#### 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 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: **7**(L8) (L3) MAPLE MANOR NURSING AND REHAB, LLC 245409 NO.(L1) 1. Initial 2. Recertification (L4) 1875 19TH STREET NORTHWEST 4. CHOW 2. STATE VENDOR OR MEDICAID NO. 3. Termination (L6) 55901 (L5) ROCHESTER, MN 5. Validation 6. Complaint (L2 ) **843242200** 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (L9) 01/13/2015 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF 04/05/2017<sup>(L34)</sup> 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: \_\_ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: From (a): A. In Compliance With \_\_\_\_ 2. Technical Personnel То (b): Program Requirements Scope of Services Limit Compliance Based On: \_\_\_ 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 12. Total Facility Beds 81 (L18) \_\_\_ 5. Life Safety Code \_\_\_ 9. Beds/Room 13. Total Certified Beds 81 (L17) B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)81 (L37) (L38) (L39) (L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Gary Nederhoff, Unit Supervisor 04/18/2017 Kamala Fiske-Downing, Enforcement Specialist 4/18/2017 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: Facility is Eligible to Participate 3. Both of the Above: \_\_\_\_ 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 01/01/1987 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41)(L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change (L44)00-Active (L27)B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00160 (L28) (L31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)



#### 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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us



#### 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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER A. Building		DA	TE OF REVIS	ΙΤ	
	B. Wing	STREET ADDRESS, CITY, STATE, ZIP CODE	4/5	5/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLE MANOR NURSING AND REHAB, LLC 18		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).

ITEI	М		DATE	ITEM			DATE	ITEM V4			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0164		Correction	ID Prefix	F0176		Correction	ID Prefix	F0241		Correction
Reg. #	483.10(h)(1)(3)(483.70(i)(2)	(i);	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	E0242		Correction	ID Prefix	Engen		Correction	ID Prefix	E0201		Correction
ID I IEIIX			Correction	I I I I I I I I I I I I I I I I I I I			- Correction	ID I IEIIX			Correction
Reg. #	483.10(f)(1)-(3)		Completed	Reg. #		(c)(2)(i-ii,iv,v) .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	E0200		Correction	ID Prefix	E0215		Correction	ID Prefix	E0222		Correction
ID I ICIIX		(1-) (1)	Correction	ID I ICIIX			- Oorrection	ID I IGIIX		\(1) (0)	Oorrection
Reg. #	483.24, 483.25	(K)(I)	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 Doctor	F000F		O ::	ID D. f.	F2222		:	ID Dog for	E0074		0 "
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			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		Carraction	ID Prefix	F0465		Carraction	ID Prefix	F0F00		Carraction
ID FIEIIX		(1) ( ) (1)	Correction	ID FIEIIX			Correction	ID FIEIIX			Correction
Reg. #	483.80(a)(1)(2)	(4)(e)(t)	Completed	Reg. #	483.90	(i)(5)	Completed	Reg. #	483.75(g)(1)(i)-(iii (h)(i)	)(2)(i)(ii)	Completed
LSC			03/13/2017	LSC			03/13/2017	LSC			03/21/2017
REVIEWE STATE AC		REVIEW (INITIAL		DATE		SIGNATURE OF	SURVEYOR			DATE	
REVIEWE CMS RO	ED BY	REVIEW (INITIAL		DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 2/1/2017				R ANY UNCORRECTED DEFICIENC	-			YES	в □ по		

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

ELSW12

## POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	/ISIT
	A. Building 01 - MAIN BUILDING 01				
245409 <sub>Y1</sub>	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).

ITE Y4		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> 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		<u> </u>
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		<del></del>
REVIEW STATE A		REVIEWED BY (INITIALS)	DATE	SIGNATU	RE OF SURVEYOR		DATI	Ε
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DATI	Ξ
FOLLOWUP TO SURVEY COMPLETED ON 1/31/2017		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO						

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

ELSW22

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

ID: ELSW

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00916 1. MEDICARE/MEDICAID PROVIDER 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) MAPLE MANOR NURSING AND REHAB, LLC 245409 NO.(L1) 1. Initial 2. Recertification (L4) 1875 19TH STREET NORTHWEST 4. CHOW 2. STATE VENDOR OR MEDICAID NO. 3. Termination (L6) 55901 (L5) ROCHESTER, MN 5. Validation 6. Complaint (L2 ) **843242200** 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (L9) 01/13/2015 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF 02/01/2017(L34) 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: \_\_ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 11. LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): \_\_\_\_ 2. Technical Personnel То (b): Program Requirements Scope of Services Limit Compliance Based On: \_\_\_ 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 12. Total Facility Beds 81 (L18) \_\_\_ 5. Life Safety Code \_\_\_ 9. Beds/Room 13. Total Certified Beds 81 (L17) **X** B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)81 (L37) (L38) (L39) (L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Kyla Einertson, HFE NE II 02/24/2017 Kamala Fiske-Downing, Enforcement Specialist 03/13/2017 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: Facility is Eligible to Participate 3. Both of the Above: \_\_\_\_ 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 01/01/1987 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41)(L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change (L44)00-Active (L27)B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00160 (L28) (L31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)



#### 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:

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

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

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

the time of a revisit;

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

<u>Informal Dispute Resolution</u> - 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.u

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

Kamala Fish Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

PRINTED: 02/24/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245409	B. WING			02/	01/2017
	PROVIDER OR SUPPLIER  MANOR NURSING AN	D REHAB, LLC		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	as your allegation o	of correction (POC) will serve f compliance upon the	F 0	000			
	enrolled in ePOC, y at the bottom of the	otance. Because you are rour signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.					
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with					
		rvey was conducted and tion(s) were also completed at dard survey."					
		complaint H5409033 was ne survey and found not to be					
		complaint H5409036 was ne survey and found not to be					
F 164 SS=D	completed during the substantiated. 483.10(h)(1)(3)(i); 4	complaint H5409039 was ne survey and found not to be 183.70(i)(2) PERSONAL ENTIALITY OF RECORDS	F 1	64			3/13/17
	medical treatment, communications, po	acy includes accommodations, written and telephone ersonal care, visits, and					
	A DIDECTADIC AD DDAVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE		TITI F		(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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG		E SURVEY MPLETED
		245409	B. WING		02	/01/2017
	PROVIDER OR SUPPLIER	ID REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 164	does not require the room for each resident to confidential person  (i) The resident has of personal and me provided at §483.70(i)(2) or oth laws.  §483.70 (i) Medical records. (2) The facility musinformation contain regardless of the forecords, except wh  (i) To the individual representative whee  (ii) Required by Law  (iii) For treatment, poperations, as permotions, as permotith 45 CFR 164.50  (iv) For public health neglect, or domestial activities, judicial and law enforcement pupurposes, research medical examiners a serious threat to by and in compliance.	and resident groups, but this e facility to provide a private dent.  has a right to secure and all and medical records.  the right to refuse the release edical records except as her applicable federal or state of the resident's records, form or storage method of the en release is-  or their resident re permitted by applicable law;  or their resident re permitted by and in compliance	F1	64		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245409	B. WING		02/0	01/2017
	PROVIDER OR SUPPLIER	ID REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 164	review, the facility f (R106) reviewed was toileting.  Findings include:  R106's current elect R106 was a fall risk transfers for toileting.  On 1/30/17, at 10:2 (NA)-F was observed bathroom. NA-F op with the bathroom of stand, pulled down product and assisted NA-F closed the baseated on the toilet, NA and assisted R106 buttocks area and a incontinent product down while being s NA-F wheeled R10 over to his side of t R106 to stand and R106's roommate I wheelchair directly of R106 being assis privacy curtain was knot and hung direct On 1/30/17, at 10:5 R106's roommate I being toileted when	tion, interview and document ailed to ensure 1 of 2 residents as provided privacy during stronic care plan indicated and required one assist for	F 164	-All room dividing curtains have checked for successful operation -All residents have ability to affect cares are completed without prividing cares and completed on resident rigorivacy during cares -All staff has been educated on appropriate maintenance notifical protocol if noticed privacy equipm operational need of maintenance -1-2x/week audits for 1 month to completed to monitor privacy prasure being offered/completed to reduring caresDON/designee is responsible -Audit results to be reviewed mor QAPI -Corrective action completed by 3	ted if acy being ht to tion nent is in be ctices esidents	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245409	B. WING	<del></del>	02/01/2017	
	PROVIDER OR SUPPLIER	D REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 176 SS=D	head of bed. NA-F a knot because who curtain becomes car confirmed privacy or privacy had not been assisting R106 onto pulling up R106's p  On 1/30/17, at 3:51 (DON) stated not powas not acceptable an embarrassment stated she would expressed to provide privacy during privacy curtain).  The facility policy D 9/1/16, indicated Privacy during privacy curtain).  483.10(c)(7) RESID DRUGS IF DEEME (c)(7) The right to some the interdisciplinary §483.21(b)(2)(ii), had practice is clinically This REQUIREMED by:  Based on observative review, the facility fassessment of self-had been complete	and hung directly above R4's stated the curtain was tied into en you open the door the aught in the door. NA-F curtains were not used and en provided for R106 when and off the toilet, and when ants.  p.m., the director of nursing roviding privacy during toileting and the DON stated it would be for both residents. The DON expect the privacy curtains to be exacy.  ignity and Respect, dated rocedure: 3. Provide residents provision of cares (e.g. close DENT SELF-ADMINISTER ED SAFE  elf-administer medications if team, as defined by as determined that this	F 1		er otential	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY PLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
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F 176	R22 was observed sitting in his wheel in place, with med the nebulizer mack R22's room or with On 1/31/17, at 7:0 walked down the haself-administration RN-B stated we haself-administration RN-B stated we haself-administer nebulizer medication 0.5-2.5 minhale one unit four self-administer nebulizer medicating if R22 we nebulizer medicating if R22 we nebulizer medication on 2/1/17, at 3:01 stated we just did assessment for R2 R22 to self-administration stated the assessing paper. On asking the assessment form provided.	d on 1/31/17, at 7:06 a.m., to be chair and had a nebulizer mask ication being administered via hine. No staff were present in hin view of R22.  7 a.m., registered nurse (RN)-B hallway and into R22's room.  22 had been assessed for of the nebulizer medication, ave an order, we can leave R22 hulizer on as long as we check sician orders, identified and 5, for DuoNeb (bronchodilator) of (milligrams)/3 ml (milliliters) or treatments, nurse will on and apply mask.	F 17	completedStaff have been educated or of self-administration assess to allowing self-administration of medication -1-2x/week audits to be commonth on residents self-administrationsDNS/designee is responsible-Audit results to be reviewed QAPI for determination of coneed to continueCorrective action completed.	pleted for one inistering e. monthly at mpliance and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	ID REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1875 19TH STREET NORTHWEST  ROCHESTER, MN 55901	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION
F 176	self-administer med safe practice. Proce evaluates the resid desire to self-admin using the evaluation medication. 2. The determine the resid self-administer med as appropriate. 483.10(a)(1) DIGNI INDIVIDUALITY  (a)(1) A facility must resident in a manner of promotes maintenather quality of life reindividuality. The fapromote the rights This REQUIREMENT by:  Based on observative review, the facility fundance to promote (R52) observed to limit which was visible to In addition, the facility from the facility fundance in the facility fundance	conor resident requests to dications if determined to be a sedure: 1. The licensed nurse ent who has expressed a hister selected medications, in for self-administration of IDT review with evaluation to dications and grant approval dications and grant approval at treat and care for each er and in an environment that unce or enhancement of his or cognizing each resident's cility must protect and of the resident.  No is not met as evidenced tion, interview and document ailed to provide care in a dignity for 1 of 1 resident nave uncovered catheter bag, of other residents and families. Dity failed to ensure dignity for esidents (R4) reviewed for	F 17	6	necked to ave ags
	R52's quarterly Min 10/21/16 indicated catheter, long and	imum Data Set (MDS) dated R52 had an indwelling Foley short-term memory problems paired decision-making skills		<ul> <li>-A VA report was filed and an invest was conducted on R4 behalf. Resu concluded no harm done to residen staff education appropriate.</li> <li>-All resident have the ability to be a if they are not treated with dignity</li> <li>-All staff has been educated on dignity</li> </ul>	t and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245409	B. WING			02/	01/2017	
	PROVIDER OR SUPPLIER	D REHAB, LLC		1	RTREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST ROCHESTER, MN 55901	, 02/		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 241	in bed and the cath was in view from the was in view from the On 1/31/2017, at 10 (NA)-A stated R52 the side of the bed R52 was in bed. Not catheter bag was viewed on 1/31/2017, 1:56 (DON) stated the fabags and my expect The DON stated cavisible, as this is a complication of the Catheter Care 1/31/17, included some and adequate hygical with an indwelling comfort, function, a complications. 2. Complication	on 1/31/17 at 10:28 a.m. to be eter bag was not covered and e hallway.  D:38 a.m. nursing assistant did not have a bag attached to to place the catheter in when A-A verified the uncovered isible from the door.  p.m. the director of nursing acility had covers for catheter ctation is they are covered. It there bags should not be dignity issue.  policy with a revision date of taff will maintain consistent ene standards for residents eatheter in order to maintain and prevent infection and other atheters bag and tubing and not allowed to touch or prevent contamination. 4. d be kept in a protective ct dignity of the resident.  FOR TOILETING:  nic care plan indicated R4 or alteration in elimination and incontinence. Required nage incontinent briefs and	F 2	241	services residents deserve -1-2x/week audits for 1 month to be completed to ensure appropriate of coverings and verbal/nonverbal communication are in place that property and maintain dignity for residents property -DON/designee is responsible property -Audit results will be reviewed more QAPI property action completed by 3/	atheter comote othly at		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		E SURVEY PLETED
		245409	B. WING			02/0	01/2017
	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE
F 241	stated "yep!" R4 stand then I will char and then I will char on 1/30/17, at 10:5 be checked and chevery two hours. From the does not tell when so we just check a R4 did not use the time he told me he urinal to R4 where the urinal to R4 where the told me told appropriately. If a representation of the told and to so.  On 1/30/17, at 3:5 stated she would be appropriately. If a representation of the told and to so.  On 1/31/17, at 2:13 knew when he had "yeah." When quering the wanted to use the urinal to him to good, but what to year and was not the laqueried if he would stated, "I would be on the toilet."  The facility policy I 9/1/16, indicated T	ated is that what I do? NA-F tated ok NA-F directed R4 to go nge you.  57 a.m., NA-F stated R4 was to nanged. I usually check his brief R4 is usually not continent and he has to go to the bathroom, and change him. NA-F stated urinal and that was the first	F 2	241			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245409	B. WING		02/	01/2017
	PROVIDER OR SUPPLIER	D REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE
F 241 F 242	his or her individual	nd respect in full recognition of	F 2			3/13/17
SS=D	(f)(1) The resident is schedules (includin health care and proconsistent with his cand plan of care and of this part.  (f)(2) The resident is about aspects of his are significant to the (f)(3) The resident is members of the concommunity activities facility.  This REQUIREMENT by:  Based on interview facility failed to ensure reviewed for choice their preferences for Findings Include:  R74 was interviewed resident indicated is past two months. R scheduled to have it switched her time to receiving the aftern maybe the morning R74 stated when her	choices  as a right to choose activities, g sleeping and waking times), viders of health care services or her interests, assessments, d other applicable provisions  as a right to make choices or her life in the facility that		-R74 indicated her bathing pron 1/30/17. R74 received a beher preference on 1/30/17. R7 Plan of Care (POC) & care guiupdated on 1/30/17All residents/responsible partiexperienced the "New Admissi Questions" questionnaire which bathing preference(s)New admissions/responsible interviewed inquiring bathing pwithin 7 days of admittance. In provided is care planned and procAll residents have potential to if bathing preferences are not	d bath per 4 care plan, ide was es have ions h inquires parties are preferences formation placed in be affected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245409	B. WING		02/	01/2017
	PROVIDER OR SUPPLIER	ND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	•	
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F 242	provided a bed bat times she had bee she was ready for yet, she needed to breathing under conever come back. situation is pissing reason I cannot ge excuse she received. Review of the currous (MDS) dated 1 interview for mental out of 15 (meaning displayed no behave the composite of the most identified the residentified the resident related to COPD a Interventions; requibathing, on Sunday Review of the wee from 11/12/16 to 1/2 receive a bath during an interview nursing assistant (on the evening bat changed to a day be the cares. NA-B standard in the coresident refused a next shift to try to co bath. NA-B stated residents refused is stated she asked residents refused asked residents asked residents asked residents refused residents refused residents refused residents refused residents refu	h either. R74 stated a couple n asked around 6:15 a.m. if a bath and she told them not take her medicine and get her ntrol first, but then stated they R74 stated, "My bathing me off, I do not see any t a bed bath. R74 stated the ed is they are so short staffed."  ent quarterly Minimum Data 0/13/16, indicated R74's brief al status BIMS score was 15 cognition is intact) and	F 242	and bathing doesn't occur as result-All staff has been educated on rerights regarding bathing preference protocols with residents who may bathing care.  -1-2x/week audits for 1 month to be completed on bathing refusals to eappropriate follow up and options provided to residents timely to material bathing hygiene.  -DON/designee is responsible -Audit results will be reviewed mor QAPI -Corrective action completed by 3/2	sidents' es and refuse  ee ensure are intain	

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F 242	resident refused a the nurse know. No challenging to get staffing and staff or During an interview nursing assistant or responsible to constated R74's bath Sundays on the experience of the staff are supposed refused bathing. If are times when we showers when the hallways.  During an interview social services (Stany concerns related she not awas services.  During an interview SS-A stated per the R74 has not receim months. SS-A stated per the R74 has not receim months. SS-A stated bathing 11/27/16, and 11/1 supposed to be of Thursdays at 2:00 supposed to documer provided and During an interview stated she spoke R74 had not had a staff or staff or supposed to the stated she spoke R74 had not had a staff or supposed to the stated she spoke R74 had not had a staff or supposed to had a supposed to had a staff or supposed to h	Il three times she needed to let A-B stated it could be bathing completed because of	F 24	.2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245409	B. WING		02	/01/2017	
	PROVIDER OR SUPPLIER	ID REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
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F 242	her scheduled bath	age 11 staff to offer a regular bath on days on Thursday and refused, staff were to offer her	F 2	242			
F 280 SS=D	was provided. 483.10(c)(2)(i-ii,iv,v	oathing was requested, none v)(3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP	F 2	280		3/13/17	
	and implementation	participate in the development n of his or her person-centered ing but not limited to:					
	including the right t be included in the prequest meetings a	cipate in the planning process, o identify individuals or roles to planning process, the right to and the right to request reson-centered plan of care.					
	expected goals and amount, frequency	icipate in establishing the doutcomes of care, the type, and duration of care, and any d to the effectiveness of the					
	(iv) The right to rec included in the plar	eive the services and/or items of care.					
		the care plan, including the gnificant changes to the plan					
	right to participate i	nall inform the resident of the n his or her treatment and esident in this right. The nust					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245409	B. WING			02/0	01/2017
	PROVIDER OR SUPPLIER	ID REHAB, LLC		18	REET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa	nge 12	F 2	80			
	(i) Facilitate the inc resident representa	lusion of the resident and/or ative.					
	(ii) Include an asse strengths and need	ssment of the resident's ls.					
		resident's personal and s in developing goals of care.					
	483.21 (b) Comprehensive	Care Plans					
	(2) A comprehensiv	ve care plan must be-					
	(i) Developed within the comprehensive	n 7 days after completion of assessment.					
	(ii) Prepared by an includes but is not l	interdisciplinary team, that imited to					
	(A) The attending p	hysician.					
	(B) A registered nuresident.	rse with responsibility for the					
	(C) A nurse aide wi resident.	th responsibility for the					
	(D) A member of fo	od and nutrition services staff.					
	the resident and the An explanation must medical record if the and their resident re	racticable, the participation of e resident's representative(s). It is to e included in a resident's e participation of the resident epresentative is determined the development of the in.					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED		
		245409	B. WING		02/01/2017
	PROVIDER OR SUPPLIER	ID REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	00 11
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 280	disciplines as deter or as requested by  (iii) Reviewed and it team after each as comprehensive and assessments. This REQUIREMED by:  Based on observareview, the facility finclude at risk for book (R74) reviewed for concerns; failed to resident's room for reviewed for particitied to revise the (R22) related to de	tte staff or professionals in mined by the resident's needs the resident.  revised by the interdisciplinary sessment, including both the	F 28	-R74 care plan has been updated to include risk for bruising -All residents receiving medications known risk for increased bruising had their care plans reviewed and updated if needed -R74 has been interviewed and has agreed to have her care conference in her room so that she can attend	with ve s held
	FOR BRUISING:  R74's physician ord 10 milligrams (MG) time a day for COP addition to 1 mg at daily. Start date 1/5  R74's current elect R72 was at increas the use of predniso  R74 was observed	ronic care plan did not address ed risk for bruising related to		-All residents are being offered alter site for care conference if not wantin attend in conference room -Policy and procedure titled 'Particip in Care Conferences' has been revie and updated -R22 care plan has been updated to include being edentulous (denture b and family declined to get fixed) -Staff educated to communicate chain resident condition via the 'Nursing Services Daily Communication' form will be brought to the next clinic meeting (held Mon-Fri except holidal special occasions) with care plans updated as neededDNS/designee is responsible -Audits of care plan meetings and recare plans will be done for at least 2	ation ewed  roken anges  n. This cal ys or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	D REHAB, LLC		18	TREET ADDRESS, CITY, STATE, ZIP CODE B75 19TH STREET NORTHWEST OCHESTER, MN 55901	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From padid not reflect identibruise.  R74's progress not to 2/1/17 the docunidentification or mo  During an interview nursing assistant (Noresidents' skin during stated she reported nurse right away.  On 2/01/17, 9:39 as werified through obsider right forearm. From the measured 4.5 centified stated she would deprogress note and subservation of bruis record. RN-C stated bruised easily.  During an interview director of nursing of residents' skin on the stated staff comples section on it for sking weights. The DON form and provide the stated if there was section on the stated in the section of the section on the section on the section of the section on the section of t	ge 14 ification or monitoring of the  es were reviewed from 1/3/17 nentation did not reflect nitoring of the bruise.  on 1/31/17, at 8:46 a.m., NA)-B stated she looked at ng daily and on bath day. NA-B I any skin concerns to the  m., registered nurse (RN)-C servation R74 had a bruise on RN-C stated the bruise meters (cm) x 4.8 cm. RN-C ocument the findings in a would enter a nursing order for se for healing on the treatment d R74 was on prednisone and  on 2/01/17, at 10:20 a.m., the (DON) stated staff monitored heir shower day. The DON ted a bath sheet that had a n issues, vital, signs and stated staff are to fill out the ne form to the nurse. The DON an identified skin issue it was	F 2			o ed at e es. QAPI d	
	progress note and completed. The DC the bruising for wor DON stated staff ar providing care and The DON stated sh	the nurse, there should be a an accident/incident report on stated nursing was to track sening and resolution. The re to monitor skin anytime they report concerns to the nurse. The would expect a care plan to esidents that are at risk for loss					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245409	B. WING			02/	01/2017
	PROVIDER OR SUPPLIER	D REHAB, LLC		1875	EET ADDRESS, CITY, STATE, ZIP CODE 5 19TH STREET NORTHWEST CHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	any skin injury.  LACK OF PARTICI  R74 was interviewed when asked do state about your medicing treatments. R74 resishe was unaware of and stated, "Does to one."  R74's care conference reviewed and reveating an interviewed and reveating any of the care consince her admission.  During an interviewe social services (SS leave her room to one SS-A stated R74 to room because she bathroom frequently had considered have room so she could conferences, SS-A offered to have a case of the stated she had talk conferences in her was a good idea as about coming down the meeting.  R74 was interviewed.	PATION IN CARE PLANNING:  ad on 1/29/17, at 3:07 p.m., if include you in decisions e, therapy, or other sponded, "No." R74 stated if what a care conference was hat tell you if I have ever been  ace progress notes were aled resident had not attended ferences held at the facility in.  and 1/30/17, at 11:55 a.m., i)-A stated R74 refused to come to care conferences. Id her she could not leave her took Lasix and used the iy. When asked if the facility ing care conferences in R74's participate in the care stated the facility had not are conference in her room.  and 2/01/17 at 9:50 a.m., SS-A ed with R74 about having care room, and R74 thought that is she would not need to worry in to the conference room for	F 2	80			
	R74 stated the soci	al worker had visited with her ving care conferences in her					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245409	B. WING		02	/01/2017
	PROVIDER OR SUPPLIER	ID REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	room. R74 stated s conferences in her like to leave her rooneed to use the bar problems.  During an interview director of nursing been offered the opheld in her room if room to attend care stated she would le participation in care not provided. REVISION OF CAIR R22's current elect Focus: self-care demobility, anxiety disdisorder, and alert included oral care; to brush BID (twice On 1/29/17, at 2:05 have no teeth or destated she did not stroom.  On 2/1/17, at 10:13 stated R22 used to dentures out of his broke. I do not thin ones. NA-E stated	the agreed to have care room. R74 stated she did not om because of her frequent throom and her breathing  on 2/01/17, at 10:15 a.m. the (DON) stated R74 should have be better to have care conferences she did not want to leave her expected to expect the conferences. The DON book for a policy regarding expected to expect the conferences and a policy was replaced to impaired sorder, borderline personality with confusion. Interventions wears dentures; assist of one expected to enture in his mouth.  a.m., R22 was observed to enture in his mouth.  a.m., registered nurse (RN)-C firmed R22 had no dentures in dithrough R22's room and see any dentures for R22 in his wear dentures. R22 threw the mouth and the dentures k they are going to get new it had been maybe a couple of had not had his dentures.	F 2	80		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED	
		245409	B. WING _		02/	01/2017
	PROVIDER OR SUPPLIER	D REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	On 2/1/17, at 10:50 service informed Rifamily does not war RN-C stated she had needs to be update.  On 2/1/17, at 2:02 pstated she had R22 the family and they replaced. SS-A state a long time ago and information regarding.  On 2/1/17, at 2:42 pstated her estory forward anytime so there should be a replaced, family not resident notes. The plan identified R22 care plan should had not ward anytime so the should had so the sho	a.m., RN-C stated social 22's dentures were broke and at the dentures replaced. ad informed R22's care plan	F 28	30		
F 281 SS=D	dated 10/1/16, indic Implementation: 1. interdisciplinary tea maintaining care pla 483.21(b)(3)(i) SEF PROFESSIONAL S (b)(3) Comprehens The services provide	m is responsible for ans on a current status. RVICES PROVIDED MEET STANDARDS	F 28	31		3/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245409	B. WING _		02/	/01/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	This REQUIREME by: Based on observareview, the facility implemented for fatemporary care plate 21 days when find is completed and of 2 residents (Refalls/accidents.  Findings include: R106's Admission R106 had diagnost dementia, rheumath vitamin D deficient 1/12/17.  During observation R106 laid in bed, for bed, bed was in athe within reach.  R106's current ele Focus: alteration in related to fall risk: Interventions: Ensifitting shoes. Locotone to propel to detoileting every two Transfers; assist of walker. Assist as resident as the facility of the same and	al standards of quality. INT is not met as evidenced ation, interview and document failed to ensure interventions alls was included on the an (this includes admission date rest comprehensive assessment care planned interventions) for 106) reviewed for  Record dated 2/1/17, identified es that included depression, toid arthritis, malaise and cy. Also admitted to facility on an on 1/31/17, at 8:57 a.m., all mat in place on floor next to low position and call light was actronic care plan identified a mobility: potential for injury due to debility, dementia. The proper motion, wheelchair, assist of estination of choice. Offer to three hours while awake. If one with forward wheeled needed.	F 28	-R106 care plan has been revisis current -Residents who have been deer risk for falls have had their care reviewed and are current -All resident who experience a f potential to be affected -Staff was educated regarding r prevention interventions to be p the communication sheet until r by the IDT on the next business which time they will be placed in electronic comprehensive care -DNS/designee is responsible -1-2x/week audits for 2 months to ensure proper intervention communications were placed at resident fallResults brought to the monthly determination of compliance an continuation -Corrective action completed by	med high plans all has new fall laced on eviewed day at the plan will occur fter a  QAPI for d	
	1/12/17, identified	Resident Plan of Care dated fall risk: yes and other was o falls interventions to prevent				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245409	B. WING _		02/	01/2017	
	PROVIDER OR SUPPLIER	ID REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 281	Continued From pa	ige 19	F 28	31			
		istant care guide sheet fall risk high and again no falls vent falls.					
	following: On 1/16/17, at 5:45 floor half in bathroo cause: needed to u movement. Interver right after supper. On 1/17/17, at 3:15 attempting to self to factors reviewed. In supervision, check	cident Reports identified the p.m., a fall in room laying on om and half in room, root se the bathroom for bowel ntion initiated: staff to toilet p.m., a fall in room, ransfer from bed. Causative ntervention implemented close frequently when in bed.					
	of toilet right after s	tiled to include the intervention supper, check frequently when on floor when in bed.					
		o.m., the DON stated she rentions implemented to be					
F 309 SS=D	dated 10/1/16, indic Implementation: 1. interdisciplinary tea maintaining care pl	m is responsible for ans on a current status. ) PROVIDE CARE/SERVICES	F 30	09		3/13/17	
	applies to all care a residents. Each re-	ie undamental principle that and services provided to facility sident must receive and the e the necessary care and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245409	B. WING			02/0	01/2017
NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC				18	TREET ADDRESS, CITY, STATE, ZIP CODE B75 19TH STREET NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 309	services to attain of practicable physical well-being, consist comprehensive as 483.25 (k) Pain Managem The facility must exprovided to resider consistent with protine comprehensive and the residents.  (I) Dialysis. The faresidents who require services, consister of practice, the concare plan, and the preferences. This REQUIREME by:  Based on observative review, the facility bruising for 3 of 3 reviewed for non-preferences.  Findings Include:  R74 was observed had a large bruise did not reflect identification or more than the progress not 2/1/17 and the concept of the physician or more residents.	or maintain the highest al, mental, and psychosocial ent with the resident's sessment and plan of care.	F3	809	-R74, R102 and R22 had bruise monitoring added to the eTAR to be checked weekly until bruises were h-On 1/31/17 and continuing thereaft staff was educated via 'Today at a C form regarding immediate reporting new skin issues (bruises, skin tears -Skin issues are added to the eTAR weekly tracking until healed and a n placed in the electronic record -All residents have potential to be at if skin concerns are not monitored -DNS/designee is responsible -Random audits of at least 5 differencesidents per week will be conducted one month to ensure that proper notification is being given and monitis occurring.	nealed der, Glance' of any s) for note is ffected ant ed for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245409	B. WING		<del></del>	02/0	01/2017
NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC				1	TREET ADDRESS, CITY, STATE, ZIP CODE 875 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	disease (COPD). On to 1 mg at HS [beding R74's current electron R72 was at increase the use of prednisor R74's bath sheet distorated to the right arm.  During an interview nursing assistant (Noresidents' skin during day. NA-B stated slot to the nurse right are considered through obstact of the nurse right forearm. From the measured 4.5 cm is a would document in the entering on the treat was on prednisone.  During an interview the DON stated the (ADON) had brough completed on 1/31/DON verified there regarding the bruise DON stated she did nurses notes regard report was not communicated when the communicated she did nurse should have.	nic obstructive pulmonary Give 10 mg in a.m. in addition time], equals 11 mg daily.  Fronic care plan did not address ed risk for bruising related to ne.  ated 1/31/17 indicated bruising  Fron 1/31/17, at 8:46 a.m.,  AA)-B stated she looked at ng cares daily and on bath ne reported any skin concerns way.  m., registered nurse (RN)-C servation R74 had a bruise on RN-C stated the bruise  4.8 cm. RN-C stated she a progress note and would er for observation of bruise for ment record. RN-C stated R74 and bruised easily.  Fron 2/01/2017, at 1:55 p.m., assistant director of nursing the R74's skin monitoring form 17 following her bath. The was no documentation in the ding the bruise and an incident pleted related to the bruise	F3	809	-Audit results will be brought to the monthly QAPI for determination of compliance and continuation -Corrective action completed by 3/		

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		245409			·····	02/01/2017	
NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC				18	REET ADDRESS, CITY, STATE, ZIP CODE 75 19TH STREET NORTHWEST DCHESTER, MN 55901	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	bruise.	e was not informed of R74's	F3	309			
	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.						
		ctronic care plan directed staff th cares for changes."					
	to 2/1/17 the docur	otes were reviewed from 1/9/17 nentation did not reflect nitoring of the bruises.					
	R102's bath sheet skin concerns.	dated 1/20/17 indicated no					
	nursing assistant (I resident's skin whe undressed, during	on 01/31/17, at 11:01 a.m., NA)-A stated she monitored on she got them dressed, cares and on shower days. s were to be reported to the					
	verified through ob- bruising on the left centimeters (cm) x hand measuring 1.	.m., registered nurse (RN)-C servation R102 to have fading forearm measuring 3 3.2 cm and to back of left 2 cm x 1.5 cm. RN-C stated any new bruises to the nurse, sess and follow up.					
	director of nursing residents' skin on t stated staff comple	on 2/01/17, at 10:20 a.m., the (DON) stated staff monitored heir shower day. The DON sted a bath sheet that had a n issues, vital, signs and					

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		245409	B. WING		02	/01/2017		
NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  1875 19TH STREET NORTHWEST  ROCHESTER, MN 55901					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 309	form and provide the stated if there was a to be addressed by progress note and a completed. The DO the bruising for wor DON stated staff ar providing care and The DON stated shad be developed for reof skin integrity, when any skin injury. R22 was observed had a scabbed area arm and a purple be R22's record did not monitoring of the bruiser not 2/1/17 the documing the state of 2/1/17 the documing of the bruises are arm and a purple of R22's bath sheet da 1/19/17 indicated not 2/1/17, at 10:01 observation R22 has measuring 2 cm x fright upper arm 4.4 R22's record lacked the bruises. RN-C staff and complete the state of the	stated staff are to fill out the perform to the nurse. The DON an identified skin issue it was the nurse, there should be a can accident/incident report on stated nursing was to track sening and resolution. The reto monitor skin anytime they report concerns to the nurse, reto would expect a care plan to residents that are at risk for loss ich would include bruising or on 1/29/17 at 1:59 p.m. R22 a with bruising on his left upper ruise on his right upper arm. It reflect identification or ruises.  Tonic care plan directed staff to ares and report changes.  The entation did not reflect nitoring of the bruises.  The entation did not reflect nitoring of the bruises.  The entation did not reflect nitoring of the bruises.  The entation did not reflect nitoring of the bruises.  The entation did not reflect nitoring of the bruises.  The entation did not reflect nitoring of the bruises.  The entation of the bruises.	F3	09				

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F 315 SS=D	expectation was bring red marks need to report form filled or needed to be meast facility computer sy document weekly complement intervent. The Skin Assessming 1/13/17, included, shouses) will be assevery seven (7) day recorded in the me responsible for proskin observations, resident's care plar appropriate, to refleintegrity, approached 483.25(e)(1)-(3) NORESTORE BLADD (e) Incontinence. (1) The facility must continent of bladdereceives services a continence unless or becomes such the maintain.  (2) For a resident who define the continence who individed the con	p.m., the DON stated her ruising, skin tears, laceration, be documented, an incident at. The DON stated the area sured and documented in the restem resident progress notes, on the areas until resolved and ation to prevent recurrence.  The policy and procedure dated skin injuries (skin tears, sessed and measured at least sys by licensed nurse, and redical record. Caregivers are mptly notifying the nurse of including bruises. The new will be revised as sect the alteration of skin resident who is the and goals for care.  DICATHETER, PREVENT UTI, DER  The strength of the resident who is the rand bowel on admission and assistance to maintain his or her clinical condition is that continence is not possible with urinary incontinence, based comprehensive assessment, the extraction demonstrates that	F3			3/13/17	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG	COMF	SURVEY PLETED
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	PROVIDER OR SUPPLIER	D REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1875 19TH STREET NORTHWEST  ROCHESTER, MN 55901	,	
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F 315	indwelling catheter is assessed for rem as possible unless demonstrates that cand  (iii) A resident who receives appropriat prevent urinary traccontinence to the e  (3) For a resident wo on the resident's continent of bowel function as particularly must ensure incontinent of bowel function as particularly must ensure incontinent of bowel function as particularly for the facility for the facilit	enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary is incontinent of bladder e treatment and services to it infections and to restore extent possible.  With fecal incontinence, based omprehensive assessment, the othat a resident who is ell receives appropriate ices to restore as much normal	F 3	-R52 received a catheter bag charcatheter covering on 1/31/17 -All residents with catheters were assessed 1/31/17 and catheter basin place -All residents with catheters have on place -NA-F was educated and signed dipolicy on 1/31/17 re: resident dignit providing urinal and not encouraging resident to be continent. A VA reposited for R4 on 1/30/17 and determ that no harm occurredBowel and bladder assessment for was completed on 2/23/2017 -All residents' bowel and bladder assessments have been reviewed current	gs were covers ignity ty of ng irt was ined	

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 315	R52 was observed in bed, the cathete attached to the be the floor.  On 1/31/17, at 10: (NA)-A stated R52 the side of the bed R52 was in bed. No catheter bag sand her expeare to be covered. Infection control of covered and rester the Catheter Care 1/31/17, included and adequate hyg with an indwelling comfort, function, complications. 2.	d on 1/31/17 at 10:28 a.m. to be or bag was not covered, was d and the bag was resting on 38 a.m. nursing assistant did not have a bag attached to d to place the catheter in when IA-A verified the uncovered resting on the floor.  In the director of nursing facility had covers for catheter ectation was all catheter bags. The DON stated it was an oncern if a catheter bag was not d on the floor.  In policy with a revision date of staff will maintain consistent in the standards for residents catheter in order to maintain and prevent infection and other catheters bag and tubing and not allowed to touch or or prevent contamination. 4. The policy with a protective feet dignity of the resident. In the program for the assist to toilet and had	F 3	-All resident have ability to be dignity is not upheld -The policy Bowel and Blade Assessment has been revieupdated -Nursing staff have been ed regarding resident dignity, a timely bowel and bladder as and individualized care plan for toileting -DNS/designee is responsib -Audits will occur at least 2x a month to ensure complian -Audit results will be brough QAPI for determination of continuationCorrective action completes	der wed and ucated ccurate and sessments interventions le per week for ce. t to monthly ompliance and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245409	B. WING _		02	/01/2017
	MAPLE MANOR NURSING AND REHAB, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 315  Continued From page 27  to R4 you usually go in your brief and I then change you. So you can just go in your brief a will change you. R4 stated is that what I do? N stated, "Yep!" R4 stated ok and proceeded to urinate in the incontinent brief.  R4's record identified a facility Bowel and Blac Quarterly review dated 9/4/16. R4's record lac a current Bowel and Bladder assessment for t 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 ourinary tract infection (UTI) (recent) and malignant neoplasm of prostate. Check and change as needed with peri-care, barrier crea assist of one for hygiene, incontinence care at each incontinent episode, monitor/document/report signs/symptoms of U assist of one for transfers, wears briefs/assist one to manage.  R4's care plan lacked to include how often R4 should be toileted and what level of incontinent 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 be checked and changed. I usually check his			STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 315	to R4 you usually genange you. So you will change you. So you will change you. R4 stated, "Yep!" R4 surinate in the income. R4's record identific Quarterly review date a current Bowel and most recent MDS of the R4's current electrons had actual/potential related to urgency urinary tract infection malignant neoplast change as needed assist of one for hyeach incontinent emonitor/document/ assist of one for trace to manage.  R4's care plan lack should be toileted at R4 had (continent, frequently incontined determine incontined further decline in bloom prevent UTIs.  On 1/30/17, at 10:5 be checked and chevery two hours. R does not tell when so we just check at R4 did not use the time he told me he	o in your brief and I then a can just go in your brief and I a stated is that what I do? NA-F stated ok and proceeded to tinent brief.  ed a facility Bowel and Bladder ated 9/4/16. R4's record lacked d Bladder assessment for the dated 11/28/16.  onic care plan indicated R4 all for alteration in elimination and incontinence. History of on (UTI) (recent) and m of prostate. Check and with peri-care, barrier cream, rejene, incontinence care after bisode, report signs/symptoms of UTI, ansfers, wears briefs/assist of and what level of incontinence occasionally incontinent, ent or always incontinent) to ent interventions to prevent ladder incontinence and	F 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245409	B. WING		02	/01/2017	
	PROVIDER OR SUPPLIER	ID REHAB, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 315	confirmed the sheet Toilet/Brief: briefs at the sheet did not in toileted.  On 1/30/17, at 2:40 confirmed the last It Assessment complement assessment after 9 care plan lacked to be toileted and R4's stated the nursing at the urinal to R4 who urinal. That tells me incontinent, becaus opportunity to toilet.  On 1/30/17, at 3:22 nursing (ADON)-D confirmed the last It assessment complement. Don 1/30/17, at 3:51 (DON) stated she with toileting appropriate the urinal, bedpan, accommodated and do so. The DON stated she with the toileting appropriate the urinal of the assessment complement. The DON stated she with the toileting appropriate the urinal of the assessment complement. The DON stated she with the toileting appropriate the urinal of the assessment complement. The DON stated she with the toileting appropriate the urinal of the assessment complement. The DON stated she with the toileting appropriate the urinal of the assessment complement. The DON stated she with the toileting appropriate the urinal of the assessment complement.	et read under the topic and pull ups. NA-F confirmed dicate how often R4 should be p.m., registered nurse (RN)-D Bowel and Bladder leted for R4 was dated 9/4/16. should have been another 1/4/16. RN-D Confirmed R4's include how often R4 should is level of continence. RN-D cassistant should have given en he requested to use the en why they are always marking se they are not giving him the end and Bladder leted for R4 was dated 9/4/16.  In p.m., the director of nursing would expect staff to offer lety. If a resident asks to use or toilet, the request should be do it was not acceptable to not lated a bowel and bladder leted for R4 was dated 9/4/16. In let would expect R4's care plan in R4 was to be toileted and lence. The DON stated R4 let to be toileted every two	F3	115			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		245409	B. WING _		02/	/01/2017
	AME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 315	knew when he had "yeah." When queri he wanted to use the the urinal to him to good, but what do yand was not the last queried if he would stated, "I would be on the toilet."  The facility policy B dated 1/15, indicated resident's comprehensely.	to go to the bathroom, stated ted how it made him feel when he urinal and staff did not give use, R4 stated, "Well not you do, Was not the first time at time, inexperienced." When like to use the toilet, R4 less embarrassed if I could go owel and Bladder Assessment and Policy: Based on the ensive assessment, the facility	F 31	5		
	bladder incontinence treatment and servi normal bowel and be possible. Procedure assessed for at least bowel and bladder done on admission status, and with a selimination patterns will be developed to appropriate individual policy failed to addribladder assessment 483.25(d)(1)(2)(n)(	ce will receive appropriate ices to restore as much bladder functioning as e: 1. Each resident will be st 72 hours to help establish voiding patterns. This will be, with significant change in ignificant change in s. 4. The residents plan of care address goals and palized interventions. The ress quarterly bowel and onts.  1)-(3) FREE OF ACCIDENT	F 32	23		3/13/17
	The facility must en (1) The resident en from accident haza (2) Each resident re	vironment remains as free rds as is possible; and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245409	B. WING _		02/	01/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	appropriate altern bed rail. If a bed must ensure corremaintenance of be to the following electron bed rails prior (2) Review the risithe resident or resinformed consent (3) Ensure that the appropriate for the This REQUIREME by:  Based on observation falls and then do f 2 residents (R1)  Findings include:  R106's Admission R106 had diagnost dementia, rheuma vitamin D deficien During observation R106 laid in bed, bed, bed was in a within reach.  R106's Morse Fall	the facility must attempt to use actives prior to installing a side or or side rail is used, the facility act installation, use, and ad rails, including but not limited aments.  Sident for risk of entrapment or to installation.  As and benefits of bed rails with sident representative and obtain prior to installation.  Be bed's dimensions are a resident's size and weight.  ENT is not met as evidenced ation, interview and document failed to consistently assess for root cause analysis evelop falls interventions for 1 06) reviewed for accidents.  Record dated 2/1/17, identified ses that included depression, atoid arthritis, malaise and	F 3:	-R106 had no adverse effects to falls -All residents who fall have pot be affected -Residents who have been derisk for falls have had their car reviewed and are current -The policy and procedure 'Fall Prevention' has been reviewed updated -Staff was educated regarding root cause of fall and immedia intervention for fall prevention placed on the communication reviewed by the IDT on the neady at which time they will be put the electronic comprehensive and the communication of the communication of the comprehensive of the comprehen	tentially to emed high e plans  If and finding of te to be sheet until ext business blaced in care plan		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	E SURVEY PLETED
		245409	B. WING			02/	01/2017
_	PROVIDER OR SUPPLIER	ID REHAB, LLC		18	TREET ADDRESS, CITY, STATE, ZIP CODE B75 19TH STREET NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	of 65 (score of 45 at R106's current electrocus: alteration in related to fall risk: content of the Interventions: Ensure fitting shoes. Locordone to propel to detaileting every two to the Interventions on the Interventions of the Interventions of the Interventions of the Interventions.  R106's Short Term 1/12/17, identified for marked, but had not falls/injuries. Also in 1/12/17.  R106's nursing assundated, identified interventions.  R106's Accident/Interventions.  R106's Accident/Interventions.	ctronic care plan identified mobility: potential for injury due to debility, dementia. Irre nonskid socks and proper notion; wheelchair, assist of stination of choice. Offer to three hours while awake.	F3	323	communications were placed after resident fallResults brought to the monthly QA determination of compliance and continuation -Corrective action completed by 3/	API for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245409	B. WING		02	/01/2017
	PROVIDER OR SUPPLIER	D REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	On 1/20/17, at 5:30 to self transfer, rolle Investigation Form cause of fall, includ cause was identified initiated. On 2/1/17, at 2:30 p	ge 32 a.m., fall in room attempting ed out of bed. The Fall Scene (FSI), which reviews for root ed only one page. No root d and no intervention was o.m., the DON confirmed root tified and no intervention was	F 3.	23		
F 325 SS=D	would expect intervious planned. The I staff are to fill out a an FSI form. The D intervention sheet violated 10/1/16, indicated 10/1/16, indicate	are Plan Quarterly Review, cated Procedure and The care planning m is responsible for ans on a current status. A is requested, but not provided. INTAIN NUTRITION STATUS DABLE n and hydration. tric and gastrostomy tubes,	F 3.	25		3/13/17
	both percutaneous percutaneous endo enteral fluids). Base comprehensive assensure that a reside (1) Maintains accepstatus, such as usu	endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's sessment, the facility must				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245409	B. WING		02/0	1/2017
	PROVIDER OR SUPPLIER	ID REHAB, LLC	1	STREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	this is not possible indicate otherwise;  (3) Is offered a ther nutritional problem orders a therapeuti This REQUIREMED by: Based on observareview, the facility fweight loss for 1 of nutrition.  Findings include:  R22's quarterly Mir 11/8/16, identified we mechanical altered gain and required of the company of the meal industrial for alterative requirements related disease) and COPI pulmonary disease related to takes a diet general, eats in Eating; resident not assist as resident a independence. Encourage snackin symptoms of dehytometric at the control of the courage snackin symptoms of dehytometric at the course snackin shall s	al condition demonstrates that or resident preferences  rapeutic diet when there is a and the health care provider c diet.  NT is not met as evidenced tion, interview and document ailed to address a severe 3 residents (R22) reviewed for simum Data Set (MDS) dated veight of 188 pounds, diet, no weight loss or weight one assist to eat.  66 p.m., R22 was observed to reelchair in the dining room, ependently.  plan identified, Focus: on in nutrition less than body ed to CKD (chronic kidney D (chronic obstructive)). At risk for dehydration liuretic. Interventions included neals in the dining room. It always feeding self. Staff to	F 325	-R22's weight is returned to baseling pounds) as of 2/20/2017. He will be weighed weekly for three months a reviewed for need to continue week weights -Scales are calibrated monthly -Policy / Procedure "Weight and He Measurements" reviewed and updathursing staff educated to have restre-weighed no later than the next at for any weight change of +/- 3# in oweek or +/-5# in one month unless otherwise ordered and if weight renunchanged, to follow policy and profor reporting and follow-upCulinary Services Manager / DON designee to review weights weekly PRN for significant changes and to involve dietician as needed -Culinary Services Manager/DON/designee is responsedAudit of 2-3 resident weights will oweekly to determine necessary revare being done and reportedResults brought to the monthly QA determination of compliance and continuation -Corrective action completed by 3/1	eight ated sident m shift one nains ocedure / and sible ccur weighs	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION UNG			E SURVEY PLETED
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	PROVIDER OR SUPPLIER	ID REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIF 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 325	R22's weights docusystem in pounds: On 2/1/17, at 8:32 at the director of nursi. The reweigh weight pounds. A loss of 1 compared to 189 poloss in one month, 1/19/17 weight reconstruction of 1/4/17 189 Wheelcd 12/19/16 186.6 Med 12/17/16 189 Mech 12/15/16 189 Mech 11/28/16 182.8 Med 11/16/16 185 Mech 11/28/16 185 Mech	herapy) as ordered. dered. Weights as ordered.  Imented in the computer  a.m., surveyor requested from ing (DON) a reweigh for R22. It reported to surveyor was 178 pounds in one month ounds on 1/4/17 (5.8 percent a severe weight loss).  Orded of 173 pounds. hair chanical Lift enical Lift enica		125			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245409	B. WING _		02	/01/2017
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COD 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 325	in the 180's. Staff hydration per polic (certified dietary material dietician) as need R22's physician of 5/24/16 for med physician of mechanical soft to the Review of R22's physician of meals, does resper day for some spounds, which is compared to the Review of registered dietician about R22's notedous of 8.5 percengetting a timely represented a reweighting a timely represented a reweighting at timely represented a reweighting at timely represented of the representation of the representation of the representation of the reviews and computer system. In the reviews and computer system for weighting and notify investigate for call nurses are to get	to monitor intake, weights, by/physician order; notify CDM nanager, RD (registered ed. rders identified an order dated ass (supplement) 2.0, 120 ml mes daily with meds due to r date 11/15/16, general diet, exture.  Thysician notes identified on been eating about 90 percent seive supplements three times weight loss. Weight is 187.6 down slightly from 188 a month on 2/1/17, at 8:32 a.m., in (RD)-F had been asked dated 1/30/17 regarding weight to over the past two weeks and weigh done. RD-F said, "If I gh to be done before I leave the here for weeks." As she did not ercent weight loss by ordering her interventions to prevent		2.5		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245409	B. WING _	<del></del>	02/	01/2017
	PROVIDER OR SUPPLIER	D REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 325	residents weekly. T for R22 had not bee her after RD-F's vis R22's weight loss s the physician shoul intervention implem. The facility policy W Measurements date Procedure: 5. If los month; 7.5% in three re-weigh within 24 heresident/legal represocial services, act notified upon identification weight loss/gain. 7. reason for weight cadd to care plan. 8. necessary. 9. If agg correct weight charmay be necessary. The facility policy D indicated Policy: a coversee clinical nut facility. Policy Interparts. The dietician will manager and clinic dietician is respons limited to: a. Assess residents; c. Collab direct care staff and address nutritional population.	stem, which includes all he DON confirmed weight loss en identified and reported to it on 1/30/17. The DON stated hould have been identified, d have been notified and an iented.  Veight and Height ed 8/1/15, indicated sor gain noted (5% in one is months; 10% in six months) mours. 6. Physician, sentative, family, nursing staff, evities, and dietary are to be fication of significant/severe. Evaluate and document hange in medical record and Implement interventions as pressive intervention does not age, a NP/MD reassessment ietician Services dated 8/1/15, qualified dietician will help ritional dietary services in the oretation and Implementation work closely with the dietary all staff. 4. Our facility's ible for, but not necessarily sing nutritional needs of orating effectively with other dispractitioners to assess and issues in the communities	F 3:			
F 329 SS=E	` '	EGIMEN IS FREE FROM RUGS	F 3	29		3/13/17

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
	245409	B. WING		<del></del>	02/01/2017	
	ID REHAB, LLC		1	875 19TH STREET NORTHWEST		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE
(d) Unnecessary D drug regimen must drugs. An unneces used  (1) In excessive do therapy); or  (2) For excessive of  (3) Without adequal  (4) Without adequal  (5) In the presence which indicate the of discontinued; or  (6) Any combination paragraphs (d)(1) the This REQUIREMENT by:  Based on interview failed to ensure an movement scale (A completed per proving (R32); failed to identify depression for 1 of determine if the antifailed to complete a assessment to determine or determine if the antifailed to complete a assessment to determine in the antifailed to region of the determine in the antifailed to complete a assessment to determine in the antifailed to region of the determine in the antifailed to complete a assessment to determine in the antifailed to region of the determine in	rugs-General. Each resident's be free from unnecessary sary drug is any drug when see (including duplicate drug duration; or the monitoring; or the indications for its use; or of adverse consequences dose should be reduced or the section. The section of the reasons stated in through (5) of this section. The section of the reasons was evidenced and record review, the facility abnormal involuntary almS) assessment was evider order for 1 of 5 residents of 5 residents (R22) to the tidepressant was affective; and a comprehensive sleep termine the need for sleep aids ia for 3 of 5 residents (R57,	F3	329	-R32 AIMES assessment is complewith a score of 0, no adverse effect delayed AIMES test -R57 is currently hospitalized, sleep assessment and monitoring will occ time of readmission, if needed -R22 sleep log is now found on the for q shift hours of sleep to be done seven days; individualized behavior now being tracked q shift -For all residents receiving psychotomedications the AIMES testing has	s from cur at TAR e for s are ropic been	
R32's diagnosis for				change/psychotropic medication ch	_	
	Continued From particles (EACH DEFICIENCY REGULATORY OR LETTE PROPERTIES (EACH DEFICIENCY REGULATORY OR LETTE PROPERTIES (A) Unnecessary Didrug regimen must drugs. An unnecessused—  (1) In excessive do therapy); or  (2) For excessive do therapy); or  (3) Without adequated (4) Without adequated (5) In the presence which indicate the odiscontinued; or  (6) Any combination paragraphs (d)(1) the This REQUIREMED (a) (b):  Based on interview failed to ensure an movement scale (A) (a) (A) (a) (A) (b) (b) (c) (c) (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d	PROVIDER OR SUPPLIER  MANOR NURSING AND REHAB, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.	PROVIDER OR SUPPLIER  MANOR NURSING AND REHAB, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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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	PROVIDER OR SUPPLIER  ### ANOR NURSING AND REHAB, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY)  REGULATORY OR LSC IDENTIFYING INFORMATION)  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 affective; and failed to complete a comprehensive sleep acsessment to determine ithe need for sleep aids ordered for insomnia for 3 of 5 residents (R52) 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 (R52) 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	ABUILDING  245409  8. WING  245409  8. WING  2576  ANOR NURSING AND REHAB, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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:  Findings include:  R32's diagnosis found on the admission record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245409	B. WING _		02/	01/2017
	PROVIDER OR SUPPLIER	D REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP OF 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 329	Disorder, recurrent, Medication Review an order dated 2/29 assessment every every six months st month for one day fantidepressant) use mg, give 0.5 mg tak for hallucinations/pa Medication Adminis of January 2017, id scheduled Quetiapi once daily.  Care plan revised of takes antipsychotic paranoia, major dependentia with behalidentifies to complements.  AIMS assessment of a score of 0 which is symptoms of tardiverelated to the use of performed AIMS as months form previous to their attention by  Interview on 2/1/17 nursing (DON) verification of the completed provider order. DON AIMS assessment to ordered. DON states	Report dated 2/1/17, identifies 0/16 to complete an AIMS 6 months, one time a day arting on the last day of the for quetiapine (fumerate an e. Quetiapine Fumarate 25 olet by mouth one time a day aranoia. Order dated 8/5/16.  Itration Record for the month entifies R32 received ne Fumarate as scheduled  In 3/28/16, identifies R32 medication related to pressive disorder, anxiety, exional episodes. Care plan the AIMS assessment every 6  Was completed on 3/1/16 with dentifies no signs or elected disorder. Facility sessment on 2/1/17 ten us assessment, after brought	F 3:	non-pharmacological approused prior to use of PRN pare medication use.  -For all residents receiving sleep logs are done on the hours of sleep per shift for sprior to their quarterly MDS Sleep logs will be reviewed PRN Staff has been educated in individualized behavior mor forms, and AIMES schedule. Policy and Procedure titled Assessment' has been reviupdated  -Audits of at least 2 resident receiving psychotropic medicated done for a month to ensure behaviors are being monitod current AIMES assessment completedAudits of at leper week receiving hypnotic completed for one month to monitoring is being done.  -DNS/designee is responsilAudits will be reviewed at it to determine compliance arCorrective action completes.	hypnotics; TAR indicating seven days schedule. quarterly and the use of nitoring, new e. I 'Sleep ewed and this per week lication will be appropriate and thas been ast 2 residents as will be a ensure sleep ole monthly QAPI and continuation	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Assessment", dated will be updated evenurse.  SLEEP ASSESSME R57's diagnosis for dated 4/11/16, iden R57's care plan las identify the use of a Medication Review identifies order for I sleep) 3 mg, give 2 sleep. Order start of Medication Administration January 2017, iden Melatonin per order  Treatment Administration January 2017, does or sleep assessment Interview on 1/31/11 nurse (RN)-B stated sleep monitoring of Interview on 1/31/11 nursing (DON) stated	e and Procedure AIMS d 8/1/15, identifies AIMS form ry 6 months by the licensed  ENT:  Ind on the admission record tifies Insomnia.  It revised on 10/27/16 does not a sleep aide.  Report dated January 2017, Melatonin (hormone to help tablets orally at bedtime for date of 10/25/16.  Itration Record (MAR) dated tifies R57 receiving scheduled for anot identify sleep monitoring int.  7, at 8:14 a.m. with registered did he was unaware of any	F3	329	,		
	Data Set (MDS)-A a the sleep assessme stated sleep assess	7, at 9:44 a.m. with Minimum a coordinator stated nurses do ents. MDS-A coordinator sments should be set up in the to know when to complete.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 329	MDS-A coordinator sleep assessment of the state of the would end assessment completed. DON state of the work of th	r verified R57 did not have a completed.  7, at 10:25 a.m. with DON expect any resident on a sleep assessment rated a sleep study should report to R57 starting a sleeping R57 did not have a sleep eted.  ASSESSMENT AND FIC MOOD S TO DETERMINE IF T IS AFFECTIVE:  Ician orders included: start inbalta (antidepressant) 60 mg in e a day for major depressive date 7/17/15, Melatonin sleep aide) 5 mg at bedtime not sleeping at night.  Indministration Record for the attified R22 was receiving the attonin as ordered.  In plan included the following: tidepressant medication we disorder. Interventions: report adverse side effects,	F3	329			

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F 329	personality disorded depressive disorded name to female personame to female peersoname to female peersoname the vecares and the vecares, yelling out, house and the vecares are an injusted of the veca	ct disorder, explosive r, anxiety disorder and r. At times calls out spouse ers thinking they are his wife. when they do not answer. nes calls out spouse name to ng they are his wife. Becomes do not answer. Behaviors erbally abusive, refusal of nallucinations/delusions, and hitting/kicking at staff. leting. Staff to assist to calm I ask resident if he is having ide reassurance if behaviors redirection. Staff will try to aviors begin. Staff will use a e. Try 1:1 visits. Focus: takes n related to sleep, on tions. Monitor/document s. Administer medications per ual dose reduction per	F3	329			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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_	PROVIDER OR SUPPLIER	ID REHAB, LLC		1875 19TH	DDRESS, CITY, STATE, ZIP CODE H STREET NORTHWEST STER, MN 55901	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	yelling, screaming.  On 2/1/17, at 3:01 p (DON) stated sleep completed upon ad needed. The DON had not been comp confirmed R22's ca resident specific sy  The facility policy P 8/1/15, indicated Pr must be conducted behaviors/symptom and recommendatic behaviors. 2. The n must reflect the spe the residents respo interventions to ma After implementatio behavior/symptom will be monitored at LACK OF COMPRI ASSESSMENT:  R102's admission r admitted on 1/9/17 amputation.  R102 had an order melatonin Tablet 3 current physician's for the PRN melato had received the m 1/23/17 according t administration reco	nappropriate, wandering,  o.m., the director of nursing assessments were to be mission, quarterly and as confirmed a sleep assessment eleted for R22. The DON are plan lacked to identify mptoms of depression.  sychotropic Medications dated rocedure: 1. An assessment to identify specific as, potential causative factors and for managing identified nedical record documentation ecific behaviors/symptoms and anse to non-pharmacological nage behaviors/symptoms. 8. On of psychotropic medication and medication side effects and documented.  EHENSIVE SLEEP  record revealed R102 was with diagnoses of left leg  for as needed (PRN) milligrams for sleep. The orders reflected a start date inin as 1/9/17 and the R102 edication PRN on 1/21/17 and o the medication	F3	29			

-	AND DUAN OF CORDECTION (IDENTIFICATION NUMBER)		` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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F 329			F 3	29			
		and analysis of sleep and continue the use of PRN					
	registered nurse (R study and sleep ass by the night shift an in the chart. RN-B v assessment in R10 stated was not sure should be complete	on 1/31/17, at 11:28 a.m. N)-B stated we have a sleep sessment that was completed d there should be a hard copy verified there was not a sleep 2's medical record. RN-B when a sleep assessment d. RN-B stated once in a sleep log put out for a omplete.					
	director of nursing ( sleep assessments resident was admitt or if we were going	on 1/31/17, at 1:56 p.m. the DON) stated she expected a to be completed when a red with a medication for sleep to start a new medication for ated a sleep assessment was or R102.					
F 371 SS=E	procedure dated 1/3 resident's record fo which could affect so observations for sle made every hour for 1-4 days may be as staff involved in the aware the assessment monitoring is completermine whether regarding a medica 483.60(i)(1)-(3) FOR	Assessment policy and 31/17, included: 1. Review of diagnosis and medications, sleep patterns. 2. Resident pep/awake pattern is to be of four (4) days. An additional president's care must be not is underway. 4. After peted, analyze patterns and to contact the physician tion need or adjustment.  OD PROCURE, SERVE - SANITARY	F 3	71		3/13/17	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		E SURVEY IPLETED
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F 371	considered satisfact authorities.  (i) This may include from local produce and local laws or received in the cooler was hardlings included by:  Based on observatives and visitors were dayroom off to the The cooler was hardlings include:  01/29/17 3:21 p.m. plastic cooler contadayroom off to the The cooler was hardlings and contadayroom off to the The cooler was hardlings and contadayroom off to the The cooler was hardlings and contadayroom off to the The cooler was hardlings and contadayroom off to the The cooler was hardlings include:	d from sources approved or ctory by federal, state or local er food items obtained directly rs, subject to applicable State egulations.  I does not prohibit or prevent g produce grown in facility of compliance with applicable bood-handling practices.  I does not preclude residents ods not procured by the facility.  I dre, distribute and serve food in refessional standards for food or regarding use and storage of esidents by family and other afe and sanitary storage,	F 37	-A Dietary Manager was hired -The facility's ice chamber policupdated on 2/22/17Dietary cleaning schedules hirevised to address concern are identified -Existing cutting boards were cand replaced with new equipm -All residents have the potential affected if cleaning schedules followed in both the kitchen and kitchenette areasAll staff has been educated or	cy was ave been eas discarded ent. al to be are not d	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245409	B. WING _		02/	01/2017	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		V 1/2V 1.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 371	ice. The cooler had one has access to p.m. Plastic cooled dayroom, unlocked.  On 1/30/17 at 10:4 a stream table used with food debris of wipe off food debris of food and servind dining room). In lastive-gallon contains melted, refrozen, a refrigerator had archeese dated 1/23 discarded days aghad dried food/del slicer which had a slicer and staff sai and the plastic coveredy to be used a heavy black oxide said this cast iron grilled cheese, etc used to open fruit of stainless steel the which also included cutting boards used other foods were refused to general to sanitize and broken.  During interview with 1/29/17, 6:20 p.m. container located entrance door said nursing assistants.	d an unlocked device and any scoop and ice. 01/29/17 6:15 with ice scoop still sitting in	F 37	expectations of clean kitchen a updated ice chamber policy -Dietary staff has been educate cleaning schedule requirement -2-3x weekly for one month au conducted to ensure physical learneas meet cleaning schedule requirements1-2x weekly for one month au conducted to ensure ice chambeing followed appropriatelyDietary Manager/designee is read -Audit results will be reviewed QAPI -Corrective action completed by	ed on is dits will be kitchen dits will be ber policy is responsible. monthly at		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIAT	
F 371	unlocked that anyoget into the cooler. next to the cooler for the cooler mentioned satistic to standard and ne stated, "That she will debris wiped off str. Administrator state the cooler was in the "I never seen it use." Review of Maple M. Rehabilitation policity Cleaning S. directed staff to ma condition. It indicat posted for all clean completion of tasks services will monitor will monitor kitcher.  General Sanitation included Staff shall.	er was in the dayroom and ne (residents, visitors) could There were cup available or use.  th Administrator on 1/31/17, at is to the findings as id that the kitchen was not up eded cleaning. She also rould expect to have food eam table before next use." id that she did not know why he main dayroom on 1/29/17. Id before."  Idanor Health Care & ies: chedules dated 10/1/08 tintain the kitchen in a sanitary ed that a cleaning schedule ing tasks, staff will initial after is, the director of nutritional or cleaning checklists weekly to and the registered dietician is anitation monthly.  of the Kitchen dated 7/13/09, maintain the sanitation of the mpliance with a written	F3	371		
	Ice Machines and I August 2001. Police machines and ice so be maintained in a aid in preventing co- implement the follo- access to ice stora	ce Storage Chests, revised by included that the ice storage chest/containers must safe and sanitary condition. To ontamination, all staff must wing precautions: Limit ge chest/containers to seep ice scoop on a clean, hard				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245409	B. WING	i	02	/01/2017	
	PROVIDER OR SUPPLIER	ND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP COI 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 371 F 441 SS=E	(a) Infection preven	n use. e)(f) INFECTION CONTROL,		371 441		3/13/17	
	and control programa a minimum, the fole (1) A system for programs of the programs of the fole (1) A system for programs of the providing and communicable discontinuous conducted according accepted national simplementation is 1 (2) Written standard	m (IPCP) that must include, at lowing elements:  eventing, identifying, reporting, controlling infections and eases for all residents, staff, , and other individuals under a contractual d upon the facility assessmenting to §483.70(e) and following standards (facility assessment					
	possible communicy before they can sp facility;  (ii) When and to who communicable discreported;  (iii) Standard and to be followed to present the communicable discreported;	veillance designed to identify cable diseases or infections read to other persons in the nom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; visolation should be used for a but not limited to:					

	TEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245409	B. WING			02/01/2017		
NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC				1875	EET ADDRESS, CITY, STATE, ZIP CODE  19TH STREET NORTHWEST  CHESTER, MN 55901	, , ,	.,=	
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F 441	depending upon the involved, and (B) A requirement least restrictive postircumstances.  (v) The circumstances.  (v) The circumstances must prohibit empedisease or infected contact with reside contact will transmoved in the facility's actions taken by the involved in the facility's actions. Personal contact with reside contact will transmove the facility's actions taken by the facility's actions. Personal circumstance in the facility's actions.	duration of the isolation, ne infectious agent or organism that the isolation should be the ssible for the resident under the nees under which the facility loyees with a communicable diskin lesions from direct ents or their food, if direct in the disease; and ene procedures to be followed a direct resident contact.	F 4	41				
	spread of infection  (f) Annual review. annual review of it program, as neces This REQUIREME by: Based on observa review the facility of control practices w cleaning/sanitizing glucometer for 1 of	The facility will conduct an s IPCP and update their		- <i>H</i> if a - <i>H</i> p g	All residents have personal gluco All residents have potential to be a glucometer equipment is not ster ppropriately All Licensed staff has been educa roper sterilization methods of lucometers 2-3x/week audit for 1 month to be ompleted to ensure proper sterilize	affected rilized ited on		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245409	B. WING			02/	01/2017	
MAPLE MANOR NURSING AND REHAB, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			02/01/2017		
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F 441	nurse (LPN)-B was blood sugar. LPN-glucometer used we residents on the extra R102's blood sugar carried the glucometer sanitizer. LPN-B reshand and cleansed with a alcohol padher left hand and LPN-B when querifor cleaning the glucometer LPN-B stated I use works. LPN-B veriprior to the glucometer LPN-B stated I use works. LPN-B veriprior to the glucometer LPN-B stated I use works. LPN-B veriprior to the glucometer medicated disinfect patient to prevent disinfect the meter prior to the disinfect to clean exposed sthoroughly and rerany other body fluiwipe to disinfect the disinfect the meter solvents to clean to meter cleaning and the residual processory.	age 49  O1 a.m., licensed practical sobserved to check R102's B stated at the time the was a glucometer used for all ast wing. LPN-B after checking ar had removed gloves and neter out to the medication cart. It was an cleansed the outside with a tissue and hand emoved the glove on her right do the outside of the glucometer and then removed the glove on washed hands. At the time ed what the facility policy was ucometer, stated I would have LPN-B stated a bleach wipe clean the glucometer and then air dry for three minutes. The dean alcohol pad, either one fied she had removed gloves neter being cleaned and had hand sanitizer and an alcohol sanitize the glucometer.  anufactured by UltraTRAK manual provided by the facility, the meter between each infection. How to clean and reference of the meter move any visible dirt, blood, or do with the wipe. Use a second the meter by following the dure below. Do not use organic the meter. We recommend for do disinfection you should use be/towelette from below:	F4	methods -DON/de: -Audit res QAPI	signee is responsible sults will be reviewed move action completed by 3	•		

-	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  1875 19TH STREET NORTHWEST  ROCHESTER, MN 55901	•			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 441	(DON) stated when glucometer was cle not the correct proof the glucometer. The remain on until the cleaned/sanitized a have been cleansed. The facility policy C glucometer dated 8 Perform hand hygicall external surfaces sides, using the ble prepared EPA germ solution to penetrat ports of the meter. wet for one minute additional minute boresident. 5. If blood meter, the procedur second time. 6. Discontainers. & Rem hygiene. 483.90(h)(5) SAFE/FUNCTIONAE ENVIRON  (h) Other Environm  The facility must prosanitary, and comforesidents, staff and (h)(5) Establish policy.	p.m., the director of nursing informed of how the multiuse aned/sanitized stated that is edure for cleaning/sanitizing a DON stated gloves should glucometer was fully and the glucometer should divith a super Sani-cloth wipe.  Ileaning and Disinfection of a /1/15, indicated Procedure: 2. ane and apply gloves. 3. Wipe is, including top, bottom and ach solution or commercially incidal wipe; avoid allowing the e the test strip and/or key and allow to air dry for an effore using on the next is visibly present on the re should be repeated a card soiled items in approved ove gloves and perform hand allow to a safe, functional, ortable environment for	F 4			3/13/17	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE COMF	SURVEY PLETED
	245409	B. WING		02/0	1/2017
	ID REHAB, LLC		1875 19TH STREET NORTHWEST		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
regulations, regard and smoking safety non-smoking reside This REQUIREMED by: Based on observareview, the facility folean environment potential to affect a and visitors who attended to the total tour the following with the walk-in food covisible debris, (feet The steel tables who have multiple food sides of table, in acceptance and food processed to the meat slicer have multiple food sides of table, in acceptance and it was less to the meat slicer have machine. The meat olastic and it was less to the top of oven no grease build up and located on the wall shood had areas of All gray plastic garb recycling had been oreparation table hedebris down outside.	ing smoking, smoking areas, at that also take into account ents.  NT is not met as evidenced tion, interview, and document railed to ensure a sanitary and in the kitchen. This had the series of the facility kitchen.  The facility kitchen.  The facility kitchen are observed: The facility kitchen are food is prepared noted to splatter debris on legs and didition, on table where meat cessor were located, food are wall approximately 2-3 feet. If multiple food debris on the testicer was covered with earned that when the plastic are it meant it was cleaned and the grease/debris was behind the stove. The stove debris /greasy film. The stored next to the food and heavily splattered food e of cans, lids and canisters.	F 465	-A Dietary Manager was hired 2/7/1 -All areas of cleanliness concern habeen addressed -Dietary cleaning schedules have be revised to address concern areas identified -Equipment concerns have been addressed through improvements a replacement parts to promote safety cleanliness compliancy -All residents have the potential to be affected if cleanliness practices are followed in both the kitchen and kitchenette areasAll staff has been educated on expectations of clean kitchen areas equipment -Dietary staff has been educated or cleaning schedule requirements & protocol for updating maintenance of the cleanliness compliance2-3x weekly for one month audits of the conducted to ensure physical kitched areas meet cleanliness compliancy standards -Dietary Manager/designee is response.	een and/or y & pe not  when will be en pnsible.	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From paregulations, regard and smoking safety non-smoking reside This REQUIREME  by: Based on observa review, the facility for clean environment potential to affect at and visitors who at  Findings include:  On 1/29/17, at 11:4  tour the following we have multiple food sides of table, in acceptable debris, (feet The steel tables whow the multiple food sides of table, in acceptable and it was lessed and it was lessed and it was lessed and it was lessed for service. The top of oven no grease build up and located on the wall hood had areas of All gray plastic garb recycling had been preparation table he debris down outsid The dry storage pare dust build up on flo The upright freezer	ROVIDER OR SUPPLIER  ANOR NURSING AND REHAB, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	A. BUILDING  245409  B. WING  245409  B. WING  ANOR NURSING AND REHAB, LLC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 51  regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.  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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	A BUILDING  245409  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1875 19TH STREET NORTHWEST  ROCHESTER, MN 55901  SUMMARY STATEMENT OF DEFICIENCIES (BEACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 51  regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.  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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245409	B. WING _		02	/01/2017	
	PROVIDER OR SUPPLIER	ND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP C 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 465	build up of ice on of The portable stainly products store on his where food stored/ The Lights over food fixture covers where with debris/grease covers.  The floor had multikitchen area. This kitchen tour on 1/2  On 1/30/17, at 10:4  the kitchen following All previous observed to have multiple and four shelves) to equipment to floor noted to have multiples and wheels.  Tour of kitchenette observed to have to the coffee maker of the floor maker of the purish refrige on bottom of inner liner.  The built in cupboard in the product of the purish refrige on bottom of inner liner.  The built in cupboard in the product of the purish refrige on bottom of inner liner.	all packages of meat had heavy eartons. ess stain cart, with paper had debris/food on shelves placed. Od preparation tables, light re yellow colored and spotted and dead insects observed in ple food debris throughout the was also noted during a brief 9/17 at 6:00 p.m.  40 a.m. during a second tour of ag observed: reation remain the same. The machine note to have a on/in spout and drip tray. If to have multiple food and secattered around entire was the same as observed. Implement carts (some with three use to transport food and for food service had been iple food/debris on all shelves, as off main dining room, the following: that a frayed cord, dusty, greasy ain filter with rust buildup, noted to have a thick sticky	F 4(	55			

FRÉFIX TAG    CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION    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		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		E SURVEY IPLETED
MAPLE MANOR NURSING AND REHAB, LLC  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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			245409	B. WING _		02/	01/2017
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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 520 483.75(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	(hinged coming off) There were several and soiled looking.  During interview on over all the listed fir indicated that the k and needed cleanir "That she would ex off stream table bef  Review of Maple M Rehabilitation polici Dietary Cleaning So directed staff to ma condition. It indicate posted for all cleani completion of tasks services will monito ensure completion will monitor kitchen  General Sanitation included Staff shall kitchen through cor comprehensive clea 483.75(g)(1)(i)-(iii)(i) COMMITTEE-MEN QUARTERLY/PLAN  (g) Quality assessm  (1) A facility must m and assurance com minimum of:	1/31/17, at 9:30 a.m. went addings with Administrator who atchen was not up to standard ag. Administrator also stated, pect to have food debris wiped fore next use."  anor Health Care & des: chedules dated 10/1/08 intain the kitchen in a sanitary ed that a cleaning schedule ing tasks, staff will initial after at the director of nutritional or cleaning checklists weekly to and the registered dietician sanitation monthly.  of the Kitchen dated 7/13/09, maintain the sanitation of the mpliance with a written aning schedule.  2)(i)(ii)(h)(i) QAA IBERS/MEET NS  ment and assurance.  naintain a quality assessment amittee consisting at a				2/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` ,	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		245409	B. WING _		02/01/2017
MAPLE MANOR NURSING AND REHAB, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 520	(ii) The Medical Dir (iii) At least three of staff, at least one of administrator, own individual in a leading (g)(2) The quality as committee must:  (i) Meet at least quiccoordinate and evaluation in a leading committee must:  (i) Meet at least quiccoordinate and evaluation in a leading committee must:  (ii) Meet at least quiccoordinate and evaluation in a leading coordinate and evaluation in a leading coordinate and evaluation in a least quality Develop and improve assessment and as necessary; and  (ii) Develop and improve of in Secretary may not records of such consuch disclosure is such committee with section.  (i) Sanctions. Good committee to ident deficiencies will not sanctions.  This REQUIREME by:  Based on interview failed to have the requality Assessment (QAA) at least quality and the potential to	rector or his/her designee; ther members of the facility's of who must be the er, a board member or other	F 52	-QAA meetings are being held quarterlyAll residents have the potentia affected if QAA meetings are n least quarterly to identify areas improvementDepartment managers have be	al to be not held at for

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		` '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245409	B. WING _	· · · · · · · · · · · · · · · · · · ·	02/	01/2017
	PROVIDER OR SUPPLIER	D REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIF 1875 19TH STREET NORTHWEST ROCHESTER, MN 55901	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 520	record reviewed from revealed the medic meetings on 1-21-1 attendance record attended the QAA mand 11-17-16.  On 2/01/2017, 2:59 based on the document attendance for QAA director did not attended the five-month spare The administrator scontact the medical	ry's QAA meeting attendance m 1-21-16 to 12-22-16 al director attended the QAA 6, 5-19-16 and 11-17-16. The revealed no physician neeting held between 5-19-16 p.m. the administrator stated mentation of meeting a meetings the medical nd a quarterly meeting during n from 5-19-16 to 11-17-16. tated the facility did not l director to review the meeting parterly QAA the medical	F 5	educated in QAA requirer -Monthly audits for 12 mo conducted to insure QAA held per CMS requiremer required attendeesPhysician educated on 1 regards to quarterly QAA regulationPhysician will attend QA/ quarterly via telephone co personED/designee is responsil -Audit results will be revie QAPI -Corrective action comple	nths will be meetings are nts with the //16/2017 in attendance A at least onference or in ble. wed monthly at	

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PRINTED: 02/23/2017 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A: BUILDING 01 - MAIN BUILDING 01 B WING 245409 01/31/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1875 19TH STREET NORTHWEST MAPLE MANOR NURSING AND REHAB, LLC ROCHESTER, MN 55901 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 INITIAL COMMENTS K 000 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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 (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

**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.

	: of connection		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED		
		245409	B. WING			01/3	31/2017		
NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC			1	TREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST COCHESTER, MN 55901					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
K 000	Angela.Kappenman THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO  1. A description of to correct the deficit 2. The actual, or pr  3. The name and/oresponsible for correvent a reoccurre (Maple Manor Nursbuilding with a (parwas constructed at original building was determined to be on 1974, addition was that was determined construction. Becauthe (1) addition are construction and mallowed for existing surveyed as one but the building is fully fire alarm system was detection and space monitored for autonotification.  The facility has a consult of the consult of	RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:  what has been, or will be, done iency.  roposed, completion date.  or title of the person rection and monitoring to ence of the deficiency.  sing & Rehab) is a 1-story tial) basement. The building (2) different times. The as constructed in 1964 and was of Type II(111) construction. In a constructed to the (East wing) and to be of Type II(111) use the original building and the of the same type o	K	000					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		ECONSTRUCTION 11 - MAIN BUILDING 01		IPLETED
		245409	B. WING			01/	31/2017
NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC			•	18	REET ADDRESS, CITY, STATE, ZIP CODE 175 19TH STREET NORTHWEST OCHESTER, MN 55901		I
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 363 SS=E	Corridor - Doors 2012 EXISTING Doors protecting or required enclosure hazardous areas s as those constructe core wood, or capa 20 minutes. Doors compartments are passage of smoke means suitable for There is no impedi doors. Clearance b floor covering is no latches are prohibit corridor doors and or combustible ma complying with 7.2 devices that releas pulled are permitte of unlimited height meeting 19.3.6.3.6 Door frames shall or other materials if the smoke compar window assemblies sprinklered compar restrictions in area frames in window a 19.3.6.3, 42 CFR F and 485 Show in REMARK protection ratings, etc. This STANDARD Corridor - Doors 2012 EXISTING	orridor openings in other than s of vertical openings, exits, or hall be substantial doors, such ed of 1-3/4 inch solid-bonded able of resisting fire for at least in fully sprinklered smoke only required to resist the . Doors shall be provided with a keeping the door closed, ment to the closing of the between bottom of door and of exceeding 1 inch. Roller ted by CMS regulations on rooms containing flammable terials. Powered doors .1.9 are permissible. Hold open se when the door is pushed or ed. Nonrated protective plates are permitted. Dutch doors are permitted. be labeled and made of steel in compliance with 8.3, unless the sare allowed per 8.3. In artments there are no or fire resistance of glass or		863	No Residents were affected lalleged deficient practice.	by this	3/13/17

PRINTED: 02/23/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B WING 245409 01/31/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1875 19TH STREET NORTHWEST MAPLE MANOR NURSING AND REHAB, LLC ROCHESTER, MN 55901 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 3 K 363 2. All Residents, Employees and Visitors required enclosures of vertical openings, exits, or have the potential to be affected by this hazardous areas shall be substantial doors, such alleged deficient practice. 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 On 2-1-2017 Maintenance dissembled door locking mechanisms, oiled and compartments are only required to resist the lubricated all moving parts, reassembled passage of smoke. Doors shall be provided with tested door and it is now functioning a means suitable for keeping the door closed. properly. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller 3. A directed in-service was conducted latches are prohibited by CMS regulations on with the Maintenance Department by the corridor doors and rooms containing flammable Regional Director on 1-31-2017 on but not or combustible materials. Powered doors limited to the Facility must ensure that all complying with 7.2.1.9 are permissible. Hold open fire door latching parts much latch during devices that release when the door is pushed or self-closing operating. pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors Quality Assurance plans to monitor meeting 19.3.6.3.6 are permitted. that all fire door latching parts much latch Door frames shall be labeled and made of steel during self-closing operating through a or other materials in compliance with 8.3, unless Quality Assurance tool conducted by the the smoke compartment is sprinklered. Fixed fire Maintenance Director and/or Designee window assemblies are allowed per 8.3. In once a week for the next month and will sprinklered compartments there are no be reviewed by the quality assurance restrictions in area or fire resistance of glass or team in our Quarterly Quality Assurance frames in window assemblies. Committee Meetings 19.3.6.3. 42 CFR Parts 403, 418, 460, 482, 483, and 485 5. Date of corrective action will be by Show in REMARKS details of doors such as fire 3/13/17. protection ratings, automatics closing devices, 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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVE COMPLETED	
		245409	B. WING	-		01/3	1/2017
	ROVIDER OR SUPPLIER	ID REHAB, LLC		18	TREET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 363	the residents, staff compartment.  This deficient pract	age 4 ice could affect the safety of all and visitors within the smoke tice was confirmed by the ce Director at the time of	K	363			
K 374 SS=D	NFPA 101 Subdivis Smoke Barrie	sion of Building Spaces - ding Spaces - Smoke Barrier	K	374	₩		3/13/17
2.	bonded wood-core resists fire for 20 m plates of unlimited are permitted to hat assemblies per 8.5 automatic-closing, are not required to egress travel. Doo clear width of 32 in doors.  19.3.7.6, 19.3.7.8, This STANDARD	arriers are 1-3/4-inch thick solid doors or of construction that ninutes. Nonrated protective height are permitted. Doors are fixed fire window in Doors are self-closing or do not require latching, and swing in the direction of ar opening provides a minimum aches for swinging or horizontal 19.3.7.9 is not met as evidenced by: Iding Spaces - Smoke Barrier	26		No Residents were affected by t	this	5
	Doors 2012 EXISTING Doors in smoke be bonded wood-core resists fire for 20 n plates of unlimited are permitted to he assemblies per 8.5 automatic-closing, are not required to	arriers are 1-3/4-inch thick solid doors or of construction that ninutes. Nonrated protective height are permitted. Doors are fixed fire window 5. Doors are self-closing or do not require latching, and swing in the direction of r opening provides a minimum			alleged deficient practice.  2. All Residents, Employees and V have the potential to be affected by alleged deficient practice.  On 2-1-2017 the west smoke barrier was sanded and operationally tested ensure it closed tightly.	isitors this r door	

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COME	SURVEY
	PROVIDER OR SUPPLIER	245409 ID REHAB, LLC	B. WING	S1 18	TREET ADDRESS, CITY, STATE, ZIP CODE	01/3	31/2017
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	OCHESTER, MN 55901  PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 374	clear width of 32 in doors. 19.3.7.6, 19.3.7.8, Findings Include: On facility tour betwon 1/31/2017, base revealed that the for The smoke barrier close tight when te This deficient practite residents, staff compartment. This deficient practice.	ches for swinging or horizontal 19.3.7.9 ween 09:00 AM and 01:00 PM ed on observation and interview ollowing include: door on the west wing did not	K	374	<ol> <li>A directed in-service was condwith the Maintenance Department Regional Director on 1-31-2017 or limited to the Facility must ensure smoke barrier doors must close tig the event of a fire. In-services will continue to be conducted again in February 2017.</li> <li>Quality Assurance plans to mothat all smoke barrier doors must of tightly in the event of a fire through Quality Assurance tool conducted Maintenance Director and/or Designonce a week for the next month are be reviewed by the quality assuranteam in our Quarterly Quality Assurance Meetings</li> <li>Date of corrective action will be</li> </ol>	by the but not that all phtly in conitor close a by the gnee and will not all arce arance	
K 511 SS=D	Utilities - Gas and Equipment using g complies with NFP electrical wiring an NFPA 70, National installations can cohazard to life.	PA 101 Utilities - Gas and Electric lities - Gas and Electric lipment using gas or related gas piping inplies with NFPA 54, National Fuel Gas Code, ctrical wiring and equipment complies with PA 70, National Electric Code. Existing callations can continue in service provided no card to life. 5.1.1, 19.5.1.1, 9.1.1, 9.1.2		511	3/13/17.		3/13/17
	Utilities - Gas and	is not met as evidenced by: Electric as or related gas piping			No Residents were affected balleged deficient practice.	y this	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	TIPI F	CONSTRUCTION	(X3) DATE	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:			of - MAIN BUILDING 01		LETED
		245409	B. WING			01/3	1/2017
	ROVIDER OR SUPPLIER			18	REET ADDRESS, CITY, STATE, ZIP CODE 175 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
K 511	electrical wiring an NFPA 70, National installations can conhazard to life. 18.5.1.1, 19.5.1.1, Findings Include:  On facility tour betton 1/31/2017, base revealed that the formulated cord.  This deficient practite residents, staff compartment.	A 54, National Fuel Gas Code, d equipment complies with Electric Code. Existing ontinue in service provided no 9.1.1, 9.1.2  ween 09:00 AM and 01:00 PM ed on observation and interview		511	<ol> <li>All Residents, Employees and have the potential to be affected by alleged deficient practice.</li> <li>Melted Cord in Kitchenette was refafter walk through on 1-31-2017.</li> <li>A directed in-service was condwith the Maintenance Department Regional Director on 1-31-2017 or limited to the Facility must ensure extension cords must only be used accordance with NFPA 101. In-se will continue to be conducted once month for the next three months.</li> <li>Quality Assurance plans to me that only acceptable power cords in accordance with NFPA 101 will used, through the use of a Quality Assurance tool conducted by the Maintenance Director and/or Desionce a week for the next month a be reviewed by the quality assuranteam in our Quarterly Quality Assurance Meetings</li> </ol>	ducted by the n but not that din rvices a conitor are used be y gnee nd will nce	
K 920 SS=D	l	al Equipment - Power Cords	к	920	5. Date of corrective action will be 3/13/17.	e by	3/13/17
	Extension Cords	ent - Power Cords and patient care vicinity are only ents of movable					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
		245409	B. WING			01/3	1/2017
	PROVIDER OR SUPPLIER			18	REET ADDRESS, CITY, STATE, ZIP CODE 875 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 920	patient-care-relate (PCREE) assembly qualified perso 10.2.3.6. Power's may not be used electronics), excerooms that do not PCREE meet UL strips for non-PCI (outside of vicinity care rooms, power standards. All poprecautions. Extension cords unimmediately upon which it was insta 10.2.4. 10.2.3.6 (NFPA 9) (NFPA 70), 590.3 This STANDARD Electrical Equipm Extension Cords Power strips in a used for componing patient-care-related (PCREE) assembly qualified person 10.2.3.6. Power may not be used electronics), excerooms that do no PCREE meet UL strips for non-PC (outside of vicinity care rooms, power standards. All poprecautions. Extensions. Extensions.	ed electrical equipment ales that have been assembled nnel and meet the conditions of strips in the patient care vicinity for non-PCREE (e.g., personal pt in long-term care resident use PCREE. Power strips for 1363A or UL 60601-1. Power REE in the patient care rooms of meet UL 1363. In non-patient er strips meet other UL wer strips are used with general ension cords are not used as a diviring of a structure. Used temporarily are removed a completion of the purpose for alled and meets the conditions of 19, 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 is not met as evidenced by: nent - Power Cords and		920	1. No Residents were affected by alleged deficient practice.  2. All Residents, Employees and have the potential to be affected by alleged deficient practice.  Extension cord in Physical Therapy was removed on 2/1/2017.  3. A directed in-service was conswith the Maintenance Department Regional Director on 1-31-2017 of limited to the Facility must ensure extension cords are for temporary and removed immediately upon completion of the purpose for which is alleged.	d Visitors by this by Room ducted t by the on but not e that all y use	×

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01				SURVEY PLETED
		245409	B. WING			01/3	31/2017
	PROVIDER OR SUPPLIER			18	REET ADDRESS, CITY, STATE, ZIP CODE B75 19TH STREET NORTHWEST OCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 920	Extension cords us immediately upon which it was install 10.2.4. 10.2.3.6 (NFPA 99 (NFPA 70), 590.3(Findings Include:  On facility tour bet on 1/31/2017, bas revealed that the fan extension cord therapy room  This deficient practing the residents, staff of the building.	sed temporarily are removed completion of the purpose for led and meets the conditions of l.), 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5  ween 09:00 AM and 01:00 PM ed on observation and interview		920	installed.  4. Quality Assurance plans to mothat all extension cords are only us temporary use and removed immedupon completion through a Quality Assurance tool conducted by the Maintenance Director and/or Designonce a week for the next month as be reviewed by the quality assuranteam in our Quarterly Quality Assurantee Meetings  5. Date of corrective action will be 3/13/17.	gnee nd will nce irance	



#### 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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Maple Manor Nursing And Rehab, LLC February 16, 2017 Page 2

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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

(X6) DATE

If continuation sheet 1 of 57

PRINTED: 02/24/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00916 02/01/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1875 19TH STREET NORTHWEST MAPLE MANOR NURSING AND REHAB, LLC ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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

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.

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

### **INITIAL COMMENTS:**

corrected.

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/in">http://www.health.state.mn.us/divs/fpc/profinfo/in</a> fobul.htm> The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health

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

ELSW11

TITLE

Electronically Signed 02/23/17 STATE FORM

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC  ROCHESTER, MM 55901  [AND ID SUMMARY STATEMENT OF DEFICIENCIES ROCHESTER, MM 55901  [AND ID RECOLATORY OR LSC IDENTIFYING INFORMATION)  PREPERT TAG  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 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 foderal 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.	-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
MAPLE MANOR NURSING AND REHAB, LLC    MAPLE MANOR NURSING AND REHAB, LLC   MANOR NURSI			00916	B. WING		02/0	1/2017
PRIÉRIX TAG  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 Departments 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.			D REHABLIC 1875 19T	H STREET N	ORTHWEST		
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.	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
FOURTH COLUMN WHICH STATES,  "PROVIDER'S PLAN OF CORRECTION." THIS	2 000	Department of Hearyou electronically, is necessary for State enter the word "context. You must then State licensure procompletion date, the corrected prior to el Minnesota Department on January 29, 30, surveyors of this Deabove provider and orders are issued. electronic plan of coreviewed these ordethey will be completed. Minnesota Department the State Licensing federal software. Tates assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned tag in column entitled "Its statute/rule out of completed in the statement of the Suggested of the Sugges	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  31 & February 1, 2017, epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted.  The health is documenting Correction Orders using ag numbers have been ented state statutes/rules for the compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection.  ARD THE HEADING OF THE WHICH STATES,				

Minnesota Department of Health

STATE FORM 6899 ELSW11 If continuation sheet 2 of 57

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILDING.			
		00916	B. WING	····	02/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ID REHAB. LLC	H STREET N TER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	age 2	2 000			
	THIS WILL APPEAR ON EACH PAGE.					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
		int investigations were also me of the licensing survey.				
		complaint H5409033 was omplaint was substantiated at 4 Subp. 3 (1426).				
		complaint H5409036 was he survey and found not to be				
		complaint H5409039 was he survey and found not to be				
2 255	MN Rule 4658.007 Assurance Commit	0 Quality Assessment and ttee	2 255			2/21/17
	assessment and as of the administrator services, the medic designated by the representing discip resident care. The assurance committed respect to which quality deficiencies address, at a mining services.	ust maintain a quality ssurance committee consisting r, the director of nursing cal director or other physician medical director, and at least ers of the nursing home's staff, lines directly involved in quality assessment and tee must identify issues with uality assurance activities are elop and implement of action to correct identified . The committee must num, incident and accident control, and medications and				

	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
Q	00916	B. WING		02/01	1/2017
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE MANOR NURSING AND REHA	AR LIC	I STREET N TER, MN 559	ORTHWEST 901		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B REGULATORY OR LSC IDENT	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
pharmacy services.  This MN Requirement is resided to have the required Quality Assessment and A (QAA) at least quarterly. Thad the potential to affect a resided in the facility at the Findings include:  Review of the facility's QA record reviewed from 1-21 revealed the medical direct meetings on 1-21-16, 5-19 attendance record reveale attended the QAA meeting and 11-17-16.  On 2/01/2017, 2:59 p.m. It based on the documentation attendance for QAA meeting director did not attend a quality the five-month span from 8. The administrator stated the contact the medical director minutes from the quarterly director did not attend.  SUGGESTED METHOD Control of the participating in QA activities compliance needs to be in TIME PERIOD FOR CORI (21) days.	cord review, the facility members attend the ssurance Committee this deficient practice all 53 residents who extime of the survey.  A meeting attendance -16 to 12-22-16 ctor attended the QAA 2-16 and 11-17-16. The extra don of meeting ngs the medical parterly meeting during 5-19-16 to 11-17-16, the facility did not for to review the meeting of QAA the medical concept of the physician or the importance of the s. Monitoring for included too.	2 255	-QAA meetings are being held at lequarterlyAll residents have the potential to affected if QAA meetings are not helast quarterly to identify areas for improvementDepartment managers have been educated in QAA requirementsMonthly audits for 12 months will conducted to insure QAA meetings held per CMS requirements with the required attendeesPhysician educated on 1/16/2017 regards to quarterly QAA attendant regulationPhysician will attend QAA at least quarterly via telephone conference personED/designee is responsibleAudit results will be reviewed mor QAPI -Corrective action completed by 2/2	be neld at nel	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00916	B. WING	<del></del>	02/0	1/2017
	PROVIDER OR SUPPLIER	D REHABILIC 1875 19TH		STATE, ZIP CODE  ORTHWEST  901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 4	2 570			
2 570	Plan of Care; Revis		2 570			3/9/17
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on observati review, the facility fainclude at risk for be (R74) reviewed for concerns; failed to president's room for reviewed for participalled to revise the	on, interview and document ailed to revise a care plan to ruising for 1 of 3 residents non-pressure related skin provide care conferences in a 1 of 3 residents (R74) pation in care planning and care plan for 1 of 3 residents ntures, who was reviewed for		Corrected		
	Findings Include:					
	LACK OF CARE PL FOR BRUISING:	LANNING FOR HIGH RISK				
	10 milligrams (MG) time a day for COP	lers included prednisone tablet , give 1 tablet by mouth one D. Give 10 mg in a.m. in HS [bedtime], equals 11 mg				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00916	B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
MAPLE	MANOR NURSING AN	II) REHAR I I C:	H STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 570	Continued From pa	age 5	2 570			
	daily. Start date 1/5	5/17.				
		ronic care plan did not address sed risk for bruising related to one.				
	had a large bruise	on 1/29/17, at 3:17 p.m., R72 on her forearm. R72's record tification or monitoring of the				
	to 2/1/17 the docum	nes were reviewed from 1/3/17 mentation did not reflect initoring of the bruise.				
	nursing assistant (I residents' skin duri	y on 1/31/17, at 8:46 a.m., NA)-B stated she looked at ng daily and on bath day. NA-B d any skin concerns to the				
	verified through ob- her right forearm. F measured 4.5 cent stated she would d progress note and observation of bruis	.m., registered nurse (RN)-C servation R74 had a bruise on RN-C stated the bruise imeters (cm) x 4.8 cm. RN-C ocument the findings in a would enter a nursing order for se for healing on the treatment d R74 was on prednisone and				
	director of nursing residents' skin on the stated staff comple section on it for skin weights. The DON form and provide the stated if there was	on 2/01/17, at 10:20 a.m., the (DON) stated staff monitored heir shower day. The DON sted a bath sheet that had a n issues, vital, signs and stated staff are to fill out the ne form to the nurse. The DON an identified skin issue it was the nurse, there should be a				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00916	B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB. LLC	I STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS - REFERENCE)	D BE	(X5) COMPLETE DATE
2 570	progress note and completed. The DO the bruising for wor DON stated staff ar providing care and The DON stated ship be developed for reof skin integrity, whany skin injury.  LACK OF PARTICI R74 was interviewed when asked do state about your medicing treatments. R74 results she was unaware of and stated, "Does to one."  R74's care conference reviewed and reveal and reveal and reveal and reveal and stated and reveal	an accident/incident report DN stated nursing was to track sening and resolution. The re to monitor skin anytime they report concerns to the nurse. He would expect a care plan to residents that are at risk for loss ich would include bruising or PATION IN CARE PLANNING:  and on 1/29/17, at 3:07 p.m., for include you in decisions the expect of the property of the pr	2 570			
	stated she had talk conferences in her	ed with R74 about having care room, and R74 thought that she would not need to worry				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00916	B. WING		02/	01/2017
	PROVIDER OR SUPPLIER	D REHABILIC 1875 19T	DRESS, CITY, SH STREET NOTER, MN 559	• • • • • • • • • • • • • • • • • • • •		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 570	about coming down the meeting.  R74 was interviewe R74 stated the soci today regarding have room. R74 stated si conferences in her like to leave her rooneed to use the bat problems.  During an interview director of nursing (been offered the opheld in her room if so room to attend care stated she would lo participation in care not provided.  REVISION OF CAF R22's current electric Focus: self-care demobility, anxiety disdisorder, and alert vincluded oral care; to brush BID (twice)  On 1/29/17, at 2:05 have no teeth or definition confiplace. RN-C looked stated she did not so room.	ge 7 Ito the conference room for Ito don 2/01/17, at 10:07 a.m., al worker had visited with her ving care conferences in her he agreed to have care room. R74 stated she did not om because of her frequent hroom and her breathing  on 2/01/17, at 10:15 a.m. the DON) stated R74 should have betion to have care conferences she did not want to leave her conferences. The DON ok for a policy regarding conferences and a policy was  RE PLAN DENTAL STATUS: ronic care plan identified: ficit related to impaired order, borderline personality with confusion. Interventions wears dentures; assist of one daily) and soak overnight.  p.m., R22 was observed to intures in his mouth.  a.m., registered nurse (RN)-C firmed R22 had no dentures in I through R22's room and see any dentures for R22 in his  a.m. nursing assistant (NA)-E				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00916		B. WING		02/0	1/2017
NAME OF PROVIDER OR SUF		1875 19TH		TATE, ZIP CODE  ORTHWEST  001		
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIENCY MUST BE PRECEDED OF COR LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
dentures out of broke. I do not ones. NA-E simonths since  On 2/1/17, at service inform family does not remaily does not replaced to be used to	ed to wear dentures. For this mouth and the deal think they are going to the deal think they are going to the deal think they are going to the deal to the deal think they are going to the deal to the dentures were the had informed R22's	entures o get new e a couple of entures. ed social re broke and placed. s care plan  es (SS)-A es. I called dentures s were broke eumented any dentures. of nursing be moving happens what nented in the R22's care d stated the I. The DON tures were  ly Review, and g for status. ECTION: could ensure	2 570			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	01/2017
	PROVIDER OR SUPPLIER	ID REHABILIC 1875 19TH	, ,	STATE, ZIP CODE  ORTHWEST  901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Nursing or designed were offered the op- conferences. Audit ensure staff were in	e could ensure all residents portunity to participate in care is could be preformed to	2 570			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			3/9/17
	by: Based on observati review, the facility for the facil	ent is not met as evidenced on, interview and document ailed to identify and monitor esidents (R74, R102 & R22) ressure related skin concerns.  on 1/29/17, at 3:17 p.m., R72 on her forearm. R72's record iffication or monitoring of the		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00916	B. WING		02/	01/2017
	PROVIDER OR SUPPLIER	ID REHABILIC 1875 19T	DRESS, CITY, S' H STREET NO TER, MN 559	DRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	R74's progress note to 2/1/17 and the do identification or more 10 milligrams (MG) time a day for chror disease (COPD). Oto 1 mg at HS [bedfer R72 was at increas the use of predniso R74's bath sheet dato the right arm.  During an interview nursing assistant (Noresidents' skin during day. NA-B stated should be right as to the nurse right as to the nurse right as to the state of the nurse right as to the nurse right as to the state of the nurse right as to the nurse right as the state of the nurse right as the nurse right	es were reviewed from 1/3/17 ocumentation did not reflect nitoring of the bruise.  ders included prednisone tablet, give 1 tablet by mouth one nic obstructive pulmonary Give 10 mg in a.m. in addition time], equals 11 mg daily.  Tonic care plan did not address ed risk for bruising related to ne.  ated 1/31/17 indicated bruising  on 1/31/17, at 8:46 a.m., NA)-B stated she looked at ng cares daily and on bath ne reported any skin concerns way.				
	verified through obsher right forearm. Firmeasured 4.5 cm x would document in enter a nursing ordinealing on the treat was on prednisone  During an interview the DON stated the (ADON) had brough completed on 1/31/DON verified there regarding the bruise	m., registered nurse (RN)-C servation R74 had a bruise on RN-C stated the bruise 4.8 cm. RN-C stated she a progress note and would er for observation of bruise for ment record. RN-C stated R74 and bruised easily.  on 2/01/2017, at 1:55 p.m., assistant director of nursing ht R74's skin monitoring form 17 following her bath. The was no documentation in the dinot find documentation in the				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00916		B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ID REHAB. LLC	I STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 11	2 830			
		ding the bruise and an incident pleted related to the bruise 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.					
		etronic care plan directed staff th cares for changes."				
	to 2/1/17 the docum	otes were reviewed from 1/9/17 nentation did not reflect nitoring of the bruises.				
	R102's bath sheet skin concerns.	dated 1/20/17 indicated no				
	nursing assistant (Note that the resident's skin whe undressed, during the resident that the resident	on 01/31/17, at 11:01 a.m., NA)-A stated she monitored n she got them dressed, cares and on shower days. s were to be reported to the				
	verified through obs bruising on the left centimeters (cm) x hand measuring 1.	m., registered nurse (RN)-C servation R102 to have fading forearm measuring 3 3.2 cm and to back of left 2 cm x 1.5 cm. RN-C stated any new bruises to the nurse, sess and follow up.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	01/2017
	PROVIDER OR SUPPLIER	ID REHABILIC 1875 19T	DRESS, CITY, S H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	During an interview director of nursing (residents' skin on the stated staff comple section on it for skin weights. The DON form and provide the stated if there was at to be addressed by progress note and a completed. The DO the bruising for wor DON stated staff ar providing care and The DON stated shad be developed for reform the skin integrity, when any skin injury.  R22 was observed had a scabbed area arm and a purple by	ron 2/01/17, at 10:20 a.m., the (DON) stated staff monitored heir shower day. The DON ted a bath sheet that had a n issues, vital, signs and stated staff are to fill out the ne form to the nurse. The DON an identified skin issue it was the nurse, there should be a can accident/incident report DN stated nursing was to track sening and resolution. The re to monitor skin anytime they report concerns to the nurse. The would expect a care plan to residents that are at risk for loss ich would include bruising or on 1/29/17 at 1:59 p.m. R22 a with bruising on his left upper ruise on his right upper arm.				
	monitor skin with car R22's progress not to 2/1/17 the docum identification or mon R22's bath sheet da 1/19/17 indicated no On 2/1/17, at 10:01 observation R22 has measuring 2 cm x 1 right upper arm 4.4	ronic care plan directed staff to ares and report changes. es were reviewed from 1/5/17 nentation did not reflect nitoring of the bruises. ated 12/31//16, 1/14/17, and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00916	B. WING		02/0	01/2017
	PROVIDER OR SUPPLIER	D REHABILIC 1875 19T	DRESS, CITY, S H STREET N TER, MN 559	• • • • • • • • • • • • • • • • • • • •		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	the bruises. RN-C sto report bruises an incident report and  On 2/2/17, at 2:57 pexpectation was bruised marks need to be report form filled out needed to be meast facility computer sydocument weekly of implement intervent.  The Skin Assessment 1/13/17, included, so bruises) will be assed every seven (7) day recorded in the mean responsible for prorestin observations, in resident's care plant appropriate, to refles integrity, approached in the grity, approached in the grity, approached integrity, appr	stated nursing assistants are d I would then fill out an report.  D.m., the DON stated her using, skin tears, laceration, be documented, an incident to the DON stated the area ured and documented in the stem resident progress notes, in the areas until resolved and tion to prevent recurrence.  The policy and procedure dated kin injuries (skin tears, essed and measured at least is by licensed nurse, and dical record. Caregivers are inptly notifying the nurse of including bruises. The				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		00916	B. WING		02/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	-	
MAPLE I	MANOR NURSING AN	ID REHAB. LLC	STREET N ER, MN 559	ORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 14	2 830			
	(21) Days.					
2 910	MN Rule 4658.052	5 Subp. 5 A.B Rehab -	2 910			3/9/17
	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.					
	by: Based on observation review, the facility for care/services to recideveloping a urinar 1 resident (R52) with catheter. In additional bladder function to for 1 of 2 residents incontinence.  Findings include:	ent is not met as evidenced ion, interview and document ailed to provide catheter duce the chance of a resident by tract infections (UTI) for 1 of the an indwelling Foley and the highest extent as possible (R4) reviewed for urinary		Corrected		
		imum Data Set (MDS) dated R52 had an indwelling Foley				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00916	B. WING		02/	01/2017	
NAME OF PROVIDER OR SUPPLIEF	ND REHABILIC 1875 19T	DDRESS, CITY, S' H STREET NO TER, MN 559	DRTHWEST			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
and moderately infor daily living.  R52 was observed in bed, the cathete attached to the bethe floor.  On 1/31/17, at 10: (NA)-A stated R52 the side of the bed R52 was in bed. No catheter bag was  On 1/31/17, 1:56 processed infection control of covered and rested infection control of covered and rested.  The Catheter Care 1/31/17, included and adequate hygwith an indwelling comfort, function, complications. 2. Complications. 2. Complications and the floor to Catheter bag should be secured drag on the floor to Catheter bag should be secured drag on the floor to Catheter bag should be secured drag on the floor to Catheter bag should be secured drag on the floor to Catheter bag should be secured drag on the floor to Catheter bag should be secured drag on the floor to Catheter bag should be secured drag on the floor to Catheter bag should be secured drag on the floor to Catheter bag should be secured drag or the floor to Catheter bag should be required to bladder, was not of bladder, required to severe cognition of the form of	short-term memory problems apaired decision-making skills on 1/31/17 at 10:28 a.m. to be er bag was not covered, was d and the bag was resting on 38 a.m. nursing assistant at did not have a bag attached to d to place the catheter in when IA-A verified the uncovered resting on the floor.  I.m. the director of nursing facility had covers for catheter ectation was all catheter bags. The DON stated it was an oncern if a catheter bag was not d on the floor.  I.e. policy with a revision date of staff will maintain consistent iene standards for residents catheter in order to maintain and prevent infection and other Catheters bag and tubing and not allowed to touch or or prevent contamination. 4. Ild be kept in a protective ect dignity of the resident.  Imum Data Set (MDS) dated d R4 was always incontinent of on a toileting program for two assist to toilet and had					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00916		B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB. LLC	I STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 910	nursing assistant (I like to lay down in h After R4 was laid in and to put the urinat to R4 you usually g change you. So you will change you. So you will change you. R4 stated, "Yep!" R4 surinate in the incon R4's record identific Quarterly review da a current Bowel and most recent MDS of R4's current electronal actual/potential related to urgency a urinary tract infection malignant neoplasm change as needed assist of one for hy each incontinent emonitor/document/lassist of one for tracone to manage.  R4's care plan lack should be toileted a R4 had (continent, frequently incontined determine incontine further decline in bl prevent UTIs.  On 1/30/17, at 10:5 be checked and chevery two hours. R4 does not tell when later when late	NA)-F asked R4 if he would his bed and R4 replied "yeah." hed, R4 stated he had to pee, al up to my penis. NA-F stated or in your brief and I then u can just go in your brief and I stated is that what I do? NA-F stated ok and proceeded to tinent brief.  Bed a facility Bowel and Bladder ated 9/4/16. R4's record lacked d Bladder assessment for the lated 11/28/16.  In for alteration in elimination and incontinence. History of on (UTI) (recent) and m of prostate. Check and with peri-care, barrier cream, giene, incontinence care after	2 910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00916	B. WING		02/	01/2017
	PROVIDER OR SUPPLIER	D REHABLIC 1875 19T	DRESS, CITY, S H STREET NO TER, MN 559	*******		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 910	R4 did not use the time he told me he R4's nursing assistation confirmed the sheet Toilet/Brief: briefs at the sheet did not intoileted.  On 1/30/17, at 2:40 confirmed the last E Assessment comple RN-D stated there is assessment after 9 care plan lacked to be toileted and R4's stated the nursing at the urinal to R4 whe urinal. That tells me incontinent, becaus opportunity to toilet.  On 1/30/17, at 3:22 nursing (ADON)-D confirmed the last E assessment completed to the urinal to R4 who urinal. The point is the urinal to R4 who urinal to to toilet R4's level of contine R4's level of conti	urinal and that was the first had to void. NA-F reviewed ant care sheet at the time and t read under the topic and pull ups. NA-F confirmed dicate how often R4 should be p.m., registered nurse (RN)-D Bowel and Bladder eted for R4 was dated 9/4/16. should have been another /4/16. RN-D Confirmed R4's include how often R4 should as level of continence. RN-D assistant should have given en he requested to use the en why they are always marking the they are not giving him the eted for R4 was dated 9/4/16.  p.m., the director of nursing would expect staff to offer eted for R4 was dated 9/4/16.  p.m., the director of nursing would expect staff to offer eted for R4 was dated 9/4/16.  p.m., the director of nursing would expect staff to offer eted for R4 was dated 9/4/16.  p.m. the director of nursing would expect staff to offer eted for R4 was dated 9/4/16.  p.m. the director of nursing would expect staff to offer eted and bowel and bladder be completed quarterly. The last facility bowel and bladder be completed quarterly. The last facility bowel and bladder eted for R4 was dated 9/4/16.  p.m. the director of nursing would expect R4's care plan and R4 was to be toileted and ence. The DON stated R4 dt to be toileted every two				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00916	B. WING		02/	01/2017
	PROVIDER OR SUPPLIER	D REHABLIC 1875 19TH	DRESS, CITY, S H STREET NO FER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 910	On 1/31/17, at 2:18 knew when he had "yeah." When queri he wanted to use the urinal to him to good, but what do yand was not the las queried if he would stated, "I would be on the toilet."  The facility policy B dated 1/15, indicate resident's compreh will ensure that each bladder incontinent treatment and servi normal bowel and bladder done on admission status, and with a selimination patterns will be developed to appropriate individual policy failed to addressed to addressed to addressed to a sessed for at least bowel and bladder sasessmer SUGGESTED MET. The Director of Nur resident toileting nereduce incontinence and by resident's with incourinary catheters. It residents could be resident's with incouring with with with incouring with with with with with with with with	p.m., R4 when queried if he to go to the bathroom, stated ed how it made him feel when he urinal and staff did not give use, R4 stated, "Well not you do, Was not the first time it time, inexperienced." When like to use the toilet, R4 less embarrassed if I could go owel and Bladder Assessment ed Policy: Based on the ensive assessment, the facility he resident with bowel and the ewill receive appropriate ices to restore as much bladder functioning as etc. 1. Each resident will be st 72 hours to help establish voiding patterns. This will be with significant change in ignificant change in ignificant change in address goals and lalized interventions. The ress quarterly bowel and hits.  THOD OF CORRECTION: sing or Designee could ensure teeds are met by assessment to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00916	B. WING		02/0	1/2017
	PROVIDER OR SUPPLIER	D REHABILIC 1875 19TH	STREET N	STATE, ZIP CODE  ORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	provided.	ge 19 R CORRECTION: Twenty One	2 910			
2 965	-Nutritional Status Subpart. 2. Nutritio must ensure that a which supplies the o determined by the o assessment. Subst	nal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food	2 965			3/9/17
	by: Based on observati review, the facility fa weight loss for 1 of nutrition.  Findings include: R22's quarterly Min 11/8/16, identified w mechanical altered gain and required o On 1/30/17, at 12:3 be seated in his whe eating the meal index R22's current care	6 p.m., R22 was observed to eelchair in the dining room,		Corrected		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ID REHAB. LLC	H STREET N FER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 965	disease) and COPI pulmonary disease related to takes a diet general, eats in Eating; resident not assist as resident a independence. Encourage snackin symptoms of dehyoturgor, dry skin, corfever. ST (speech to Supplements as on R22's weights docusystem in pounds: On 2/1/17, at 8:32 at the director of nurs. The reweigh weigh pounds. A loss of 1 compared to 189 ploss in one month, 1/19/17 weight reconstruction of 1/2/19/16 186.6 Med 12/19/16 189 Mech 12/19/16 189 Mech 12/15/16 189 Mech 11/28/16 182.8 Mech 11/28/16 182.8 Mech 11/28/16 185 mech 11/28/16 mech 11/28/16 185 mech 11/28/16 185 mech 11/28/16 185 mech 11/28/16	ed to CKD (chronic kidney D (chronic obstructive)). At risk for dehydration iuretic. Interventions included neals in the dining room. It always feeding self. Staff to allows. Encourage courage fluid, due to foul of the second	2 965			

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NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC  STREET ADDRESS, CITY, STATE, ZIP CODE  1875 19TH STREET NORTHWEST  ROCHESTER, MN 55901	AND DUAN OF CODDECTION IDENTIFICATION NUMBER.					X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC  STREET ADDRESS, CITY, STATE, ZIP CODE  1875 19TH STREET NORTHWEST  ROCHESTER, MN 55901							
MAPLE MANOR NURSING AND REHAB, LLC  1875 19TH STREET NORTHWEST ROCHESTER, MN 55901			00916	B. WING		02/0	1/2017
MAPLE MANOR NURSING AND REHAB, LLC ROCHESTER, MN 55901	NAME OF	PROVIDER OR SUPPLIER					
CONTRACTOR CONTRACTOR DESCRIPTION OF DESCRIPTION OF DESCRIPTION OF CORPORATION OF	MAPLE	MANOR NURSING AN	ID REHAB. LLC				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		(EACH DEFICIENCY			CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
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 (millillers) 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 (millilliters) 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.	2 965	consume > (greate daily and show no see dehydration. Will mon 11/16/16 Nutritic assessment: Diet in 2.0, 120 ml (millilite meds. Fluids to be dependent on staff > 75 percent. Textus wallowing. Curren weight graph very ein the 180's. Staff to hydration per policy (certified dietary madietician) as neede R22's physician or 5/24/16 for med pad (milliliters) three tim weight loss. Order mechanical soft textus Review of R22's physician or 5/24/16 for med pad (milliliters) three tim weight loss. Order mechanical soft textus Review of R22's physician or of meals, does recept and for some weight loss of som	er than) 75 percent of meals signs/symptoms of naintain adequate nutrition. on/Dietary Note nutritional mechanical Soft with Med Passers) three times daily with encouraged. Resident is for food/fluid and usual intake, ures altered for chewing, it weight 187.6 pounds and erratic. Resident's usual weight o monitor intake, weights, y/physician order; notify CDM anager, RD (registered id. ders identified an order dated ass (supplement) 2.0, 120 ml nes daily with meds due to date 11/15/16, general diet, xture.  In the supplements three times weight loss. Weight is 187.6 own slightly from 188 a month of 2/1/17, at 8:32 a.m., (RD)-F had been asked ated 1/30/17 regarding weight over the past two weeks and weigh done. RD-F said, "If I gh to be done before I leave the nere for weeks." As she did not recent weight loss by ordering ner interventions to prevent to loss.				

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AND DIAN OF CODDECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			D. WING			
		00916	B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	II) REHAR I I C:	H STREET N TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 965	director of nursing system for weights day and written do nurse reviews and computer system. If found they notify Drawsing and notify to Investigate for caus Nurses are to get at that same day. The of the computer system weekly. The for R22 had not be her after RD-F's vis R22's weight loss of the physician shoul intervention implementation. The facility policy Weasurements dat Procedure: 5. If los month; 7.5% in the re-weigh within 24 resident/legal represocial services, act notified upon identified upon identification weight loss/gain. The facility policy Dindicated Policy: a coversee clinical nutfacility. Policy Interpolicy Dindicated Policy: a coversee clinical nutfacility.	(DON) stated the facility was to obtain weights on bath on on the bath sheet. The documents the weight into the life significant weight loss is ON or the assistant director of the nurse practitioner. Sative factors and rectify. It reweigh if way out of range on the RD prints off weight sheet out stem, which includes all the DON confirmed weight loss are identified and reported to sit on 1/30/17. The DON stated should have been identified, and have been notified and an inented.  Weight and Height ed 8/1/15, indicated s or gain noted (5% in one see months; 10% in six months) hours. 6. Physician, seentative, family, nursing staff, sivities, and dietary are to be fication of significant/severe. Evaluate and document thange in medical record and Implement interventions as gressive intervention does not nge, a NP/MD reassessment				

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00916		B. WING		02/01/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	D REHAB. LLC	I STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
2 965	Continued From pa	ge 23	2 965			
	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 (21) days.	R CORRECTION: Twenty-one				
21015	MN Rule 4658.0610 Requirements- Sai	O Subp. 7 Dietary Staff nitary conditi	21015			3/9/17
	procedures and cor	conditions. Sanitary nditions must be maintained in dietary department at all				
	by: Based on observati review, the facility fa spread of food born potential to affect a	ent is not met as evidenced on, interview, and document ailed to prevent the potential ne illness, which had the ll 57 residents in the facility, no ate out of the kitchen.		Corrected		
	Findings include:					
	01/29/17 3:21 p.m.	A metal portable cart with a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00916	B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	II) REHAR I I C	H STREET N FER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	plastic cooler conta dayroom off to the The cooler was hall with plastic scoop leice. The cooler had one has access to p.m. Plastic cooler dayroom, unlocked  On 1/30/17 at 10:40 a stream table used with food debris on wipe off food debris of food and serving dining room). In largive-gallon container melted, refrozen, ar refrigerator had an cheese dated 1/23/discarded days ago had dried food/debraicer which had a pslicer and staff said and the plastic coveready to be used as heavy black oxide of said this cast iron provided the cutting boards used other foods were not difficult to sanitize and broken.  During interview with 1/29/17, 6:20 p.m. iccontainer located in cooler to the cooler to the container located in cooler to the cooler t	uining ice was in the front right of the main entrance. If to three/fourths full of ice, eft inside in contact with the lan unlocked device and any scoop and ice. 01/29/17 6:15 with ice scoop still sitting in	21015			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00916				02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB. LLC	ER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21015	nursing assistants during water pass. the afternoon and that since the cooler unlocked that anyonget into the cooler. Next to the cooler for the cooler was in the coole	to fill the resident pitchers We usually pass fresh water in hen again later. NA-C noted or was in the dayroom and ne (residents, visitors) could There were cup available or use.  Ith Administrator on 1/31/17, at so to the findings as id that the kitchen was not up eded cleaning. She also rould expect to have food earn table before next use." If that she did not know why ne main dayroom on 1/29/17. If the did not know why ne main dayroom on 1/29/17. If the did not know why ne main dayroom on 1/29/17. If the did not know why ne main dayroom on 1/29/17, if the director of nutritional or cleaning schedule ing tasks, staff will initial after so, the director of nutritional or cleaning checklists weekly to and the registered dietician sanitation monthly.  It is fill the resident passed in the sanitation of the mpliance with a written	21015			

` ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '					X3) DATE SURVEY COMPLETED	
	00916		B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 02/0	.,
MAPLE I	MANOR NURSING AN	ID REHAB. LLC		ORTHWEST		
		ROCHES	TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 26	21015			
	access to ice storage chest/containers to employees only. Keep ice scoop on a clean, hard surface when not in use.					
	dietary manager an in-service all dietary	THOD OF CORRECTION: The ad registered dietician could by staff on need to keep the at clean and sanitary. Also to ince.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21390	MN Rule 4658.080	0 Subp. 4 A-I Infection Control	21390			3/9/17
	control program mu procedures which page 4. surveillance collection to identify residents; B. a system for control of outbreaks. C. isolation and reduce risk of trans. D. in-service exprevention and con E. a resident here.	ealth program including an				
	defined in part 465 procedures of resid the prevention and F. the development of the practices, including defined in part 4656 G. a system for H. a system for	ram, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of ect infection control, such as				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
MAPLE I	MAPLE MANOR NURSING AND REHAB, LLC  1875 19T ROCHES			ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 27	21390			
	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.			Corrected		
	Findings include:					
	nurse (LPN)-B was blood sugar. LPN-E glucometer used we residents on the ear R102's blood sugar carried the glucometer was anitizer. LPN-B reinhand and cleansed with a alcohol pad a her left hand and w LPN-B when queries for cleaning the glucometer as the glucometer as LPN-B stated I used works. LPN-B verifiprior to the glucometer as	1 a.m., licensed practical observed to check R102's stated at the time the as a glucometer used for all st wing. LPN-B after checking had removed gloves and eter out to the medication cart. The sand cleansed the outside with a tissue and hand moved the glove on her right the outside of the glucometer and then removed the glove on ashed hands. At the time and what the facility policy was cometer, stated I would have PN-B stated a bleach wipe clean the glucometer and then air dry for three minutes. It is an alcohol pad, either one ed she had removed gloves eter being cleaned and had and sanitizer and an alcohol				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	1/2017
	PROVIDER OR SUPPLIER	D REHABILIC 1875 19TH	DRESS, CITY, S I STREET NO IER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	pad to clean and sa  The glucometer ma Complete owner's r indicated disinfect t patient to prevent ir disinfect the meter, prior to the disinfect to clean exposed si thoroughly and rem any other body fluid wipe to disinfect the disinfecting procede solvents to clean th meter cleaning and the disinfecting wipe Micro-Kill Plus by M  On 1/30/17, at 3:51 (DON) stated when glucometer was cle not the correct procede the glucometer. The remain on until the cleaned/sanitized a have been cleansed  The facility policy C glucometer dated 8 Perform hand hygic all external surfaces sides, using the ble prepared EPA germ solution to penetrat ports of the meter. wet for one minute additional minute be resident. 5. If blood meter, the procedur	unifize the glucometer. Inufactured by UltraTRAK manual provided by the facility, he meter between each affection. How to clean and the meter must be cleaned tion. Use one disinfecting wipe arfaces of the meter ove any visible dirt, blood, or with the wipe. Use a second the meter by following the are below. Do not use organic the meter. We recommend for disinfection you should use the elowelette from below:	21390			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00916	B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	D BEHAR LIC	I STREET N ER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21390	containers. &. Rem hygiene.  Suggested Method Nursing or designed procedures to ensure regarding glove used The Director of Nureducate staff and a to ensure compliant Time Period for Condays.	ove gloves and perform hand of Correction: The Director of e could review policies and ure, proper infection control e and cleaning of glucometers. sing or designee could n auditing system developed ce. rrection: Twenty one (21)	21390			
21426	(a) A nursing home maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volumed the shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, interes. The Department of extechnical assistance intation of the guidelines.	21426			3/9/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	1/2017
	PROVIDER OR SUPPLIER	D REHABILIC 1875 19TH		STATE, ZIP CODE  ORTHWEST  901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 30	21426			
	by: Based on interview failed to ensure a fa assessment was co ongoing staff trainin tuberculosis skin te and read within the residents (R69, R10 for Tuberculosis and	and record review, facility acility tuberculosis risk ampleted, policy identified ag related to tuberculosis, sting (TST) was completed 72 hour time frame for 5 of 6 on, R56, R27, R25) reviewed d for 5 of 6 staff (S1, S2, S3, worked directly with the		Corrected		
	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 received a St	to the facility on 1/20/17. ep 1 TST on 1/20/17. Results ed. Step 2 TST test scheduled				
	had received a Step previous admission	o the facility on 10/18/16. R56 o 1 TST on 8/6/16, with a . The results of the skin test ed. Step 2 TST was not				
	received a Step 1 T not documented. R	o the facility on 9/26/16. R27 (ST on 9/26/16. Results were 27 received Step 2 TST on mented results on 10/12/16 of m induration.				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING	<del></del>	02/0	1/2017
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE MAI	NOR NURSING AN	D REHAB. LLC	1 STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Since	TST completed of ocumented. Step 2 8/16. No results of 1 was hired on 8/3 ovide any documented of 2 was hired on 2/2 ST with document m induration. No see 2 worked until 1/2 ocumentation of a 3 was hired on 11/2 ocumented as negacility unable to procumented as negacility unable to procumentation of a 3 was hired on 2/2 14/16. Facility unable to procumentation of a 3 ompleted or a Step ompleted.  5 was hired on 1/1 ocumentation of a 3 ompleted or a Step ompleted.  6 was hired on 1/1 ocumentation. Facumentation that a scheduled.  accility was asked to complete on 8/1/15 ocumented o	o the facility on 8/25/16. Step n 8/27/16. No results 2 TST was completed on locumented.  8/16. Facility was unable to entation of a Step 1 or Step 2 ed.  2/16 and received a Step 1 red results of negative with 0 second TST was completed.  1/17, facility unable to provide Step 2 TST being completed.  //25/16. S3 received her Step 1 on 11/30/16. Test was gative with 0 mm induration. rovide documentation of a	21426			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00916	B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	II) REHAR I I C:	H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21426	Continued From pa	age 32	21426			
	document was requ	uested.				
	Surveillance and C identify ongoing sta	and Procedure Tuberculosis ontrol dated 8/1/15 does not aff education related to the plan ent of a resident with active				
	of Nursing (DON). screenings and Ste completed for staff floor. Results of TE maintained in the eresults should be dwell as documente should include date negative/positive a DON stated when a screening and Step admission. Results paper form as well include negative/poinduration present. step 1 and 2, are a medication administ to perform test and test. DON stated fa facility risk assess 8/1/15 and stated to completed a risk as 1/30/17, after docustated she was una received related to any documentation training. Interview on 2/1/17 director of nursing	7, at 12:32 p.m. with Director DON stated Tuberculosis op 1 TST needs to be before their first day on the screening should be employee records. Step 1 TST locumented on paper form as d in Point Click Care and e and time read, and any induration present. A resident is admitted a TB of 1 TST is completed on day of are to be documented on the as in Point Click Care to be sitive results and any DON stated the TST including utomatically entered into the stration record (MAR) for staff I when to read results of the acility was unable to find the ment that was completed on the nurse consultant had seessment document on ment was requested. DON aware of any training staff had TB and was unable to provide a that staff had received				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY LETED
		00916	B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ID REHAB. LLC		ORTHWEST		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21426	Continued From pa	age 33	21426			
	the form is left for the after reading the TS placed in ADON's reviews the forms to out completely and member for their selection. Interview on 2/1/17 stated she would excontain TB screening.	be read over the weekend, he floor nurses to complete ST results. The form is then mailbox. ADON stated she to ensure they have been filled then schedules the staff econd step TST.  If, at 10:07 a.m. with DON, expect all employee files to the ngs and TST results. DON contained necessary				
	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.					
	director of nursing of review policies and components of the monitoring program education and the facility staff could be regulations and the director of nursing a monitoring system compliance.	THOD OF CORRECTION: The (DON) and/or designee could procedures related to the infection control and TB including ongoing staff facility risk assessment. The educated on the TB is two step TST process. The and/or designee could develop in to ensure ongoing				
	(21) days.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ID REHAB. LLC	I STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Subpart 1. General must be free from a unnecessary drug in A. in excessive therapy; B. for excessive C. without adea D. in the prese which indicate the addiscontinued. In addition to the dipart 4658.1310, the with provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Fade Department of Health Care Finance This standard is incavailable through the system and the State subject to frequent This MN Requirements on interview Based on interview	al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or trug regimen review required in e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the Ith and Human Services, sing Administration, April 1992. Corporated by reference. It is ne Minitex interlibrary loan the Law Library. It is not change.	21535	Corrected		3/9/17
	failed to ensure an movement scale (A completed per prov (R32); failed to ider depression for 1 of determine if the antifailed to complete a assessment to determine the determine to determine the determine to determine the d	abnormal involuntary abnormal involuntary alMS) assessment was rider order for 1 of 5 residents ntify specific symptoms of 5 residents (R22) to tidepressant was affective; and a comprehensive sleep ermine the need for sleep aids ia for 3 of 5 residents (R57,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	1/2017
	PROVIDER OR SUPPLIER	D REHABLUC 1875 19T	DRESS, CITY, S H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	R22, R102) reviewed medications.  Findings include:  R32's diagnosis foudated 1/7/15, identification Review an order dated 2/29 assessment every every six months st month for one day from antidepressant) used mg, give 0.5 mg tab for hallucinations/pathonic daily.  Care plan revised of takes antipsychotic paranoia, major dependentia with behalf identifies to complemenths.  AIMS assessment of a score of 0 which if symptoms of tardiverelated to the use of performed AIMS as months form previote to their attention by	and on the admission record fies Major Depressive unspecified.  Report dated 2/1/17, identifies 8/16 to complete an AIMS 5 months, one time a day arting on the last day of the for quetiapine (fumerate an e. Quetiapine Fumarate 25 olet by mouth one time a day aranoia. Order dated 8/5/16.  Atration Record for the month entifies R32 received ne Fumarate as scheduled on 3/28/16, identifies R32 medication related to pressive disorder, anxiety, avioral episodes. Care plan the AIMS assessment every 6 was completed on 3/1/16 with dentifies no signs or e dyskinesia (side effects f antipsychotics). Facility sessment on 2/1/17 ten ius assessment, after brought surveyor.	21535			
		, at 9:43 a.m. with director of ied an AIMS assessment had				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3)			(X3) DATE SURVEY COMPLETED	
		00040	B. WING		00/0	4 (004 =	
		00916			02/0	1/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE  ORTHWEST			
MAPLE	MANOR NURSING AN	ID REHAB. LLC	TER, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21535	not been completed provider order. DOI AIMS assessment ordered. DON state responsible for composition of the provider ordered. DON state responsible for composition of the provider of the pr	d every 6 months per the N stated she would expect the to have been completed as ed the floor nurses are appleting all assessments.  e and Procedure AIMS d 8/1/15, identifies AIMS formory 6 months by the licensed ENT:  und on the admission record tifies Insomnia.  It revised on 10/27/16 does not a sleep aide.  Report dated January 2017, Melatonin (hormone to help tablets orally at bedtime for date of 10/25/16.  Stration Record (MAR) dated tifies R57 receiving scheduled r.  tration Record (TAR) dated a not identify sleep monitoring int.  7, at 8:14 a.m. with registered d he was unaware of any courring for R57.	21535	DEFICIENCY)			
	nursing (DON) stat	7, at 8:26 a.m. with director of ed sleep assessments occur sion, quarterly and as needed.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00916	B. WING		02/0	1/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MAPLE	MANOR NURSING AN	ID REHAB. LLC	I STREET N TER, MN 55	ORTHWEST 901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
21535	Interview on 1/31/1 Data Set (MDS)-A at the sleep assessment stated sleep assess TAR for the nurses MDS-A coordinator sleep assessment of the sleep as	7, at 9:44 a.m. with Minimum a coordinator stated nurses do ents. MDS-A coordinator sments should be set up in the to know when to complete. Everified R57 did not have a completed.  7, at 10:25 a.m. with DON expect any resident on a sleep assessment stated a sleep study should reto R57 starting a sleeping R57 did not have a sleep eted.  ASSESSMENT AND FIC MOOD S TO DETERMINE IF T IS AFFECTIVE:  Ician orders included: start inbalta (antidepressant) 60 mg included and pressive date 7/17/15, Melatonin sleep aide) 5 mg at bedtime not sleeping at night.  Indiministration Record for the attified R22 was receiving the attonin as ordered.  In plan included the following: tidepressant medication we disorder. Interventions: report adverse side effects,	21535				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00916	B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	II) REHAR I I C:	H STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	antidepressant user Pharmacist/medicarecommendation arecommendation arecommendation arecommendation arecommendation are socialized condupersonality disorded depressive disorded name to female personality depressive disorded name to female personality being monitored: vocares, yelling out, it sleepiness at night Offer food/fluids/toi quiet area. Staff will provibegin. Staff will provibegin. Staff will provibegin. Staff will try re-approach if behaviors endication melatonin. Interver adverse side effect doctor order. Gradin pharmacist/doctor/recommendation are computer were the were charted on evidence of cares, screaming of cares, screaming of home. Review of the time of interview the time of interview of the time of th	e. Gradual dose reduction per al doctor or nurse practitioner is able and if applicable. I doctor or nurse practitioner is able and if applicable. I doctor or nurse practitioner is able and if applicable. I doct disorder, explosive in anxiety disorder and in a times calls out spouse ers thinking they are his wife. I when they do not answer, in they are his wife. I do not answer in they are his wife. I do not	21535			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	1/2017
	PROVIDER OR SUPPLIER	D REHABLIC 1875 19T	DRESS, CITY, S H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	abusive behavior, grabbing, kicking, h spitting, pushing, re movement, repeats behavior, sexually i yelling, screaming.  On 2/1/17, at 3:01 p (DON) stated sleep completed upon ad needed. The DON had not been comp confirmed R22's caresident specific sy  The facility policy P 8/1/15, indicated Pr must be conducted behaviors/symptom and recommendation behaviors. 2. The nust reflect the spethe residents responsiterventions to ma After implementation behavior/symptom will be monitored at LACK OF COMPRI ASSESSMENT:  R102's admission radmitted on 1/9/17 amputation.  R102 had an order melatonin Tablet 3 current physician's for the PRN melato	biting, frequent crying, itting, pinching, scratching, piection of care, repeats verbalization, threatening nappropriate, wandering, o.m., the director of nursing assessments were to be mission, quarterly and as confirmed a sleep assessment leted for R22. The DON re plan lacked to identify mptoms of depression.  Sychotropic Medications dated ocedure: 1. An assessment to identify specific is, potential causative factors ons for managing identified nedical record documentation ecific behaviors/symptoms and nse to non-pharmacological nage behaviors/symptoms. 8. on of psychotropic medication and medication side effects and documented.	21535			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	1/2017
	PROVIDER OR SUPPLIER	D REHABILIC 1875 19TH		STATE, ZIP CODE  ORTHWEST  901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	1/23/17 according the administration reconstruction	o the medication rd.  ord lacked a comprehensive and analysis of sleep and continue the use of PRN  on 1/31/17, at 11:28 a.m.  N)-B stated we have a sleep sessment that was completed d there should be a hard copy rerified there was not a sleep 2's medical record. RN-B when a sleep assessment as leep log put out for a sleep log put out for a smplete.  on 1/31/17, at 1:56 p.m. the DON) stated she expected a to be completed when a leed with a medication for sleep to start a new medication for ated a sleep assessment was	21535			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY LETED
		00916	B. WING		02/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
MAPLE I	MANOR NURSING AN	ID REHAB. LLC	STREET N ER, MN 559	ORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ige 41	21535			
	The Director of Nur psychoactive medic to meet the require regulations.	THOD OF CORRECTION: rsing could review the use of cations with the licensed staff ments of the state and federal R CORRECTION: Twenty One				
21565	MN Rule 4658.132 Medications Self Ad	5 Subp. 4 Administration of dmin	21565			3/9/17
	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.					
	by: Based on observat review, the facility f assessment of self had been complete	ent is not met as evidenced ion, interview and document ailed to ensure a safety administration of medication of for 1 of 2 residents (R22) to self-administer a nebulizer		Corrected		
	Finding include:					
	sitting in his wheeld in place, with media	on 1/31/17, at 7:06 a.m., to be chair and had a nebulizer mask cation being administered via ine. No staff were present in in view of R22.				
	walked down the ha	a.m., registered nurse (RN)-B allway and into R22's room. 22 had been assessed for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	01/2017
	PROVIDER OR SUPPLIER	ID REHABILIC 1875 19TH	DRESS, CITY, S I STREET NO FER, MN 559	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21565	self-administration of RN-B stated we have alone with the nebut on him.  R22's current physical order dated 4/13/15 solution 0.5-2.5 mg inhale one unit four self-administer nebut dispense medication. However, R22's recindicating if R22 was nebulizer medication. On 2/1/17, at 3:01 pstated we just did a assessment for R22 R22 to self-administration stated the assessment for R25 R22 to self-administration stated the assessment form D stated the assessment form D provided.  The facility policy M dated revision 11/1/center's policy to hoself-administer medication. Proceed a self-administer medication of the self-administer medication of the self-administer medication.	of the nebulizer medication, we an order, we can leave R22 dizer on as long as we check cian orders, identified and 5, for DuoNeb (bronchodilator) (milligrams)/3 ml (milliliters) times a day. May treatments, nurse will an and apply mask.  Ford lacked an assessment as able to self-administer the en safely.  D.m., the director of nursing self-administration 2, we obtained the order for other the nebulizer last week.  R22 electronic record and s no assessment for for the nebulizer. The DON tent might have been done on a see the medication DON at this time, none was dedication Self-Administration (16, indicated Policy: It is the onor resident requests to dications if determined to be a redure: 1. The licensed nurse ent who has expressed a hister selected medications,	21565			
	center's policy to he self-administer med safe practice. Proceed evaluates the residence to self-administer	onor resident requests to dications if determined to be a edure: 1. The licensed nurse ent who has expressed a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00916	B. WING		02/0	1/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		-
MAPLE	MANOR NURSING AN	ID REHAR LLC	H STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 43	21565			
	The director of nurs current for SAM, ar trained. Residents assessed, and a sy could be devised. medication pass tir the quality committ	THOD OF CORRECTION: sing could ensure policies are not licensed staff have been who wish to SAM could be estem for indicating this to staff Audits could be conducted at nes, and the results brought to see for review.  R CORRECTION: Fourteen				
21665	MN Rule 4658.140	0 Physical Environment	21665			3/13/17
	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.					
	by: Based on observat review the facility fa control practices we cleaning/sanitizing glucometer for 1 of east wing who had the glucometer.  Findings include:  On 1/30/17, at 11:0 nurse (LPN)-B was blood sugar. LPN-E glucometer used we residents on the east	ent is not met as evidenced ion, interview and document ailed to ensure proper infection ere implemented when a multi-resident use 3 residents (R102) on the blood sugars checked utilizing 1 a.m., licensed practical observed to check R102's 3 stated at the time the as a glucometer used for all st wing. LPN-B after checking had removed gloves and		-All residents have personal glucor -All residents have potential to be a if glucometer equipment is not ster appropriately -All Licensed staff has been educa 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 mon QAPI -Corrective action completed by 3/1	affected rilized ted on eation	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	01/2017
	PROVIDER OR SUPPLIER	D REHABILIC 1875 19TH	DRESS, CITY, S I STREET NO IER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	carried the glucometer wanitizer. LPN-B rei hand and cleansed with a alcohol pad a her left hand and w LPN-B when querie for cleaning the gluto check on that. Leshould be used to clet the glucometer a LPN-B stated I used works. LPN-B verifiprior to the glucometer at LPN-B stated I used works. LPN-B verifiprior to the glucometer and to clean and sa tissue and head to clean and sa tissue and head to clean exposed so thoroughly and remany other body fluid wipe to disinfect the disinfect the disinfect the disinfecting procedus olvents to clean the meter cleaning and the disinfecting wipe Micro-Kill Plus by Mon 1/30/17, at 3:51 (DON) stated when glucometer was clean the glucometer. The	eter out to the medication cart.  yes and cleansed the outside  yith a tissue and hand moved the glove on her right the outside of the glucometer and then removed the glove on ashed hands. At the time ashed hands. At the time ashed hands and the facility policy was cometer, stated I would have PN-B stated a bleach wipe clean the glucometer and then air dry for three minutes. In alcohol pad, either one and sanitizer and an alcohol anitize the glucometer.  Inufactured by UltraTRAK manual provided by the facility, he meter between each affection. How to clean and the meter must be cleaned tion. Use one disinfecting wipe aurfaces of the meter ove any visible dirt, blood, or I with the wipe. Use a second the meter by following the aure below. Do not use organic the meter. We recommend for disinfection you should use the eltowelette from below:	21665			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00916	B. WING	<del></del>	02/0	1/2017
	PROVIDER OR SUPPLIER	D REHABILIC 1875 19TH		STATE, ZIP CODE  ORTHWEST  901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	cleaned/sanitized a have been cleansed. The facility policy C glucometer dated 8 Perform hand hygicall external surfaces sides, using the ble prepared EPA germ solution to penetrat ports of the meter. Wet for one minute additional minute be resident. 5. If blood meter, the procedur second time. 6. Discontainers. & Remhygiene.  SUGGESTED MET kitchen manager ar could in-service die housekeeping/main keep the kitchen in clean. Also to frequented	nd the glucometer should d with a super Sani-cloth wipe.  leaning and Disinfection of a /1/15, indicated Procedure: 2. The and apply gloves. 3. Wipe is, including top, bottom and ach solution or commercially vicidal wipe; avoid allowing the e the test strip and/or key 4. Ensure the meter remains an allow to air dry for an efore using on the next is visibly present on the re should be repeated a card soiled items in approved ove gloves and perform hand the the test of the test and maintenance manager.	21665			
21805		.651 Subd. 5 Patients & ac.Bill of Rights	21805			3/13/17
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE :	
		00916	B. WING		02/01/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	ID REHAB. LLC	H STREET N TER, MN 559	ORTHWEST		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21805	O5 Continued From page 46		21805			
21805	This MN Requirem by: Based on observat review, the facility f manner to promote (R52) observed to which was visible to In addition, the faci toileting for 1 of 2 rourinary incontinence.  Findings include: R52's quarterly Min 10/21/16 indicated catheter, long and and moderately improved in bed and the cath was in view from the On 1/31/2017, at 10 (NA)-A stated R52 the side of the bed R52 was in bed. No catheter bag was voor 1/31/2017, 1:56 (DON) stated the fabags and my expect The DON stated cavisible, as this is a The Catheter Care 1/31/17, included sand adequate hygical states.	ent is not met as evidenced ion, interview and document ailed to provide care in a dignity for 1 of 1 resident have uncovered catheter bag, o other residents and families. lity failed to ensure dignity for esidents (R4) reviewed for e.  simum Data Set (MDS) dated R52 had an indwelling Foley short-term memory problems baired decision-making skills  on 1/31/17 at 10:28 a.m. to be eter bag was not covered and the hallway.  0:38 a.m. nursing assistant did not have a bag attached to to place the catheter in when A-A verified the uncovered isible from the door.  5 p.m. the director of nursing acility had covers for catheter catation is they are covered. In the term of the ter	21805	-R52 received catheter bag coveri 1/31/17 -All residents with catheters were within facility on 1/31/17 and found catheter covers -All residents who have catheters potential to be affected if catheter are left uncovered -All staff has been educated on disservices residents deserve -A VA report was filed and an invewas conducted on R4 behalf. Resconcluded no harm done to reside staff education appropriateAll resident have the ability to be if they are not treated with dignity -All staff has been educated on disservices residents deserve -1-2x/week audits for 1 month to be completed to ensure appropriate coverings and verbal/nonverbal communication are in place that p and maintain dignity for residents -DON/designee is responsible -Audit results will be reviewed mor QAPI -Corrective action completed by 3/2	checked I to have have have bags gnified stigation ults ent and affected gnified be catheter romote	
	comfort, function, a	eatheter in order to maintain and prevent infection and other atheters bag and tubing				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	01/2017
	PROVIDER OR SUPPLIER	D REHABLIC 1875 19T	DRESS, CITY, SH STREET NOTER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	should be secured drag on the floor to Catheter bag should holder/bag to protect ENSURE DIGNITY R4's current electro had actual/potential related to urgency a assist of one to man check and change and check and change and the urinal up to you usually go in you usually go in you. So you can just change you. R4 stated "yep!" R4 stated "yep!" R4 stated "yep!" R4 stated then I will chan on 1/30/17, at 10:5 be checked and cheevery two hours. R4 does not tell when I so we just check ar R4 did not use the attime he told me he on 1/30/17, at 2:40 stated the nursing atthe urinal to R4 whe urinal.	and not allowed to touch or prevent contamination. 4. d be kept in a protective of dignity of the resident.  FOR TOILETING: Inic care plan indicated R4 of or alteration in elimination and incontinence. Required nage incontinent briefs and as need.  on 1/30/17, at 10:21 a.m., NA)-F asked R4 if he would have and R4 replied "yeah." bed, R4 stated he had to pee, my penis. NA-F stated to R4 our brief and then I will change at pee in your brief and I will ted is that what I do? NA-F atted ok NA-F directed R4 to go ge you.  7 a.m., NA-F stated R4 was to anged. I usually check his brief at is usually not continent and the has to go to the bathroom, and change him. NA-F stated urinal and that was the first				
	appropriately. If a re	spect staff to offer toileting esident asks to use the urinal, e request should be				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY LETED
7.1.12 . 27.1.1	o. oo2011011		A. BUILDING:			
		00916	B. WING		02/0	1/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE N	MANOR NURSING AN	II) REHAR I I C	H STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	age 48	21805			
	accommodated and do so.	d it was not acceptable to not				
	knew when he had "yeah." When quer he wanted to use the the urinal to him to good, but what to yand was not the las queried if he would	s p.m., R4 when queried if he to go to the bathroom, stated ied how it made him feel when he urinal and staff did not give use, R4 stated, "Well not ou do, Was not the first time at time, inexperienced." When like to use the toilet, R4 less embarrassed if I could go				
	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.					
	The director of nurs develop policies an residents are treate nursing or designed staff members on t nursing or designed	THOD OF CORRECTION: sing (DON) or designee could ad procedures to ensure ed with dignity. The director of e could educate all appropriate he processes. The director of e could develop monitoring ongoing compliance				
	TIME PERIOD FOI (21) Days.	R CORRECTION: Twenty-one				
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			3/9/17
	Subd. 10. Particip notification of family	pation in planning treatment; y members.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	D REHAB. LLC	STREET N TER, MN 559	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21830	(a) Residents shalin the planning of the includes the opport alternatives with incopportunity to requested care conferences, a family member or oboth. In the event the present, a family member or conferences.  (b) If a resident with unconscious or concommunicate, the feefforts as required either a family mem writing by the reside an emergency that admitted to the facifamily member to pelanning, unless that to believe the reside directive to the consequence included in notifying a family member included in notifying a family member to pelanning, the facility efforts, consistent we practice, to determine executed an advance esident's health care this paragraph, "reactive to the possible of the consequence of	ge 49  Il have the right to participate peir health care. This right unity to discuss treatment and dividual caregivers, the gest and participate in formal and the right to include a ther chosen representative or that the resident cannot be gember or other representative dent may be included in such who enters a facility is natose or is unable to acility shall make reasonable under paragraph (c) to notify other or a person designated in the resident has been lity. The facility shall allow the articipate in treatment the facility knows or has reason ent has an effective advance trary or knows the resident has that they do not want a family in treatment planning. After ember but prior to allowing a articipate in treatment or must make reasonable with reasonable medical ne if the resident has ce directive relative to the re decisions. For purposes of asonable efforts" include: the personal effects of the ession of the facility; my emergency contact or tacted under this section	21830			

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:  (X3) DATE COM			SURVEY LETED
		00916	B. WING		02/0	1/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MAPLE	MANOR NURSING AN	ID REHAB. LLC		ORTHWEST		
ROCHES			TER, MN 559	901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21830	Continued From page 50		21830			
21830	whether the resider directive and wheth physician to whom care; and  (4) inquiring of the resident normally gwhether the resider directive. If a facility designated emergenember to participal accordance with the liable to resident for the notification of the mergency contact family member was patient's privacy rigus (c) In making reasonable facility shall attembers or a designated member or a designated the medical reconstruction of the facility shall attembers or a designation of the facility shall attembers or a designation of the facility shall attembers or a designation, the facility and the medical reconstruction of the facility and the facility has been member or designated emergency that the residentifying and notification designated emergency or lethat assists a facility subdivision is not liad amages on the great and the medical reconstruction.	ant has executed an advance are the resident has a the resident normally goes for the physician to whom the oes for care, if known, at has executed an advance y notifies a family member or ency contact or allows a family ate in treatment planning in a paragraph, the facility is not a damages on the grounds that the family member or or the participation of the simproper or violated the	21830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00916	B. WING		02/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	MANOR NURSING AN	D REHAR LLC:	I STREET N TER, MN 55	ORTHWEST 901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21830		family member was improper	21830			
	by: Based on interview facility failed to ensi reviewed for choice	and document review, the ure 1 of 3 residents (R74) s received baths according to r bathing frequency.		Corrected		
	R74 was interviewer resident indicated spast two months. Rescheduled to have I switched her time to receiving the aftern maybe the morning R74 stated when he good she had aske provided a bed bath times she had been she was ready for a yet, she needed to breathing under connever come back. I situation is pissing the received excuse she received Review of the current Set (MDS) dated 10 interview for mental out of 15 (meaning displayed no behave	d on 1/29/17, at 2:46 p.m., the he had not had a bath for the 74 stated she used to be baths in the afternoon, but of the mornings as she was not oon baths and she thought is would work better for staff. For breathing had not been very differ a bed bath and was not neither. R74 stated a couple in asked around 6:15 a.m. if it bath and she told them not take her medicine and get her introl first, but then stated they R74 stated, "My bathing me off, I do not see any a bed bath. R74 stated the dis they are so short staffed."  Int quarterly Minimum Data 0/13/16, indicated R74's brief I status BIMS score was 15 cognition is intact) and ioral concerns.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/0	1/2017
	PROVIDER OR SUPPLIER	D REHABILIC 1875 19TI		STATE, ZIP CODE  ORTHWEST  901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21830	identified the resider related to COPD ar Interventions; requibathing, on Sunday Review of the week from 11/12/16 to 1/2 receive a bath durin  During an interview nursing assistant (Non the evening bath changed to a day bher cares. NA-B stawhen a resident has sheet and in the coresident refused as next shift to try to cobath. NA-B stated seresidents refused bit stated she asked rewould like a bath duresident refused all the nurse know. NA challenging to get bit staffing and staff care supposed refused to shower staff are supposed refused bathing. No are times when we showers when there hallways.	ent as having self -care deficited history of lower back pain. red assist of one staff with and Thursdays at 2:00 p.m.  All bathing sheets reviewed 29/17, indicated R74 did not ang the time period reviewed.  Ton 1/31/2017, at 8:33 a.m.  All B stated R74 used to be an ath. NA-B stated R74 directed ated staff are to document ath. NA-B stated if a shower, staff should tell the complete the bath or offer a bed staff needed to document if athing in point of care. NA-B esidents three times, if they uring her shift and stated, if the three times she needed to let athing completed because of				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00916	B. WING		02/0	1/2017	
	NAME OF PROVIDER OR SUPPLIER  MAPLE MANOR NURSING AND REHAB, LLC  1875 19TH STREET NORTHWEST ROCHESTER, MN 55901						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21830	any concerns related stated she not award services.  During an interview SS-A stated per the R74 has not received months. SS-A state R74 refused bathing 11/27/16, and 11/17 supposed to be offer Thursdays at 2:00 pusupposed to docum were provided and buring an interview stated she spoke we R74 had not had a stated the nursing a not offering R74 be be care planed for sher scheduled bath Sunday and if R74 a bed bath.  A policy regarding be was provided.  SUGGESTED MET The administrator con the need for self-	ge 53  )-A stated she was unaware of ed to bathing for R74. SS-A re R74 was refused bathing  on 01/30/17, at 2:56 p.m. documentation on bathing ed a bath in the last two d there was documentation g on 1/29/17, 1/26/16, 1/5/17, 1/26/16, SS-A stated R74 was ered bathing on Sundays and o.m. SS-A stated staff were nent when bathing services if residents refused bathing.  on 1/31/17, at 7:02 a.m. SS-A exith a couple aides and stated bath for two months. SS-A existants she spoke to were d baths. SS-A stated it would staff to offer a regular bath on days on Thursday and refused, staff were to offer her exithing was requested, none  CHOD OF CORRECTION: ould in-service all employees of choice in residents choices.  R CORRECTION: Twenty-one	21830				
21855	MN St. Statute 144. Residents of HC Fa	.651 Subd. 15 Patients & ac.Bill of Rights	21855			3/13/17	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		00916	B. WING		02/0	1/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
MAPLE	MAPLE MANOR NURSING AND REHAB, LLC  1875 19TH STREET NORTHWEST ROCHESTER, MN 55901						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21855	Subd. 15. Treatm residents shall have and privacy as it rel personal care progressions. Treatm confidential and shaprivacy shall be residential and shaprivacy shall be residential and other a except as needed frassistance.  This MN Requirements:  This MN Requirements:  Based on observation review, the facility for (R106) reviewed was toileting.  Findings include:  R106's current elect R106 was a fall risk transfers for toileting.  On 1/30/17, at 10:2 (NA)-F was observed bathroom. NA-F op with the bathroom of stand, pulled down product and assisted NA-F closed the baseated on the toilet the toilet. When R1 using the toilet, NA-and assisted R106 buttocks area and a incontinent product down while being set.	nent privacy. Patients and the right to respectfulness ates to their medical and ram. Case discussion, nation, and treatment are all be conducted discreetly. Spected during toileting, activities of personal hygiene, or patient or resident safety or ent is not met as evidenced on, interview and document ailed to ensure 1 of 2 residents as provided privacy during	21855	-All room dividing curtains have be checked for successful operation -All residents have ability to affect cares are completed without privatoffered -All staff educated on resident right privacy during cares -All staff has been educated on appropriate maintenance notificati protocol if noticed privacy equipmed operational need of maintenance1-2x/week audits for 1 month to be completed to monitor privacy practice of the completed to reside during caresDON/designee is responsible -Audit results to be reviewed monity QAPI -Corrective action completed by 3.	ed if cy being nt to ion ent is in be stices are nts		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	D REHABLIC 1875 19TI	DRESS, CITY, S H STREET NO TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21855	over to his side of the R106 to stand and R106's roommate F wheelchair directly of R106 being assis privacy curtain was knot and hung direct On 1/30/17, at 10:5 R106's roommate F being toileted when and when NA-F wa pants. NA-F confirm tide into a big knot a head of bed. NA-F a knot because whe curtain becomes care confirmed privacy of privacy had not because where curtain becomes care confirmed privacy of privacy had not because where curtain becomes care confirmed privacy of privacy had not because where curtain becomes care confirmed privacy had not because where curtain becomes care confirmed privacy had not because where curtain becomes care confirmed privacy had not because the pulling up R106's proposed to provide privacy during privacy curtain).  SUGGESTED MET The Director of Nurcould develop, review procedures to ensuraintained. The Director of The Director of Nurcould develop, review procedures to ensuraintained. The Director of The Director of Nurcould develop, review procedures to ensuraintained. The Director of Nurcould Director Director of Nurcould D	the room. NA-F then assisted pulled up R106's pants. R4, was seated in his across from R106, in full view sted to pull up his pants. R4's noted to be tide into a big ctly above R4's head of bed.  7 a.m., NA-F confirmed R4 was able to view R106 getting on and off the toilet, as assisting to pull up R106's ned R4's privacy curtain was and hung directly above R4's stated the curtain was tied into the root open the door the aught in the door. NA-F curtains were not used and an provided for R106 when and off the toilet, and when ants.  p.m., the director of nursing roviding privacy during toileting. The DON stated it would be for both residents. The DON spect the privacy curtains to be				

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
		00916	B. WING		02/	01/2017		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MAPLE	MANOR NURSING AN	ID REHAR LLC	H STREET N TER, MN 55	ORTHWEST 901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE		
21855	Continued From pa	ige 56	21855					
	the policies and pro Nursing Services o monitoring systems compliance.	ocedures. The Director of r designee could develop s to ensure ongoing						
	TIME PERIOD FOI Twenty-One (21) da							

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