5/4/16, at 8:35 a.m. R22 continued to have long fingernails with a dark substance underneath several of the nails. R22's care plan dated 4/27/16, identified R22 had an alteration in his activities of daily living (ADLs), and required, "Assist of 1" for his personal hygiene. When interviewed on 5/4/16, at 1:12 p.m. nursing assistant (NA)-D stated R22 was not resistant with cares and received a weekly shower every Tuesday. R22 required assistance from staff to complete his personal hygiene cares, "We assist him." NA-D observed R22's long fingernails and stated, "They are a little long," and they should be trimmed and cleaned. R22's NA/R (nursing assistant, registered) & (and) HHA (home health aide) Bath Sheet dated 5/3/16, identified R22 received a shower on that date, and provided a space for staff to check if the residents, "Fingernails cut." This space had a black "X" marked in it, indicating R22's nails had been cut when he received his bath. On 5/5/16, at 8:26 a.m. the assistant director of nursing (ADON) stated the NA staff should be	F 312	to encourage resident to allow assistance with shaving on a daily basis. Shaving audits on resident 39 will be conducted periodically as facility does NA/R care audits to ensure shaving is completed in accordance with the resident plan of care. Resident 22□s care plan has been updated to encourage resident to allow nail care to be completed with weekly bath and as needed. Nail care audits on resident 39 will be conducted periodically as facility does NA/R care audits to ensure nail care is completed in accordance with the resident plan of care. 2. Actions taken to identify other potential residents having similar occurrences: Residents identified as having potential to be affected by area cited are any residents who require staff assistance with shaving or nail care. 3. Measures put in place to ensure deficient practice does not recur: Education was provided to care related staff by June 10, 2016 on nail care, shaving and following the resident care plan/NA/R care guide. 4. Effective implementation of actions will be monitored by: The facility will complete five NA/R care observations weekly for 3 months. 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. 5. Those responsible to maintain compliance will be: The Acting Director of	

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F 312	Continued From page 7 marking the bath sheet if nail care was completed. The ADON stated she spoke with the NA responsible for completing R22's bath on 5/3/16. The NA verified she documented trimming his nails, but admitted not completing the cares after being asked. Further, the ADON stated nail care for all residents should be completed, "Every bath day." An undated facility Nail Care policy identified nails, "Will be maintained without irregular/rough areas and clean as evidenced by visibility thus promoting resident's feeling of well-being" The policy directed, "Resident's fingernails will be observed with cares, checked on bath day, and trimmed as needed." R39's annual minimal data set (MDS) dated 3/30/16 indicated that he had severe cognitive impairment, needed assistance with daily hygiene, and did not display rejection of cares behaviors. On 5/2/16 at 4:58 p.m., R39 was observed with long white hairs approximately 1/4' (inch) long under the bridge of his nose and along the upper lip. On 5/4/16 at 6:57 a.m., nursing assistant (NA)-F assisted R39 with morning cares and toileting. While in the bathroom, NA-F brushed R39's teeth and assisted him to wash his face before walking back to the wheelchair. Once in the wheelchair, NA-F left R39's room. Continuous observation was conducted through 8:51 a.m. when R39 was brought to the dining room for breakfast. No further daily morning cares were performed. R39 was not offered assistance with shaving. On 5/4/16, at 12:58 p.m., R39 was observed in	F 312	Nursing is responsible for compliance.	

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F 312	Continued From page 8 the dining room with the same white hairs on his upper lip. New stubble approximately 1/8' long appeared on his face and cheeks. During interview on 5/4/16, at 1:46 p.m., NA-F stated R39 was shaved on shower days and did not know what day or time it was done. NA-F also stated R39 sometimes refused [cares] and confirmed R39 was not shaved this morning. R39's current care plan dated 3/31/16, indicated he had an alteration in ADL (activities of daily living) dependence due to the diagnoses of Parkinson's disease and dementia. R39's care plan further stated he needed one person assist with daily hygiene and was to be shaved every morning. An untitled nurse assistant sheet, dated 5/3/16, identified R39 and directed nursing assistants to shave him every morning. Review of the facility policy titled, Shaving a Resident, identified "Residents who are unable to shave themselves will be shaved by staff." The policy directed staff to shave male residents daily.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		6/13/16

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F 329	Continued From page 9 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete gradual dose reductions (GDR) on psychotropics or provide physician justification for their use for 2 of 5 residents (R39, R12) reviewed for unnecessary medications. Findings include: R39's annual minimal data set (MDS) dated 3/30/16, identified R39 had severe cognitive impairment and took a daily antidepressant medication. R39's signed Physician Order Report dated 4/12/16, identified R39 had current orders for the following psychotropic medications: Started on 7/11/14, Trazodone (anti-depressant) 50 mg at bedtime for insomnia Started on 7/11/14, Trazodone 50 mg tab at bedtime as needed for insomnia	F 329	It is the policy of Haven Homes to ensure all residents drug regimen is free from unnecessary drugs. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s: Resident 39 has been assessed by his GNP resulting in a discontinuation of his scheduled Trazadone. Resident 12 has been assessed by her GNP resulting in a discontinuation of her scheduled clonazepam. 2. Actions taken to identify other potential residents having similar occurrences: The facility will continue to have monthly pharmacist drug regimen reviews completed on all residents. Recommendations from this review will be communicated to the resident□s medical provider for follow-up on any	

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F 329	Continued From page 10 Started on 2/4/16, Seroquel (anti-psychotic) 25 mg at bedtime for dementia with behavioral disturbances R39's most recent PHQ-9 (a screening used to detect depression) dated 3/30/16, identified R39 had no identified depression with a score of 0 (0-4 indicated no depression). R39's Mood/Depression Indicators were reviewed from 12/15, to 4/16. R39 displayed behaviors indicating trouble sleeping 4 times in 12/15, twice in 1/16, 5 times in 3/16, and 3 times in 4/16. Interventions at these times were non-pharmacological. No instances were documented in 2/16. R39's progress notes were reviewed from 9/15, to 3/16. R39 displayed occasional self-transfers during the night in 2/16, 3/16, and 4/16. R39 self transferred twice in 10/15. No other documented behaviors. Review of R39's as needed Trazodone use in the medication administrations records (MAR's) for 12/15, through 4/16 identified the following: R39 used the as needed Trazodone 0 times in 12/15, twice in 1/16, 0 times in 2/16, once in 3/16, and 0 times in 4/16. R39's medical record was reviewed. There were no identified attempts at dose reduction for R39's continued use of trazadone since initiated on 7/11/14. Additionally, there was no documentation from R39's nurse practitioner/physician identifying the rationale or risk/benefit for the continued use of Trazodone with no attempts at dose reduction.	F 329	recommendations made. 3. Measures put in place to ensure deficient practice does not recur: A meeting was held with the facilities pharmacy provider to review the expectation of the consulting pharmacist on May 23, 2016. A drug regimen of all current residents was completed on May 23, 2016. Education was provided to care related staff by June 10, 2016 on regulations related to gradual dose reductions and providing non-pharmacological interventions prior to utilizing pharmacological interventions. 4. Effective implementation of actions will be monitored by: The interdisciplinary team will audit each residents psychoactive medication use during their next MDS assessment period to ensure the resident has an adequate indication for use, is being monitored for effect on target behaviors and has an attempted gradual dose reduction attempt if not clinically contraindicated. The facility psychoactive medication utilization 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 MDS Coordinator is responsible for compliance.	

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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 329	Continued From page 11 During interview on 5/5/16, at 2:51 p.m. the director of nursing (DON) thought staff was trying more non-pharmacological interventions before giving the PRN trazadone. The DON stated the Trazodone had actually been started in 2012 and was not aware of any attempt to reduce the dose since then. R12's annual Minimum Data Set (MDS) dated 4/20/16, identified R12 had intact cognition, and took a daily antianxiety medication. R12's signed Physician Order Report dated 5/2/16, identified R12 had current orders for the following psychotropic medications: Started on 7/27/14, Clonazepam (anti-anxiety) 0.5 mg daily at 12:00 p.m. for generalized anxiety disorder Started on 10/13/14, Clonazepam 0.5 mg twice a day at 06:00 a.m. and 8:00 p.m. Started on 7/27/14, Lexapro (anti-depressant) 20 mg once an evening for generalized anxiety disorder R12's most recent PHQ-9 (a screening used to detect depression) dated 4/19/16, identified R12 had no identified depression with a score of 1 (0-4 identified as no depression). R12's medical record was reviewed. There were no identified attempts to reduce R12's use of Clonazepam since 10/13/14. In addition, there was no documentation from R12's physician identifying rationale for ongoing use. During interview on 5/5/16, at 9:38 a.m. nursing assistant (NA)-E stated R12 had no indications of anxiety, "[R12] is always happy." When interviewed on 5/5/16, at 9:43 a.m.	F 329		

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F 329	Continued From page 12 licensed practical nurse (LPN)-C stated to her knowledge R12 had never demonstrated any issues with being depressed or anxious. "[I've] never seen any of that come from her." Further, LPN-C stated she was unsure when the last trial reduction for Clonazepam was attempted for R12. During interview on 5/5/16, at 1:16 p.m. the director of nursing (DON) stated R12 was started on the medication in 7/14 for concerns with "anxiety and depression". The DON was unaware if a reduction in dose had ever been attempted for R12. During a follow-up interview on 5/5/16, at 1:35 p.m. the DON stated she reviewed R12's medical record. There was no documentation from the physician to justify the continued use of the Clonazepam. A facility Psychotropic Drug Monitoring policy dated 6/2000, identified a resident's drug regimen will be free from unnecessary drugs by not, "Administering a drug without adequate indications for use." The policy directed, "Any resident who is on a psychotropic drug will be evaluated for a drug holiday or drug reduction. This will be done to determine if the resident's symptoms can be controlled by a lower dose or to see if the dose can be eliminated entirely." However, the policy did not identify or direct staff to ensure physician documentation of justification was present if the dose of medication could not be reduced, or if there was a history of failed reductions.	F 329		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT	F 373		6/13/16

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F 373	Continued From page 13 A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques.	F 373		

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F 373	Continued From page 14 Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R53) reviewed for assistance with eating, was assessed to be safely fed by a non-nursing staff. Findings include: R53's 30 day Minimum Data Set (MDS) dated 3/19/16, identified R53 was admitted most recently on 2/19/16, had moderately impaired cognition, mechanically altered diet, required extensive assistance with eating, and received speech therapy. The Care Area Assessment (CAA) dated 2/29/16, identified R53 required assistance with activities of daily living. It also identified R53 had a pureed (foods that require no chewing) diet, with nectar	F 373	It is the policy of Haven Homes to ensure all residents are provided services by qualified individuals in accordance with their established plan of care. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s: Resident 53 is currently only assisted by Licensed/registered nursing staff. On May 2,2016 during the MDH survey the unlicensed staff (HUC) was provided written re-education indicating only licensed/registered nursing staff are permitted to assist with feeding residents. 2. Actions taken to identify other potential residents having similar occurrences: Residents identified as having potential to be affected by area	

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F 373	Continued From page 15 thickened liquids, and required assistance with meals from staff. An order was received for speech therapy. Physician Order Report signed 5/2/16, identified diagnoses including Parkinson's disease and dysphagia (difficulty swallowing). It also identified a pureed diet with nectar thickened liquids and an order for speech therapy. R53's care plan dated 4/27/16, identified a need for assistance by staff at meals. The speech therapy discharge observation report dated 4/4/16, identified R53 was seen by SLP 19 times since initial evaluation on 2/23/16, for dysphagia and aphasia related to general weakness and dementia. It identified R53's swallow ability remained moderately to severely impaired with continued dependence on pureed foods and nectar thickened liquids to allow adequate oral intake and minimize aspiration risk. During observation on 5/2/16, at 6:04 p.m. in the main dining room, R53 was seated at a table, being assisted to eat by nursing assistant (NA)-A. NA-A brought R53 his food, and began assisting him to eat. The health unit coordinator (HUC) approached NA-A, who got up from the chair and left the dining room, and the HUC took her place with R53. The HUC was observed to lift a spoon with pureed food to R53's mouth, and place it inside his mouth. The HUC remained at the table for approximately ten minutes until NA-A returned. Licensed practical nurse (LPN)-A was observed in the dining room, assisting residents at an adjacent table. When interviewed on 5/2/16, at 8:33 p.m. the	F 373	cited are any residents who require staff assistance with eating . 3. Measures put in place to ensure deficient practice does not recur: Education was provided to care related staff on May 2, 2016 during the MDH survey. This training will be reviewed again with staff by June 10, 2016 to ensure resident are assisted with eating by appropriate staff. 4. Effective implementation of actions will be monitored by: The facility will complete three CMS QIS Dining observation audits weekly for 3 months to ensure only licensed/registered staff are assisting residents with eating. 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 Acting Director of Nursing is responsible for compliance.	

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F 373	Continued From page 16	F 373		

HUC stated she typically worked four 10 hour days, from 8:00 a.m. - 6:30 p.m. and helped in the dining room if the staff needed help. The HUC stated R53 needed help when NA-A left the dining room, and LPN-A was supervising her. The HUC stated she received training on feeding a "couple years ago" with a former director of nursing (DON) who sat down with her and "just talked". However, the HUC verified no formal paid feeding assistant training was provided. The HUC also stated she helped out in the dining room by bringing residents in, passing coffee, but "very rarely" fed residents. The HUC further stated she only did it "in a pinch", and identified no staff have had a problem with her feeding in the past. The HUC stated on 5/2/16, she fed R53 "a quarter" of his meal before NA-A returned to take over.

On 5/2/16, the director of nursing (DON) provided education to the HUC, identifying the HUC was not permitted to feed residents in the dining room at any time because she was not certified to do so.

When interviewed on 5/3/16, at 8:07 a.m. cook-A stated the HUC had been observed out on the floor feeding residents when the staff was short. Cook-A stated this occurred approximately once per week.

When interviewed on 5/3/16, at 2:11 p.m. LPN-A stated nurses, trained medication aids, and nursing assistants were the only staff allowed to assist residents to eat. LPN-A indicated part of the responsibilities of the nurse in the dining room was to be sure only these people were assisting to feed in the dining room. LPN-A stated he observed R53 eating supper in the dining room on 5/2/16, and there was a nursing assistant at

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F 373	Continued From page 17 the table, and later he did notice HUC at the same table. However, he believed HUC was trained to feed, and never saw the HUC place any food in R53's mouth. When interviewed on 5/3/16, at 2:21 p.m. NA-A stated she assisted R53 to eat on 5/2/16, and left the dining room to assist another resident. NA-A stated she believed someone had to be sitting at the table, and the HUC sat to take her place. NA-A stated she did not report off to the nurse that she needed to leave the dining room. When interviewed on 5/4/16, at 12:59 p.m. speech therapist (SLP) stated R53 returned from the hospital on a pureed diet with nectar thickened liquids. He was seen by speech therapy to see if this could be changed. However, he was assessed not to be safe for a diet upgrade, and would be a choking risk. At the time of discharge from speech therapy, no specific feeding techniques were in place. R53 was able to eat independently on some days. However, with the progression of Parkinson's disease, there was difficulty in lifting the spoon, and more assistance was required to increase the intake. The SLP also stated she observed R53 on 5/3/16, during supper at the request of the facility, and no change was observed since his discharge from speech therapy. The facility policy titled Feeding a Resident, dated 5/05, identified residents unable to feed themselves are fed by all properly trained personnel. The responsibility of all nursing staff is to provide assistance to residents who are unable to feed themselves.	F 373		
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		6/13/16

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F 425 SS=D	Continued From page 18 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) 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 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure insulin was discarded timely for 2 of 2 residents (R47, R30) observed to have expired insulin vials available for use in 2 of 3 medication carts reviewed. Findings include: During observation of medication storage on the south medication cart with trained medication aide (TMA)-A on 5/2/16, at 1:09 p.m. several opened bottles of insulin were reviewed. R47 had an opened vial of Humalog insulin (medication	F 425	It is the policy of Haven Homes to ensure all residents are provided drugs and biologicals which are within their acceptable date perimeters for use based on pharmacy/manufacturers recommendations. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s: Insulin vials for both R-47 & R-30 were removed from use, and replaced with new vials during the survey. 2. Actions taken to identify other	

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F 425	Continued From page 19 used to treat high blood sugar) which TMA-A stated was still being used for R47. TMA-A stated it was a "Little over half" full. The bottle had a yellow label which identified it had been opened on 3/31/16 (32 days prior). TMA-A stated she thought insulin was to be discarded 14 days after being opened, but was not sure and she would ask the registered nurse (RN). TMA-A asked RN-B when insulin should be discarded after opening, and RN-B stated, "28 days." TMA-A then reviewed the label on R47's Humalog vial and stated, "I'd say it's expired." During observation of medication storage on the East medication cart with licensed practical nurse (LPN)-B on 5/2/16, at 1:27 p.m. several bottles of opened insulin were reviewed. R30 had an opened vial of Lantus insulin which LPN-B stated was currently being used for R30, and was opened on "3/31/16 [32 days prior]" according to the yellow label. LPN-B reviewed the yellow label further and stated it identified the insulin should have been discarded, "After 28 days" of being opened and a, "New bottle" was needed. Further, LPN-B stated the nurses working on the carts were responsible for, "Making sure things aren't expired." When interviewed on 5/5/16, at 2:58 p.m. the director of quality registered nurse (RN)-C stated insulin should be removed from the medication carts, "When it expires," because that was the, "Manufacturers recommendations." A facility Insulin Storage Recommendations sheet dated 3/15, identified Humalog and Lantus insulin should be discarded, "28 days" after being opened when stored at room temperature.	F 425	potential residents having similar occurrences: All residents who receive insulin have the potential of being affected by this practice. 3. Measures put in place to ensure deficient practice does not recur: Education was provided to licensed staff by June 7, 2016 on the procedure to date when opening drugs or biologicals and the need to check the expiration date prior to administration of these drugs. 4. Effective implementation of actions will be monitored by: The facility will complete three CMS QIS medication storage audits weekly for 3 months to ensure all drugs and biologicals are not expired. 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 Acting Director of Nursing is responsible for compliance.	

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F 428	Continued From page 20	F 428		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist identified irregularities in the medication regimen of 2 of 5 residents (R12, R39) reviewed for unnecessary medication use. Findings include: R12's annual Minimum Data Set (MDS) dated 4/20/16, identified R12 had intact cognition, and took a daily antianxiety medication. R12's signed Physician Order Report dated 5/2/16, identified R12 had current orders for the following psychotropic medications: Started on 7/27/14, Clonazepam (anti-anxiety) 0.5 mg daily at 12:00 p.m. for generalized anxiety disorder Started on 10/13/14, Clonazepam 0.5 mg twice a day at 06:00 a.m. and 8:00 p.m. Started on 7/27/14, Lexapro (anti-depressant) 20 mg once an evening for generalized anxiety	F 428	It is the policy of Haven Homes to ensure all residents drug regimen is reviewed for unnecessary medication use. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s: Resident 39 has been assessed by his GNP resulting in a discontinuation of his scheduled Trazadone. Resident 12 has been assessed by her GNP resulting in a discontinuation of her scheduled clonazepam. 2. Actions taken to identify other potential residents having similar occurrences: The facility will continue to have monthly pharmacist drug regimen reviews completed on all residents. Recommendations from this review will be communicated to the resident□s medical provider for follow-up on any recommendations made.	6/13/16

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F 428	Continued From page 21 disorder R12's most recent PHQ-9 (a screening used to detect depression) dated 4/19/16, identified R12 had no identified depression with a score of 1 (0-4 identified no depression). R12's medical record was reviewed. There were no identified attempts to reduce R12's use of Clonazepam since 10/13/14. Additionally, there was no documentation from R12's physician identifying the rationale or risk/benefit for ongoing use. During interview on 5/5/16, at 9:38 a.m. nursing assistant (NA)-E stated R12 displayed no indications of anxiety "[R12] is always happy." When interviewed on 5/5/16, at 9:43 a.m. licensed practical nurse (LPN)-C stated to her knowledge R12 had never demonstrated any issues with being depressed or anxious. "I've never seen any of that come from her." Further, LPN-C stated she was unsure when the last attempt at dosage reduction had been. R12's Medication Regimen Review(s) for the previous year were reviewed. On 5/4/15, the consulting pharmacist (CP) identified R12's trend of improving PHQ9 scores (less depression signs and symptoms) adding, "[decrease] Klonopin [clonazepam] ?" Subsequent notes by the CP through 4/14/16 failed to address R12's clonazepam use. The reviews indicated "NI" for no identified irregularities. There were no recommendations located in R12's medical record to show the physician had been notified of the CP's questioned clonazepam dose reduction on 5/4/15.	F 428	3. Measures put in place to ensure deficient practice does not recur: A meeting was held with the facilities pharmacy provider to review the expectation of the consulting pharmacist on May 23, 2016. A drug regimen of all current residents was completed on May 23, 2016. Education was provided to care related staff by June 10, 2016 on providing timely follow up on any pharmacy recommendations generated by the monthly drug regimen review and on providing non-pharmacological interventions prior to utilizing pharmacological interventions. 4. Effective implementation of actions will be monitored by: The interdisciplinary team will audit each resident psychoactive medication use during their MDS assessment period to ensure the resident has an adequate indication for use, is being monitored for effect on target behaviors and has an attempted gradual dose reduction attempt if not clinically contraindicated. The facility psychoactive medication utilization 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 MDS Coordinator is responsible for compliance.	

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F 428	Continued From page 22	F 428		

During interview on 5/5/16, at 1:16 p.m. the director of nursing (DON) stated R12 was started on the medication in 7/14 for, "anxiety and depression". The DON was unaware if a reduction in dosage had ever been attempted for R12.

During a follow-up interview on 5/5/16, at 1:35 p.m. the DON stated she reviewed R12's medical record. There was no documentation from the physician to justify the continued use of the Clonazepam. During the interview at 1:38 p.m., the CP stated R12 had been diagnosed with breast cancer in early 2015, and showed an increase in her depression at that time, however had improved since then. R12 had a GDR completed in 9/14 which was tolerated. The CP stated the use of Clonazepam, "hasn't been addressed," in the previous year because he, felt it was contraindicated. There had been no input form the physician.

A facility Psychotropic Drug Monitoring policy dated 6/00, identified a resident's drug regimen will be free from unnecessary drugs by not, "Administering a drug without adequate indications for use." The policy directed, "Any resident who is on a psychotropic drug will be evaluated for a drug holiday or drug reduction. This will be done to determine if the resident's symptoms can be controlled by a lower dose or to see if the dose can be eliminated entirely." However, the policy did not identify or direct staff to ensure physician documentation of justification was present if the dose of medication could not be reduced, or if there had been previous failed attempts at reduction.
R39's annual minimal data set (MDS) dated

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

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F 428	Continued From page 23 3/30/16, identified R39 had severe cognitive impairment and took a daily antidepressant medication. R39's signed Physician Order Report dated 4/12/16, identified R39 had current orders for the following psychotropic medications: Started on 7/11/14, Trazodone (anti-depressant) 50 mg at bedtime for insomnia Started on 7/11/14, Trazodone 50 mg tab at bedtime as needed for insomnia Started on 2/4/16, Seroquel (anti-psychotic) 25 mg at bedtime for dementia with behavioral disturbances R39's most recent PHQ-9 (a screening used to detect depression) dated 3/30/16, identified R39 had no identified depression with a score of 0 (0-4 identified as no depression). R39's Mood/Depression Indicators were reviewed from 12/15, to 3/16. R39 displayed behaviors indicating trouble sleeping 4 times in 12/15, twice in 1/16, 5 times in 3/16, and 3 times in 4/16. Interventions at these times were non-pharmacological. No instances were documented in 2/15. R39's progress notes were reviewed from 9/15 to 3/16. R39 displayed occasional self-transfers during the night in 2/16, 3/16, and 4/16. R39 self transferred twice in 10/15. No other behaviors were documented. Review of R39's as needed Trazodone use in the medication administrations records (MAR's) for 12/15, through 4/16 identified the following: R39 used the as needed Trazodone 0 times in 12/15, twice in 1/16, 0 times in 2/16, once in 3/16, and 0	F 428		

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F 428	Continued From page 24 times in 4/16. R39's medical record was reviewed. There were no identified attempts to reduce R39's use of Trazodone it was started on 7/11/14. Additionally, there was no documentation from R39's nurse practitioner/physician identifying the rationale or risk/benefit for the ongoing use of Trazodone. During interview on 5/5/16 at 2:51 p.m., the director of nursing (DON) thought staff were trying more non-pharmacological interventions before giving the PRN Trazodone. The DON stated the Trazodone had actually been started in 2012 and she was not aware of any attempt to reduce the dose since then. Gradual Dose Reduction Tracking Report for the facility, dated 3/3/16, indicated Trazodone therapy had started 5/14/12, listed the next gradual dose reduction (GDR) evaluation on 5/5/16, however; no date was listed under the "last GDR attempt" column. There was no documentation under the clinical contraindication column. R39's Medication Regimen Review(s) for the previous year were reviewed. In 9/15, the consulting pharmacist (CP) noted that R39's Ativan had been discontinued with a possible decrease in Trazodone. There was no documentation in R39's medical record to reflect the reduction of Trazodone. On 2/19/16, the CP noted R39's Seroquel had been increased due to hallucinations and PRN Trazodone had been used 3 times between 10/15 and 3/16. Monthly reviews were marked "NI" for no identified irregularities and no recommendations were given. Monthly Medication Regimen Reviews for 10/15, 11/15, 12/15, and 1/16 were not provided.	F 428		

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F 428	Continued From page 25 During interview on 5/5/16, at 5:04 p.m., the CP stated that the Trazodone had been started in 2012, and increased in 2014. The CP was not aware of any attempts at a GDR but thought a GDR would be appropriate if R39 was sleeping without using PRN Trazadone for 6 months, and no noted increase in PHQ-9 scores. The CP stated no communication or recommendations had been made to R39's physician and the CP was focused on R39's anti psychotic medication.	F 428		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident care equipment was kept in a clean and sanitary condition for 1 of 1 residents (R16) observed to have a wheelchair cushion in disrepair. Findings include: R16's quarterly Minimum Data Set (MDS) dated 2/29/16, identified R16 had frequent urinary incontinence and used a, "Pressure reducing device in chair." During observation on 5/2/16, at 2:31 p.m. R16 was in bed with her wheelchair positioned at the bedside with a thick black cushion on the seat.	F 465	It is the policy of Haven Homes to ensure all residents are provided equipment which is clean, sanitary and in good repair. To assure continued compliance the following plan has been put into place 1. Regarding cited resident/s: R 16□s wheelchair cushion was replaced during the survey on May 3, 2016. Equipment audits will be completed on R16 as facility completes CMS QIS interviewable/non-interviewable audits 2. Actions taken to identify other potential residents having similar occurrences: All residents who utilize resident care equipment have the	6/13/16

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F 465	Continued From page 26 The cushion had a wax type covering on the cushion, however the middle section of the seat was tattered and worn away exposing black foam from the inside of the cushion. The tattered area of the cushion was approximately 4-5 inches in size. On 5/3/16, at 2:54 p.m. R16's wheelchair cushion remained tattered with black foam exposed on the seat. When interviewed on 5/3/16, at 2:55 p.m. nursing assistant (NA)-C stated R16 was, "Incontinent most of the time." NA-C observed R16's tattered wheelchair cushion and stated she had, "Noticed it before," adding with R16's incontinence it appeared to be wet at times, "Every time she [R16] stands up, I think it's wet." The cushion had been tattered and in disrepair for approximately, "Two months" NA-C stated, and described the cushion to look like, "The plastic [covering] peeling off" which exposed the, "Sponge foam" inside of the cushion. Further, NA-C stated the night shift staff was responsible to clean the resident care equipment. During interview on 5/3/16, at 3:30 p.m. the assistant director of nursing (ADON) stated R16 had urinary incontinence, and at times R16's clothing and wheelchair had been known to become soiled with urine as a result. The ADON observed R16's wheelchair cushion and stated she was not aware it was in disrepair adding it shouldn't be used, "all raggedy like that." Further, the ADON stated if staff noticed a cushion was in disrepair, they should notify the nurses and have it fixed or replaced. A policy was resident care equipment maintenance was requested, but none was provided.	F 465	potential to be affected. 3. Measures put in place to ensure deficient practice does not recur: Education was provided to care related staff by June 10, 2016 on monitoring and replacing resident care equipment if it is worn or damaged. The facility wheelchair/walker cleaning schedule has been updated to include the monitoring of the condition of the equipment 4. Effective implementation of actions will be monitored by: The facility will complete 3 audits using the modified CMS QIS Resident Interview Observation or the modified CMS QIS Non-interviewable resident observation weekly for 3 months. 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 Acting Director of Nursing is responsible for compliance.	

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

F5497025

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 3, 2016. At the time of this survey, Haven Homes of Maple Plain was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/26/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 has a complete 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 monitored for fire department notification. The facility has a capacity of 52 and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care	K 056		6/2/16

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K 056	Continued From page 2 facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect all 47 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:00 AM and 1:00 PM on May 3, 2016, observations reveled that the gauges on the automatic sprinkler system have not been calibrated since 2006. This deficient practice was verified by the Director of Environmental Services at the time of inspection .	K 056	1. The fire sprinkler gauges will be replaced and dated with installation and renewal dates. 2. It will be completed on June 2, 2016 3. The work to be completed by Summit Companies and overseen by Scott Gosewisch, Environmental Services Director	
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066		6/2/16

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K 066	Continued From page 3 (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, policy review and staff interview, the facility failed to follow policy for the designated resident smoking in accordance with NFPA LSC (00) Edition Section 19.7.4, and the facility's smoking policy. This deficient practice could affect all 47 residents. Findings include: 1. On facility tour between 9:00 AM and 1:00 PM on May 3, 2016, It was observed that the designated employee smoking area had cigarette butts disposed of in the trash can with combustible material. 2. On facility tour between 9:00 AM and 1:00 PM on May 3, 2016, It was observed that the designated employee smoking area was positioned directly adjacent to the natural gas	K 066	1. The smoking area will be moved from its current location to across the parking lot away from gas meters and entry door. 2. It will be completed on June 2, 2016 3. This completed by Scott Gosewisch, Environmental Services Director	

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K 066	Continued From page 4 meter and piping into the building. This deficient practice was verified by the Director of Environmental Services at the time of inspection.	K 066		