

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 93FU

Facility ID: 00520

020499

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 93FU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00520

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN# 24-5276

At the time of the standard survey completed January 16, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On March 4, 2013, the Minnesota Department of Health and, on February 21, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on January 16, 2013, effective February 22, 2013. Therefore, the remedies outlined in our letter dated January 30, 2013, will not be imposed. See attached CMS-2567B forms for the results of the March 4, 2013 and February 21, 2013 revisits.



Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5276

April 8, 2013

Mr. Doug Dolinsky, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

Dear Mr. Dolinsky:

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 February 22, 2013 the above facility is certified for:

149 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 149 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Shellae Dietrich".

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

March 5, 2013

Mr. Doug Dolinsky, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

RE: Project Number S5276023

Dear Mr. Dolinsky:

On January 30, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 16, 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 4, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 21, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 16, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 22, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 16, 2013, effective February 22, 2013 and therefore remedies outlined in our letter to you dated January 30, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Shellae Dietrich".

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

5276r113.rtf

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245276	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/4/2013
Name of Facility MAPLEWOOD CARE CENTER		Street Address, City, State, Zip Code 1900 SHERREN AVENUE MAPLEWOOD, MN 55109

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 F0329 Reg. # 483.25(l) LSC _____	Correction Completed 02/22/2013	ID Prefix F0356 Reg. # 483.30(e) LSC _____	Correction Completed 02/22/2013	ID Prefix F0428 Reg. # 483.60(c) LSC _____	Correction Completed 02/22/2013
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 SR/sd	Date: 03/05/13	Signature of Surveyor: 16022	Date: 03/04/13
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/16/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245276	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 2/21/2013
Name of Facility MAPLEWOOD CARE CENTER		Street Address, City, State, Zip Code 1900 SHERREN AVENUE MAPLEWOOD, MN 55109

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 K0018	Correction Completed 02/08/2013	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	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By PS/sd	Date: 03/05/13	Signature of Surveyor: 12424	Date: 03/04/13
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/15/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN# 24-5276

At the time of the standard survey completed January 16, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5464

January 30, 2013

Mr. Doug Dolinsky, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

RE: Project Number S5276023

Dear Mr. Dolinsky:

On January 16, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Sue Reuss
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793

Fax: (651) 201-3790

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 February 25, 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 February 25, 2013 the following remedy will be imposed:

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

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 April 16, 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 July 16, 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

Maplewood Care Center

January 30, 2013

Page 6

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Shellae Dietrich". The script is cursive and fluid.

Shellae Dietrich, Program Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

5276s13.rtf

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

PRINTED: 01/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(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.	F 000	This Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the facility, its Administrator or any employee, 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 the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance within ten days of the 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 with this time frame should in no way be considered or construed as agreement with the allegation of non-compliance or admissions by the facility.		02/03/2013 RECEIVED 09391
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.	2/11/13 SER			

RECEIVED

FEB -7 2013

COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Executive Director

(X6) DATE

2/6/13

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.

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

PRINTED: 01/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medication regimens were free of unnecessary medications for 2 of 10 residents reviewed for medication usage, R10 who had inadequate parameters for the use of pain medications and R29 with inadequate justification of duplicate therapy for the treatment of dementia. Findings include: R29 was receiving duplicate drug therapy for dementia without justification for continued usage. R29, who resided on the secure unit, received namenda 10 milligrams (mg) twice a day (bid) and aricept 10 mg daily (qd) both for Alzheimer dementia. R29 had been receiving them prior to August of 2012. The physician progress notes 12/10/12 revealed worsening behaviors, having more confusion and agitation, which in part resulted in hospitalization in December 2012. The physician note indicated to continue medications. The quarterly minimum data set (MDS) completed 12/12 indicated R29's cognition was unable to recall any words or phrases said to her. A mood assessment, completed 12/11/12, revealed no signs of depression. However, the resident showed increased anxiety and	F 329	F 329 It is the policy of Volunteers of America Maplewood Care Center to promote unnecessary drug use from the residents drug regimen. Resident 29's medication regimen was reviewed by licensed pharmacist on 1/25/13. Per psychiatry note 1/16/13: "do not discontinue Aricept/Namenda, prescribed for comfort in late stage dementia and to assist with confusion, not a cure". Resident 10's medication regimen was reviewed by licensed pharmacist on 1/24/13 with a recommendation to add parameters for use for PRN Oxycodone and PRN Tylenol orders. Policies and procedures were reviewed for unnecessary medication use and monitoring protocols. Nursing staff was re-educated on unnecessary medications and necessity of having appropriate parameters for prn orders. Report run on prn orders without parameters, reviewed for needed clarification. Maplewood Care Center will continue to have pharmacist perform medication regimen reviews monthly. The review will continue to include preventing, identifying, reporting, and resolving medication related problems or irregularities and collaborate with other members of disciplinary team. The pharmacist will provide a summary of all recommendations and irregularities to the facility QA committee monthly for three months and then quarterly. Upon review of this report, system changes will be implemented if indicated. Director of Nursing and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only.		1/25/13 REVISED 01-03-13

2/22/13 ✓

PRINTED: 01/30/2013
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 93FU11 Facility ID: 00520 If continuation sheet Page 3 of 10

PRINTED: 01/30/2013
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete

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

PRINTED: 01/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 4 verified that parameters were lacking in the record. On 01/17/13 at 11:45 a.m. Consulting Pharmacist (CP) was interviewed and stated that she reviewed all of the medications monthly and was aware of R10 using ES Tylenol and oxycodon PRN for pain. CP indicated that since R10 did not use PRN medications excessively she was not that concerned.			01/16/13 01/20/13 (WAIVED) 03/01	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	F 356 It is the policy of Volunteers of America Maplewood Care Center to post the nurse staffing data on a daily basis and that it is placed in a prominent place readily available to residents and visitors. Policies and procedures regarding the posting of nursing hours were reviewed and revised. Training was done with all receptionists as to the process to guarantee compliance. Nurse managers also re-educated on posting staffing hours. Random audits will be done to ensure compliance with new process. The results of this monitoring will be reported to the QA committee monthly for three months. Upon this review, revisions will be made if indicated. Business Office Manager and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only. 2/22/13 ✓	01/16/13 01/20/13 (WAIVED) 03/01	

PRINTED: 01/30/2013
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(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 356	Continued From page 6 as they occur. Admission/discharges need to be changed as they occur on total census. This information will be obtained from staffing schedule. All changes must occur immediately. Nurse Managers have been notified to email changes to receptionist."				
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the pharmacy services failed to identify and act upon medication regimen irregularities for 2 of 10 residents reviewed for medication usage, R10 who had inadequate parameters for the use of pain medications and R29 with inadequate justification of duplicate therapy for the treatment of dementia. Findings include: R29's diagnoses including Alzheimer dementia, depression, and bipolar. R29 resided on the secure unit. The physician progress notes 12/10/12 revealed worsening behaviors, having				01/20/13 APPROVED 09391

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F 428	Continued From page 7 more confusion and agitation, which in part resulted in hospitalization in December 2012. Physician note indicated to continue medications. R29 was received namenda and aricept both for Alzheimer dementia. The quarterly minimum data set (MDS) completed 12/12 indicated R29's cognition was unable to recall any words or phrases said to her. Mood assessment, completed 12/11/12, revealed no signs of depression. However the resident showed increased anxiety and depression and a decline in cognition. Mood was stable and resident was accepting of staffs redirection and reassurance. R29 was not able to complete the BIMS (brief interview for mental status) due to severe cognitive decline. On 1/16/13 at 11:45 a.m. registered nurse (RN)-D was interviewed about the continued use of the medications namenda and aricept, both for Alzheimer dementia. RN-D indicated the staff, pharmacist and registered nurse practitioner (RNP) have been working on decreasing medications and reviewing all unnecessary medications on all residents on the secure unit, however the medications for R29 had not been assessed for unnecessary medications. RN-D verified the medications should be assessed for continued need and indicated there was no documentation by pharmacy regarding the medications. Resident (R10) had been receiving extra strength (ES)Tylenol and oxycodone as needed (PRN) for pain without adequate parameters for the use of two pain medications.	F 428	It is the policy of Volunteers of America Maplewood Care Center to have the medication regimen of each resident reviewed at least once a month by a licensed pharmacist and the pharmacist must report any irregularities to the MD and DON, and be acted upon. Resident 29's medication regimen was reviewed by licensed pharmacist on 1/25/13. Per psychiatry note 1/16/13: "do not discontinue Aricept/Namenda, prescribed for comfort in late stage dementia and assist with confusion, not a cure". Resident 10's medication regimen was reviewed by licensed pharmacist on 1/24/13 with a recommendation to add parameters for use for the PRN oxycodone and PRN Tylenol orders. Policies and procedures were reviewed for regulatory compliance completion. Nurse Managers were re-educated on said policies for appropriate follow through. Maplewood Care Center will continue to have the pharmacist perform medication regimen reviews monthly. The review will continue to include preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team. The pharmacy consultant will provide a summary of all recommendations and irregularities to the facility QA meeting monthly for three months and then quarterly. Upon review of this report, system changes will be implemented if indicated. Director of Nursing and/or designee will be responsible for maintaining compliance.	01/20/13	01/20/13

2/22/13

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F 428	Continued From page 8 Resident (R10) was diagnosed with neuropathy, chronic pain syndrome, Schizophrenia, sleep disorder, multiple sclerosis and osteoporosis. The current physician's orders, dated 12/19/12, included oxycodone 2.5 milligrams (mg) as needed every 6 hours and ES Tylenol 500 mg 2 tablets four times daily PRN for pain. The pain assessment, dated 12/12/12, identified R10 had chronic foot and leg pain and received scheduled and PRN pain medications. It indicated R10 was also receiving lyrica and neurontin for pain management. The annual Minimum Data Set (MDS), dated, 12/13/12, identified R10 as having no memory impairment and was cognitively intact with a brief interview for mental status (BIMS) score of 14. It identified R10 experienced frequent pain and was on pain medication. The Care Area Assessment (CAA) Summary for pain, dated 12/22/12, indicated R10 had alteration in comfort related to the diagnosis and was on PRN and scheduled medications for pain management. The current plan of care, dated 12/22/12, identified R10 was at risk for alteration in comfort related to multiple diagnosis and goal was that R10 would report level of discomfort and the pain would be reduced. The interventions included PRN pain medications and utilized non-pharmaceutical interventions to promote comfort. Medication administration records (MAR) from 11/1/12 to 01/16/13 were reviewed for PRN use				01/16/13 APPROVED 0938-0391

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F-428	Continued From page 9 of pain medications and the following doses were administered: November 2012: 10 doses of oxycodone and 13 doses of ES Tylenol. December 2012: 7 doses of oxycodone and 14 doses of ES Tylenol. January 2013: 5 doses of oxycodone and 4 doses of ES Tylenol. Monthly review of medications conducted by the pharmacist did not report the irregularity of duplicate therapy to manage pain. The record lacked parameters to justify the use of 2 PRN pain medications. On 01/16/13 at 2:50 p.m. Registered Nurse Manager (RN-C) was interviewed and after reviewing the electronic and paper record for R10 RN-C stated, "I don't know why she is on two pain medications...if Tylenol is helping the resident then she doesn't really need oxycodone." RN-C verified that parameters were lacking in the record. On 01/17/13 at 11:45 a.m. Consulting Pharmacist (CP) was interviewed and stated that she reviewed all of the medications monthly and was aware of R10 using ES Tylenol and oxycodon PRN for pain. CP indicated that since R10 did not use PRN medications excessively she was not that concerned.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
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K 000 INITIAL COMMENTS

K 000

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.

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Maplewood Care Center 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 TO:

HEALTHCARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145

Or by email to:



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Douglas Dolansky

TITLE

Executive Director

(X6) DATE

2/6/13

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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K 000	Continued From page 1 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. This 3-story building was determined to be of Type II(222) construction. It has a full basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 157 beds and had a census of 140 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors	K 018	It is the policy of Volunteers of America Maplewood Care Center to maintain the building in accordance to NFPA 101 Life Safety Code Standards. To meet compliance with this regulation we will have smoke detectors installed in the storage rooms noted in survey and remove the doors. Project to be completed by 2-8-2013. Environmental Services Director and/or designee will be responsible for maintaining compliance.	28-13	

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K 018	Continued From page 2 are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation the facility did not have corridor doors that meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the safety of all residents, staff and visitors. Findings include: On facility tour between 09:00 AM and 01:00 PM on 01/15/2013, it was observed that the corridor doors to the storage rooms on the 1st, 2nd and 3rd floors, were blocked open by a scale used for weighing residents. Storage Room doors were blocked open in the following areas: 3rd floor across from room 325. 2nd floor across from room 225. 1st floor across from room 112. This deficiency was verified by facility Director of Environmental Services (TB),	K 018			