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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ELSW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00916

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/13/2015**

6. DATE OF SURVEY **04/05/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 04/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 4/18/2017 (L20)

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

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

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.
00160
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245409

April 18, 2017

Mr. Grant Brandon, Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

Dear Mr. Brandon:

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 13, 2017 the above facility is certified for:

81 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 18, 2017

Mr. Grant Brandon, Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

RE: Project Numbers S5409027

Dear Mr. Brandon:

On February 16, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 1, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 5, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 13, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 1, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 21, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 1, 2017, effective March 21, 2017 and therefore remedies outlined in our letter to you dated February 16, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245409 Y1	A. Building B. Wing Y2	4/5/2017 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164	Correction	ID Prefix F0176	Correction	ID Prefix F0241	Correction
Reg. # 483.10(h)(1)(3)(i); 483.70(i)(2)	Completed	Reg. # 483.10(c)(7)	Completed	Reg. # 483.10(a)(1)	Completed
LSC	03/13/2017	LSC	03/13/2017	LSC	03/13/2017
ID Prefix F0242	Correction	ID Prefix F0280	Correction	ID Prefix F0281	Correction
Reg. # 483.10(f)(1)-(3)	Completed	Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	03/13/2017	LSC	03/13/2017	LSC	03/13/2017
ID Prefix F0309	Correction	ID Prefix F0315	Correction	ID Prefix F0323	Correction
Reg. # 483.24, 483.25(k)(l)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)(n)(1)-(3)	Completed
LSC	03/13/2017	LSC	03/13/2017	LSC	03/13/2017
ID Prefix F0325	Correction	ID Prefix F0329	Correction	ID Prefix F0371	Correction
Reg. # 483.25(g)(1)(3)	Completed	Reg. # 483.45(d)(e)(1)-(2)	Completed	Reg. # 483.60(i)(1)-(3)	Completed
LSC	03/13/2017	LSC	03/13/2017	LSC	03/13/2017
ID Prefix F0441	Correction	ID Prefix F0465	Correction	ID Prefix F0520	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)(5)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i)	Completed
LSC	03/13/2017	LSC	03/13/2017	LSC	03/21/2017

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/1/2017	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245409 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/13/2017 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	03/13/2017	LSC K0374	03/13/2017	LSC K0511	03/13/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0920	03/13/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/31/2017	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ELSW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00916

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/13/2015**

6. DATE OF SURVEY **02/01/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 02/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/13/2017 (L20)

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

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

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.
00160
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 16, 2017

Ms. Margaret Holm, Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

RE: Project Number S5409027

Dear Ms. Holm:

On February 1, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 1, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5409033, H5409036 and H5409039 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:

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

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

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

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 13, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 13, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 1, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 1, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	02/01/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. "A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey." An investigation of complaint H5409033 was completed during the survey and found not to be substantiated. An investigation of complaint H5409036 was completed during the survey and found not to be substantiated. An investigation of complaint H5409039 was completed during the survey and found not to be substantiated.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and	F 164		3/13/17

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

Electronically Signed | 02/23/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	02/01/2017

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F 164	Continued From page 1 meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by:	F 164		

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F 164	Continued From page 2 Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R106) reviewed was provided privacy during toileting. Findings include: R106's current electronic care plan indicated R106 was a fall risk and required one assist for transfers for toileting. On 1/30/17, at 10:21 a.m., nursing assistant (NA)-F was observed to assist R106 to the bathroom. NA-F opened the bathroom door, and with the bathroom door open assisted R106 to stand, pulled down R106's pants and incontinent product and assisted R106 to sit on the toilet. NA-F closed the bathroom door after R106 was seated on the toilet until R106 was finished using the toilet. When R106 indicated he was done using the toilet, NA-F opened the bathroom door and assisted R106 to stand, cleansed R106's buttocks area and assisted R106 to pull up his incontinent product and pants. R106's pants fell down while being seated in his wheelchair and NA-F wheeled R106 out of the bathroom doorway over to his side of the room. NA-F then assisted R106 to stand and pulled up R106's pants. R106's roommate R4, was seated in his wheelchair directly across from R106, in full view of R106 being assisted to pull up his pants. R4's privacy curtain was noted to be tide into a big knot and hung directly above R4's head of bed. On 1/30/17, at 10:57 a.m., NA-F confirmed R106's roommate R4 was able to view R106 being toileted when getting on and off the toilet, and when NA-F was assisting to pull up R106's pants. NA-F confirmed R4's privacy curtain was	F 164	-All room dividing curtains have been checked for successful operation -All residents have ability to affected if cares are completed without privacy being offered -All staff educated on resident right to privacy during cares -All staff has been educated on appropriate maintenance notification protocol if noticed privacy equipment is in operational need of maintenance. -1-2x/week audits for 1 month to be completed to monitor privacy practices are being offered/completed to residents during cares. -DON/designee is responsible -Audit results to be reviewed monthly at QAPI -Corrective action completed by 3/13/17	

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F 164	Continued From page 3 tide into a big knot and hung directly above R4's head of bed. NA-F stated the curtain was tied into a knot because when you open the door the curtain becomes caught in the door. NA-F confirmed privacy curtains were not used and privacy had not been provided for R106 when assisting R106 onto and off the toilet, and when pulling up R106's pants. On 1/30/17, at 3:51 p.m., the director of nursing (DON) stated not providing privacy during toileting was not acceptable. The DON stated it would be an embarrassment for both residents. The DON stated she would expect the privacy curtains to be used to provide privacy. The facility policy Dignity and Respect, dated 9/1/16, indicated Procedure: 3. Provide residents with privacy during provision of cares (e.g. close privacy curtain).	F 164		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safety assessment of self-administration of medication had been completed for 1 of 2 residents (R22) who was observed to self-administer a nebulizer medication. Finding include:	F 176	-R22 has had a self-administration assessment completed 2/23/17 to determine ability to self-administer nebulizers and inhalers. -Residents wishing to self-administer nebulizers and inhalers have the potential to be affected if an assessment of their ability to safely self-administer medications is not	3/13/17

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F 176	Continued From page 4 R22 was observed on 1/31/17, at 7:06 a.m., to be sitting in his wheelchair and had a nebulizer mask in place, with medication being administered via the nebulizer machine. No staff were present in R22's room or within view of R22. On 1/31/17, at 7:07 a.m., registered nurse (RN)-B walked down the hallway and into R22's room. When queried if R22 had been assessed for self-administration of the nebulizer medication, RN-B stated we have an order, we can leave R22 alone with the nebulizer on as long as we check on him. R22's current physician orders, identified and order dated 4/13/15, for DuoNeb (bronchodilator) solution 0.5-2.5 mg (milligrams)/3 ml (milliliters) inhale one unit four times a day. May self-administer neb treatments, nurse will dispense medication and apply mask. However, R22's record lacked an assessment indicating if R22 was able to self-administer the nebulizer medication safely. On 2/1/17, at 3:01 p.m., the director of nursing stated we just did a self-administration assessment for R22, we obtained the order for R22 to self-administer the nebulizer last week. The DON reviewed R22 electronic record and confirmed there was no assessment for self-administration for the nebulizer. The DON stated the assessment might have been done on paper. On asking to see the medication assessment form DON at this time, none was provided. The facility policy Medication Self-Administration dated revision 11/1/16, indicated Policy: It is the	F 176	completed. -Staff have been educated on completion of self-administration assessments prior to allowing self-administration of medication. -1-2x/week audits to be completed for one month on residents self-administering medications. -DNS/designee is responsible. -Audit results to be reviewed monthly at QAPI for determination of compliance and need to continue. -Corrective action completed by 3/13/2017	

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F 176	Continued From page 5 center's policy to honor resident requests to self-administer medications if determined to be a safe practice. Procedure: 1. The licensed nurse evaluates the resident who has expressed a desire to self-administer selected medications, using the evaluation for self-administration of medication. 2. The IDT review with evaluation to determine the resident's competency to self-administer medications and grant approval as appropriate.	F 176		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care in a manner to promote dignity for 1 of 1 resident (R52) observed to have uncovered catheter bag, which was visible to other residents and families. In addition, the facility failed to ensure dignity for toileting for 1 of 2 residents (R4) reviewed for urinary incontinence. Findings include: R52's quarterly Minimum Data Set (MDS) dated 10/21/16 indicated R52 had an indwelling Foley catheter, long and short-term memory problems and moderately impaired decision-making skills for daily living.	F 241	-R52 received catheter bag covering 1/31/17 -All residents with catheters were checked within facility on 1/31/17 and found to have catheter covers -All residents who have catheters have potential to be affected if catheter bags are left uncovered -All staff has been educated on dignified services residents deserve -A VA report was filed and an investigation was conducted on R4 behalf. Results concluded no harm done to resident and staff education appropriate. -All resident have the ability to be affected if they are not treated with dignity -All staff has been educated on dignified	3/13/17

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F 241	Continued From page 6 R52 was observed on 1/31/17 at 10:28 a.m. to be in bed and the catheter bag was not covered and was in view from the hallway. On 1/31/2017, at 10:38 a.m. nursing assistant (NA)-A stated R52 did not have a bag attached to the side of the bed to place the catheter in when R52 was in bed. NA-A verified the uncovered catheter bag was visible from the door. On 1/31/2017, 1:56 p.m. the director of nursing (DON) stated the facility had covers for catheter bags and my expectation is they are covered. The DON stated catheter bags should not be visible, as this is a dignity issue. The Catheter Care policy with a revision date of 1/31/17, included staff will maintain consistent and adequate hygiene standards for residents with an indwelling catheter in order to maintain comfort, function, and prevent infection and other complications. 2. Catheters bag and tubing should be secured and not allowed to touch or drag on the floor to prevent contamination. 4. Catheter bag should be kept in a protective holder/bag to protect dignity of the resident. ENSURE DIGNITY FOR TOILETING: R4's current electronic care plan indicated R4 had actual/potential for alteration in elimination related to urgency and incontinence. Required assist of one to manage incontinent briefs and check and change as need. During observation on 1/30/17, at 10:21 a.m., nursing assistant (NA)-F asked R4 if he would like to lay down in his bed and R4 replied "yeah." After R4 was laid in bed, R4 stated he had to pee, put the urinal up to my penis. NA-F stated to R4 you usually go in your brief and then I will change you. So you can just pee in your brief and I will	F 241	services residents deserve -1-2x/week audits for 1 month to be completed to ensure appropriate catheter coverings and verbal/nonverbal communication are in place that promote and maintain dignity for residents -DON/designee is responsible -Audit results will be reviewed monthly at QAPI -Corrective action completed by 3/13/17	

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F 241	Continued From page 7	F 241		

change you. R4 stated is that what I do? NA-F stated "yep!" R4 stated ok NA-F directed R4 to go and then I will change you.

On 1/30/17, at 10:57 a.m., NA-F stated R4 was to be checked and changed. I usually check his brief every two hours. R4 is usually not continent and does not tell when he has to go to the bathroom, so we just check and change him. NA-F stated R4 did not use the urinal and that was the first time he told me he had to void.

On 1/30/17, at 2:40 p.m., registered nurse (RN)-D stated the nursing assistant should have given the urinal to R4 when he requested to use the urinal.

On 1/30/17, at 3:51 p.m., the director of nursing stated she would expect staff to offer toileting appropriately. If a resident asks to use the urinal, bedpan, or toilet, the request should be accommodated and it was not acceptable to not do so.

On 1/31/17, at 2:18 p.m., R4 when queried if he knew when he had to go to the bathroom, stated "yeah." When queried how it made him feel when he wanted to use the urinal and staff did not give the urinal to him to use, R4 stated, "Well not good, but what to you do, Was not the first time and was not the last time, inexperienced." When queried if he would like to use the toilet, R4 stated, "I would be less embarrassed if I could go on the toilet."

The facility policy Dignity and Respect dated 9/1/16, indicated The community shall promote care for residents in a manner and in an environment that maintains or enhances each

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F 241	Continued From page 8 resident's dignity and respect in full recognition of his or her individuality.	F 241		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R74) reviewed for choices received baths according to their preferences for bathing frequency. Findings Include: R74 was interviewed on 1/29/17, at 2:46 p.m., the resident indicated she had not had a bath for the past two months. R74 stated she used to be scheduled to have baths in the afternoon, but switched her time to the mornings as she was not receiving the afternoon baths and she thought maybe the mornings would work better for staff. R74 stated when her breathing had not been very good she had asked for a bed bath and was not	F 242	-R74 indicated her bathing preferences on 1/30/17. R74 received a bed bath per her preference on 1/30/17. R74 care plan, Plan of Care (POC) & care guide was updated on 1/30/17. -All residents/responsible parties have experienced the "New Admissions Questions" questionnaire which inquires bathing preference(s). -New admissions/responsible parties are interviewed inquiring bathing preferences within 7 days of admittance. Information provided is care planned and placed in POC. -All residents have potential to be affected if bathing preferences are not provided	3/13/17

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F 242	Continued From page 9 provided a bed bath either. R74 stated a couple times she had been asked around 6:15 a.m. if she was ready for a bath and she told them not yet, she needed to take her medicine and get her breathing under control first, but then stated they never come back. R74 stated, "My bathing situation is pissing me off, I do not see any reason I cannot get a bed bath. R74 stated the excuse she received is they are so short staffed." Review of the current quarterly Minimum Data Set (MDS) dated 10/13/16, indicated R74's brief interview for mental status BIMS score was 15 out of 15 (meaning cognition is intact) and displayed no behavioral concerns. Review of the most current plan of care for R74, identified the resident as having self -care deficit related to COPD and history of lower back pain. Interventions; required assist of one staff with bathing, on Sunday and Thursdays at 2:00 p.m. Review of the weekly bathing sheets reviewed from 11/12/16 to 1/29/17, indicated R74 did not receive a bath during the time period reviewed. During an interview on 1/31/2017, at 8:33 a.m. nursing assistant (NA)-B stated R74 used to be on the evening bathing schedule and had been changed to a day bath. NA-B stated R74 directed her cares. NA-B stated staff are to document when a resident had a shower on the shower sheet and in the computer. NA-B stated if a resident refused a shower, staff should tell the next shift to try to complete the bath or offer a bed bath. NA-B stated staff needed to document if residents refused bathing in point of care. NA-B stated she asked residents three times, if they would like a bath during her shift and stated, if the	F 242	and bathing doesn't occur as result. -All staff has been educated on residents' rights regarding bathing preferences and protocols with residents who may refuse bathing care. -1-2x/week audits for 1 month to be completed on bathing refusals to ensure appropriate follow up and options are provided to residents timely to maintain bathing hygiene. -DON/designee is responsible -Audit results will be reviewed monthly at QAPI -Corrective action completed by 3/13/17.	

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F 242	Continued From page 10	F 242		

resident refused all three times she needed to let the nurse know. NA-B stated it could be challenging to get bathing completed because of staffing and staff calling in.

During an interview on 1/31/2017, at 10:16 a.m. nursing assistant (NA)-A stated the aides were responsible to complete the showers. NA-A stated R74's bath days were Thursday and Sundays on the evening shift. NA-A stated R74 refused to shower 60% of the time. NA-A stated staff are supposed to document when residents refused bathing. NA-A stated to be honest there are times when we can't get to any of the baths or showers when there are only two aides on the hallways.

During an interview on 1/30/17, at 11:42 a.m. social services (SS)-A stated she was unaware of any concerns related to bathing for R74. SS-A stated she not aware R74 was refused bathing services.

During an interview on 01/30/17, at 2:56 p.m. SS-A stated per the documentation on bathing R74 has not received a bath in the last two months. SS-A stated there was documentation R74 refused bathing on 1/29/17, 1/26/16, 1/5/17, 11/27/16, and 11/17/16. SS-A stated R74 was supposed to be offered bathing on Sundays and Thursdays at 2:00 p.m. SS-A stated staff were supposed to document when bathing services were provided and if residents refused bathing.

During an interview on 1/31/17, at 7:02 a.m. SS-A stated she spoke with a couple aides and stated R74 had not had a bath for two months. SS-A stated the nursing assistants she spoke to were not offering R74 bed baths. SS-A stated it would

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F 242	Continued From page 11 be care planed for staff to offer a regular bath on her scheduled bath days on Thursday and Sunday and if R74 refused, staff were to offer her a bed bath. A policy regarding bathing was requested, none was provided.	F 242		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--	F 280		3/13/17

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F 280	Continued From page 12 (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 280		

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F 280	Continued From page 13 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise a care plan to include at risk for bruising for 1 of 3 residents (R74) reviewed for non-pressure related skin concerns; failed to provide care conferences in a resident's room for 1 of 3 residents (R74) reviewed for participation in care planning and failed to revise the care plan for 1 of 3 residents (R22) related to dentures, who was reviewed for dental status. Findings Include: LACK OF CARE PLANNING FOR HIGH RISK FOR BRUISING: R74's physician orders included prednisone tablet 10 milligrams (MG), give 1 tablet by mouth one time a day for COPD. Give 10 mg in a.m. in addition to 1 mg at HS [bedtime], equals 11 mg daily. Start date 1/5/17. R74's current electronic care plan did not address R72 was at increased risk for bruising related to the use of prednisone. R74 was observed on 1/29/17, at 3:17 p.m., R72 had a large bruise on her forearm. R72's record	F 280	-R74 care plan has been updated to include risk for bruising -All residents receiving medications with known risk for increased bruising have had their care plans reviewed and updated if needed -R74 has been interviewed and has agreed to have her care conferences held in her room so that she can attend -All residents are being offered alternative site for care conference if not wanting to attend in conference room -Policy and procedure titled 'Participation in Care Conferences' has been reviewed and updated -R22 care plan has been updated to include being edentulous (denture broken and family declined to get fixed) -Staff educated to communicate changes in resident condition via the 'Nursing Services Daily Communication' form. This form will be brought to the next clinical meeting (held Mon-Fri except holidays or special occasions) with care plans updated as needed. -DNS/designee is responsible -Audits of care plan meetings and resident care plans will be done for at least 2	

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F 280	Continued From page 14 did not reflect identification or monitoring of the bruise. R74's progress notes were reviewed from 1/3/17 to 2/1/17 the documentation did not reflect identification or monitoring of the bruise. During an interview on 1/31/17, at 8:46 a.m., nursing assistant (NA)-B stated she looked at residents' skin during daily and on bath day. NA-B stated she reported any skin concerns to the nurse right away. On 2/01/17, 9:39 a.m., registered nurse (RN)-C verified through observation R74 had a bruise on her right forearm. RN-C stated the bruise measured 4.5 centimeters (cm) x 4.8 cm. RN-C stated she would document the findings in a progress note and would enter a nursing order for observation of bruise for healing on the treatment record. RN-C stated R74 was on prednisone and bruised easily. During an interview on 2/01/17, at 10:20 a.m., the director of nursing (DON) stated staff monitored residents' skin on their shower day. The DON stated staff completed a bath sheet that had a section on it for skin issues, vital, signs and weights. The DON stated staff are to fill out the form and provide the form to the nurse. The DON stated if there was an identified skin issue it was to be addressed by the nurse, there should be a progress note and an accident/incident report completed. The DON stated nursing was to track the bruising for worsening and resolution. The DON stated staff are to monitor skin anytime they providing care and report concerns to the nurse. The DON stated she would expect a care plan to be developed for residents that are at risk for loss	F 280	residents per week for one month to ensure care conferences are offered at alternative areas and care plans are updated timely with resident changes. -Audits will be reviewed at monthly QAPI for determination of compliance and continuation. -Corrective action completed by 3/13/2017	

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F 280	Continued From page 15	F 280		

of skin integrity, which would include bruising or any skin injury.

LACK OF PARTICIPATION IN CARE PLANNING:

R74 was interviewed on 1/29/17, at 3:07 p.m., when asked do staff include you in decisions about your medicine, therapy, or other treatments. R74 responded, "No." R74 stated she was unaware of what a care conference was and stated, "Does that tell you if I have ever been to one."

R74's care conference progress notes were reviewed and revealed resident had not attended any of the care conferences held at the facility since her admission.

During an interview on 1/30/17, at 11:55 a.m., social services (SS)-A stated R74 refused to leave her room to come to care conferences. SS-A stated R74 told her she could not leave her room because she took Lasix and used the bathroom frequently. When asked if the facility had considered having care conferences in R74's room so she could participate in the care conferences, SS-A stated the facility had not offered to have a care conference in her room.

During an interview on 2/01/17 at 9:50 a.m., SS-A stated she had talked with R74 about having care conferences in her room, and R74 thought that was a good idea as she would not need to worry about coming down to the conference room for the meeting.

R74 was interviewed on 2/01/17, at 10:07 a.m., R74 stated the social worker had visited with her today regarding having care conferences in her

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F 280	Continued From page 16	F 280		

room. R74 stated she agreed to have care conferences in her room. R74 stated she did not like to leave her room because of her frequent need to use the bathroom and her breathing problems.

During an interview on 2/01/17, at 10:15 a.m. the director of nursing (DON) stated R74 should have been offered the option to have care conferences held in her room if she did not want to leave her room to attend care conferences. The DON stated she would look for a policy regarding participation in care conferences and a policy was not provided.

REVISION OF CARE PLAN DENTAL STATUS:

R22's current electronic care plan identified: Focus: self-care deficit related to impaired mobility, anxiety disorder, borderline personality disorder, and alert with confusion. Interventions included oral care; wears dentures; assist of one to brush BID (twice daily) and soak overnight.

On 1/29/17, at 2:05 p.m., R22 was observed to have no teeth or dentures in his mouth.

On 2/1/17, at 9:59 a.m., registered nurse (RN)-C by observation confirmed R22 had no dentures in place. RN-C looked through R22's room and stated she did not see any dentures for R22 in his room.

On 2/1/17, at 10:13 a.m. nursing assistant (NA)-E stated R22 used to wear dentures. R22 threw the dentures out of his mouth and the dentures broke. I do not think they are going to get new ones. NA-E stated it had been maybe a couple of months since R22 had not had his dentures.

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F 280	Continued From page 17 On 2/1/17, at 10:50 a.m., RN-C stated social service informed R22's dentures were broke and family does not want the dentures replaced. RN-C stated she had informed R22's care plan needs to be updated. On 2/1/17, at 2:02 p.m. social services (SS)-A stated she had R22's broken dentures. I called the family and they did not want the dentures replaced. SS-A stated R22's dentures were broke a long time ago and she had not documented any information regarding R22's broken dentures. On 2/1/17, at 2:42 p.m. the director of nursing (DON) stated her expectation would be moving forward anytime something like that happens there should be a report filled out on what happened, family notified and documented in the resident notes. The DON confirmed R22's care plan identified R22 had dentures and stated the care plan should have been updated. The DON stated she was not aware R22's dentures were broken. The facility policy Care Plan Quarterly Review, dated 10/1/16, indicated Procedure and Implementation: 1. The care planning interdisciplinary team is responsible for maintaining care plans on a current status.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 281		3/13/17

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F 281	Continued From page 18 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions implemented for falls was included on the temporary care plan (this includes admission date to 21 days when first comprehensive assessment is completed and care planned interventions) for 1 of 2 residents (R106) reviewed for falls/accidents. Findings include: R106's Admission Record dated 2/1/17, identified R106 had diagnoses that included depression, dementia, rheumatoid arthritis, malaise and vitamin D deficiency. Also admitted to facility on 1/12/17. During observation on 1/31/17, at 8:57 a.m., R106 laid in bed, fall mat in place on floor next to bed, bed was in a low position and call light was within reach. R106's current electronic care plan identified Focus: alteration in mobility: potential for injury related to fall risk: due to debility, dementia. Interventions: Ensure nonskid socks and proper fitting shoes. Locomotion; wheelchair, assist of one to propel to destination of choice. Offer toileting every two to three hours while awake. Transfers; assist of one with forward wheeled walker. Assist as needed. R106's Short Term Resident Plan of Care dated 1/12/17, identified fall risk: yes and other was marked, but had no falls interventions to prevent falls.	F 281	-R106 care plan has been reviewed and is current -Residents who have been deemed high risk for falls have had their care plans reviewed and are current -All resident who experience a fall has potential to be affected -Staff was educated regarding new fall prevention interventions to be placed on the communication sheet until reviewed by the IDT on the next business day at which time they will be placed in the electronic comprehensive care plan -DNS/designee is responsible -1-2x/week audits for 2 months will occur to ensure proper intervention communications were placed after a resident fall. -Results brought to the monthly QAPI for determination of compliance and continuation -Corrective action completed by 3/13/17	

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F 281	Continued From page 19 R106's nursing assistant care guide sheet undated, identified fall risk high and again no falls interventions to prevent falls. R106's Accident/Incident Reports identified the following: On 1/16/17, at 5:45 p.m., a fall in room laying on floor half in bathroom and half in room, root cause: needed to use the bathroom for bowel movement. Intervention initiated: staff to toilet right after supper. On 1/17/17, at 3:15 p.m., a fall in room, attempting to self transfer from bed. Causative factors reviewed. Intervention implemented close supervision, check frequently when in bed. R106's care plan failed to include the intervention of toilet right after supper, check frequently when in bed, and fall mat on floor when in bed. On 2/1/17, at 2:32 p.m., the DON stated she would expect interventions implemented to be care planned. The facility policy Care Plan Quarterly Review, dated 10/1/16, indicated Procedure and Implementation: 1. The care planning interdisciplinary team is responsible for maintaining care plans on a current status.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and	F 309		3/13/17

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F 309	Continued From page 20 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor bruising for 3 of 3 residents (R74, R102 & R22) reviewed for non-pressure related skin concerns. Findings Include: R74 was observed on 1/29/17, at 3:17 p.m., R72 had a large bruise on her forearm. R72's record did not reflect identification or monitoring of the this bruise. R74's progress notes were reviewed from 1/3/17 to 2/1/17 and the documentation did not reflect identification or monitoring of the bruise. R74's physician orders included prednisone tablet 10 milligrams (MG), give 1 tablet by mouth one	F 309	-R74, R102 and R22 had bruise monitoring added to the eTAR to be checked weekly until bruises were healed -On 1/31/17 and continuing thereafter, staff was educated via 'Today at a Glance' form regarding immediate reporting of any new skin issues (bruises, skin tears…) -Skin issues are added to the eTAR for weekly tracking until healed and a note is placed in the electronic record -All residents have potential to be affected if skin concerns are not monitored -DNS/designee is responsible -Random audits of at least 5 different residents per week will be conducted for one month to ensure that proper notification is being given and monitoring is occurring.	

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F 309	Continued From page 21 time a day for chronic obstructive pulmonary disease (COPD). Give 10 mg in a.m. in addition to 1 mg at HS [bedtime], equals 11 mg daily. R74's current electronic care plan did not address R72 was at increased risk for bruising related to the use of prednisone. R74's bath sheet dated 1/31/17 indicated bruising to the right arm. During an interview on 1/31/17, at 8:46 a.m., nursing assistant (NA)-B stated she looked at residents' skin during cares daily and on bath day. NA-B stated she reported any skin concerns to the nurse right away. On 2/01/17, 9:39 a.m., registered nurse (RN)-C verified through observation R74 had a bruise on her right forearm. RN-C stated the bruise measured 4.5 cm x 4.8 cm. RN-C stated she would document in a progress note and would enter a nursing order for observation of bruise for healing on the treatment record. RN-C stated R74 was on prednisone and bruised easily. During an interview on 2/01/2017, at 1:55 p.m., the DON stated the assistant director of nursing (ADON) had brought R74's skin monitoring form completed on 1/31/17 following her bath. The DON verified there was no documentation regarding the bruise in R74's clinical record. The DON stated she did not find documentation in the nurses notes regarding the bruise and an incident report was not completed related to the bruise which should have been completed. During an interview on 2/01/2017, at 2:07 p.m., the DON stated that RN-B who had worked	F 309	-Audit results will be brought to the monthly QAPI for determination of compliance and continuation -Corrective action completed by 3/13/17	

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F 309	Continued From page 22 yesterday stated he was not informed of R74's bruise. R102 was observed on 1/29/17, at 5:47 p.m., R102 had bruises on his left forearm and back of his left hand. R102's record did not reflect identification or monitoring of these bruises. R102's current electronic care plan directed staff to, "monitor skin with cares for changes." R102's progress notes were reviewed from 1/9/17 to 2/1/17 the documentation did not reflect identification or monitoring of the bruises. R102's bath sheet dated 1/20/17 indicated no skin concerns. During an interview on 01/31/17, at 11:01 a.m., nursing assistant (NA)-A stated she monitored resident's skin when she got them dressed, undressed, during cares and on shower days. NA-A stated bruises were to be reported to the nurse right away. On 2/01/17, 9:54 a.m., registered nurse (RN)-C verified through observation R102 to have fading bruising on the left forearm measuring 3 centimeters (cm) x 3.2 cm and to back of left hand measuring 1.2 cm x 1.5 cm. RN-C stated staff should report any new bruises to the nurse, for the nurse to assess and follow up. During an interview on 2/01/17, at 10:20 a.m., the director of nursing (DON) stated staff monitored residents' skin on their shower day. The DON stated staff completed a bath sheet that had a section on it for skin issues, vital, signs and	F 309		

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weights. The DON stated staff are to fill out the form and provide the form to the nurse. The DON stated if there was an identified skin issue it was to be addressed by the nurse, there should be a progress note and an accident/incident report completed. The DON stated nursing was to track the bruising for worsening and resolution. The DON stated staff are to monitor skin anytime they providing care and report concerns to the nurse. The DON stated she would expect a care plan to be developed for residents that are at risk for loss of skin integrity, which would include bruising or any skin injury.
R22 was observed on 1/29/17 at 1:59 p.m. R22 had a scabbed area with bruising on his left upper arm and a purple bruise on his right upper arm. R22's record did not reflect identification or monitoring of the bruises.

R22's current electronic care plan directed staff to monitor skin with cares and report changes.

R22's progress notes were reviewed from 1/5/17 to 2/1/17 the documentation did not reflect identification or monitoring of the bruises.

R22's bath sheet dated 12/31//16, 1/14/17, and 1/19/17 indicated no skin concerns.

On 2/1/17, at 10:01 a.m., RN-C verified through observation R22 had bruising on left upper arm measuring 2 cm x 1 cm and 1.5 cm x 1 cm. On right upper arm 4.4 cm x 0.6 cm. RN-C confirmed R22's record lacked identification or monitoring of the bruises. RN-C stated nursing assistants are to report bruises and I would then fill out an incident report and report.

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F 309	Continued From page 24 On 2/2/17, at 2:57 p.m., the DON stated her expectation was bruising, skin tears, laceration, red marks need to be documented, an incident report form filled out. The DON stated the area needed to be measured and documented in the facility computer system resident progress notes, document weekly on the areas until resolved and implement intervention to prevent recurrence. The Skin Assessment policy and procedure dated 1/13/17, included, skin injuries (skin tears, bruises) will be assessed and measured at least every seven (7) days by licensed nurse, and recorded in the medical record. Caregivers are responsible for promptly notifying the nurse of skin observations, including bruises. The resident's care plan will be revised as appropriate, to reflect the alteration of skin integrity, approaches and goals for care.	F 309		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 315		3/13/17

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	245409	A. BUILDING _____ B. WING _____	02/01/2017

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F 315	Continued From page 25 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide catheter care/services to reduce the chance of a resident developing a urinary tract infections (UTI) for 1 of 1 resident (R52) with an indwelling Foley catheter. In addition, the facility failed to maintain bladder function to the highest extent as possible for 1 of 2 residents (R4) reviewed for urinary incontinence. Findings include: R52's quarterly Minimum Data Set (MDS) dated 10/21/16 indicated R52 had an indwelling Foley catheter, long and short-term memory problems and moderately impaired decision-making skills for daily living.	F 315	-R52 received a catheter bag change and catheter covering on 1/31/17 -All residents with catheters were assessed 1/31/17 and catheter bags were in place -All residents with catheters have covers in place -NA-F was educated and signed dignity policy on 1/31/17 re: resident dignity of providing urinal and not encouraging resident to be continent. A VA report was filed for R4 on 1/30/17 and determined that no harm occurred. -Bowel and bladder assessment for R4 was completed on 2/23/2017 -All residents' bowel and bladder assessments have been reviewed and are current	

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F 315	Continued From page 26 R52 was observed on 1/31/17 at 10:28 a.m. to be in bed, the catheter bag was not covered, was attached to the bed and the bag was resting on the floor. On 1/31/17, at 10:38 a.m. nursing assistant (NA)-A stated R52 did not have a bag attached to the side of the bed to place the catheter in when R52 was in bed. NA-A verified the uncovered catheter bag was resting on the floor. On 1/31/17, 1:56 p.m. the director of nursing (DON) stated the facility had covers for catheter bags and her expectation was all catheter bags are to be covered. The DON stated it was an infection control concern if a catheter bag was not covered and rested on the floor. The Catheter Care policy with a revision date of 1/31/17, included staff will maintain consistent and adequate hygiene standards for residents with an indwelling catheter in order to maintain comfort, function, and prevent infection and other complications. 2. Catheters bag and tubing should be secured and not allowed to touch or drag on the floor to prevent contamination. 4. Catheter bag should be kept in a protective holder/bag to protect dignity of the resident. R4's quarterly Minimum Data Set (MDS) dated 11/28/16, indicated R4 was always incontinent of bladder, was not on a toileting program for bladder, required two assist to toilet and had severe cognition deficit. During observation on 1/30/17, at 10:21 a.m., nursing assistant (NA)-F asked R4 if he would like to lay down in his bed and R4 replied "yeah." After R4 was laid in bed, R4 stated he had to pee, and to put the urinal up to my penis. NA-F stated	F 315	-All resident have ability to be affected if dignity is not upheld -The policy Bowel and Bladder Assessment has been reviewed and updated -Nursing staff have been educated regarding resident dignity, accurate and timely bowel and bladder assessments and individualized care plan interventions for toileting -DNS/designee is responsible -Audits will occur at least 2x per week for a month to ensure compliance. -Audit results will be brought to monthly QAPI for determination of compliance and continuation. -Corrective action completed 3/13/2017	

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to R4 you usually go in your brief and I then change you. So you can just go in your brief and I will change you. R4 stated is that what I do? NA-F stated, "Yep!" R4 stated ok and proceeded to urinate in the incontinent brief.

R4's record identified a facility Bowel and Bladder Quarterly review dated 9/4/16. R4's record lacked a current Bowel and Bladder assessment for the most recent MDS dated 11/28/16.

R4's current electronic care plan indicated R4 had actual/potential for alteration in elimination related to urgency and incontinence. History of urinary tract infection (UTI) (recent) and malignant neoplasm of prostate. Check and change as needed with peri-care, barrier cream, assist of one for hygiene, incontinence care after each incontinent episode, monitor/document/report signs/symptoms of UTI, assist of one for transfers, wears briefs/assist of one to manage.

R4's care plan lacked to include how often R4 should be toileted and what level of incontinence R4 had (continent, occasionally incontinent, frequently incontinent or always incontinent) to determine incontinent interventions to prevent further decline in bladder incontinence and prevent UTIs.

On 1/30/17, at 10:57 a.m., NA-F stated R4 was to be checked and changed. I usually check his brief every two hours. R4 is usually not continent and does not tell when he has to go to the bathroom, so we just check and change him. NA-F stated R4 did not use the urinal and that was the first time he told me he had to void. NA-F reviewed R4's nursing assistant care sheet at the time and

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confirmed the sheet read under the topic Toilet/Brief: briefs and pull ups. NA-F confirmed the sheet did not indicate how often R4 should be toileted.

On 1/30/17, at 2:40 p.m., registered nurse (RN)-D confirmed the last Bowel and Bladder Assessment completed for R4 was dated 9/4/16. RN-D stated there should have been another assessment after 9/4/16. RN-D Confirmed R4's care plan lacked to include how often R4 should be toileted and R4's level of continence. RN-D stated the nursing assistant should have given the urinal to R4 when he requested to use the urinal. That tells me why they are always marking incontinent, because they are not giving him the opportunity to toilet.

On 1/30/17, at 3:22 p.m., the assistant director of nursing (ADON)-D reviewed R4's record and confirmed the last Bowel and Bladder assessment completed for R4 was dated 9/4/16.

On 1/30/17, at 3:51 p.m., the director of nursing (DON) stated she would expect staff to offer toileting appropriately. If a resident asks to use the urinal, bedpan, or toilet, the request should be accommodated and it was not acceptable to not do so. The DON stated a bowel and bladder assessment was to be completed quarterly. The DON confirmed the last facility bowel and bladder assessment completed for R4 was dated 9/4/16. The DON stated she would expect R4's care plan to include how often R4 was to be toileted and R4's level of continence. The DON stated R4 should be scheduled to be toileted every two hours and per the resident request.

On 1/31/17, at 2:18 p.m., R4 when queried if he

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F 315	Continued From page 29 knew when he had to go to the bathroom, stated "yeah." When queried how it made him feel when he wanted to use the urinal and staff did not give the urinal to him to use, R4 stated, "Well not good, but what do you do, Was not the first time and was not the last time, inexperienced." When queried if he would like to use the toilet, R4 stated, "I would be less embarrassed if I could go on the toilet." The facility policy Bowel and Bladder Assessment dated 1/15, indicated Policy: Based on the resident's comprehensive assessment, the facility will ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible. Procedure: 1. Each resident will be assessed for at least 72 hours to help establish bowel and bladder voiding patterns. This will be done on admission, with significant change in status, and with a significant change in elimination patterns. 4. The residents plan of care will be developed to address goals and appropriate individualized interventions. The policy failed to address quarterly bowel and bladder assessments.	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		3/13/17

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F 323	Continued From page 30 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently comprehensively assess for root cause analysis of falls and then develop falls interventions for 1 of 2 residents (R106) reviewed for accidents. Findings include: R106's Admission Record dated 2/1/17, identified R106 had diagnoses that included depression, dementia, rheumatoid arthritis, malaise and vitamin D deficiency. During observation on 1/31/17, at 8:57 a.m., R106 laid in bed, fall mat in place on floor next to bed, bed was in a low position and call light was within reach. R106's Morse Fall Scale (a tool used to determine falls risk) dated 1/2/17, identified score	F 323	-R106 had no adverse effects regarding to falls -All residents who fall have potentially to be affected -Residents who have been deemed high risk for falls have had their care plans reviewed and are current -The policy and procedure 'Fall Prevention' has been reviewed and updated -Staff was educated regarding finding of root cause of fall and immediate intervention for fall prevention to be placed on the communication sheet until reviewed by the IDT on the next business day at which time they will be placed in the electronic comprehensive care plan -DNS/designee is responsible -1-2x/week audits for 2 months will occur to ensure proper intervention	

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F 323	Continued From page 31 of 65 (score of 45 and higher, high risk). R106's current electronic care plan identified Focus: alteration in mobility: potential for injury related to fall risk: due to debility, dementia. Interventions: Ensure nonskid socks and proper fitting shoes. Locomotion; wheelchair, assist of one to propel to destination of choice. Offer toileting every two to three hours while awake. Transfers; assist of one with forward wheeled walker. Assist as needed. R106's Short Term Resident Plan of Care dated 1/12/17, identified fall risk: yes and other was marked, but had no falls interventions to prevent falls/injuries. Also included admission date of 1/12/17. R106's nursing assistant care guide sheet undated, identified fall risk high and again no falls interventions. R106's Accident/Incident Reports identified the following: On 1/13/17, 8:45 p.m., a fall public bathroom. Last time toileted 6:15 p.m., root cause: wandering, looking for exit. No intervention put into place. On 2/1/17, at 2:30 p.m., the director of nursing (DON) confirmed no intervention was initiated. On 1/16/17, at 5:45 p.m., fall in room laying on floor half in bathroom and half in room, root cause: needed to use the bathroom for bowel movement. Intervention initiated: staff to toilet right after supper. On 1/17/17, at 3:15 p.m., fall in room, attempting to self transfer from bed. Causative factors reviewed. Intervention implemented close supervision, check frequently when in bed.	F 323	communications were placed after a resident fall. -Results brought to the monthly QAPI for determination of compliance and continuation -Corrective action completed by 3/13/17	

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F 323	Continued From page 32 On 1/20/17, at 5:30 a.m., fall in room attempting to self transfer, rolled out of bed. The Fall Scene Investigation Form (FSI), which reviews for root cause of fall, included only one page. No root cause was identified and no intervention was initiated. On 2/1/17, at 2:30 p.m., the DON confirmed root cause was not identified and no intervention was implemented. On 2/1/17, at 2:32 p.m., the DON stated she would expect interventions implemented to be care planned. The DON stated when a fall occurs staff are to fill out an accident /incident report and an FSI form. The DON stated we also have a fall intervention sheet which staff can utilize to initiate an intervention right away after a fall. The facility policy Care Plan Quarterly Review, dated 10/1/16, indicated Procedure and Implementation: 1. The care planning interdisciplinary team is responsible for maintaining care plans on a current status. A facility fall policy was requested, but not provided.	F 323		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless	F 325		3/13/17

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F 325	Continued From page 33 the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to address a severe weight loss for 1 of 3 residents (R22) reviewed for nutrition. Findings include: R22's quarterly Minimum Data Set (MDS) dated 11/8/16, identified weight of 188 pounds, mechanical altered diet, no weight loss or weight gain and required one assist to eat. On 1/30/17, at 12:36 p.m., R22 was observed to be seated in his wheelchair in the dining room, eating the meal independently. R22's current care plan identified, Focus: potential for alteration in nutrition less than body requirements related to CKD (chronic kidney disease) and COPD (chronic obstructive pulmonary disease). At risk for dehydration related to takes a diuretic. Interventions included diet general, eats meals in the dining room. Eating; resident not always feeding self. Staff to assist as resident allows. Encourage independence. Encourage fluid, due to foul smelling urine. Encourage snacking. Monitor for signs and symptoms of dehydration; dry tongue, poor skin turgor, dry skin, concentrated urine, dark urine,	F 325	-R22's weight is returned to baseline (186 pounds) as of 2/20/2017. He will be weighed weekly for three months and then reviewed for need to continue weekly weights -Scales are calibrated monthly -Policy / Procedure "Weight and Height Measurements" reviewed and updated -Nursing staff educated to have resident re-weighed no later than the next am shift for any weight change of +/- 3# in one week or +/-5# in one month unless otherwise ordered and if weight remains unchanged, to follow policy and procedure for reporting and follow-up. -Culinary Services Manager / DON / designee to review weights weekly and PRN for significant changes and to involve dietician as needed -Culinary Services Manager/DON/designee is responsible -Audit of 2-3 resident weights will occur weekly to determine necessary re-weighs are being done and reported. -Results brought to the monthly QAPI for determination of compliance and continuation -Corrective action completed by 3/13/2017	

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F 325	Continued From page 34 fever. ST (speech therapy) as ordered. Supplements as ordered. Weights as ordered. R22's weights documented in the computer system in pounds: On 2/1/17, at 8:32 a.m., surveyor requested from the director of nursing (DON) a reweigh for R22. The reweigh weight reported to surveyor was 178 pounds. A loss of 11 pounds in one month compared to 189 pounds on 1/4/17 (5.8 percent loss in one month, a severe weight loss). 1/19/17 weight recorded of 173 pounds. 1/4/17 189 Wheelchair 12/19/16 186.6 Mechanical Lift 12/17/16 189 Mechanical Lift 12/15/16 189 Mechanical Lift 11/28/16 182.8 Mechanical Lift 11/16/16 185 Mechanical Lift R22's progress notes identified on 1/30/17 Nutrition/Dietary Note Current weight documented at 173 pounds and this reflects weight loss of 8.5 percent in two weeks. Registered dietician request reweigh for accuracy but not same day or next a.m.. However, reweigh was completed on 2/1/17 as requested by surveyor and found to be 178 pounds. . On 11/22/16 Nutrition/Dietary Note Resident will consume > (greater than) 75 percent of meals daily and show no signs/symptoms of dehydration. Will maintain adequate nutrition. On 11/16/16 Nutrition/Dietary Note nutritional assessment: Diet mechanical Soft with Med Pass 2.0, 120 ml (milliliters) three times daily with meds. Fluids to be encouraged. Resident is dependent on staff for food/fluid and usual intake, > 75 percent. Textures altered for chewing, swallowing. Current weight 187.6 pounds and weight graph very erratic. Resident's usual weight	F 325		

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in the 180's. Staff to monitor intake, weights, hydration per policy/physician order; notify CDM (certified dietary manager, RD (registered dietician) as needed.
R22's physician orders identified an order dated 5/24/16 for med pass (supplement) 2.0, 120 ml (milliliters) three times daily with meds due to weight loss. Order date 11/15/16, general diet, mechanical soft texture.

Review of R22's physician notes identified on 11/15/16 R22 had been eating about 90 percent of meals, does receive supplements three times per day for some weight loss. Weight is 187.6 pounds, which is down slightly from 188 a month ago.

During interview on 2/1/17, at 8:32 a.m., registered dietician (RD)-F had been asked about R22's note dated 1/30/17 regarding weight loss of 8.5 percent over the past two weeks and getting a timely reweigh done. RD-F said, "If I requested a reweigh to be done before I leave the facility, I would be here for weeks." As she did not address the 8.5 percent weight loss by ordering supplements or other interventions to prevent further rapid weight loss.

During interview on 2/1/17, at 2:46 p.m., the director of nursing (DON) stated the facility system for weights was to obtain weights on bath day and written down on the bath sheet. The nurse reviews and documents the weight into the computer system. If significant weight loss is found they notify DON or the assistant director of nursing and notify the nurse practitioner. Investigate for causative factors and rectify. Nurses are to get a reweigh if way out of range on that same day. The RD prints off weight sheet out

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F 325	Continued From page 36 of the computer system, which includes all residents weekly. The DON confirmed weight loss for R22 had not been identified and reported to her after RD-F's visit on 1/30/17. The DON stated R22's weight loss should have been identified, the physician should have been notified and an intervention implemented. The facility policy Weight and Height Measurements dated 8/1/15, indicated Procedure: 5. If loss or gain noted (5% in one month; 7.5% in three months; 10% in six months) re-weigh within 24 hours. 6. Physician, resident/legal representative, family, nursing staff, social services, activities, and dietary are to be notified upon identification of significant/severe weight loss/gain. 7. Evaluate and document reason for weight change in medical record and add to care plan. 8. Implement interventions as necessary. 9. If aggressive intervention does not correct weight change, a NP/MD reassessment may be necessary. The facility policy Dietician Services dated 8/1/15, indicated Policy: a qualified dietician will help oversee clinical nutritional dietary services in the facility. Policy Interpretation and Implementation 3. The dietician will work closely with the dietary manager and clinical staff. 4. Our facility's dietician is responsible for, but not necessarily limited to: a. Assessing nutritional needs of residents; c. Collaborating effectively with other direct care staff and practitioners to assess and address nutritional issues in the communities population.	F 325		
F 329 SS=E	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		3/13/17

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F 329	Continued From page 37 (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an abnormal involuntary movement scale (AIMS) assessment was completed per provider order for 1 of 5 residents (R32); failed to identify specific symptoms of depression for 1 of 5 residents (R22) to determine if the antidepressant was affective; and failed to complete a comprehensive sleep assessment to determine the need for sleep aids ordered for insomnia for 3 of 5 residents (R57, R22, R102) reviewed for unnecessary medications. Findings include: R32's diagnosis found on the admission record dated 1/7/15, identifies Major Depressive	F 329	-R32 AIMES assessment is complete with a score of 0, no adverse effects from delayed AIMES test -R57 is currently hospitalized, sleep assessment and monitoring will occur at time of readmission, if needed -R22 sleep log is now found on the TAR for q shift hours of sleep to be done for seven days; individualized behaviors are now being tracked q shift -For all residents receiving psychotropic medications the AIMES testing has been set up to be done on admission and quarterly and with significant change/psychotropic medication changes. Individualized behaviors are now set up for each resident as well as	

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F 329	Continued From page 38 Disorder, recurrent, unspecified. Medication Review Report dated 2/1/17, identifies an order dated 2/29/16 to complete an AIMS assessment every 6 months, one time a day every six months starting on the last day of the month for one day for quetiapine (fumerate an antidepressant) use. Quetiapine Fumarate 25 mg, give 0.5 mg tablet by mouth one time a day for hallucinations/paranoia. Order dated 8/5/16. Medication Administration Record for the month of January 2017, identifies R32 received scheduled Quetiapine Fumarate as scheduled once daily. Care plan revised on 3/28/16, identifies R32 takes antipsychotic medication related to paranoia, major depressive disorder, anxiety, dementia with behavioral episodes. Care plan identifies to complete AIMS assessment every 6 months. AIMS assessment was completed on 3/1/16 with a score of 0 which identifies no signs or symptoms of tardive dyskinesia (side effects related to the use of antipsychotics). Facility performed AIMS assessment on 2/1/17 ten months form previous assessment, after brought to their attention by surveyor. Interview on 2/1/17, at 9:43 a.m. with director of nursing (DON) verified an AIMS assessment had not been completed every 6 months per the provider order. DON stated she would expect the AIMS assessment to have been completed as ordered. DON stated the floor nurses are responsible for completing all assessments.	F 329	non-pharmacological approaches to be used prior to use of PRN psychotropic medication use. -For all residents receiving hypnotics; sleep logs are done on the TAR indicating hours of sleep per shift for seven days prior to their quarterly MDS schedule. Sleep logs will be reviewed quarterly and PRN Staff has been educated in the use of individualized behavior monitoring, new forms, and AIMES schedule. -Policy and Procedure titled 'Sleep Assessment' has been reviewed and updated -Audits of at least 2 residents per week receiving psychotropic medication will be done for a month to ensure appropriate behaviors are being monitored and current AIMES assessment has been completed. --Audits of at least 2 residents per week receiving hypnotics will be completed for one month to ensure sleep monitoring is being done. -DNS/designee is responsible -Audits will be reviewed at monthly QAPI to determine compliance and continuation -Corrective action completed by 3/13/2017	

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F 329	Continued From page 39	F 329		

Policy titled, "Police and Procedure AIMS Assessment", dated 8/1/15, identifies AIMS form will be updated every 6 months by the licensed nurse.

SLEEP ASSESSMENT:

R57's diagnosis found on the admission record dated 4/11/16, identifies Insomnia.

R57's care plan last revised on 10/27/16 does not identify the use of a sleep aide.

Medication Review Report dated January 2017, identifies order for Melatonin (hormone to help sleep) 3 mg, give 2 tablets orally at bedtime for sleep. Order start date of 10/25/16.

Medication Administration Record (MAR) dated January 2017, identifies R57 receiving scheduled Melatonin per order.

Treatment Administration Record (TAR) dated January 2017, does not identify sleep monitoring or sleep assessment.

Interview on 1/31/17, at 8:14 a.m. with registered nurse (RN)-B stated he was unaware of any sleep monitoring occurring for R57.

Interview on 1/31/17, at 8:26 a.m. with director of nursing (DON) stated sleep assessments occur shortly after admission, quarterly and as needed.

Interview on 1/31/17, at 9:44 a.m. with Minimum Data Set (MDS)-A a coordinator stated nurses do the sleep assessments. MDS-A coordinator stated sleep assessments should be set up in the TAR for the nurses to know when to complete.

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F 329	Continued From page 40 MDS-A coordinator verified R57 did not have a sleep assessment completed. Interview on 1/31/17, at 10:25 a.m. with DON stated she would expect any resident on Melatonin to have a sleep assessment completed. DON stated a sleep study should have occurred prior to R57 starting a sleeping aide. DON verified R57 did not have a sleep assessment completed. LACK OF SLEEP ASSESSMENT AND RESIDENT SPECIFIC MOOD SYMPTOMS/SIGNS TO DETERMINE IF ANTIDEPRESSANT IS AFFECTIVE: R22's current physician orders included: start date 12/27/15, Cymbalta (antidepressant) 60 mg (milligrams) one time a day for major depressive disorder and start date 7/17/15, Melatonin (hormone used for sleep aide) 5 mg at bedtime for behaviors and not sleeping at night. R22's Medication Administration Record for the month of 1/17, identified R22 was receiving the Cymbalta and Melatonin as ordered. R22's current care plan included the following: Focus: takes an antidepressant medication related to depressive disorder. Interventions: monitor/document/report adverse side effects, administer medication as ordered. Monitor/document effectiveness. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of antidepressant use. Gradual dose reduction per Pharmacist/medical doctor or nurse practitioner recommendation as able and if applicable. Focus: social services mood and behavior; displays signs of mood/behavior possibly related	F 329		

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F 329	Continued From page 41	F 329		

to socialized conduct disorder, explosive personality disorder, anxiety disorder and depressive disorder. At times calls out spouse name to female peers thinking they are his wife. Becomes agitated when they do not answer. Interventions: At times calls out spouse name to female peers thinking they are his wife. Becomes agitated when they do not answer. Behaviors being monitored: verbally abusive, refusal of cares, yelling out, hallucinations/delusions, sleepiness at night and hitting/kicking at staff. Offer food/fluids/toileting. Staff to assist to calm quiet area. Staff will ask resident if he is having pain. Staff will provide reassurance if behaviors begin. Staff will try redirection. Staff will try to re-approach if behaviors begin. Staff will use a calm speaking voice. Try 1:1 visits. Focus: takes hypnotic medication related to sleep, on melatonin. Interventions. Monitor/document adverse side effects. Administer medications per doctor order. Gradual dose reduction per pharmacist/doctor/nurse practitioner recommendation as able and if applicable.

On 2/1/17, at 10:13 a.m., nursing assistant (NA)-D when queried what behaviors were the nursing assistants charting on in the computer for R22, NA-D stated the behaviors charted on in the computer were the same for all residents and were charted on every shift. NA-D sated R22 had behaviors of yelling out, combativeness, refusal of cares, screaming wanted wife and wanted to go home. Review of the behaviors with NA-D at the time of interview being documented in the facility computer system for all residents were abusive behavior, biting, frequent crying, grabbing, kicking, hitting, pinching, scratching, spitting, pushing, rejection of care, repeats movement, repeats verbalization, threatening

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F 329	Continued From page 42 behavior, sexually inappropriate, wandering, yelling, screaming. On 2/1/17, at 3:01 p.m., the director of nursing (DON) stated sleep assessments were to be completed upon admission, quarterly and as needed. The DON confirmed a sleep assessment had not been completed for R22. The DON confirmed R22's care plan lacked to identify resident specific symptoms of depression. The facility policy Psychotropic Medications dated 8/1/15, indicated Procedure: 1. An assessment must be conducted to identify specific behaviors/symptoms, potential causative factors and recommendations for managing identified behaviors. 2. The medical record documentation must reflect the specific behaviors/symptoms and the residents response to non-pharmacological interventions to manage behaviors/symptoms. 8. After implementation of psychotropic medication behavior/symptom and medication side effects will be monitored and documented. LACK OF COMPREHENSIVE SLEEP ASSESSMENT: R102's admission record revealed R102 was admitted on 1/9/17 with diagnoses of left leg amputation. R102 had an order for as needed (PRN) melatonin Tablet 3 milligrams for sleep. The current physician's orders reflected a start date for the PRN melatonin as 1/9/17 and the R102 had received the medication PRN on 1/21/17 and 1/23/17 according to the medication administration record. R102's medical record lacked a comprehensive	F 329		

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F 329	Continued From page 43 sleep assessment and analysis of sleep monitoring to initiate and continue the use of PRN melatonin. During an interview on 1/31/17, at 11:28 a.m. registered nurse (RN)-B stated we have a sleep study and sleep assessment that was completed by the night shift and there should be a hard copy in the chart. RN-B verified there was not a sleep assessment in R102's medical record. RN-B stated was not sure when a sleep assessment should be completed. RN-B stated once in a while, we will see a sleep log put out for a resident for us to complete. During an interview on 1/31/17, at 1:56 p.m. the director of nursing (DON) stated she expected a sleep assessments to be completed when a resident was admitted with a medication for sleep or if we were going to start a new medication for sleep. The DON stated a sleep assessment was probably not done for R102. The Sleep/Awake Assessment policy and procedure dated 1/31/17, included: 1. Review resident's record for diagnosis and medications, which could affect sleep patterns. 2. Resident observations for sleep/awake pattern is to be made every hour for four (4) days. An additional 1-4 days may be assessed if necessary. 3. All staff involved in the resident's care must be aware the assessment is underway. 4. After monitoring is completed, analyze patterns and determine whether to contact the physician regarding a medication need or adjustment.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		3/13/17

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F 371	Continued From page 44 (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prevent the potential spread of food borne illness, which had the potential to affect all 57 residents in the facility, staff and visitors who ate out of the kitchen. Findings include: 01/29/17 3:21 p.m. A metal portable cart with a plastic cooler containing ice was in the front dayroom off to the right of the main entrance. The cooler was half to three/fourths full of ice, with plastic scoop left inside in contact with the	F 371	-A Dietary Manager was hired 2/7/17 -The facility's ice chamber policy was updated on 2/22/17. --Dietary cleaning schedules have been revised to address concern areas identified -Existing cutting boards were discarded and replaced with new equipment. -All residents have the potential to be affected if cleaning schedules are not followed in both the kitchen and kitchenette areas. -All staff has been educated on	

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F 371	Continued From page 45 ice. The cooler had an unlocked device and any one has access to scoop and ice. 01/29/17 6:15 p.m. Plastic cooler with ice scoop still sitting in dayroom, unlocked. On 1/30/17 at 10:40 a.m. during tour of kitchen, a stream table used for lunch service, observed with food debris on the surface, (cook did not wipe off food debris prior to inserting containers of food and serving lunch to resident in the north dining room). In large chest freezer, an opened five-gallon container of chocolate ice cream, melted, refrozen, and freezer burnt. Kitchenette refrigerator had an open container of cottage cheese dated 1/23/17 and should have been discarded days ago. Also the meat slicer itself had dried food/debris on the surface of the meat slicer which had a plastic cover over the meat slicer and staff said it had been used previously and the plastic cover meant it was cleaned and ready to be used again. The cast iron pan had a heavy black oxide coating the inside of pan. Staff said this cast iron pan was used for frying eggs, grilled cheese, etc. The mounted can opener used to open fruit and vegetables, located on end of stainless steel table had a thick food build up which also included the cutting blade. All colored cutting boards used for vegetables, meats, and other foods were noted to have deep grooves (difficult to sanitize) and storage rack was soiled and broken. During interview with nursing assistant (NA)-C on 1/29/17, 6:20 p.m. in regards to the plastic container located in the day room near the front entrance door said that the ice used by the nursing assistants to fill the resident pitchers during water pass. We usually pass fresh water in the afternoon and then again later. NA-C noted	F 371	expectations of clean kitchen areas & updated ice chamber policy -Dietary staff has been educated on cleaning schedule requirements -2-3x weekly for one month audits will be conducted to ensure physical kitchen areas meet cleaning schedule requirements. -1-2x weekly for one month audits will be conducted to ensure ice chamber policy is being followed appropriately. -Dietary Manager/designee is responsible. -Audit results will be reviewed monthly at QAPI -Corrective action completed by 3/13/17.	

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F 371	Continued From page 46	F 371		

that since the cooler was in the dayroom and unlocked that anyone (residents, visitors) could get into the cooler. There were cup available next to the cooler for use.

During interview with Administrator on 1/31/17, at 9:30 a.m. in regards to the findings as aforementioned said that the kitchen was not up to standard and needed cleaning. She also stated, "That she would expect to have food debris wiped off stream table before next use." Administrator stated that she did not know why the cooler was in the main dayroom on 1/29/17. "I never seen it used before."

Review of Maple Manor Health Care & Rehabilitation policies:
Dietary Cleaning Schedules dated 10/1/08 directed staff to maintain the kitchen in a sanitary condition. It indicated that a cleaning schedule posted for all cleaning tasks, staff will initial after completion of tasks, the director of nutritional services will monitor cleaning checklists weekly to ensure completion and the registered dietician will monitor kitchen sanitation monthly.

General Sanitation of the Kitchen dated 7/13/09, included Staff shall maintain the sanitation of the kitchen through compliance with a written comprehensive cleaning schedule.

Ice Machines and Ice Storage Chests, revised August 2001. Policy included that the ice machines and ice storage chest/containers must be maintained in a safe and sanitary condition. To aid in preventing contamination, all staff must implement the following precautions: Limit access to ice storage chest/containers to employees only. Keep ice scoop on a clean, hard

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F 371	Continued From page 47 surface when not in use.	F 371		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 441		3/13/17

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F 441	Continued From page 48 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper infection control practices were implemented when cleaning/sanitizing a multi-resident use glucometer for 1 of 3 residents (R102) on the east wing who had blood sugars checked utilizing the glucometer. Findings include:	F 441	-All residents have personal glucometers -All residents have potential to be affected if glucometer equipment is not sterilized appropriately -All Licensed staff has been educated on proper sterilization methods of glucometers -2-3x/week audit for 1 month to be completed to ensure proper sterilization	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 49 On 1/30/17, at 11:01 a.m., licensed practical nurse (LPN)-B was observed to check R102's blood sugar. LPN-B stated at the time the glucometer used was a glucometer used for all residents on the east wing. LPN-B after checking R102's blood sugar had removed gloves and carried the glucometer out to the medication cart. LPN-B donned gloves and cleansed the outside of the glucometer with a tissue and hand sanitizer. LPN-B removed the glove on her right hand and cleansed the outside of the glucometer with a alcohol pad and then removed the glove on her left hand and washed hands. At the time LPN-B when queried what the facility policy was for cleaning the glucometer, stated I would have to check on that. LPN-B stated a bleach wipe should be used to clean the glucometer and then let the glucometer air dry for three minutes. LPN-B stated I used an alcohol pad, either one works. LPN-B verified she had removed gloves prior to the glucometer being cleaned and had used a tissue and hand sanitizer and an alcohol pad to clean and sanitize the glucometer. The glucometer manufactured by UltraTRAK Complete owner's manual provided by the facility, indicated disinfect the meter between each patient to prevent infection. How to clean and disinfect the meter, the meter must be cleaned prior to the disinfection. Use one disinfecting wipe to clean exposed surfaces of the meter thoroughly and remove any visible dirt, blood, or any other body fluid with the wipe. Use a second wipe to disinfect the meter by following the disinfecting procedure below. Do not use organic solvents to clean the meter. We recommend for meter cleaning and disinfection you should use the disinfecting wipe/towelette from below:	F 441	methods -DON/designee is responsible -Audit results will be reviewed monthly at QAPI -Corrective action completed by 3/13/17	

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F 441	Continued From page 50 Micro-Kill Plus by Medline. On 1/30/17, at 3:51 p.m., the director of nursing (DON) stated when informed of how the multiuse glucometer was cleaned/sanitized stated that is not the correct procedure for cleaning/sanitizing the glucometer. The DON stated gloves should remain on until the glucometer was fully cleaned/sanitized and the glucometer should have been cleansed with a super Sani-cloth wipe. The facility policy Cleaning and Disinfection of a glucometer dated 8/1/15, indicated Procedure: 2. Perform hand hygiene and apply gloves. 3. Wipe all external surfaces, including top, bottom and sides, using the bleach solution or commercially prepared EPA germicidal wipe; avoid allowing the solution to penetrate the test strip and/or key ports of the meter. 4. Ensure the meter remains wet for one minute an allow to air dry for an additional minute before using on the next resident. 5. If blood is visibly present on the meter, the procedure should be repeated a second time. 6. Discard soiled items in approved containers. &. Remove gloves and perform hand hygiene.	F 441		
F 465 SS=C	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and	F 465		3/13/17

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F 465	Continued From page 51 regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a sanitary and clean environment in the kitchen. This had the potential to affect all 58 residents in the facility and visitors who ate out of the facility kitchen. Findings include: On 1/29/17, at 11:45 a.m. during the initial kitchen tour the following was observed: The walk-in food cooler floor was sticky with visible debris, (feet stuck to floor). The steel tables where food is prepared noted to have multiple food splatter debris on legs and sides of table, in addition, on table where meat slicer and food processor were located, food splatter going up the wall approximately 2-3 feet. The meat slicer had multiple food debris on the machine. The meat slicer was covered with plastic and it was learned that when the plastic cover was on slicer it meant it was cleaned and ready for service. The top of oven noted to have heavy dust and grease build up and the grease/debris was located on the wall behind the stove. The stove hood had areas of debris /greasy film. All gray plastic garbage bins used for trash and recycling had been stored next to the food preparation table had heavily splattered food debris down outside of cans, lids and canisters. The dry storage pantry noted to have dirt and dust build up on floors. The upright freezer noted to have frost build up on inner walls and the boxes of frozen food	F 465	-A Dietary Manager was hired 2/7/17 -All areas of cleanliness concern have been addressed -Dietary cleaning schedules have been revised to address concern areas identified -Equipment concerns have been addressed through improvements and/or replacement parts to promote safety & cleanliness compliancy -All residents have the potential to be affected if cleanliness practices are not followed in both the kitchen and kitchenette areas. -All staff has been educated on expectations of clean kitchen areas & equipment -Dietary staff has been educated on cleaning schedule requirements & protocol for updating maintenance when necessary for maintaining kitchen cleanliness compliance. -2-3x weekly for one month audits will be conducted to ensure physical kitchen areas meet cleanliness compliancy standards -Dietary Manager/designee is responsible. -Audit results will be reviewed monthly at QAPI -Corrective action completed by 3/13/17.	

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F 465	Continued From page 52 stacked and several packages of meat had heavy build up of ice on cartons. The portable stainless stain cart, with paper products store on had debris/food on shelves where food stored/placed. The Lights over food preparation tables, light fixture covers where yellow colored and spotted with debris/grease and dead insects observed in covers. The floor had multiple food debris throughout the kitchen area. This was also noted during a brief kitchen tour on 1/29/17 at 6:00 p.m. On 1/30/17, at 10:40 a.m. during a second tour of the kitchen following observed: All previous observation remain the same. The cupboard by ice machine note to have a heavy lime buildup on/in spout and drip tray. The floor continued to have multiple food debris/food droppings scattered around entire kitchen floor which was the same as observed the evening before. All plastic food/equipment carts (some with three and four shelves) use to transport food and equipment to floor for food service had been noted to have multiple food/debris on all shelves, legs and wheels. Tour of kitchenette off main dining room, observed to have the following: The coffee maker had a frayed cord,dusty, greasy film on top, and drain filter with rust buildup The juice machine, noted to have a thick sticky greasy film on top of machine. The upright refrigerator noted to have food debris on bottom of inner shelf, rusty, cracks in the door liner. The built in cupboards and counter tops had a greasy film. The cupboard doors were broken	F 465		

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F 465	Continued From page 53 (hinged coming off) under sink. There were several ceiling tiles heavily stained and soiled looking. During interview on 1/31/17, at 9:30 a.m. went over all the listed findings with Administrator who indicated that the kitchen was not up to standard and needed cleaning. Administrator also stated, "That she would expect to have food debris wiped off stream table before next use." Review of Maple Manor Health Care & Rehabilitation policies: Dietary Cleaning Schedules dated 10/1/08 directed staff to maintain the kitchen in a sanitary condition. It indicated that a cleaning schedule posted for all cleaning tasks, staff will initial after completion of tasks, the director of nutritional services will monitor cleaning checklists weekly to ensure completion and the registered dietician will monitor kitchen sanitation monthly. General Sanitation of the Kitchen dated 7/13/09, included Staff shall maintain the sanitation of the kitchen through compliance with a written comprehensive cleaning schedule.	F 465		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services;	F 520		2/21/17

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F 520	Continued From page 54 (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have the required members attend the Quality Assessment and Assurance Committee (QAA) at least quarterly. This deficient practice had the potential to affect all 53 residents who resided in the facility at the time of the survey.	F 520	-QAA meetings are being held at least quarterly. -All residents have the potential to be affected if QAA meetings are not held at least quarterly to identify areas for improvement. -Department managers have been	

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F 520	Continued From page 55 Findings include: Review of the facility's QAA meeting attendance record reviewed from 1-21-16 to 12-22-16 revealed the medical director attended the QAA meetings on 1-21-16, 5-19-16 and 11-17-16. The attendance record revealed no physician attended the QAA meeting held between 5-19-16 and 11-17-16. On 2/01/2017, 2:59 p.m. the administrator stated based on the documentation of meeting attendance for QAA meetings the medical director did not attend a quarterly meeting during the five-month span from 5-19-16 to 11-17-16. The administrator stated the facility did not contact the medical director to review the meeting minutes from the quarterly QAA the medical director did not attend.	F 520	educated in QAA requirements. -Monthly audits for 12 months will be conducted to insure QAA meetings are held per CMS requirements with the required attendees. -Physician educated on 1/16/2017 in regards to quarterly QAA attendance regulation. -Physician will attend QAA at least quarterly via telephone conference or in person. -ED/designee is responsible. -Audit results will be reviewed monthly at QAPI -Corrective action completed by 2/21/17.	

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	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/31/2017**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Maple Manor Nursing & Rehab was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/22/2017

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. (Maple Manor Nursing & Rehab) is a 1-story building with a (partial) basement. 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. In 1974, addition was constructed to the (East wing) that was determined to be of Type II(111) construction. 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 sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 81 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than	K 363	1. No Residents were affected by this alleged deficient practice.	3/13/17

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K 363	Continued From page 3 required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 1/31/2017, based on observation and interview revealed that the following include: The fire doors by room 28 and 32 did not latch tight when tested.	K 363	2. All Residents, Employees and Visitors have the potential to be affected by this alleged deficient practice. On 2-1-2017 Maintenance dissembled door locking mechanisms, oiled and lubricated all moving parts, reassembled tested door and it is now functioning properly. 3. A directed in-service was conducted with the Maintenance Department by the Regional Director on 1-31-2017 on but not limited to the Facility must ensure that all fire door latching parts much latch during self-closing operating. 4. Quality Assurance plans to monitor that all fire door latching parts much latch during self-closing operating through a Quality Assurance tool conducted by the Maintenance Director and/or Designee once a week for the next month and will be reviewed by the quality assurance team in our Quarterly Quality Assurance Committee Meetings 5. Date of corrective action will be by 3/13/17.	

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K 363	Continued From page 4 This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363		
K 374 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum	K 374	1. No Residents were affected by this alleged deficient practice. 2. All Residents, Employees and Visitors have the potential to be affected by this alleged deficient practice. On 2-1-2017 the west smoke barrier door was sanded and operationally tested to ensure it closed tightly.	3/13/17

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

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K 374	Continued From page 5 clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 1/31/2017, based on observation and interview revealed that the following include: The smoke barrier door on the west wing did not close tight when tested. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 374	3. A directed in-service was conducted with the Maintenance Department by the Regional Director on 1-31-2017 on but not limited to the Facility must ensure that all smoke barrier doors must close tightly in the event of a fire. In-services will continue to be conducted again in February 2017. 4. Quality Assurance plans to monitor that all smoke barrier doors must close tightly in the event of a fire through a Quality Assurance tool conducted by the Maintenance Director and/or Designee once a week for the next month and will be reviewed by the quality assurance team in our Quarterly Quality Assurance Committee Meetings 5. Date of corrective action will be by 3/13/17.	
K 511 SS=D	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Utilities - Gas and Electric Equipment using gas or related gas piping	K 511	1. No Residents were affected by this alleged deficient practice.	3/13/17

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 _____	**01/31/2017**

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K 511	Continued From page 6 complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 1/31/2017, based on observation and interview revealed that the following include: The coffee maker in the upper kitchenette has a melted cord. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511	2. All Residents, Employees and Visitors have the potential to be affected by this alleged deficient practice. Melted Cord in Kitchenette was removed after walk through on 1-31-2017. 3. A directed in-service was conducted with the Maintenance Department by the Regional Director on 1-31-2017 on but not limited to the Facility must ensure that extension cords must only be used in accordance with NFPA 101. In-services will continue to be conducted once a month for the next three months. 4. Quality Assurance plans to monitor that only acceptable power cords are used in accordance with NFPA 101 will be used, through the use of a Quality Assurance tool conducted by the Maintenance Director and/or Designee once a week for the next month and will be reviewed by the quality assurance team in our Quarterly Quality Assurance Committee Meetings 5. Date of corrective action will be by 3/13/17.	
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable	K 920		3/13/17

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K 920	Continued From page 7 patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure.	K 920	1. No Residents were affected by this alleged deficient practice. 2. All Residents, Employees and Visitors have the potential to be affected by this alleged deficient practice. Extension cord in Physical Therapy Room was removed on 2/1/2017. 3. A directed in-service was conducted with the Maintenance Department by the Regional Director on 1-31-2017 on but not limited to the Facility must ensure that all extension cords are for temporary use and removed immediately upon completion of the purpose for which it was	

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K 920	Continued From page 8 Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 1/31/2017, based on observation and interview revealed that the following include: An extension cord was found in the Physical therapy room This deficient practice could affect the safety of all the residents, staff and visitors within this section of the building. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	installed. 4. Quality Assurance plans to monitor that all extension cords are only used for temporary use and removed immediately upon completion through a Quality Assurance tool conducted by the Maintenance Director and/or Designee once a week for the next month and will be reviewed by the quality assurance team in our Quarterly Quality Assurance Committee Meetings 5. Date of corrective action will be by 3/13/17.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
February 16, 2017

Ms. Margaret Holm, Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5409027 and Complaint Numbers H5409033, H5409036, and H5409039.

Dear Ms. Holm:

The above facility was surveyed on January 29, 2017 through February 1, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5409033, H5409036, and H5409039. Complaint H5409033 was substantiated at Minnesota Statute 144A.04 Subp. 3 (1426). At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Complaints H5409036, and H5409039 were unsubstantiated.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule

number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor 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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	02/01/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 29, 30, 31 & February 1, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. In addition, complaint investigations were also completed at the time of the licensing survey. An investigation of complaint H5409033 was completed. This complaint was substantiated at MN Statute 144A.04 Subp. 3 (1426). An investigation of complaint H5409036 was completed during the survey and found not to be substantiated. An investigation of complaint H5409039 was completed during the survey and found not to be substantiated.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and	2 255		2/21/17

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2 255	Continued From page 3 pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to have the required members attend the Quality Assessment and Assurance Committee (QAA) at least quarterly. This deficient practice had the potential to affect all 53 residents who resided in the facility at the time of the survey. Findings include: Review of the facility's QAA meeting attendance record reviewed from 1-21-16 to 12-22-16 revealed the medical director attended the QAA meetings on 1-21-16, 5-19-16 and 11-17-16. The attendance record revealed no physician attended the QAA meeting held between 5-19-16 and 11-17-16. On 2/01/2017, 2:59 p.m. the administrator stated based on the documentation of meeting attendance for QAA meetings the medical director did not attend a quarterly meeting during the five-month span from 5-19-16 to 11-17-16. The administrator stated the facility did not contact the medical director to review the meeting minutes from the quarterly QAA the medical director did not attend. SUGGESTED METHOD OF CORRECTION: The administrator could educate the physician or his/her representative on the importance of participating in QA activities. Monitoring for compliance needs to be included too. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255	-QAA meetings are being held at least quarterly. -All residents have the potential to be affected if QAA meetings are not held at least quarterly to identify areas for improvement. -Department managers have been educated in QAA requirements. -Monthly audits for 12 months will be conducted to insure QAA meetings are held per CMS requirements with the required attendees. -Physician educated on 1/16/2017 in regards to quarterly QAA attendance regulation. -Physician will attend QAA at least quarterly via telephone conference or in person. -ED/designee is responsible. -Audit results will be reviewed monthly at QAPI -Corrective action completed by 2/21/17.	

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2 570	Continued From page 4	2 570		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise a care plan to include at risk for bruising for 1 of 3 residents (R74) reviewed for non-pressure related skin concerns; failed to provide care conferences in a resident's room for 1 of 3 residents (R74) reviewed for participation in care planning and failed to revise the care plan for 1 of 3 residents (R22) related to dentures, who was reviewed for dental status. Findings Include: LACK OF CARE PLANNING FOR HIGH RISK FOR BRUISING: R74's physician orders included prednisone tablet 10 milligrams (MG), give 1 tablet by mouth one time a day for COPD. Give 10 mg in a.m. in addition to 1 mg at HS [bedtime], equals 11 mg	2 570	Corrected	3/9/17

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2 570	Continued From page 5 daily. Start date 1/5/17. R74's current electronic care plan did not address R72 was at increased risk for bruising related to the use of prednisone. R74 was observed on 1/29/17, at 3:17 p.m., R72 had a large bruise on her forearm. R72's record did not reflect identification or monitoring of the bruise. R74's progress notes were reviewed from 1/3/17 to 2/1/17 the documentation did not reflect identification or monitoring of the bruise. During an interview on 1/31/17, at 8:46 a.m., nursing assistant (NA)-B stated she looked at residents' skin during daily and on bath day. NA-B stated she reported any skin concerns to the nurse right away. On 2/01/17, 9:39 a.m., registered nurse (RN)-C verified through observation R74 had a bruise on her right forearm. RN-C stated the bruise measured 4.5 centimeters (cm) x 4.8 cm. RN-C stated she would document the findings in a progress note and would enter a nursing order for observation of bruise for healing on the treatment record. RN-C stated R74 was on prednisone and bruised easily. During an interview on 2/01/17, at 10:20 a.m., the director of nursing (DON) stated staff monitored residents' skin on their shower day. The DON stated staff completed a bath sheet that had a section on it for skin issues, vital, signs and weights. The DON stated staff are to fill out the form and provide the form to the nurse. The DON stated if there was an identified skin issue it was to be addressed by the nurse, there should be a	2 570		

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2 570	Continued From page 6 progress note and an accident/incident report completed. The DON stated nursing was to track the bruising for worsening and resolution. The DON stated staff are to monitor skin anytime they providing care and report concerns to the nurse. The DON stated she would expect a care plan to be developed for residents that are at risk for loss of skin integrity, which would include bruising or any skin injury. LACK OF PARTICIPATION IN CARE PLANNING: R74 was interviewed on 1/29/17, at 3:07 p.m., when asked do staff include you in decisions about your medicine, therapy, or other treatments. R74 responded, "No." R74 stated she was unaware of what a care conference was and stated, "Does that tell you if I have ever been to one." R74's care conference progress notes were reviewed and revealed resident had not attended any of the care conferences held at the facility since her admission. During an interview on 1/30/17, at 11:55 a.m., social services (SS)-A stated R74 refused to leave her room to come to care conferences. SS-A stated R74 told her she could not leave her room because she took Lasix and used the bathroom frequently. When asked if the facility had considered having care conferences in R74's room so she could participate in the care conferences, SS-A stated the facility had not offered to have a care conference in her room. During an interview on 2/01/17 at 9:50 a.m., SS-A stated she had talked with R74 about having care conferences in her room, and R74 thought that was a good idea as she would not need to worry	2 570		

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2 570	Continued From page 7 about coming down to the conference room for the meeting. R74 was interviewed on 2/01/17, at 10:07 a.m., R74 stated the social worker had visited with her today regarding having care conferences in her room. R74 stated she agreed to have care conferences in her room. R74 stated she did not like to leave her room because of her frequent need to use the bathroom and her breathing problems. During an interview on 2/01/17, at 10:15 a.m. the director of nursing (DON) stated R74 should have been offered the option to have care conferences held in her room if she did not want to leave her room to attend care conferences. The DON stated she would look for a policy regarding participation in care conferences and a policy was not provided. REVISION OF CARE PLAN DENTAL STATUS: R22's current electronic care plan identified: Focus: self-care deficit related to impaired mobility, anxiety disorder, borderline personality disorder, and alert with confusion. Interventions included oral care; wears dentures; assist of one to brush BID (twice daily) and soak overnight. On 1/29/17, at 2:05 p.m., R22 was observed to have no teeth or dentures in his mouth. On 2/1/17, at 9:59 a.m., registered nurse (RN)-C by observation confirmed R22 had no dentures in place. RN-C looked through R22's room and stated she did not see any dentures for R22 in his room. On 2/1/17, at 10:13 a.m. nursing assistant (NA)-E	2 570		

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	00916	A. BUILDING: _____ B. WING _____	02/01/2017

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2 570	Continued From page 8 stated R22 used to wear dentures. R22 threw the dentures out of his mouth and the dentures broke. I do not think they are going to get new ones. NA-E stated it had been maybe a couple of months since R22 had not had his dentures. On 2/1/17, at 10:50 a.m., RN-C stated social service informed R22's dentures were broke and family does not want the dentures replaced. RN-C stated she had informed R22's care plan needs to be updated. On 2/1/17, at 2:02 p.m. social services (SS)-A stated she had R22's broken dentures. I called the family and they did not want the dentures replaced. SS-A stated R22's dentures were broke a long time ago and she had not documented any information regarding R22's broken dentures. On 2/1/17, at 2:42 p.m. the director of nursing (DON) stated her expectation would be moving forward anytime something like that happens there should be a report filled out on what happened, family notified and documented in the resident notes. The DON confirmed R22's care plan identified R22 had dentures and stated the care plan should have been updated. The DON stated she was not aware R22's dentures were broken. The facility policy Care Plan Quarterly Review, dated 10/1/16, indicated Procedure and Implementation: 1. The care planning interdisciplinary team is responsible for maintaining care plans on a current status. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could ensure nursing staff revise resident care plans when indicated and in a timely manner. The Director of	2 570		

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2 570	Continued From page 9 Nursing or designee could ensure all residents were offered the opportunity to participate in care conferences. Audits could be preformed to ensure staff were in compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor bruising for 3 of 3 residents (R74, R102 & R22) reviewed for non-pressure related skin concerns. Findings Include: R74 was observed on 1/29/17, at 3:17 p.m., R72 had a large bruise on her forearm. R72's record did not reflect identification or monitoring of the this bruise.	2 830	Corrected	3/9/17

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2 830	Continued From page 10 R74's progress notes were reviewed from 1/3/17 to 2/1/17 and the documentation did not reflect identification or monitoring of the bruise. R74's physician orders included prednisone tablet 10 milligrams (MG), give 1 tablet by mouth one time a day for chronic obstructive pulmonary disease (COPD). Give 10 mg in a.m. in addition to 1 mg at HS [bedtime], equals 11 mg daily. R74's current electronic care plan did not address R72 was at increased risk for bruising related to the use of prednisone. R74's bath sheet dated 1/31/17 indicated bruising to the right arm. During an interview on 1/31/17, at 8:46 a.m., nursing assistant (NA)-B stated she looked at residents' skin during cares daily and on bath day. NA-B stated she reported any skin concerns to the nurse right away. On 2/01/17, 9:39 a.m., registered nurse (RN)-C verified through observation R74 had a bruise on her right forearm. RN-C stated the bruise measured 4.5 cm x 4.8 cm. RN-C stated she would document in a progress note and would enter a nursing order for observation of bruise for healing on the treatment record. RN-C stated R74 was on prednisone and bruised easily. During an interview on 2/01/2017, at 1:55 p.m., the DON stated the assistant director of nursing (ADON) had brought R74's skin monitoring form completed on 1/31/17 following her bath. The DON verified there was no documentation regarding the bruise in R74's clinical record. The DON stated she did not find documentation in the	2 830		

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2 830	Continued From page 11 nurses notes regarding the bruise and an incident report was not completed related to the bruise which should have been completed. During an interview on 2/01/2017, at 2:07 p.m., the DON stated that RN-B who had worked yesterday stated he was not informed of R74's bruise. R102 was observed on 1/29/17, at 5:47 p.m., R102 had bruises on his left forearm and back of his left hand. R102's record did not reflect identification or monitoring of these bruises. R102's current electronic care plan directed staff to, "monitor skin with cares for changes." R102's progress notes were reviewed from 1/9/17 to 2/1/17 the documentation did not reflect identification or monitoring of the bruises. R102's bath sheet dated 1/20/17 indicated no skin concerns. During an interview on 01/31/17, at 11:01 a.m., nursing assistant (NA)-A stated she monitored resident's skin when she got them dressed, undressed, during cares and on shower days. NA-A stated bruises were to be reported to the nurse right away. On 2/01/17, 9:54 a.m., registered nurse (RN)-C verified through observation R102 to have fading bruising on the left forearm measuring 3 centimeters (cm) x 3.2 cm and to back of left hand measuring 1.2 cm x 1.5 cm. RN-C stated staff should report any new bruises to the nurse, for the nurse to assess and follow up.	2 830		

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2 830	Continued From page 12 During an interview on 2/01/17, at 10:20 a.m., the director of nursing (DON) stated staff monitored residents' skin on their shower day. The DON stated staff completed a bath sheet that had a section on it for skin issues, vital, signs and weights. The DON stated staff are to fill out the form and provide the form to the nurse. The DON stated if there was an identified skin issue it was to be addressed by the nurse, there should be a progress note and an accident/incident report completed. The DON stated nursing was to track the bruising for worsening and resolution. The DON stated staff are to monitor skin anytime they providing care and report concerns to the nurse. The DON stated she would expect a care plan to be developed for residents that are at risk for loss of skin integrity, which would include bruising or any skin injury. R22 was observed on 1/29/17 at 1:59 p.m. R22 had a scabbed area with bruising on his left upper arm and a purple bruise on his right upper arm. R22's record did not reflect identification or monitoring of the bruises. R22's current electronic care plan directed staff to monitor skin with cares and report changes. R22's progress notes were reviewed from 1/5/17 to 2/1/17 the documentation did not reflect identification or monitoring of the bruises. R22's bath sheet dated 12/31//16, 1/14/17, and 1/19/17 indicated no skin concerns. On 2/1/17, at 10:01 a.m., RN-C verified through observation R22 had bruising on left upper arm measuring 2 cm x 1 cm and 1.5 cm x 1 cm. On right upper arm 4.4 cm x 0.6 cm. RN-C confirmed R22's record lacked identification or monitoring of	2 830		

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2 830	Continued From page 13 the bruises. RN-C stated nursing assistants are to report bruises and I would then fill out an incident report and report. On 2/2/17, at 2:57 p.m., the DON stated her expectation was bruising, skin tears, laceration, red marks need to be documented, an incident report form filled out. The DON stated the area needed to be measured and documented in the facility computer system resident progress notes, document weekly on the areas until resolved and implement intervention to prevent recurrence. The Skin Assessment policy and procedure dated 1/13/17, included, skin injuries (skin tears, bruises) will be assessed and measured at least every seven (7) days by licensed nurse, and recorded in the medical record. Caregivers are responsible for promptly notifying the nurse of skin observations, including bruises. The resident's care plan will be revised as appropriate, to reflect the alteration of skin integrity, approaches and goals for care. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring non-pressure related skin conditions. The director of nursing or her designee could develop policeis and procedures regarding assessing for causitive factors and implementing interventions related to falls. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensue residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty One	2 830		

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2 830	Continued From page 14 (21) Days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide catheter care/services to reduce the chance of a resident developing a urinary tract infections (UTI) for 1 of 1 resident (R52) with an indwelling Foley catheter. In addition, the facility failed to maintain bladder function to the highest extent as possible for 1 of 2 residents (R4) reviewed for urinary incontinence. Findings include: R52's quarterly Minimum Data Set (MDS) dated 10/21/16 indicated R52 had an indwelling Foley	2 910	Corrected	3/9/17

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2 910	Continued From page 15 catheter, long and short-term memory problems and moderately impaired decision-making skills for daily living. R52 was observed on 1/31/17 at 10:28 a.m. to be in bed, the catheter bag was not covered, was attached to the bed and the bag was resting on the floor. On 1/31/17, at 10:38 a.m. nursing assistant (NA)-A stated R52 did not have a bag attached to the side of the bed to place the catheter in when R52 was in bed. NA-A verified the uncovered catheter bag was resting on the floor. On 1/31/17, 1:56 p.m. the director of nursing (DON) stated the facility had covers for catheter bags and her expectation was all catheter bags are to be covered. The DON stated it was an infection control concern if a catheter bag was not covered and rested on the floor. The Catheter Care policy with a revision date of 1/31/17, included staff will maintain consistent and adequate hygiene standards for residents with an indwelling catheter in order to maintain comfort, function, and prevent infection and other complications. 2. Catheters bag and tubing should be secured and not allowed to touch or drag on the floor to prevent contamination. 4. Catheter bag should be kept in a protective holder/bag to protect dignity of the resident. R4's quarterly Minimum Data Set (MDS) dated 11/28/16, indicated R4 was always incontinent of bladder, was not on a toileting program for bladder, required two assist to toilet and had severe cognition deficit. During observation on 1/30/17, at 10:21 a.m.,	2 910		

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2 910	Continued From page 16 nursing assistant (NA)-F asked R4 if he would like to lay down in his bed and R4 replied "yeah." After R4 was laid in bed, R4 stated he had to pee, and to put the urinal up to my penis. NA-F stated to R4 you usually go in your brief and I then change you. So you can just go in your brief and I will change you. R4 stated is that what I do? NA-F stated, "Yep!" R4 stated ok and proceeded to urinate in the incontinent brief. R4's record identified a facility Bowel and Bladder Quarterly review dated 9/4/16. R4's record lacked a current Bowel and Bladder assessment for the most recent MDS dated 11/28/16. R4's current electronic care plan indicated R4 had actual/potential for alteration in elimination related to urgency and incontinence. History of urinary tract infection (UTI) (recent) and malignant neoplasm of prostate. Check and change as needed with peri-care, barrier cream, assist of one for hygiene, incontinence care after each incontinent episode, monitor/document/report signs/symptoms of UTI, assist of one for transfers, wears briefs/assist of one to manage. R4's care plan lacked to include how often R4 should be toileted and what level of incontinence R4 had (continent, occasionally incontinent, frequently incontinent or always incontinent) to determine incontinent interventions to prevent further decline in bladder incontinence and prevent UTIs. On 1/30/17, at 10:57 a.m., NA-F stated R4 was to be checked and changed. I usually check his brief every two hours. R4 is usually not continent and does not tell when he has to go to the bathroom, so we just check and change him. NA-F stated	2 910		

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2 910	Continued From page 17 R4 did not use the urinal and that was the first time he told me he had to void. NA-F reviewed R4's nursing assistant care sheet at the time and confirmed the sheet read under the topic Toilet/Brief: briefs and pull ups. NA-F confirmed the sheet did not indicate how often R4 should be toileted. On 1/30/17, at 2:40 p.m., registered nurse (RN)-D confirmed the last Bowel and Bladder Assessment completed for R4 was dated 9/4/16. RN-D stated there should have been another assessment after 9/4/16. RN-D Confirmed R4's care plan lacked to include how often R4 should be toileted and R4's level of continence. RN-D stated the nursing assistant should have given the urinal to R4 when he requested to use the urinal. That tells me why they are always marking incontinent, because they are not giving him the opportunity to toilet. On 1/30/17, at 3:22 p.m., the assistant director of nursing (ADON)-D reviewed R4's record and confirmed the last Bowel and Bladder assessment completed for R4 was dated 9/4/16. On 1/30/17, at 3:51 p.m., the director of nursing (DON) stated she would expect staff to offer toileting appropriately. If a resident asks to use the urinal, bedpan, or toilet, the request should be accommodated and it was not acceptable to not do so. The DON stated a bowel and bladder assessment was to be completed quarterly. The DON confirmed the last facility bowel and bladder assessment completed for R4 was dated 9/4/16. The DON stated she would expect R4's care plan to include how often R4 was to be toileted and R4's level of continence. The DON stated R4 should be scheduled to be toileted every two hours and per the resident request.	2 910		

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2 910	Continued From page 18 On 1/31/17, at 2:18 p.m., R4 when queried if he knew when he had to go to the bathroom, stated "yeah." When queried how it made him feel when he wanted to use the urinal and staff did not give the urinal to him to use, R4 stated, "Well not good, but what do you do, Was not the first time and was not the last time, inexperienced." When queried if he would like to use the toilet, R4 stated, "I would be less embarrassed if I could go on the toilet." The facility policy Bowel and Bladder Assessment dated 1/15, indicated Policy: Based on the resident's comprehensive assessment, the facility will ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible. Procedure: 1. Each resident will be assessed for at least 72 hours to help establish bowel and bladder voiding patterns. This will be done on admission, with significant change in status, and with a significant change in elimination patterns. 4. The residents plan of care will be developed to address goals and appropriate individualized interventions. The policy failed to address quarterly bowel and bladder assessments. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or Designee could ensure resident toileting needs are met by assessment to reduce incontinence for residents with incontinence and by educating all nursing staff on resident's with incontinence and resident's using urinary catheters. Random audits of incontinent residents could be done. Random observations of resident's with incontinence and urinary catheters could be done to ensure proper services are	2 910		

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2 910	Continued From page 19 provided. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to address a severe weight loss for 1 of 3 residents (R22) reviewed for nutrition. Findings include: R22's quarterly Minimum Data Set (MDS) dated 11/8/16, identified weight of 188 pounds, mechanical altered diet, no weight loss or weight gain and required one assist to eat. On 1/30/17, at 12:36 p.m., R22 was observed to be seated in his wheelchair in the dining room, eating the meal independently. R22's current care plan identified, Focus: potential for alteration in nutrition less than body	2 965	Corrected	3/9/17

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2 965	Continued From page 20 requirements related to CKD (chronic kidney disease) and COPD (chronic obstructive pulmonary disease). At risk for dehydration related to takes a diuretic. Interventions included diet general, eats meals in the dining room. Eating; resident not always feeding self. Staff to assist as resident allows. Encourage independence. Encourage fluid, due to foul smelling urine. Encourage snacking. Monitor for signs and symptoms of dehydration; dry tongue, poor skin turgor, dry skin, concentrated urine, dark urine, fever. ST (speech therapy) as ordered. Supplements as ordered. Weights as ordered. R22's weights documented in the computer system in pounds: On 2/1/17, at 8:32 a.m., surveyor requested from the director of nursing (DON) a reweigh for R22. The reweigh weight reported to surveyor was 178 pounds. A loss of 11 pounds in one month compared to 189 pounds on 1/4/17 (5.8 percent loss in one month, a severe weight loss). 1/19/17 weight recorded of 173 pounds. 1/4/17 189 Wheelchair 12/19/16 186.6 Mechanical Lift 12/17/16 189 Mechanical Lift 12/15/16 189 Mechanical Lift 11/28/16 182.8 Mechanical Lift 11/16/16 185 Mechanical Lift R22's progress notes identified on 1/30/17 Nutrition/Dietary Note Current weight documented at 173 pounds and this reflects weight loss of 8.5 percent in two weeks. Registered dietician request reweigh for accuracy but not same day or next a.m.. However, reweigh was completed on 2/1/17 as requested by surveyor and found to be 178 pounds. . On 11/22/16 Nutrition/Dietary Note Resident will	2 965		

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2 965	Continued From page 21 consume > (greater than) 75 percent of meals daily and show no signs/symptoms of dehydration. Will maintain adequate nutrition. On 11/16/16 Nutrition/Dietary Note nutritional assessment: Diet mechanical Soft with Med Pass 2.0, 120 ml (milliliters) three times daily with meds. Fluids to be encouraged. Resident is dependent on staff for food/fluid and usual intake, > 75 percent. Textures altered for chewing, swallowing. Current weight 187.6 pounds and weight graph very erratic. Resident's usual weight in the 180's. Staff to monitor intake, weights, hydration per policy/physician order; notify CDM (certified dietary manager, RD (registered dietician) as needed. R22's physician orders identified an order dated 5/24/16 for med pass (supplement) 2.0, 120 ml (milliliters) three times daily with meds due to weight loss. Order date 11/15/16, general diet, mechanical soft texture. Review of R22's physician notes identified on 11/15/16 R22 had been eating about 90 percent of meals, does receive supplements three times per day for some weight loss. Weight is 187.6 pounds, which is down slightly from 188 a month ago. During interview on 2/1/17, at 8:32 a.m., registered dietician (RD)-F had been asked about R22's note dated 1/30/17 regarding weight loss of 8.5 percent over the past two weeks and getting a timely reweigh done. RD-F said, "If I requested a reweigh to be done before I leave the facility, I would be here for weeks." As she did not address the 8.5 percent weight loss by ordering supplements or other interventions to prevent further rapid weight loss. During interview on 2/1/17, at 2:46 p.m., the	2 965		

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2 965	Continued From page 22 director of nursing (DON) stated the facility system for weights was to obtain weights on bath day and written down on the bath sheet. The nurse reviews and documents the weight into the computer system. If significant weight loss is found they notify DON or the assistant director of nursing and notify the nurse practitioner. Investigate for causative factors and rectify. Nurses are to get a reweigh if way out of range on that same day. The RD prints off weight sheet out of the computer system, which includes all residents weekly. The DON confirmed weight loss for R22 had not been identified and reported to her after RD-F's visit on 1/30/17. The DON stated R22's weight loss should have been identified, the physician should have been notified and an intervention implemented. The facility policy Weight and Height Measurements dated 8/1/15, indicated Procedure: 5. If loss or gain noted (5% in one month; 7.5% in three months; 10% in six months) re-weigh within 24 hours. 6. Physician, resident/legal representative, family, nursing staff, social services, activities, and dietary are to be notified upon identification of significant/severe weight loss/gain. 7. Evaluate and document reason for weight change in medical record and add to care plan. 8. Implement interventions as necessary. 9. If aggressive intervention does not correct weight change, a NP/MD reassessment may be necessary. The facility policy Dietician Services dated 8/1/15, indicated Policy: a qualified dietician will help oversee clinical nutritional dietary services in the facility. Policy Interpretation and Implementation 3. The dietician will work closely with the dietary manager and clinical staff. 4. Our facility's dietician is responsible for, but not necessarily	2 965		

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2 965	Continued From page 23 limited to: a. Assessing nutritional needs of residents; c. Collaborating effectively with other direct care staff and practitioners to assess and address nutritional issues in the communities population. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and dietary services could review and revise policies and procedures for proper monitoring of weight loss. Nursing and dietary staff could be educated as necessary to the importance of monitoring weights. The DON or designee, along with the dietary staff, could audit weight loss on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prevent the potential spread of food borne illness, which had the potential to affect all 57 residents in the facility, staff and visitors who ate out of the kitchen. Findings include: 01/29/17 3:21 p.m. A metal portable cart with a	21015	Corrected	3/9/17

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21015	Continued From page 24 plastic cooler containing ice was in the front dayroom off to the right of the main entrance. The cooler was half to three/fourths full of ice, with plastic scoop left inside in contact with the ice. The cooler had an unlocked device and any one has access to scoop and ice. 01/29/17 6:15 p.m. Plastic cooler with ice scoop still sitting in dayroom, unlocked. On 1/30/17 at 10:40 a.m. during tour of kitchen, a stream table used for lunch service, observed with food debris on the surface, (cook did not wipe off food debris prior to inserting containers of food and serving lunch to resident in the north dining room). In large chest freezer, an opened five-gallon container of chocolate ice cream, melted, refrozen, and freezer burnt. Kitchenette refrigerator had an open container of cottage cheese dated 1/23/17 and should have been discarded days ago. Also the meat slicer itself had dried food/debris on the surface of the meat slicer which had a plastic cover over the meat slicer and staff said it had been used previously and the plastic cover meant it was cleaned and ready to be used again. The cast iron pan had a heavy black oxide coating the inside of pan. Staff said this cast iron pan was used for frying eggs, grilled cheese, etc. The mounted can opener used to open fruit and vegetables, located on end of stainless steel table had a thick food build up which also included the cutting blade. All colored cutting boards used for vegetables, meats, and other foods were noted to have deep grooves (difficult to sanitize) and storage rack was soiled and broken. During interview with nursing assistant (NA)-C on 1/29/17, 6:20 p.m. in regards to the plastic container located in the day room near the front entrance door said that the ice used by the	21015		

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21015	Continued From page 25 nursing assistants to fill the resident pitchers during water pass. We usually pass fresh water in the afternoon and then again later. NA-C noted that since the cooler was in the dayroom and unlocked that anyone (residents, visitors) could get into the cooler. There were cup available next to the cooler for use. During interview with Administrator on 1/31/17, at 9:30 a.m. in regards to the findings as aforementioned said that the kitchen was not up to standard and needed cleaning. She also stated, "That she would expect to have food debris wiped off stream table before next use." Administrator stated that she did not know why the cooler was in the main dayroom on 1/29/17. "I never seen it used before." Review of Maple Manor Health Care & Rehabilitation policies: Dietary Cleaning Schedules dated 10/1/08 directed staff to maintain the kitchen in a sanitary condition. It indicated that a cleaning schedule posted for all cleaning tasks, staff will initial after completion of tasks, the director of nutritional services will monitor cleaning checklists weekly to ensure completion and the registered dietician will monitor kitchen sanitation monthly. General Sanitation of the Kitchen dated 7/13/09, included Staff shall maintain the sanitation of the kitchen through compliance with a written comprehensive cleaning schedule. Ice Machines and Ice Storage Chests, revised August 2001. Policy included that the ice machines and ice storage chest/containers must be maintained in a safe and sanitary condition. To aid in preventing contamination, all staff must implement the following precautions: Limit	21015		

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21015	Continued From page 26 access to ice storage chest/containers to employees only. Keep ice scoop on a clean, hard surface when not in use. SUGGESTED METHOD OF CORRECTION: The dietary manager and registered dietician could in-service all dietary staff on need to keep the kitchen environment clean and sanitary. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as	21390		3/9/17

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21390	Continued From page 27 disinfectants, antiseptics, gloves, and incontinence products; and l. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper infection control practices were implemented when cleaning/sanitizing a multi-resident use glucometer for 1 of 3 residents (R102) on the east wing who had blood sugars checked utilizing the glucometer. Findings include: On 1/30/17, at 11:01 a.m., licensed practical nurse (LPN)-B was observed to check R102's blood sugar. LPN-B stated at the time the glucometer used was a glucometer used for all residents on the east wing. LPN-B after checking R102's blood sugar had removed gloves and carried the glucometer out to the medication cart. LPN-B donned gloves and cleansed the outside of the glucometer with a tissue and hand sanitizer. LPN-B removed the glove on her right hand and cleansed the outside of the glucometer with a alcohol pad and then removed the glove on her left hand and washed hands. At the time LPN-B when queried what the facility policy was for cleaning the glucometer, stated I would have to check on that. LPN-B stated a bleach wipe should be used to clean the glucometer and then let the glucometer air dry for three minutes. LPN-B stated I used an alcohol pad, either one works. LPN-B verified she had removed gloves prior to the glucometer being cleaned and had used a tissue and hand sanitizer and an alcohol	21390	Corrected	

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21390	Continued From page 28 pad to clean and sanitize the glucometer. The glucometer manufactured by UltraTRAK Complete owner's manual provided by the facility, indicated disinfect the meter between each patient to prevent infection. How to clean and disinfect the meter, the meter must be cleaned prior to the disinfection. Use one disinfecting wipe to clean exposed surfaces of the meter thoroughly and remove any visible dirt, blood, or any other body fluid with the wipe. Use a second wipe to disinfect the meter by following the disinfecting procedure below. Do not use organic solvents to clean the meter. We recommend for meter cleaning and disinfection you should use the disinfecting wipe/towelette from below: Micro-Kill Plus by Medline. On 1/30/17, at 3:51 p.m., the director of nursing (DON) stated when informed of how the multiuse glucometer was cleaned/sanitized stated that is not the correct procedure for cleaning/sanitizing the glucometer. The DON stated gloves should remain on until the glucometer was fully cleaned/sanitized and the glucometer should have been cleansed with a super Sani-cloth wipe. The facility policy Cleaning and Disinfection of a glucometer dated 8/1/15, indicated Procedure: 2. Perform hand hygiene and apply gloves. 3. Wipe all external surfaces, including top, bottom and sides, using the bleach solution or commercially prepared EPA germicidal wipe; avoid allowing the solution to penetrate the test strip and/or key ports of the meter. 4. Ensure the meter remains wet for one minute an allow to air dry for an additional minute before using on the next resident. 5. If blood is visibly present on the meter, the procedure should be repeated a second time. 6. Discard soiled items in approved	21390		

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21390	Continued From page 29 containers. &. Remove gloves and perform hand hygiene. Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures to ensure, proper infection control regarding glove use and cleaning of glucometers. The Director of Nursing or designee could educate staff and an auditing system developed to ensure compliance. Time Period for Correction: Twenty one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		3/9/17

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21426	Continued From page 30 This MN Requirement is not met as evidenced by: Based on interview and record review, facility failed to ensure a facility tuberculosis risk assessment was completed, policy identified ongoing staff training related to tuberculosis, tuberculosis skin testing (TST) was completed and read within the 72 hour time frame for 5 of 6 residents (R69, R101, R56, R27, R25) reviewed for Tuberculosis and for 5 of 6 staff (S1, S2, S3, S4, S5) hired and worked directly with the residents. Findings include: R69 was admitted to the facility on 1/5/17. R69 received a Step 1 TST on 1/5/17. Test results were not documented. R69 received a Step 2 TST on 1/19/17. TST results were read on 1/21/17, documents identify test was negative with a 0 mm induration. R101 was admitted to the facility on 1/20/17. R101 received a Step 1 TST on 1/20/17. Results were not documented. Step 2 TST test scheduled for 2/3/17. R56 was admitted to the facility on 10/18/16. R56 had received a Step 1 TST on 8/6/16, with a previous admission. The results of the skin test was not documented. Step 2 TST was not completed. R27 was admitted to the facility on 9/26/16. R27 received a Step 1 TST on 9/26/16. Results were not documented. R27 received Step 2 TST on 10/10/16 with documented results on 10/12/16 of negative with a 0 mm induration.	21426	Corrected	

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21426	Continued From page 31 R25 was admitted to the facility on 8/25/16. Step 1 TST completed on 8/27/16. No results documented. Step 2 TST was completed on 9/8/16. No results documented. S1 was hired on 8/3/16. Facility was unable to provide any documentation of a Step 1 or Step 2 TST being completed. S2 was hired on 2/2/16 and received a Step 1 TST with documented results of negative with 0 mm induration. No second TST was completed. S2 worked until 1/21/17, facility unable to provide documentation of a Step 2 TST being completed. S3 was hired on 11/25/16. S3 received her Step 1 TST after hire date on 11/30/16. Test was documented as negative with 0 mm induration. Facility unable to provide documentation of a Step 2 TST being completed. S4 was hired on 2/25/16 and worked until 3/14/16. Facility unable to provide any documentation of a TB screening being completed or a Step 1 and Step 2 TST being completed. S5 was hired on 1/13/17. S5 received Step 1 TST on 1/13/17. Results documented as negative with 0 mm induration. Facility unable to provide documentation that a Step 2 TST was completed or scheduled. Facility was asked to provide the completed facility TB risk assessment. Facility provided a document that identified the last assessment was completed on 8/1/15, but was unable to provide any further documentation. Facility completed a TB risk assessment worksheet on 1/30/17 after	21426		

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21426	Continued From page 32 document was requested. Policy titled Policy and Procedure Tuberculosis Surveillance and Control dated 8/1/15 does not identify ongoing staff education related to the plan of care and treatment of a resident with active Tuberculosis. Interview on 1/31/17, at 12:32 p.m. with Director of Nursing (DON). DON stated Tuberculosis screenings and Step 1 TST needs to be completed for staff before their first day on the floor. Results of TB screening should be maintained in the employee records. Step 1 TST results should be documented on paper form as well as documented in Point Click Care and should include date and time read, negative/positive and any induration present. DON stated when a resident is admitted a TB screening and Step 1 TST is completed on day of admission. Results are to be documented on the paper form as well as in Point Click Care to include negative/positive results and any induration present. DON stated the TST including step 1 and 2, are automatically entered into the medication administration record (MAR) for staff to perform test and when to read results of the test. DON stated facility was unable to find the facility risk assessment that was completed on 8/1/15 and stated the nurse consultant had completed a risk assessment document on 1/30/17, after document was requested. DON stated she was unaware of any training staff had received related to TB and was unable to provide any documentation that staff had received training. Interview on 2/1/17, at 8:08 a.m. with assistant director of nursing (ADON), stated she was responsible for completing the initial TST for employees and scheduling 2nd step tests. ADON	21426		

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21426	Continued From page 33 stated if a test is to be read over the weekend, the form is left for the floor nurses to complete after reading the TST results. The form is then placed in ADON's mailbox. ADON stated she reviews the forms to ensure they have been filled out completely and then schedules the staff member for their second step TST. Interview on 2/1/17, at 10:07 a.m. with DON, stated she would expect all employee files to contain TB screenings and TST results. DON verified not all files contained necessary information. Interview on 2/1/17, at 10:52 a.m. with human resources (HR), verified TB screenings and TST results should be maintained in employee records. HR verified S1, S2, S3, S4 and S5 were all missing necessary documentation for TB screenings and/or TST results. Policy titled, "Policy and Procedure Tuberculosis Surveillance and Control", dated 8/1/15 identifies staff and residents are required to have baseline screenings and two separate TST. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program including ongoing staff education and the facility risk assessment. Facility staff could be educated on the TB regulations and the two step TST process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		

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21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure an abnormal involuntary movement scale (AIMS) assessment was completed per provider order for 1 of 5 residents (R32); failed to identify specific symptoms of depression for 1 of 5 residents (R22) to determine if the antidepressant was affective; and failed to complete a comprehensive sleep assessment to determine the need for sleep aids ordered for insomnia for 3 of 5 residents (R57,	21535	Corrected	3/9/17

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21535	Continued From page 35 R22, R102) reviewed for unnecessary medications. Findings include: R32's diagnosis found on the admission record dated 1/7/15, identifies Major Depressive Disorder, recurrent, unspecified. Medication Review Report dated 2/1/17, identifies an order dated 2/29/16 to complete an AIMS assessment every 6 months, one time a day every six months starting on the last day of the month for one day for quetiapine (fumerate an antidepressant) use. Quetiapine Fumarate 25 mg, give 0.5 mg tablet by mouth one time a day for hallucinations/paranoia. Order dated 8/5/16. Medication Administration Record for the month of January 2017, identifies R32 received scheduled Quetiapine Fumarate as scheduled once daily. Care plan revised on 3/28/16, identifies R32 takes antipsychotic medication related to paranoia, major depressive disorder, anxiety, dementia with behavioral episodes. Care plan identifies to complete AIMS assessment every 6 months. AIMS assessment was completed on 3/1/16 with a score of 0 which identifies no signs or symptoms of tardive dyskinesia (side effects related to the use of antipsychotics). Facility performed AIMS assessment on 2/1/17 ten months form previous assessment, after brought to their attention by surveyor. Interview on 2/1/17, at 9:43 a.m. with director of nursing (DON) verified an AIMS assessment had	21535		

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not been completed every 6 months per the provider order. DON stated she would expect the AIMS assessment to have been completed as ordered. DON stated the floor nurses are responsible for completing all assessments.

Policy titled, "Police and Procedure AIMS Assessment", dated 8/1/15, identifies AIMS form will be updated every 6 months by the licensed nurse.

SLEEP ASSESSMENT:

R57's diagnosis found on the admission record dated 4/11/16, identifies Insomnia.

R57's care plan last revised on 10/27/16 does not identify the use of a sleep aide.

Medication Review Report dated January 2017, identifies order for Melatonin (hormone to help sleep) 3 mg, give 2 tablets orally at bedtime for sleep. Order start date of 10/25/16.

Medication Administration Record (MAR) dated January 2017, identifies R57 receiving scheduled Melatonin per order.

Treatment Administration Record (TAR) dated January 2017, does not identify sleep monitoring or sleep assessment.

Interview on 1/31/17, at 8:14 a.m. with registered nurse (RN)-B stated he was unaware of any sleep monitoring occurring for R57.

Interview on 1/31/17, at 8:26 a.m. with director of nursing (DON) stated sleep assessments occur shortly after admission, quarterly and as needed.

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21535	Continued From page 37 Interview on 1/31/17, at 9:44 a.m. with Minimum Data Set (MDS)-A a coordinator stated nurses do the sleep assessments. MDS-A coordinator stated sleep assessments should be set up in the TAR for the nurses to know when to complete. MDS-A coordinator verified R57 did not have a sleep assessment completed. Interview on 1/31/17, at 10:25 a.m. with DON stated she would expect any resident on Melatonin to have a sleep assessment completed. DON stated a sleep study should have occurred prior to R57 starting a sleeping aide. DON verified R57 did not have a sleep assessment completed. LACK OF SLEEP ASSESSMENT AND RESIDENT SPECIFIC MOOD SYMPTOMS/SIGNS TO DETERMINE IF ANTIDEPRESSANT IS AFFECTIVE: R22's current physician orders included: start date 12/27/15, Cymbalta (antidepressant) 60 mg (milligrams) one time a day for major depressive disorder and start date 7/17/15, Melatonin (hormone used for sleep aide) 5 mg at bedtime for behaviors and not sleeping at night. R22's Medication Administration Record for the month of 1/17, identified R22 was receiving the Cymbalta and Melatonin as ordered. R22's current care plan included the following: Focus: takes an antidepressant medication related to depressive disorder. Interventions: monitor/document/report adverse side effects, administer medication as ordered. Monitor/document effectiveness. Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of	21535		

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antidepressant use. Gradual dose reduction per Pharmacist/medical doctor or nurse practitioner recommendation as able and if applicable. Focus: social services mood and behavior; displays signs of mood/behavior possibly related to socialized conduct disorder, explosive personality disorder, anxiety disorder and depressive disorder. At times calls out spouse name to female peers thinking they are his wife. Becomes agitated when they do not answer. Interventions: At times calls out spouse name to female peers thinking they are his wife. Becomes agitated when they do not answer. Behaviors being monitored: verbally abusive, refusal of cares, yelling out, hallucinations/delusions, sleepiness at night and hitting/kicking at staff. Offer food/fluids/toileting. Staff to assist to calm quiet area. Staff will ask resident if he is having pain. Staff will provide reassurance if behaviors begin. Staff will try redirection. Staff will try to re-approach if behaviors begin. Staff will use a calm speaking voice. Try 1:1 visits. Focus: takes hypnotic medication related to sleep, on melatonin. Interventions. Monitor/document adverse side effects. Administer medications per doctor order. Gradual dose reduction per pharmacist/doctor/nurse practitioner recommendation as able and if applicable.

On 2/1/17, at 10:13 a.m., nursing assistant (NA)-D when queried what behaviors were the nursing assistants charting on in the computer for R22, NA-D stated the behaviors charted on in the computer were the same for all residents and were charted on every shift. NA-D sated R22 had behaviors of yelling out, combativeness, refusal of cares, screaming wanted wife and wanted to go home. Review of the behaviors with NA-D at the time of interview being documented in the facility computer system for all residents were

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abusive behavior, biting, frequent crying, grabbing, kicking, hitting, pinching, scratching, spitting, pushing, rejection of care, repeats movement, repeats verbalization, threatening behavior, sexually inappropriate, wandering, yelling, screaming.

On 2/1/17, at 3:01 p.m., the director of nursing (DON) stated sleep assessments were to be completed upon admission, quarterly and as needed. The DON confirmed a sleep assessment had not been completed for R22. The DON confirmed R22's care plan lacked to identify resident specific symptoms of depression.

The facility policy Psychotropic Medications dated 8/1/15, indicated Procedure: 1. An assessment must be conducted to identify specific behaviors/symptoms, potential causative factors and recommendations for managing identified behaviors. 2. The medical record documentation must reflect the specific behaviors/symptoms and the residents response to non-pharmacological interventions to manage behaviors/symptoms. 8. After implementation of psychotropic medication behavior/symptom and medication side effects will be monitored and documented.

LACK OF COMPREHENSIVE SLEEP ASSESSMENT:

R102's admission record revealed R102 was admitted on 1/9/17 with diagnoses of left leg amputation.

R102 had an order for as needed (PRN) melatonin Tablet 3 milligrams for sleep. The current physician's orders reflected a start date for the PRN melatonin as 1/9/17 and the R102 had received the medication PRN on 1/21/17 and

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21535	Continued From page 40 1/23/17 according to the medication administration record. R102's medical record lacked a comprehensive sleep assessment and analysis of sleep monitoring to initiate and continue the use of PRN melatonin. During an interview on 1/31/17, at 11:28 a.m. registered nurse (RN)-B stated we have a sleep study and sleep assessment that was completed by the night shift and there should be a hard copy in the chart. RN-B verified there was not a sleep assessment in R102's medical record. RN-B stated was not sure when a sleep assessment should be completed. RN-B stated once in a while, we will see a sleep log put out for a resident for us to complete. During an interview on 1/31/17, at 1:56 p.m. the director of nursing (DON) stated she expected a sleep assessments to be completed when a resident was admitted with a medication for sleep or if we were going to start a new medication for sleep. The DON stated a sleep assessment was probably not done for R102. The Sleep/Awake Assessment policy and procedure dated 1/31/17, included: 1. Review resident's record for diagnosis and medications, which could affect sleep patterns. 2. Resident observations for sleep/awake pattern is to be made every hour for four (4) days. An additional 1-4 days may be assessed if necessary. 3. All staff involved in the resident's care must be aware the assessment is underway. 4. After monitoring is completed, analyze patterns and determine whether to contact the physician regarding a medication need or adjustment.	21535		

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21535	Continued From page 41 SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the use of psychoactive medications with the licensed staff to meet the requirements of the state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safety assessment of self-administration of medication had been completed for 1 of 2 residents (R22) who was observed to self-administer a nebulizer medication. Finding include: R22 was observed on 1/31/17, at 7:06 a.m., to be sitting in his wheelchair and had a nebulizer mask in place, with medication being administered via the nebulizer machine. No staff were present in R22's room or within view of R22. On 1/31/17, at 7:07 a.m., registered nurse (RN)-B walked down the hallway and into R22's room. When queried if R22 had been assessed for	21565	Corrected	3/9/17

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21565	Continued From page 42 self-administration of the nebulizer medication, RN-B stated we have an order, we can leave R22 alone with the nebulizer on as long as we check on him. R22's current physician orders, identified and order dated 4/13/15, for DuoNeb (bronchodilator) solution 0.5-2.5 mg (milligrams)/3 ml (milliliters) inhale one unit four times a day. May self-administer neb treatments, nurse will dispense medication and apply mask. However, R22's record lacked an assessment indicating if R22 was able to self-administer the nebulizer medication safely. On 2/1/17, at 3:01 p.m., the director of nursing stated we just did a self-administration assessment for R22, we obtained the order for R22 to self-administer the nebulizer last week. The DON reviewed R22 electronic record and confirmed there was no assessment for self-administration for the nebulizer. The DON stated the assessment might have been done on paper. On asking to see the medication assessment form DON at this time, none was provided. The facility policy Medication Self-Administration dated revision 11/1/16, indicated Policy: It is the center's policy to honor resident requests to self-administer medications if determined to be a safe practice. Procedure: 1. The licensed nurse evaluates the resident who has expressed a desire to self-administer selected medications, using the evaluation for self-administration of medication. 2. The IDT review with evaluation to determine the resident's competency to self-administer medications and grant approval as appropriate.	21565		

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21565	Continued From page 43 SUGGESTED METHOD OF CORRECTION: The director of nursing could ensure policies are current for SAM, and licensed staff have been trained. Residents who wish to SAM could be assessed, and a system for indicating this to staff could be devised. Audits could be conducted at medication pass times, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21565		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper infection control practices were implemented when cleaning/sanitizing a multi-resident use glucometer for 1 of 3 residents (R102) on the east wing who had blood sugars checked utilizing the glucometer. Findings include: On 1/30/17, at 11:01 a.m., licensed practical nurse (LPN)-B was observed to check R102's blood sugar. LPN-B stated at the time the glucometer used was a glucometer used for all residents on the east wing. LPN-B after checking R102's blood sugar had removed gloves and	21665	-All residents have personal glucometers -All residents have potential to be affected if glucometer equipment is not sterilized appropriately -All Licensed staff has been educated on proper sterilization methods of glucometers -2-3x/week audit for 1 month to be completed to ensure proper sterilization methods -DON/designee is responsible -Audit results will be reviewed monthly at QAPI -Corrective action completed by 3/13/17	3/13/17

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21665	Continued From page 44 carried the glucometer out to the medication cart. LPN-B donned gloves and cleansed the outside of the glucometer with a tissue and hand sanitizer. LPN-B removed the glove on her right hand and cleansed the outside of the glucometer with a alcohol pad and then removed the glove on her left hand and washed hands. At the time LPN-B when queried what the facility policy was for cleaning the glucometer, stated I would have to check on that. LPN-B stated a bleach wipe should be used to clean the glucometer and then let the glucometer air dry for three minutes. LPN-B stated I used an alcohol pad, either one works. LPN-B verified she had removed gloves prior to the glucometer being cleaned and had used a tissue and hand sanitizer and an alcohol pad to clean and sanitize the glucometer. The glucometer manufactured by UltraTRAK Complete owner's manual provided by the facility, indicated disinfect the meter between each patient to prevent infection. How to clean and disinfect the meter, the meter must be cleaned prior to the disinfection. Use one disinfecting wipe to clean exposed surfaces of the meter thoroughly and remove any visible dirt, blood, or any other body fluid with the wipe. Use a second wipe to disinfect the meter by following the disinfecting procedure below. Do not use organic solvents to clean the meter. We recommend for meter cleaning and disinfection you should use the disinfecting wipe/towelette from below: Micro-Kill Plus by Medline. On 1/30/17, at 3:51 p.m., the director of nursing (DON) stated when informed of how the multiuse glucometer was cleaned/sanitized stated that is not the correct procedure for cleaning/sanitizing the glucometer. The DON stated gloves should remain on until the glucometer was fully	21665		

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21665	Continued From page 45 cleaned/sanitized and the glucometer should have been cleansed with a super Sani-cloth wipe. The facility policy Cleaning and Disinfection of a glucometer dated 8/1/15, indicated Procedure: 2. Perform hand hygiene and apply gloves. 3. Wipe all external surfaces, including top, bottom and sides, using the bleach solution or commercially prepared EPA germicidal wipe; avoid allowing the solution to penetrate the test strip and/or key ports of the meter. 4. Ensure the meter remains wet for one minute an allow to air dry for an additional minute before using on the next resident. 5. If blood is visibly present on the meter, the procedure should be repeated a second time. 6. Discard soiled items in approved containers. &. Remove gloves and perform hand hygiene. SUGGESTED METHOD OF CORRECTION: The kitchen manager and maintenance manager could in-service dietary staff and housekeeping/maintenance staff the need to keep the kitchen in a state of good repair and clean. Also to frequently monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		3/13/17

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21805	Continued From page 46 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care in a manner to promote dignity for 1 of 1 resident (R52) observed to have uncovered catheter bag, which was visible to other residents and families. In addition, the facility failed to ensure dignity for toileting for 1 of 2 residents (R4) reviewed for urinary incontinence. Findings include: R52's quarterly Minimum Data Set (MDS) dated 10/21/16 indicated R52 had an indwelling Foley catheter, long and short-term memory problems and moderately impaired decision-making skills for daily living. R52 was observed on 1/31/17 at 10:28 a.m. to be in bed and the catheter bag was not covered and was in view from the hallway. On 1/31/2017, at 10:38 a.m. nursing assistant (NA)-A stated R52 did not have a bag attached to the side of the bed to place the catheter in when R52 was in bed. NA-A verified the uncovered catheter bag was visible from the door. On 1/31/2017, 1:56 p.m. the director of nursing (DON) stated the facility had covers for catheter bags and my expectation is they are covered. The DON stated catheter bags should not be visible, as this is a dignity issue. The Catheter Care policy with a revision date of 1/31/17, included staff will maintain consistent and adequate hygiene standards for residents with an indwelling catheter in order to maintain comfort, function, and prevent infection and other complications. 2. Catheters bag and tubing	21805	-R52 received catheter bag covering 1/31/17 -All residents with catheters were checked within facility on 1/31/17 and found to have catheter covers -All residents who have catheters have potential to be affected if catheter bags are left uncovered -All staff has been educated on dignified services residents deserve -A VA report was filed and an investigation was conducted on R4 behalf. Results concluded no harm done to resident and staff education appropriate. -All resident have the ability to be affected if they are not treated with dignity -All staff has been educated on dignified services residents deserve -1-2x/week audits for 1 month to be completed to ensure appropriate catheter coverings and verbal/nonverbal communication are in place that promote and maintain dignity for residents -DON/designee is responsible -Audit results will be reviewed monthly at QAPI -Corrective action completed by 3/13/17	

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should be secured and not allowed to touch or drag on the floor to prevent contamination. 4. Catheter bag should be kept in a protective holder/bag to protect dignity of the resident.

ENSURE DIGNITY FOR TOILETING:
R4's current electronic care plan indicated R4 had actual/potential for alteration in elimination related to urgency and incontinence. Required assist of one to manage incontinent briefs and check and change as need.

During observation on 1/30/17, at 10:21 a.m., nursing assistant (NA)-F asked R4 if he would like to lay down in his bed and R4 replied "yeah." After R4 was laid in bed, R4 stated he had to pee, put the urinal up to my penis. NA-F stated to R4 you usually go in your brief and then I will change you. So you can just pee in your brief and I will change you. R4 stated is that what I do? NA-F stated "yep!" R4 stated ok NA-F directed R4 to go and then I will change you.

On 1/30/17, at 10:57 a.m., NA-F stated R4 was to be checked and changed. I usually check his brief every two hours. R4 is usually not continent and does not tell when he has to go to the bathroom, so we just check and change him. NA-F stated R4 did not use the urinal and that was the first time he told me he had to void.

On 1/30/17, at 2:40 p.m., registered nurse (RN)-D stated the nursing assistant should have given the urinal to R4 when he requested to use the urinal.

On 1/30/17, at 3:51 p.m., the director of nursing stated she would expect staff to offer toileting appropriately. If a resident asks to use the urinal, bedpan, or toilet, the request should be

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21805	Continued From page 48 accommodated and it was not acceptable to not do so. On 1/31/17, at 2:18 p.m., R4 when queried if he knew when he had to go to the bathroom, stated "yeah." When queried how it made him feel when he wanted to use the urinal and staff did not give the urinal to him to use, R4 stated, "Well not good, but what to you do, Was not the first time and was not the last time, inexperienced." When queried if he would like to use the toilet, R4 stated, "I would be less embarrassed if I could go on the toilet." The facility policy Dignity and Respect dated 9/1/16, indicated The community shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop policies and procedures to ensure residents are treated with dignity. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members.	21830		3/9/17

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21830	Continued From page 49 (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section	21830		

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whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the

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21830	Continued From page 51 participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R74) reviewed for choices received baths according to their preferences for bathing frequency. Findings Include: R74 was interviewed on 1/29/17, at 2:46 p.m., the resident indicated she had not had a bath for the past two months. R74 stated she used to be scheduled to have baths in the afternoon, but switched her time to the mornings as she was not receiving the afternoon baths and she thought maybe the mornings would work better for staff. R74 stated when her breathing had not been very good she had asked for a bed bath and was not provided a bed bath either. R74 stated a couple times she had been asked around 6:15 a.m. if she was ready for a bath and she told them not yet, she needed to take her medicine and get her breathing under control first, but then stated they never come back. R74 stated, "My bathing situation is pissing me off, I do not see any reason I cannot get a bed bath. R74 stated the excuse she received is they are so short staffed." Review of the current quarterly Minimum Data Set (MDS) dated 10/13/16, indicated R74's brief interview for mental status BIMS score was 15 out of 15 (meaning cognition is intact) and displayed no behavioral concerns. Review of the most current plan of care for R74,	21830	Corrected	

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21830	Continued From page 52 identified the resident as having self -care deficit related to COPD and history of lower back pain. Interventions; required assist of one staff with bathing, on Sunday and Thursdays at 2:00 p.m. Review of the weekly bathing sheets reviewed from 11/12/16 to 1/29/17, indicated R74 did not receive a bath during the time period reviewed. During an interview on 1/31/2017, at 8:33 a.m. nursing assistant (NA)-B stated R74 used to be on the evening bathing schedule and had been changed to a day bath. NA-B stated R74 directed her cares. NA-B stated staff are to document when a resident had a shower on the shower sheet and in the computer. NA-B stated if a resident refused a shower, staff should tell the next shift to try to complete the bath or offer a bed bath. NA-B stated staff needed to document if residents refused bathing in point of care. NA-B stated she asked residents three times, if they would like a bath during her shift and stated, if the resident refused all three times she needed to let the nurse know. NA-B stated it could be challenging to get bathing completed because of staffing and staff calling in. During an interview on 1/31/2017, at 10:16 a.m. nursing assistant (NA)-A stated the aides were responsible to complete the showers. NA-A stated R74's bath days were Thursday and Sundays on the evening shift. NA-A stated R74 refused to shower 60% of the time. NA-A stated staff are supposed to document when residents refused bathing. NA-A stated to be honest there are times when we can't get to any of the baths or showers when there are only two aides on the hallways. During an interview on 1/30/17, at 11:42 a.m.	21830		

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21830	Continued From page 53 social services (SS)-A stated she was unaware of any concerns related to bathing for R74. SS-A stated she not aware R74 was refused bathing services. During an interview on 01/30/17, at 2:56 p.m. SS-A stated per the documentation on bathing R74 has not received a bath in the last two months. SS-A stated there was documentation R74 refused bathing on 1/29/17, 1/26/16, 1/5/17, 11/27/16, and 11/17/16. SS-A stated R74 was supposed to be offered bathing on Sundays and Thursdays at 2:00 p.m. SS-A stated staff were supposed to document when bathing services were provided and if residents refused bathing. During an interview on 1/31/17, at 7:02 a.m. SS-A stated she spoke with a couple aides and stated R74 had not had a bath for two months. SS-A stated the nursing assistants she spoke to were not offering R74 bed baths. SS-A stated it would be care planed for staff to offer a regular bath on her scheduled bath days on Thursday and Sunday and if R74 refused, staff were to offer her a bed bath. A policy regarding bathing was requested, none was provided. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all employees on the need for self choice in residents choices. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights	21855		3/13/17

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21855	Continued From page 54 Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R106) reviewed was provided privacy during toileting. Findings include: R106's current electronic care plan indicated R106 was a fall risk and required one assist for transfers for toileting. On 1/30/17, at 10:21 a.m., nursing assistant (NA)-F was observed to assist R106 to the bathroom. NA-F opened the bathroom door, and with the bathroom door open assisted R106 to stand, pulled down R106's pants and incontinent product and assisted R106 to sit on the toilet. NA-F closed the bathroom door after R106 was seated on the toilet until R106 was finished using the toilet. When R106 indicated he was done using the toilet, NA-F opened the bathroom door and assisted R106 to stand, cleansed R106's buttocks area and assisted R106 to pull up his incontinent product and pants. R106's pants fell down while being seated in his wheelchair and NA-F wheeled R106 out of the bathroom doorway	21855	-All room dividing curtains have been checked for successful operation -All residents have ability to affected if cares are completed without privacy being offered -All staff educated on resident right to privacy during cares -All staff has been educated on appropriate maintenance notification protocol if noticed privacy equipment is in operational need of maintenance. -1-2x/week audits for 1 month to be completed to monitor privacy practices are being offered/completed to residents during cares. -DON/designee is responsible -Audit results to be reviewed monthly at QAPI -Corrective action completed by 3/13/17	

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over to his side of the room. NA-F then assisted R106 to stand and pulled up R106's pants. R106's roommate R4, was seated in his wheelchair directly across from R106, in full view of R106 being assisted to pull up his pants. R4's privacy curtain was noted to be tide into a big knot and hung directly above R4's head of bed.

On 1/30/17, at 10:57 a.m., NA-F confirmed R106's roommate R4 was able to view R106 being toileted when getting on and off the toilet, and when NA-F was assisting to pull up R106's pants. NA-F confirmed R4's privacy curtain was tide into a big knot and hung directly above R4's head of bed. NA-F stated the curtain was tied into a knot because when you open the door the curtain becomes caught in the door. NA-F confirmed privacy curtains were not used and privacy had not been provided for R106 when assisting R106 onto and off the toilet, and when pulling up R106's pants.

On 1/30/17, at 3:51 p.m., the director of nursing (DON) stated not providing privacy during toileting was not acceptable. The DON stated it would be an embarrassment for both residents. The DON stated she would expect the privacy curtains to be used to provide privacy.

The facility policy Dignity and Respect, dated 9/1/16, indicated Procedure: 3. Provide residents with privacy during provision of cares (e.g. close privacy curtain).

SUGGESTED METHOD OF CORRECTION: The Director of Nursing Services or designee could develop, review, and/or revise policies and procedures to ensure all residents' privacy is maintained. The Director of Nursing Services or designee could educate all appropriate staff on

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21855	Continued From page 56 the policies and procedures. The Director of Nursing Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21855		