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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 91M1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00916

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245409**

2.STATE VENDOR OR MEDICAID NO.
(L2) **843242200**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/25/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

On March 25, 2013 and March 13, 2013, the Departments of Health and Public Safety completed Post Certification Revisits (PCR) and verified correction of the deficiencies issued at the time of the Extended Survey, effective March 19, 2013. Refer to the CMS 2567b forms for both health and life safety code.

Effective March 19, 2013, the facility is certified for 81 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NEII 03/31/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 05/22/2013 (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
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/05/2013 CO. 91M1

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/26/2013
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5409

May 22, 2013

Mr. Patrick Blum, Administrator
Maple Manor Healthcare & Rehabilitation
1875 19th Street Northwest
Rochester, Minnesota 55901

Dear Mr. Blum:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 19, 2013 the above facility is certified for:

81 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 81 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 31, 2013

Mr. Patrick Blum, Administrator
Maple Manor Healthcare & Rehabilitation
1875 19th Street Northwest
Rochester, Minnesota 55901

RE: Project Number S5409023

Dear Mr. Blum:

On February 26, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on February 7, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 25, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 13, 2013 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 an extended survey, completed on February 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 19, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 7, 2013, effective March 19, 2013 and therefore remedies outlined in our letter to you dated February 26, 2013, will not be imposed.

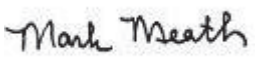
However, as we notified you in our letter of February 26, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 7, 2013.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5409rf13.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245409	A. Building B. Wing	3/25/2013

Name of Facility	Street Address, City, State, Zip Code
MAPLE MANOR HEALTHCARE & REHAB	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/19/2013**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **03/19/2013**
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GPN	03/31/2013	19694	03/25/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/7/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245409	A. Building B. Wing 01 - MAIN BUILDING 01	3/13/2013

Name of Facility	Street Address, City, State, Zip Code
MAPLE MANOR HEALTHCARE & REHAB	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 02/06/2013	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 02/11/2013	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 02/18/2013
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 MM/PS	Date: 03/31/2013	Signature of Surveyor: 25822	Date: 03/13/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/5/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 31, 2013

Mr. Patrick Blum, Administrator
Maple Manor Healthcare & Rehabilitation
1875 19th Street Northwest
Rochester, Minnesota 55901

Re: Enclosed Reinspection Results - Project Number S5409023

Dear Mr. Blum:

On March 25, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 7, 2013, with orders received by you on March 1, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File 5409r13lic.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00916	A. Building B. Wing	3/25/2013

Name of Facility	Street Address, City, State, Zip Code
MAPLE MANOR HEALTHCARE & REHAB	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20285** Reg. # **MN Rule 4658.0100 Subp. 2** LSC	Correction Completed **03/19/2013**	ID Prefix **20555** Reg. # **MN Rule 4658.0405 Subp. 1** LSC	Correction Completed **03/19/2013**	ID Prefix **21410** Reg. # **MN Rule 4658.0815 Subp. 1** LSC	Correction Completed **03/25/2013**
ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp. 2** LSC	Correction Completed **03/19/2013**	ID Prefix **21942** Reg. # **MN St. Statute 144A.10 Subd. 8** LSC	Correction Completed **03/19/2013**	ID Prefix **21980** Reg. # **MN St. Statute 626.557 Subd. 3** LSC	Correction Completed **03/19/2013**
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GPN	03/31/2013	19694	03/25/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/7/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 91M1

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245409**

2.STATE VENDOR OR MEDICAID NO.
(L2) **843242200**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/07/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the Feburary 7, 2013 extended survey the facility was not in substantial compliance with Federal participation requirements. Conditions in the facility constituted Substandard Quality of Care (SQC). Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Robin Lewis, HFE NEII — 03/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist — 03/25/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/26/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9318

February 26, 2013

Mr. Patrick Blum, Administrator
Maple Manor Healthcare & Rehabilitation
1875 19th Street Northwest
Rochester, Minnesota 55901

RE: Project Number S5409023, H5409024 and H5409025

Dear Mr. Blum:

On February 7, 2013, an extended 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. In addition, at the time of the February 7, 2013 survey the Minnesota Department of Health completed an investigation of complaint numbers H5409024 and H540902 that were found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 19, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 19, 2013 the following remedy will be imposed:

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care.

If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Maple Manor Healthcare & Rehab is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective Februar y 7, 2013. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 7, 2013 (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 August 7, 2013 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5409s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	02/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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. An extended survey was completed during the time of the standard recertification survey. A standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5409024 and H5409025 and both had not been substantiated during this survey.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225	See Attachment 1 3-13-13 MPN	3/19/13

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

ADMINISTRATOR 3/8/13

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 225	Continued From page 1 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of misappropriation of resident property immediately (means as soon as possible) to the designated state agency (Office of Health & Facility Complaints [OHFC] division of Minnesota Department of Health-MDH) for 3 of 4 residents (R14, R2, R35) reviewed for abuse prohibition. Findings include: R14 had an allegation of $11 dollars missing on	F 225		

Attachment 1

483.13(c)(1)(ii)-(iii), (c)(2-4) Tag F225
Staff Treatment of Residents

Maple Manor Healthcare and Rehab requires that all alleged resident mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property be 1) reported immediately to the administrator and other appropriate officials and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action is taken. The facility intervenes to prevent further potential abuse while the investigation is in process.

Maple Manor Healthcare and Rehab does not knowingly employ individuals who have been found guilty of abusing, neglecting, or mistreating residents. Any knowledge of actions against an employee which would indicate unfitness for service as a nursing assistant or in other resident care positions are investigated and reported to the State nurse aid registry or licensing authorities.

The facility's vulnerable policies, Adult Incident Reporting and Resident Abuse Prevention Plan, were reviewed and revised. The policy language clearly reflects that the appropriate regulatory/government agencies are to be immediately notified (as soon as possible upon the becoming aware of the concerns) of alleged violations involving resident mistreatment, neglect, abuse, misappropriation of resident property.

The nursing staff were instructed on the vulnerable adult prevention and reporting policies during the February 25, 2013 mandatory meeting. During the March 11 and 12, 2013 mandatory meetings, all staff will be instructed on 1) the facility's zero tolerance policy for abuse/neglect/misappropriation of property 2) the residents' rights to be free from abuse 3) the definition of a vulnerable adult 4) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation of property 5) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 6) timely reporting of incidents 7) the procedures for communicating/ documenting resident concerns/incidents and 8) internal reporting of vulnerable adult issues especially those related to missing property. The staff are reeducated on vulnerable adult issues at least every twelve months and vulnerable adult reporting/investigation is addressed as part of the new employee orientation process.

The reports of small amounts ($10-19) of missing money by resident numbers 14, 2, and 35 were appropriately investigated. It could not be determined whether the money was taken or misplaced by the resident. The money was replaced by the facility.

Future allegations of resident maltreatment or misappropriation of personal property will be reported immediately to the state/county agencies according to facility policy.

Compliance will be monitored by the Social Worker through an audit of the incident reports and reporting time frames for three months. If noncompliance is noted, additional monitoring and staff education will be done. Compliance will be discussed during the April quarterly Quality Assurance Committee meeting and reviewed during subsequent meetings.

Completion date: March 19, 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 2 10/16/12 however; OHFC had not been notified until 10/17/12. R2 had an allegation of $19 dollars missing on 10/27/13 however; OHFC had not been notified until 11/6/12. R35 had an allegation of $ 10 dollars missing on 1/15/13 however; OHFC had not been notified until 1/16/13. When interviewed on 2/7/13, at 3:18 p.m. the social worker verified her interpretation of the vulnerable adult reporting requirements was the facility had up-to twenty-four hours to submit the initial report to OHFC. The social worker verified R14, R2, and R35 vulnerable adult reports were not completed to OHFC immediately (as soon as possible) upon staff becoming aware of the concerns. When interviewed on 2/6/2013, at 11:20 a.m., the director of nursing (DON) verified the vulnerable adult allegations for R14, R2, R35 had not been reported immediately (as soon as possible) to OHFC because they thought they had up-to the 24 hours to report. Review of the VULNERABLE ADULT INCIDENT REPORTING policy dated 6/11/10, instructed staff the facility was required to report all reportable incidents to the Minnesota Department of Health MDH electronically immediately but no later than 24 hours of knowledge of an alleged incident.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226	See Attachment 2	3/19/13

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F 226	Continued From page 3 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop an abuse prevention policy which required immediately (means as soon as possible) reporting all alleged violations of abuse, neglect, and misappropriation of property to the Administrator, and failed to implement their vulnerable adult policy requiring the immediate (means as soon as possible) reporting of alleged violations to the State Agency (Office of Health Facility Complaints (OHFC)) of allegations of missing monies for 3 of 4 residents (R14, R2 and R35) in the sample reviewed for abuse prohibition. This had the potential to affect 63 of 63 residents residing in the facility. Findings include: Review of the VULNERABLE ADULT INCIDENT REPORTING policy dated 6/11/10, instructed staff the facility was required to report all reportable incidents to the Minnesota Department of Health MDH electronically immediately but no later than 24 hours of knowledge of an alleged incident. The policy instructed staff to call the Administrator/DON to report VA (vulnerable adult) incident. Review of these three allegations of misappropriation of personal property it was noted that the facility had not reported to OHFC	F 226		

Attachment 2

Regulation 483.13(c) Tag F226
Staff Treatment of Residents

Maple Manor Healthcare and Rehab has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures address the seven following components: screening, training, prevention, identification, investigation, protection and reporting/response.

Maple Manor Healthcare and Rehab recognize and respect each resident's right to be free from mistreatment and misappropriation of property and does all that is within their control to prevent such occurrences. The staff 1) identifies residents who are at risk for abuse, neglect and/or misappropriation of property as well as those at risk of abusing others 2) develops intervention strategies to prevent occurrences and 3) continually reassesses the effectiveness of the interventions.

The policies and procedures for communicating and reporting alleged mistreatment and misappropriation of resident property were reviewed and revised to reflect immediate reporting to the Minnesota Department of Health and the Olmsted County Vulnerable Adult Common Entry Point. The staff responsible for reporting suspected abuse to the state agencies were informed of the policy changes.

The reports of small amounts ($10-19) of missing money by resident numbers 14, 2, and 35 were appropriately investigated. It could not be determined whether the money was taken or misplaced by the resident. The money was replaced by the facility. Future allegations of resident maltreatment or misappropriation of personal property will be reported immediately to the state/county agencies according to facility policy.

The Social Worker will monitor compliance with the vulnerable adult reporting requirements of the Minnesota Department of Health and as outlined in the facility's *Resident Abuse Prevention Plan* by auditing the vulnerable adult reports for the next three months. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed during the April Quality Assurance and Assessment and Committee meeting and ongoing.

Completion date: March 19, 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 4 immediately upon being made aware of the allegation but waited up to 24 hours or after to report. 1. R14 had an allegation of $11 dollars missing on 10/16/12 however; OHFC had not been notified until 10/17/12. 2. R2 had an allegation of $19 dollars missing on 10/27/13 however; OHFC had not been notified until 11/6/12. 3. R35 had an allegation of $ 10 dollars missing on 1/15/13 however; OHFC had not been notified until 1/16/13. When interviewed on 2/6/2013 at 11:00 a.m., the social worker verified the VULNERABLE ADULT INCIDENT REPORTING policy dated 6/11/10 instructed staff to call the Administrator/DON to report the VA (vulnerable adult) incident. The social worker confirmed she thought she had up to twenty four hours to complete the initial vulnerable adult report to the OHFC. When interviewed on 2/6/12 at 11:20 a.m., the director of nursing (DON) verified the VULNERABLE ADULT INCIDENT REPORTING policy dated 6/11/10 instructed staff to call the Administrator/DON to report the VA (vulnerable adult) incident. The DON verified the policy did not instruct staff that the administrator must be "immediately" notified of all vulnerable adult incidents. When interviewed on 2/7/13, at 3:18 p.m. the social worker verified her interpretation of the vulnerable adult reporting requirements was the	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 5 facility had up-to twenty-four hours to submit the initial vulnerable adult incident report to OHFC. The social worker verified the vulnerable adult reports for R14, R2 and R35 had not been immediately (as soon as possible) reported to OHFC.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop a comprehensive care plan to include medications for 3 of 10 residents (R92, R42, R55) reviewed for unnecessary medications.	F 279	See Attachment 3	3/19/13

Attachment 3

Regulation 483.20(d,k) Tag F279
Comprehensive Care Plans

Maple Manor Healthcare and Rehab uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The individualized care plan 1) includes measurable objectives and timetables to meet the resident's needs as identified in the comprehensive assessment 2) describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and 3) recognizes the residents' right to refuse cares/services.

The care plan related policies/procedures and the staff responsibilities for development and revision of the comprehensive plans of care were reviewed and revised. A medication side effect reference sheet, physician's standing orders, and the information/instructions/ precautions listed on the medication/treatment administration records will be incorporated by reference as part of the resident's plan of care. At the time of admission, an initial temporary care plan is implemented; the interdisciplinary plan of care is developed within seven days after completion of the comprehensive assessment.

During the March 12, 2013 mandatory meeting, the licensed nurses will be instructed 1) on the new care plan policies and 2) that care plans must address pertinent symptoms/ conditions including cardiac and endocrine related diagnoses and treatments. The care plans of new residents will include conditions consistent with the following minimum data set criteria: "Active diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death." The care plans of current residents will be updated to comply with the above criteria at the time of the quarterly care conference and with a significant change in condition.

Resident number 92 - The resident's care plan was updated to reflect the cardiac related diagnoses and precautions/side effects for the related medications.

Resident number 42 – The resident's care plan was updated to reflect the cardiac related diagnoses and precautions/side effects for the related medications.

Resident number 55 - The resident's care plan was updated to reflect the cardiac related diagnoses and precautions/side effects for medications prescribed to treat cardiac symptoms and hypothyroidism.

To monitor compliance, the Clinical Manager will conduct care plan audits weekly for one month. If care plan omissions are identified, additional care plan audits and staff training will be done. Compliance will be discussed at the April quarterly Quality Assurance and Assessment Committee meeting.

Completion Date: March 19, 2013

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F 279	Continued From page 6 Findings include: R92 did not have current medications with concerns/side effects/precautions in the current care plans. R92 was admitted to the facility on 8/14/12 with diagnoses including but not limited to ventricular tachycardia, hyperlipidemia, cerebral vascular accident and atrial fibrillation. During medical record review for medication usage indicated R92 received medications including aspirin low dose, Digoxin (medication used for heart rate and rhythm). During care plan review the staff was not directed to take apical pulse prior to giving Digoxin or to hold according to the physician ' s recommendation to prevent a decrease in heart rate which could cause problems with fainting, falling, etc. and when to contact the physician. Also to monitor for signs and symptoms of toxicity which include anorexia (not eating), vision changes (blurred vision) confusion, depression, and not to give with food. Lipitor (medication used for high cholesterol), Amlodipine (medication used for high blood pressure), Metoprolol succinate (medication used for blood pressure and heart rate). The care plan had not directed staff to assess blood pressure according to the physician and apical pulse immediately before drug was administered, when to hold the medication and when to update the physician. Also to monitor for unrelieved headache; vomiting, constipation, palpitations, peripheral or facial swelling, weight gain of five pounds per week or respiratory changes. Coumadin (medication used to thin the blood)	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	02/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7 precautions had not been care planned and there were no interventions to direct staff on the risk of increased bruising, bleeding at any site (increased chance for fatal bleeding if 65 or more years old), effects may be decreased if taken with foods rich in vitamins K and increased effectiveness with foods with vitamin E and cranberry juice. R42 did not have current medications with concerns/precautions/side effects for all staff to monitor for in the current care plans. R42 was admitted to the facility on 5/3/12 with diagnoses including but not limited to hyperlipidemia, hypertension, chronic ischemic heart disease and anemia. During medical record review for medication usage indicated R52 received medications including aspirin low dose, Cozaar (medication used for high blood pressure), Amlodipine (medication used for high blood pressure), Simvastatin (medication used for high cholesterol), Lopressor (medication used for blood pressure and heart rate). The care plan had not directed staff to assess blood pressure and apical pulse immediately before drug was administered, when to hold the medication and when to update the physician. R55 did not have current medications with precautions/side effects/concerns to be monitored by all direct care staff in the current	F 279		

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F 279	Continued From page 8 care plans. R55 was admitted to the facility on 5/4/12 with diagnoses including but not limited to hyperlipidemia, paralysis agitans, hypothyroidism and osteoarthrosis. During medical record review for medication usage indicated R55 received medications including aspirin low dose, Amiodarone (medication used for high blood pressure), Simvastatin (medication used for high cholesterol), and Levothroid (medication used for thyroid conditions). The care plan had not directed staff when giving Levothroid to give before breakfast to prevent insomnia. Other considerations not addressed in the care plan include, take 20 minutes before a meal, not to take antacids or iron preparations within 8 hours of taking thyroid medication, report chest pain, rapid heart rate, palpitations, heat intolerance, excessive sweating, increased nervousness, agitation, or lethargy. The care plan had not directed staff to assess blood pressure and apical pulse immediately before Amiodarone was administered or according to the physician ' s recommendation, when to hold the medication and when to update the physician. Low dose aspirin could increase bruising tendency and there was no information in care plan to address bruising, when to report and what interventions could be helpful to prevent bruising from occurring. During interview on 2/7/13 at 9:42 a.m., MDS coordinator verified the medications were not in the care plan and verified the medications should have been part of the care plan. MDS coordinator	F 279		

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F 279	Continued From page 9 indicated cardiac conditions and medication is usually not care planned. If the medications cannot be coded on the MDS as a current problem they are not care planned. MDS coordinator verified Coumadin was on the most current MDS. During policy review dated 3/18/08 titled CARE PLAN directed staff the purpose of the care plan was to provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a temporary care plan to sufficiently meet the multiple health needs of newly admitted residents, prior to completion of the first comprehensive assessment and comprehensive care plan (to be developed by day 21 form admission) for 2 of 3 residents (R103, R97) who both expired shortly after admission to the facility and both were a closed record review. Findings include: R103 lacked of temporary care plan for pain, anxiety, pressure ulcers, communication, aspirations precautions, skin integrity, resuscitation status, and lacked documentation of a plan of care for personal cares.	F 281	See Attachment 4	3/19/13

Attachment 4

Regulation 483.20(k)(3)(I) Tag F281
Comprehensive Care Plans

Maple Manor Healthcare and Rehab provides or arranges for resident cares and services by appropriate qualified persons that meet accepted practice standards for quality. Prior to the development of the interdisciplinary plan of care, the initial plan of provides for the immediate care of the resident's nursing, medical, and psychosocial needs.

The policies and procedures for implementation of the initial plan of care have been reviewed and revised. A *Temporary Care Plan* form will be used to record relevant care and condition information from the discharging hospital, previous long term care facility, and/or other care giver and will serve as the resident's initial plan of care.

During the March 12, 2013 mandatory meeting, the licensed nurses will be instructed on the need for an initial temporary care plan and the implementation of the *Temporary Care Plan* form. The form will be completed on all new admissions.

Resident number 103 was receiving hospice services and died at the facility November 23, 2012. The care plan issues have been reviewed and are being addressed as part of the facility's ongoing quality improvement program and staff education activities.

Resident number 97 was receiving hospice services and died at the facility September 10 2012. The care plan issues have been reviewed and are being addressed as part of the facility's ongoing quality improvement program and staff education activities.

Compliance will be monitored by the Director of Nursing or her designee through random reviews of temporary care plans for one month. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the April quarterly Quality Assurance Committee meeting.

Completion date: March 19, 2013

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	245409	A. BUILDING _____ B. WING _____	02/07/2013

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MAPLE MANOR HEALTHCARE & REHAB	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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F 281	Continued From page 10 R103 was admitted to the facility 11/20/12 with diagnoses that included comfort care, myocardial infarction, heart failure, dementia, significant dysphagia with aspiration, and diabetes. R103 expired 11/23/12. The hospital dismissal summary dated 11/20/12 was reviewed. The dismissal summary indicated R103 was terminally ill and required end of life care; had risk factors of aspiration precautions, skin integrity precautions, and fall precautions; was cognitively impaired; was totally dependent on staff for eating, bathing, dressing, grooming, toileting, transfer, and mobility; had a pressure ulcer; was not to have oral intake; used continuous oxygen; was on bed rest. The dismissal summary listed physician orders for as needed Ativan (antianxiety medication) for nausea/sleep, agitation; as needed Haldol (antipsychotic) medication for agitation; as needed Morphine for pain. The medical record was reviewed. The Facility Behavior Documentation Sheets listed target behaviors and interventions, but no behaviors or documentation had been identified as having occurred. The Comprehensive Risk Data Collection dated 11/20/12 indicated R103 had open wounds behind right knee, left knee, lower left leg, and coccyx areas. An undated Nurse to Nurse Report indicated the resident had severe advanced dementia; had a do not resuscitate status; was to be repositioned every 2 hours and as needed; required assist of one for all ADLs; had stage 2 skin ulcer on gluteal fold, and blisters on legs, was incontinent of bladder and bowel; was not to have oral food or fluids and was on	F 281		

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F 281	Continued From page 11 aspiration precautions; had no pain; received oxygen. However, no temporary care plan was found. R97 lacked a temporary care plan related to fluid restriction and therapeutic diet, continuous use of oxygen dyspnea and fatigue, anxiety, lower leg edema, behaviors, pain management, behavioral management, management of a Foley catheter, and lacked documentation of a plan of care for personal cares. R97 was admitted 9/7/12 and had diagnoses that included decompensated end stage congestive heart failure, hypervolemia and dyspnea, renal failure, and severe chronic obstructive pulmonary disease. The resident expired 9/21/12. The medical record was reviewed. The interdisciplinary notes of 9/7/12 indicated R97 was dyspnea (short of breath); used continuous oxygen; was ambulatory with assist; fatigued easily; was to receive a low sodium diet, and fluid restriction; was able to feed self; received Prozac for depression; received Klonopin and Ativan for anxiety, agitation, seizures, nausea, dyspnea; had a Foley catheter in place. The hospital discharge summary dated 9/7/12 indicated the resident was to have overall palliative goals. The undated Nurse to Nurse Report indicated the resident was hypervolemic (too much fluid), experienced dyspnea (shortness of breath), and had COPD; required assist of one and walker for mobility; was to received physical and occupational therapy; had an indwelling Foley catheter; had a fluid restriction and to received 1200 cc fluid from dietary and 800 cc fluid from nursing; had	F 281		

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F 281	Continued From page 12 oxygen; received psychotropic medications-Clonazepam, Ativan, Trazodone. However, no temporary care plan was found. During an interview on 2/6/13 at 3:00 p.m. registered nurse (RN)-B stated no care plan was developed until after the minimum data set (MDS) was completed by day 21 from admission. Unit slips were completed for the nursing assistants, but the unit slip was not kept. She verified no care plan was developed related to pain, anxiety, aspiration precautions until a full care plan was developed. During an interview on 2/7/13 at 8:00 a.m. RN-B stated that only the unit slip would contain information the nursing assistant needed to provide resident care and that a care plan was not completed until after the Minimum Data Set (MDS) and Care Area Assessments (CAA) were completed. During an interview on 2/7/13 at 8:30 a.m. RN-A stated that nursing was also to use the unit slips since the unit slips were kept in a drawer by the nursing station and that no separate temporary care plan was developed. During an interview on 2/7/13 at 4:00 p.m. the director of nursing indicated the Unit slips were used as the temporary care plan, and that these were nursing assistant worksheets. She added the unit slips were not kept because they listed multiple residents on them and that individual care plans were not developed at admission. DON indicated the unit slips were developed by the case manager from the Nurse to Nurse report.	F 281		

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F 281	Continued From page 13 During the exit conference on 2/7/13 at 6:00 p.m. the director of nursing (DON) stated she was aware temporary care plans should be developed within 24 hours. DON stated temporary care plans were on the unit slips, but that copies were not kept, so the process needed a change. RN-A stated the facility used the unit sheets, but that the information was destroyed. RN-B stated a new process needed to be developed.	F 281		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	See Attachment 5	3/19/13

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure signs and symptoms of pain were identified before giving pain medication and to assess if the pain medication was effective to relieve pain when as needed (PRN) medication were used for 2 of 3 residents (R103, R109) who had severe pain symptoms, were a closed record review and both died shortly after being admitted to the facility. Findings include: R103 received as needed (PRN) morphine (pain medication) without indication of pain or if the morphine had been effective for pain relief. R103 was admitted to the facility 11/20/12 and had medical diagnoses that included Parkinson's disease, coronary artery disease, dementia, and heart failure. The hospital dismissal summary dated 11/20/12 listed physician orders for as needed Ativan (antianxiety medication) for nausea/sleep, agitation; as needed Haldol (antipsychotic) medication for agitation; as needed Morphine for pain. R103 had expired 11/23/12. Review of the medication administration record (MAR) revealed R103 had received PRN morphine seven times from admission on November 20th through the 23rd time period. The treatment record (TR) showed documentation as a + or - for " monitor for s/s [signs and symptoms] of pain q [every] shift and PRN using pain scale." The TR indicated only	F 329		

Attachment 5

483.25(l) Tag F329
Unnecessary Drugs

Maple Manor Healthcare and Rehab staff ensure that each resident's drug regime is free from unnecessary drugs. The resident's drug regime is reviewed by the staff, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued.

The resident's medication regimes are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during the routine 30/60 day visits and more often as indicated. Medications are also reviewed during the quarterly care conferences. An effort is made to simplify medication regimens while assuring maximum therapeutic benefit and resident comfort.

The medication related policies and procedures were reviewed and found appropriate. During the February 25, 2013 mandatory meeting, the nurses were instructed on the need to document the signs and symptoms of pain and the effectiveness of as needed (PRN) pain medication administered.

Resident number 103 was receiving hospice services and died at the facility November 23, 2012. The medication documentation issues have been reviewed and are being addressed as part of the facility's ongoing quality improvement program and staff education activities.

Resident number 109 was receiving comfort care and died at the facility September 10, 2012. The medication documentation issues have been reviewed and are being addressed as part of the facility's ongoing quality improvement program and staff education activities.

The clinical manager will monitor for adequate documentation of parameters/effectiveness of PRN analgesic medication through routine record audits for one month. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the May 2013 Quality Assessment and Assurance Committee meeting and ongoing.

Completion date: March 19, 2013

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F 329	Continued From page 15 morning, evening and night shift monitoring and no PRN monitoring and did not include location, intensity, or duration of the pain or if pain medication was given. The TR indicated no pain on 4 of 7 times documented on the TR monitoring, even though R103 had received morphine during that same time period. There was no documentation of morphine effectiveness for five of the 7 doses given to the resident found in the records and none provided by the facility. Review of the interdisciplinary notes revealed documentation on two occasions of administering the morphine with relief, but did not describe the intensity, location, or duration of the pain. No pain assessment was found in the medical record. R109 received as needed Dilaudid for pain and Lorazepam for anxiety, without documentation if the pain medication was or was not effective to relieve pain nor had there been signs and/or symptoms of pain identified to administer the pain medication. R109 was admitted to the facility on 11/20/12 and had diagnoses that included neutropenic septic shock, acute ischemic cardiomyopathy, and acute kidney injury. R109 had physician orders for Dilaudid every 2 hours as needed, Ativan every 4 hours as needed and Acetaminophen suppository every 4 hours as needed. R109 had expired on 11/23/12. The medication administration record (MAR) was reviewed and indicated R109 received Dilaudid three times and Lorazepam twice. The facility's Pain PRN Sheet did not indicate R109 had pain. The interdisciplinary team (IDT) notes of 1/21/12	F 329		

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F 329	Continued From page 16 at 4:02 p.m. indicated " signs and [sp] symptoms of pain relieved by PRN medications. Signs of anxiety relieved by PRN medications." The documentation did not identify medication given, reason or symptoms for which it was given and any non-pharmacological interventions attempted and an IDT note of 11/21/12 at 10:51 p.m. stated, "No PRN pain medication needed this shift." At 11:26 p.m. on 11/22/12 the IDT notes indicated the resident was restless and had signs of pain which was relieved with scheduled and PRN medications, but did not identify the PRN medication given. During an interview on 2/6/13 at 3:00 p.m. registered nurse (RN)-B stated any PRN medication administered are to have effectiveness for pain relief and this documentation should be in the interdisciplinary team notes. During an interview on 2/7/12 at 4:00 p.m. the director of nursing stated administration of PRN medications should be on the PRN forms or the interdisciplinary notes. Staff can use either, but do not need to document on both.	F 329		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews	F 497	See Attachment 6	3/19/13

Attachment 6

Regulation 483.75(e)(8) Tag F497
Regular Inservice Education

The goal of Maple Manor Healthcare and Rehab is to conduct a performance review of every nursing assistant at least once every twelve months. In-service training 1) is offered no less than twelve hours per year 2) addresses areas of weakness as identified on the nursing assistants' performance reviews 3) addresses the special needs of residents as determined appropriate by facility staff and 4) addresses provision of care and services for cognitively impaired residents.

The policies and procedures for tracking performance evaluations have been reviewed and revised. The human resource staff will send the supervisor a notice 30 days in advance of the due date for a performance evaluation and log the date the evaluation was completed. The supervisor will be sent a reminder notice if the evaluation is not completed in a timely manner. Performance evaluations for employees on leave and students who work during the summer/college breaks will be done as soon as practical upon their return to work.

The policies and procedure for providing and tracking required inservice education were reviewed and found appropriate. During the mandatory meetings on March 11 and 12, 2013, the nursing assistants will be reminded of the 12-hour yearly educational requirement, the educational opportunities available via the web-based Health Care Academy, and training session provided by the facility staff/guest presenters. The staff will be informed of the disciplinary actions including possible termination for not following the facility's policies and regulatory requirements for staff training.

The human resource staff will monitor compliance through audits of completion dates of performance evaluations and inservice training records. Compliance will be reviewed during the May Quality Assurance Committee meeting.

Completion Date: March 19, 2013

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F 497	Continued From page 17 and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure an annual performance review was completed for 3 of 5 employees (E5, E6, E7) who had worked for more than one year at the facility: facility failed to ensure each nursing assistant had at a minimum 12 hours of in-service training per year for 2 of 5 employees (E5, E4) who had worked for more than one year at the facility Findings include: The facility lacked annual performance evaluations on employees Record review of E5's file revealed a hire date of 08/10/10. There was no documentation in the employee's file to show an evaluation of the employee's performance had been completed since 11/2010. Record review of E6's file revealed a hire date of 11/7/06. There was no documentation in the employee's file to show an evaluation of the employee's performance had been completed since 11/7/11. Record review of E7's file revealed no documentation in the employee's file to show an	F 497		

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F 497	Continued From page 18 evaluation of the employee's performance had been completed since 1/10/12. E5 in-service attendance sheet indicated date of hire was 8/10/10, and for the year 2012 there was no documentation for in-services. E4 in-service attendance sheet indicated date of hire was 10/15/10, and for the year 2012 four hours and 30 minutes was documented. The in-service director was unavailable for interview. During interview on 2/7/13 at 1:25 p.m., the director of nursing indicated one of the employees was a college student and only works part time and the other was on medical leave for part of the year making it hard for them to get in to make the in-services. During interview on 2/7/13 at 5:20 p.m., the director of nursing (DON) verified performance reviews were to be done within 90 days of hire and then annually. DON indicated the business office or human resources tracks when the performance reviews were to be done. DON indicated one of the employees records that was pulled was a college student and hard to get a hold of.	F 497		

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	245409	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/05/2013

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MAPLE MANOR HEALTHCARE & REHAB	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Maple Manor Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok PS 3-11-13 RECEIVED MAR 11 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 03.19.2013
EXIT: 02.07.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/8/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1	K 000		

By email to:
Barbara.Lundberg@state.mn.us and
Marian.Whitney@state.mn.us

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

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

2. The actual, or proposed, completion date.

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

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

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

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

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K 000	Continued From page 2 The facility has a capacity of 81 beds and had a census of 62 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barrier wall in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, 8.3.2 and 8.3.6. The deficient practice could affect 30 out of 61 residents. Findings include: On facility tour between 10:30 AM and 12:00 noon on 02/05/2013, observation revealed that the smoke barrier by resident room #16 has an open penetration around a several low voltage cables above the lay in ceiling.	K 025	K025 The open penetration around the low voltage cables has been sealed with intumescent caulk. All openings made by Maple Manor staff through fire/smoke barriers are promptly sealed with intumescent caulk. The penetration around the low voltage cables was made by an outside contractor. Checking for penetrations in the fire barrier above the fire doors is now done monthly as part of the procedure for checking the operation of the fire doors. The Maintenance Director will be responsible for monitoring compliance. Completion date: February 6, 2013	

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K 025	Continued From page 3 NOTE: All smoke barriers need to be checked from exterior wall to exterior wall. This deficient practice was confirmed by the Facility Maintenance Director (JT) at the time of discovery.	K 025		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observations, the fire alarm system has not been installed and maintained in accordance with the requirements of NFPA 72 1999. This deficient practice could affect all residents. Findings include: On facility tour between 10:30 AM and 12:00 noon on 02/05/2013, it was observed that in the 1st floor linen chute room where the D.A.C.T. (Digital Alarm Communicator Transmitter) panel room is. The room was not equipped with	K 052	K052 The facility contracted with Custom Alarm Company to install a smoke detector in the first floor linen chute room. The smoke detector was installed February 11, 2013. The detector is monitored by the fire alarm board located at the nurses' station. Maintenance Director will be responsible for monitoring compliance. Completion date: February 11, 2013	

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K 052	Continued From page 4 automatic smoke detection. This deficient practice was confirmed by the Facility Maintenance Director (JT) at the time of discovery.	K 052		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7 and 1999 NFPA 13, 5-13.6. FINDINGS INCLUDE: On facility tour between 10:30 AM and 12:00 noon on 02/05/2013, observation revealed that the basement fire sprinkler riser closet does not have fire sprinkler protection.	K 056	K056 The facility contracted with Summit Fire Protection Company to annually check all sprinklers and sprinkler systems for code compliance. Summit installed a sprinkler in the fire sprinkler riser closet February 18, 2013. The Maintenance Director will monitor compliance. Completion date: February 18, 2013	

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K 056	Continued From page 5 This deficient practice was confirmed by the Facility Maintenance Director (JT) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 056		

STATEMENT OF COMPLIANCE

Maple Manor Health Care and Rehabilitation has been providing high quality services to the community for the past 49 years. The facility's policies and procedures have been developed over the years in accordance with State and Federal Regulations and community practice standards.

Maple Manor Health Care and Rehabilitation objects to and disagrees with both the findings of noncompliance and the level of deficiencies cited.

Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agent or other individuals who draft or may be discussed in the Credible Allegation of Compliance.

In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by this Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency.

Accordingly, this Credible Allegation of Compliance is being submitted solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare and Medical Assistance programs.

The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegation of noncompliance or admissions by the Facility.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9318

February 26, 2013

Mr. Patrick Blum, Administrator
Maple Manor Healthcare & Rehabilitation
1875 19th Street Northwest
Rochester, Minnesota 55901

Re: State Nursing Home Licensing Orders - Project Number S5409023, H5409024 and H5409025

Dear Mr. Blum:

The above facility was surveyed on February 4, 2013 through February 7, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5409024 H5409025, That were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

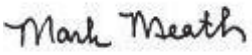
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast Rochester, Minnesota 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff at (507) 206-2731.

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00916	A. BUILDING _____ B. WING _____	02/07/2013

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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: On February 4, 5, 6 and 7, 2013, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

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2 000	Continued From page 1 Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904. A standard recertification survey was conducted with State Licensing survey and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5409024 and H5409024 and both had not been substantiated during this survey.	2 000	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. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance	2 285		

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2 285	Continued From page 2 of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure an annual performance review was completed for 3 of 5 employees (E5, E6, E7) who had worked for more than one year at the facility: facility failed to ensure each nursing assistant had at a minimum 12 hours of in-service training per year for 2 of 5 employees (E5, E4) who had worked for more than one year at the facility Findings include: The facility lacked annual performance evaluations on employees Record review of E5's file revealed a hire date of 08/10/10. There was no documentation in the employee's file to show an evaluation of the employee's performance had been completed since 11/2010. Record review of E6's file revealed a hire date of 11/7/06. There was no documentation in the employee's file to show an evaluation of the employee's performance had been completed since 11/7/11. Record review of E7's file revealed no documentation in the employee's file to show an evaluation of the employee's performance had been completed since 1/10/12. E5 in-service attendance sheet indicated date of	2 285		

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2 285	Continued From page 3 hire was 8/10/10, and for the year 2012 there was no documentation for in-services. E4 in-service attendance sheet indicated date of hire was 10/15/10, and for the year 2012 four hours and 30 minutes was documented. The in-service director was unavailable for interview. During interview on 2/7/13 at 1:25 p.m., the director of nursing indicated one of the employees was a college student and only works part time and the other was on medical leave for part of the year making it hard for them to get in to make the in-services. During interview on 2/7/13 at 5:20 p.m., the director of nursing (DON) verified performance reviews were to be done within 90 days of hire and then annually. DON indicated the business office or human resources tracks when the performance reviews were to be done. DON indicated one of the employees records that was pulled was a college student and hard to get a hold of. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could review and revise policies and procedures for evaluating staff performance reviews. The Director of Nursing could perform monthly audits to ensure annual performance reviews are being performed and annual requirement for 12 hours in-service were completed. TIME PERIOD FOR CORRECTIONS: Fourteen (14) days.	2 285		

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2 555	Continued From page 4	2 555		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to develop a comprehensive care plan to include medications for 3 of 10 residents (R92, R42, R55) reviewed for unnecessary medications. Findings include: R92 did not have current medications with concerns/side effects/precautions in the current care plans. R92 was admitted to the facility on 8/14/12 with diagnoses including but not limited to ventricular tachycardia, hyperlipidemia, cerebral vascular accident and atrial fibrillation. During medical record review for medication usage indicated R92 received medications	2 555		

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2 555	Continued From page 5 including aspirin low dose, Digoxin (medication used for heart rate and rhythm). During care plan review the staff was not directed to take apical pulse prior to giving Digoxin or to hold according to the physician ' s recommendation to prevent a decrease in heart rate which could cause problems with fainting, falling, etc. and when to contact the physician. Also to monitor for signs and symptoms of toxicity which include anorexia (not eating), vision changes (blurred vision) confusion, depression, and not to give with food. Lipitor (medication used for high cholesterol), Amlodipine (medication used for high blood pressure), Metoprolol succinate (medication used for blood pressure and heart rate). The care plan had not directed staff to assess blood pressure according to the physician and apical pulse immediately before drug was administered, when to hold the medication and when to update the physician. Also to monitor for unrelieved headache; vomiting, constipation, palpitations, peripheral or facial swelling, weight gain of five pounds per week or respiratory changes. Coumadin (medication used to thin the blood) precautions had not been care planned and there were no interventions to direct staff on the risk of increased bruising, bleeding at any site (increased chance for fatal bleeding if 65 or more years old), effects may be decreased if taken with foods rich in vitamins K and increased effectiveness with foods with vitamin E and cranberry juice. R42 did not have current medications with concerns/precautions/side effects for all staff to monitor for in the current care plans. R42 was admitted to the facility on 5/3/12 with	2 555		

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2 555	Continued From page 6 diagnoses including but not limited to hyperlipidemia, hypertension, chronic ischemic heart disease and anemia. During medical record review for medication usage indicated R52 received medications including aspirin low dose, Cozaar (medication used for high blood pressure), Amlodipine (medication used for high blood pressure), Simvastatin (medication used for high cholesterol), Lopressor (medication used for blood pressure and heart rate). The care plan had not directed staff to assess blood pressure and apical pulse immediately before drug was administered, when to hold the medication and when to update the physician. R55 did not have current medications with precautions/side effects/concerns to be monitored by all direct care staff in the current care plans. R55 was admitted to the facility on 5/4/12 with diagnoses including but not limited to hyperlipidemia, paralysis agitans, hypothyroidism and osteoarthrosis. During medical record review for medication usage indicated R55 received medications including aspirin low dose, Amiodarone (medication used for high blood pressure), Simvastatin (medication used for high cholesterol), and Levothroid (medication used for thyroid conditions). The care plan had not directed staff when giving Levothroid to give before breakfast to prevent insomnia. Other considerations not addressed in the care plan include, take 20 minutes before a meal, not to	2 555		

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2 555	Continued From page 7 take antacids or iron preparations within 8 hours of taking thyroid medication, report chest pain, rapid heart rate, palpitations, heat intolerance, excessive sweating, increased nervousness, agitation, or lethargy. The care plan had not directed staff to assess blood pressure and apical pulse immediately before Amiodarone was administered or according to the physician ' s recommendation, when to hold the medication and when to update the physician. Low dose aspirin could increase bruising tendency and there was no information in care plan to address bruising, when to report and what interventions could be helpful to prevent bruising from occurring. During interview on 2/7/13 at 9:42 a.m., MDS coordinator verified the medications were not in the care plan and verified the medications should have been part of the care plan. MDS coordinator indicated cardiac conditions and medication is usually not care planned. If the medications cannot be coded on the MDS as a current problem they are not care planned. MDS coordinator verified Coumadin was on the most current MDS. During policy review dated 3/18/08 titled CARE PLAN directed staff the purpose of the care plan was to provide a multi-disciplinary comprehensive plan of care which provides a working tool that profiles the needs of each resident. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could develop a system to educate staff and develop a monitoring system to ensure staff are reviewing and revising the care plan as indicated in order to provide appropriate care and services. The Director of Nursing could develop and implement a random	2 555		

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2 555	Continued From page 8 audit tool to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 555		
21410	MN Rule 4658.0815 Subp. 1 Employee Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Information bulletin 09-02 Tuberculosis Prevention and Control: Nursing Home. Minnesota Rule 4658.0815 Subpart 1 Employee Tuberculosis Program is waived. Conditions of Wavier: - Follow the U. S. Centers for Disease Control and Prevention ' s "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005," Morbidity and Mortality Weekly Report (MMWR) 2005;54 (No. RR-17), and as subsequently amended, for infection control procedures and requirements ("CDC Guidelines"). Refer to this document for complete definitions of terms. - Assign administrative responsibility for the TB infection control program to appropriate personnel. Administrative responsibilities include the establishment of an infection control team (one or more individuals), completion (and periodic update) of a written TB risk assessment, development (and periodic review) of a written TB infection control plan, and screening of health care workers (HCWs) for TB as discussed below. - Conduct a problem evaluation if a case of suspected or confirmed TB disease is not promptly recognized and appropriate measures	21410		

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21410	Continued From page 9 are not taken. - Perform an investigation in collaboration with the local health department if health-care-associated transmission of M. tuberculosis is suspected. This MN Requirement is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure that all health care workers received a timely tuberculin skin test for 3 of 5 employees (E1, E2 and E3) newly hired by the facility. Findings include: During document review on 2/5/13, five employee records were reviewed for baseline TB screening upon hire with findings as follows: E1 was hired on 12/10/12. The employee received the first step of the mantoux skin test on 12/10/12, interpreted on 12/12/12 with results of zero millimeters (mm) of induration. The employee received the second step mantoux on 2/4/13. E2 was hired on 11/12/12. The employee	21410		

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21410	Continued From page 10 received the first step of the mantoux skin test on 11/07/12, interpreted on 11/09/12 with results of zero millimeters (mm) of induration. The employee received the second step mantoux on 2/4/13. E3 was hired on 10/22/12. The employee received the first step of the mantoux skin test on 10/20/12, interpreted on 10/22/12 with results of zero millimeters (mm) of induration. The employee had not received the second step mantoux. During review of the facility policy titled T.B. Infection Control program for Residents/Employees/Volunteers, revised 2/9/12, indicated all employees shall have a 2-step tuberculin skin test. During interview on 2/7/13 at 10:29 a.m., infection control nurse indicated the second step mantoux should be given within 3 weeks after step one is given and the facility usually has the second step done within 10 days from step first. During interview on 2/7/13 at 1:38 p.m., the director of nursing was interviewed and indicated the infection control nurse was responsible for making sure the mantoux steps were completed. DON indicated the second step should be done within 3 weeks, but there was no federal tag that indicated when the second one had to be done. DON indicated it is sometimes hard to get the employee to come in for the second mantoux. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could monitor to assure TB screening procedures were developed and implemented to ensure staff were free of TB prior to working with residents.	21410		

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21410	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21410		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure signs and symptoms of pain were identified before giving pain medication and to assess if the pain medication was effective to relieve pain when as needed (PRN) medication were used for 2 of 3 residents (R103, R109) who had severe pain symptoms, were a closed record review and both died shortly after being admitted	21540		

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21540	Continued From page 12 to the facility. Findings include: R103 received as needed (PRN) morphine (pain medication) without indication of pain or if the morphine had been effective for pain relief. R103 was admitted to the facility 11/20/12 and had medical diagnoses that included Parkinson's disease, coronary artery disease, dementia, and heart failure. The hospital dismissal summary dated 11/20/12 listed physician orders for as needed Ativan (antianxiety medication) for nausea/sleep, agitation; as needed Haldol (antipsychotic) medication for agitation; as needed Morphine for pain. R103 had expired 11/23/12. Review of the medication administration record (MAR) revealed R103 had received PRN morphine seven times from admission on November 20th through the 23rd time period. The treatment record (TR) showed documentation as a + or - for " monitor for s/s [signs and symptoms] of pain q [every] shift and PRN using pain scale." The TR indicated only morning, evening and night shift monitoring and no PRN monitoring and did not include location, intensity, or duration of the pain or if pain medication was given. The TR indicated no pain on 4 of 7 times documented on the TR monitoring, even though R103 had received morphine during that same time period. There was no documentation of morphine effectiveness for five of the 7 doses given to the resident found in the records and none provided by the facility. Review of the interdisciplinary notes revealed documentation on two occasions of administering the morphine with relief, but did not describe the	21540		

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21540	Continued From page 13 intensity, location, or duration of the pain. No pain assessment was found in the medical record. R109 received as needed Dilaudid for pain and Lorazepam for anxiety, without documentation if the pain medication was or was not effective to relieve pain nor had there been signs and/or symptoms of pain identified to administer the pain medication. R109 was admitted to the facility on 11/20/12 and had diagnoses that included neutropenic septic shock, acute ischemic cardiomyopathy, and acute kidney injury. R109 had physician orders for Dilaudid every 2 hours as needed, Ativan every 4 hours as needed and Acetaminophen suppository every 4 hours as needed. R109 had expired on 11/23/12. The medication administration record (MAR) was reviewed and indicated R109 received Dilaudid three times and Lorazepam twice. The facility's Pain PRN Sheet did not indicate R109 had pain. The interdisciplinary team (IDT) notes of 1/21/12 at 4:02 p.m. indicated " signs and [sp] symptoms of pain relieved by PRN medications. Signs of anxiety relieved by PRN medications." The documentation did not identify medication given, reason or symptoms for which it was given and any non-pharmacological interventions attempted and an IDT note of 11/21/12 at 10:51 p.m. stated, "No PRN pain medication needed this shift." At 11:26 p.m. on 11/22/12 the IDT notes indicated the resident was restless and had signs of pain which was relieved with scheduled and PRN medications, but did not identify the PRN medication given. During an interview on 2/6/13 at 3:00 p.m.	21540		

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21540	Continued From page 14 registered nurse (RN)-B stated any PRN medication administered are to have effectiveness for pain relief and this documentation should be in the interdisciplinary team notes. During an interview on 2/7/12 at 4:00 p.m. the director of nursing stated administration of PRN medications should be on the PRN forms or the interdisciplinary notes. Staff can use either, but do not need to document on both. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by:	21942		

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21942	Continued From page 15 Based on interview the facility failed to make an attempt to form a family council within the past year. This had the potential to affect 63 of 63 residents currently in the facility. Findings include: There was no documentation of an attempt to start a family council in 2012. During interview on 2/6/13 at 9:43 a.m., social service director indicated the facility had done it only once a year because only two family members would show up in the past. The social service director continued to say that the facility had not made an attempt over the past year to attempt to encourage families to form a family council. SUGGESTED METHOD OF CORRECTION: The administrator or designee will contact families and attempt on a yearly basis to began a family council. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21942		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated	21980		

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21980	Continued From page 16 reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.	21980		

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21980	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of misappropriation of resident property immediately (means as soon as possible) to the designated state agency (Office of Health & Facility Complaints [OHFC] division of Minnesota Department of Health-MDH) for 3 of 4 residents (R14, R2, R35) reviewed for abuse prohibition. Findings include: R14 had an allegation of $11 dollars missing on 10/16/12 however; OHFC had not been notified until 10/17/12. R2 had an allegation of $19 dollars missing on 10/27/13 however; OHFC had not been notified until 11/6/12. R35 had an allegation of $ 10 dollars missing on 1/15/13 however; OHFC had not been notified until 1/16/13. When interviewed on 2/7/13, at 3:18 p.m. the social worker verified her interpretation of the vulnerable adult reporting requirements was the facility had up-to twenty-four hours to submit the initial report to OHFC. The social worker verified R14, R2, and R35 vulnerable adult reports were not completed to OHFC immediately (as soon as possible) upon staff becoming aware of the concerns. When interviewed on 2/6/2013, at 11:20 a.m., the director of nursing (DON) verified the vulnerable adult allegations for R14, R2, R35 had not been reported immediately (as soon as possible) to OHFC because they thought they had up-to the	21980		

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21980	Continued From page 18 24 hours to report. Review of the VULNERABLE ADULT INCIDENT REPORTING policy dated 6/11/10, instructed staff the facility was required to report all reportable incidents to the Minnesota Department of Health MDH electronically immediately but no later than 24 hours of knowledge of an alleged incident. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980		