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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MLV4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00226

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245462**

2. STATE VENDOR OR MEDICAID NO. (L2) **731342000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MARANATHA CARE CENTER**
(L4) **5409 69TH AVENUE NORTH**
(L5) **BROOKLYN CENTER, MN** (L6) **55429**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/10/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **97** (L18)

13.Total Certified Beds **97** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	97			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date : Amy Charais, HFE NE II 04/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 05/06/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

24-5462

At the time of the standard survey completed March 10, 2016 the facility was found not to be in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), whereby corrections are required.

On March 24, 2016, a Minimum Data Set (MDS) 3.0/Staffing Focused Survey was completed to verify compliance with Federal certification regulations. This survey found most serious to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

As a result of finding that the facility continues to not be in substantial compliance, we have recommended to the CMS Region V Office that the following enforcement remedy be imposed:

-Mandatory Denial of Payment for new admissions effective June 10, 2016

If the DPNA goes into effect the facility would be subject to a two year loss of NATCEP beginning June 10, 2016.

Post Certification Revisit (PCR) to follow. Please refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction.

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
March 25, 2016

Ms. Anne O'Connor, Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

RE: Project Number S5462029 and H5462059

Dear Ms. O'Connor:

On March 10, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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 March 10, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5462059 that was 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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

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 April 19, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 19, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 June 10, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint, H5462059 was completed. The complaint was not substantiated.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		4/3/16

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

Electronically Signed | 04/03/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan to include interventions for pain management for 1 of 1 resident (R39) assessed to have pain with activities of daily living and range of motion. Findings include: R39's admission Minimum Data Set (MDS) dated 1/11/16, indicated R39 was severely cognitively impaired, required extensive assistance with all activities of daily living, and had limited mobility in all extremities. An admission Pain Evaluation dated 1/5/16, indicated R39 had a history of pain and diagnosis which indicate a potential for discomfort or risk for pain. Behavioral indicators of pain included aggressive behaviors, striking out and protecting area. The Pain summary indicated "Resident is on scheduled oxycodone [narcotic]." "Noted striking, protecting areas and aggressive at time [of] care." A subsequent pain assessment dated 1/16/16, also indicated R39 was noted to strike, protect areas and display aggression at time of care. The assessment identified these behaviors as non-verbal indicators of pain. R39's care plan dated 1/22/16, identified risk for pain related to contractures and neuralgia, but did not address interventions to decrease pain with activities of daily living, even though R39 had	F 279	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency. Resident (R39)'s care plan for pain was reviewed and updated to include additional interventions for pain management. All resident care plans related to pain will be reviewed to ensure appropriate interventions from the pain assessment are included in their care plan. All residents will continue to be assessed per the RAI schedule and with any new onset of pain or change of condition. Education regarding the care planning process was started on 3/31/16 and is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 been assessed to have pain with cares on two separate assessments. A review of the March 2016 Medication Administration Record indicated R39 received scheduled pain medication at 9:00 a.m., 2:00 p.m., and 8:00 p.m., but no medication was administered prior to morning cares even though he was assessed to have pain with cares. During an observation on 3/10/16, at 8:19 a.m., nursing assistant (NA)-B and NA-C were observed performing morning cares for R39. The NAs provided R39 a pillow to hold during cares. When staff lifted R39's left arm to wash underneath, R39 yelled out loudly "OW" and pulled away from the NAs as they provided upper extremity cares. The resident displayed facial grimacing as he yelled. The resident again yelled out "Ow, Ow, Ow!" while NA-B and NA-C applied compression hose to his lower extremities. The licensed practical (LPN)-A was in the room at the time of the observation and did not indicate to the NAs to stop cares so pain relief could be provided. Nor did the NAs indicate to the nurse that R39 needed pain relief. R39 appeared comfortable throughout the remainder of his morning cares. LPN-A left the room before the resident was transferred in the wheelchair. Cares were observed up to the point of transferring R39 in the wheelchair. The NAs indicated they were going to transfer him in the wheelchair. Although the NAs provided R39 with a pillow to hold to prevent striking out, all three facility staff had two opportunities to provide R39 comfort from the pain, however, neither the nurse nor the NAs interrupted the upper care and the donning of the hose to provide R39 with pain relief.	F 279	ongoing. The policy and procedure regarding care planning was reviewed and is current. Staff were instructed on the importance of monitoring for signs and symptoms of pain and documenting in the care plan. Random audits on 10% of resident will be completed weekly for one month and monthly thereafter by the Clinical Coordinators or designee to ensure compliance. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as needed. The Clinical Administrator will be responsible for ongoing compliance. The completion date for certification purposes will be 4/19/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3	F 279		

During an observation on 3/10/16, at 2:46 p.m., R39 was observed during a transfer and displayed no signs of pain or discomfort.

During an interview on 3/10/16, at 11:53 a.m. NA-C stated it was normal for R39 to yell out during care, especially in the morning." He stated in the evening, "not as much." He stated it happens at least a couple of times a week.

During an interview on 3/10/16, at 11:53 a.m., licensed practical nurse (LPN)-A stated NA's have not reported pain during transfers but stated, "screaming out during transfer is typical" for R39. LPN-A stated R39 had pain with transfer when he was admitted but he was "not sure" if he had since then. LPN-A further stated R39 had scheduled pain medication, but did not receive the medication prior to morning cares.

During an interview on 3/10/16, at 12:00 p.m., registered nurse (RN)-D stated she had not observed R39 having any pain but stated he does have behaviors with cares. She stated she was aware he was resistive with care but was not aware if they were related to pain.

During an interview on 3/10/16, at 12:44 p.m. occupational therapist (OT)-E stated a range of motion program was trialed for R39 but was not initiated due to not tolerating. OT-E stated R39 was "combative" and would "grimace" during range of motion.

During an interview on 3/10/16, at 3:14 p.m., NA-D stated R39 displays behaviors. She stated, "He fights in the evening at bedtime." She stated R39 called out "ouch, ouch." She stated she was unsure if R39 was having pain but stated, "All the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4 time he makes the noise." During a subsequent interview on 3/10/16, at 2:36 p.m., RN-D stated, "we got orders for pain medication prior to morning cares now that you brought it to our attention." New orders for pain management include: scheduled pain medication prior to morning cares and pain monitoring five times daily. A facility policy titled Care Plan Policy and Procedure, dated August 2014, directed staff to gather information to provide data for the resident care plan specific to the resident's needs. "The care plan will ensure the resident has the appropriate care required to maintain or attain the resident's highest level of practicable function possible."	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to develop an admission plan of care for 1 of 3 residents (R234) who had been admitted to the facility recently and was identified at risk for falls. Findings include: On 3/8/16, at 3:24 p.m. R234 was observed lying in bed on top of the covers with the lights off and the television on. R234's call light was within	F 281	Resident (R234) was discharged at the time of notification so care plan was unable to be updated. Education to Clinical Coordinators, who are responsible for updating the fall interventions on resident care plans, was completed immediately and will be ongoing. All residents residing on the TCU were reviewed for current care plans. All residents admitted to the care center have a temporary care plan initiated as part of	4/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 reach. A white dressing observed on R234's right knee. R234's wheel chair was across from the bed. R234 stated she did not really fall on 3/5/16. R234 stated was transferring from bed to wheelchair and had forgotten to lock the brakes, so the wheelchair started to roll away and she went down on her right knee. The Fall Risk Data Collection dated 2/24/16, indicated, "Pt [patient] is AOx3 [alert and oriented times three] and able to make needs known. Pt transferred to the TCU [transitional care unit] following hospitalization at ABNW [Abbott North Western] for a R [right] TKA [total knee arthroplasty] (replacement). Pt transferred to the TCU via Medivan at 1730 [5:30 p.m.]. Pt is at risk for falls r/t [related/to] assistance needed with transferring and ADLs [activities of daily living] due to R TKA and pain. Pt also has a hemovac [drain for blood] in place and needs assistance with managing the tubing connected." The Individual Resident Care Plan dated 2/24/16, did not identify fall risk as a problem for R234. R234's admission Minimum Data Set (MDS) dated 3/1/16, indicated R234 was moderately cognitively impaired and required extensive assistance with transfers. The Progress Note dated 3/7/16, indicated R234 fell on 3/5/16, while transferring from bed to wheelchair and bleeding observed at incision site. The Fall Care Area Assessment dated 3/8/16, indicated R234 was at risk for falls. R234 was working with therapy with goal of improvement. The Admission Record dated 3/10/16, noted	F 281	the admission process. The care plan for each resident is developed and updated as part of the RAI process initially, quarterly and with a significant change of condition or resident preference and/or with the initiation of a new or changed intervention. Education to nursing staff was conducted regarding the development of a care plan that includes a resident's fall risk and current fall interventions. Education regarding the importance of completing and updating a temporary care plan with new or changing interventions was conducted and is ongoing. Random audits on 10% of residents will be completed weekly for one month and monthly thereafter by the Clinical Coordinators or designee to ensure compliance. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as needed. The Clinical Administrator is responsible for ongoing compliance. The completion date for certification purposes will be 4/19/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 6	F 281		

R234 was admitted to the facility on 2/24/16. R234's diagnoses were listed as right artificial knee joint following replacement surgery, osteoarthritis of both knees, with knee contractures and difficulty walking. The care plan did not indicate R234 had fallen on 3/5/16, or what interventions had been put in place.

During interview on 3/9/16, at 2:26 p.m. registered nurse (RN)-A nurse manager stated, "Her fall risk and her fall are not on her care plan because I did not put it there. I should have done it."

During interview on 3/10/16, at 9:38 a.m. director of nursing (DON) stated, "The temporary care plans are to be kept up to date. Yes, if a resident is identified as at risk for falls it should be care planned. If a resident falls that should be added to the care plan and what the intervention is."

On 3/10/16, at 10:56 a.m. DON verified the fall risk and fall were not care planned for R234.

The Care Plan Policy and Procedure modified August 2014 instructed staff, "It is the policy of Presbyterian Homes to initiate a temporary care plan within 24 hours of admission and complete and [sic] comprehensive care plan prior to the initial care conference. The care plan will ensure the resident has the appropriate care required to maintain or attain the resident's highest level of practicable function possible." 10. "The care plan is to be changed and updated as the care changes for the resident and as the resident changes occur it will be written on the paper care plan in the resident's medical record. It is to be current at all times. It is recommended that the care plan is printed annually."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately assess to identify and implement appropriate interventions for pain for 1 of 3 resident (R39) reviewed for pain. This caused actual harm for R39 who experienced pain during care. Findings include: R39 was observed on 3/9/16, at 8:17 a.m. sitting in a reclining wheel chair. His left leg was extended out with the foot slightly inverted. A pillow was in place under his knees and calves. During an observation on 3/10/16, at 8:19 a.m., nursing assistant (NA)-B and NA-C were observed performing morning cares for R39. The NAs provided R39 a pillow to hold during cares. When staff lifted R39's left arm to wash underneath, R39 yelled out loudly "OW" and pulled away from the NAs as they provided upper extremity cares. The resident displayed facial grimacing as he yelled. The resident again yelled out "Ow, Ow, Ow!" while NA-B and NA-C applied compression hose to his lower extremities. The licensed practical (LPN)-A was in the room at the	F 309	Resident (R39) was comprehensively assessed for pain and the NP/physician was updated. New orders were received for change in pain management schedule and additional non- pharmacological interventions were put in place. All residents are assessed for pain upon admission, quarterly and or with significant change of condition or new onset of pain in conjunction with RAI process. Any new onset of pain is reviewed at daily interdisciplinary meetings. Nursing staff were re-educated on pain management including non-verbal symptoms of pain, communicating and assessing for pain and the use of non-pharmacological interventions for pain on 2/24/16, 3/10/16 and ongoing. The policy of assessment and treatment for pain was reviewed and is current. All medication administration records (E-MAR) are reviewed weekly by the Clinical Coordinators for changes in PRN usage of pain medications effectiveness. Random audits of 10% of residents will be	4/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 time of the observation and did not intervene or ask the NAs to stop cares so pain relief could be provided. The NAs did not suggest to the nurse that R39 needed pain relief. LPN-A left the room before the resident was transferred into the wheelchair. When the NAs initiated transferring R39 to the wheelchair, they had R39 hold a pillow to prevent the resident from striking out during the care. The surveyor stepped out of the room during the transfer at 8:37 a.m. R39 could be heard screaming out loudly across the hall and through two closed doors during the transfer to the wheelchair. Another surveyor who was in the dining room when R39 screamed out. That surveyor said R39's screaming was heard all the way to the dining room. R39's room was approximately the third room from the dining room. An admission Pain Evaluation dated 1/5/16, indicated R39 had a history of pain, and potential for discomfort or risk for pain. Behavioral indicators of pain included aggressive behaviors, striking out and protecting area. The summary on the Pain Evaluation indicated "Resident is on scheduled oxycodone [narcotic]." "Noted striking, protecting areas and aggressive at time [of] care." R39's admission Minimum Data Set (MDS) dated 1/11/16, indicated he was severely cognitively impaired, required extensive assistance with all ADLs, and had limited mobility in all extremities. In addition, the MDS did denote R39 had behaviors of hitting and kicking out during cares one to three times a week, but no refusals of care were noted. Another pain assessment dated 1/16/16, indicated R39 was noted to strike, protect areas	F 309	completed weekly for two months and monthly thereafter by the Clinical Coordinators or designee to ensure compliance. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as needed. The Clinical Administrator is responsible for ongoing compliance. The completion date for certification purposes will be is 4/19/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9	F 309		

and display aggression at time of care. The assessment identified these behaviors as non-verbal indicators of pain.

R39's care plan dated 1/22/16, identified a potential for pain related to decreased mobility, contractures, and neuralgia.

A review of the March 2016 Medication Administration Record indicated R39 received scheduled pain medication at 9:00 a.m., 2:00 p.m., and 8:00 p.m.. There was no evidence medications were administered prior to morning cares, even though R39 had been assessed to have pain with cares.

An undated and untitled Nursing Assistant Assignment sheet, indicated R39 experienced behaviors of striking out, but did not indicate R39 had indicators of pain. The Assignment sheet identified direction to provide R39 with a pillow to hold to prevent hitting and striking out at staff during cares.

During an interview on 3/10/16, at 11:53 a.m. NA-C stated it was normal for R39 to yell out during care, especially in the morning." He stated in the evening, "not as much." He stated it happens at least a couple of times a week.

During an interview on 3/10/16, at 11:53 a.m., licensed practical nurse (LPN)-A stated the NA's had not reported pain during transfers but stated, "screaming out during transfer is typical" for R39. LPN-A stated R39 had expressed pain with transfers when he was admitted but he was "not sure" whether R39 continued to have pain. LPN-A further stated R39 had scheduled pain medication, but verified R39 did not receive pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 medication prior to morning cares. During an interview on 3/10/16 at 12:00 p.m., registered nurse (RN)-D stated she had not observed R39 having any pain, but stated he did have behaviors during cares. RN-D stated she was aware he was resistive with care but was not aware whether the behaviors were related to pain. During an interview on 3/10/16, at 12:42 p.m., the physical therapist (PT)-E stated R39 had been evaluated for transfers but was combative with treatment. During an interview on 3/10/16, at 12:44 occupational therapist (OT)-E stated a range of motion program had been trialed for R39 but was not initiated due to R39's inability to tolerate it. OT-E said R39 was "combative" and would "grimace" during range of motion. During an interview on 3/10/16, at 1:34 p.m., the director of nursing (DON) stated the facility tries to monitor pain. He stated the nursing assistants chart when pain was noted would alert the nurse in the electronic record to assess. The DON stated R39 was not currently having any specific daily or every shift pain monitoring conducted by a licensed nurse. During an interview on 3/10/16, at 3:14 p.m., NA-D verified R39 displays behaviors. She stated, "He fights in the evening at bedtime and calls out ouch, ouch." NA-D stated she was unsure whether R39 was having pain but stated, "All the time he makes the noise." NA-D stated she charted R39's calling out and resistance to cares as behaviors and not pain.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 During a subsequent interview on 3/10/16, at 2:36 p.m., RN-D stated, "we got orders to provide pain medication prior to morning cares now that you brought it to our attention." Review of the 3/10/16 orders for pain management included, scheduled pain medication prior to morning cares and pain monitoring five times daily. A facility policy titled Pain Assessment and Management Policy, dated March 2015, indicated: "It is the right that all residents have the appropriate pain assessment and pain management," and to aid residents in maintaining a comfortable level of function in activities of daily living. The policy directed staff to assess the resident that cannot consistently verbalize pain by interviewing staff regarding nonverbal indicators as pain, symptoms of pain, specific times and activities that appear to cause the resident pain. The policy further directed staff to update the physician in order to start or change a pain management program. While R39's pain assessment indicated he displayed nonverbal indicators of pain during cares and staff had reported pain with range of motion and activities of daily living, there was no indication of pain management interventions utilized to reduce discomfort with morning cares. In addition, there had been no assessment to determine whether the behaviors R39 displayed were related to pain. In addition, although R39 was receiving scheduled pain medication, the medications were not being administered until after R39's morning cares were completed.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		4/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility to implement a gradual dose reduction of an antipsychotic for 1 of 5 residents (R71) reviewed for unnecessary medications. Findings include: During an observation on 3/8/16, at 2:55 p.m., R71 was involved in a group activity in the common area of the unit. She was playing a	F 329	Resident (R71) Gradual Dose Reduction (GDR) was reviewed upon notification from surveyor by a Clinical Coordinator and Pharmacist. A request for clinical rationale for the continued use of Seroquel was sent to the psychiatrist and/or a request for GDR. A discussion will be held with the family regarding appropriateness of antipsychotic medications and possibility of GDR.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 musical instrument and singing. During an observation on 3/9/16 at 8:33 a.m., R71 was in bed sleeping. During an observation at 12:00 p.m., she was sitting at a table in the dining room with her head resting on her arm. A review of R71 ' s Physicians Orders dated 9/15, indicated R71 received quetiapine (Seroquel-an anti-psychotic medication) 25 milligrams (mg) every morning and 50 mg every evening. A review of R71 ' s Physician's Orders indicated on 10/2/15, noted an order to reduce R71's Seroquel from 25 mg every morning to 12.5 mg every morning and to reduce her evening Seroquel dose from 50 mg to 25 mg. A subsequent order dated the same day indicated, "Cancel previous order." There was no clinical rationale to support the discontinuation of the order. However, a facility Progress Note dated 10/6/15, indicated, "Pt [patient] family wishes to change back to her primary Dr. [doctor]. " A review of the pharmacy consultants Record of Medication Regimen Review dated 10/8/15, indicated an order to reduce Seroquel was refused by family. There was no indication of continued efforts decrease R71's Quetiapine dose until 12/21/15. On 1/5/16, the facility received a faxed response from R71's primary physician which indicated, dementia with past psychosis and delirium, gets increased anxiety as Seroquel decreased. However, there was no indication of anxiety, nor was there a diagnosis of anxiety in the medical record. R71's quarterly Minimum Data Set (MDS) dated 12/21/15, indicated she was severely cognitively	F 329	All residents on psychotropic medications were reviewed to ensure appropriate GDR reviews had been conducted according to facility policy and procedure. The policy and procedure related to GDR reviews was reviewed and is current. Education to Clinical Coordinators was done regarding the importance of the GDR process. Clinical Coordinators/designee will complete GDR reviews on all residents upon admission, day seven, quarterly, annually, with significant changes and monthly and as needed with dose changes. Results of the GDR reviews will be documented in PCC upon completion. Random audits on 10% of residents will be completed weekly for one month and monthly thereafter by the Clinical Coordinators or designee to ensure compliance. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as needed. The Clinical Administrator is responsible for ongoing compliance. The completion date for certification purposes will be 4/19/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 14	F 329		

impaired and displayed no behaviors. The MDS indicated R71 had delusions however, a review of facility Progress Notes dated August 2015 through March 2016 indicated she had one episode on 1/20/16, and she was started on an antibiotic for a urinary tract infection on 1/22/16. R71's previous MDS indicated no delusions and no behaviors. R71's diagnosis included major depressive episode with past psychosis, dementia without behavioral disturbance, recurrent major depression and insomnia.

During an interview on 3/10/16, registered nurse (RN)-D stated R71 had not currently been having behaviors. She further stated R71's family was concerned R71 would not take care of herself and stated that happened a few years ago when R71's husband passed away. RN-D stated R71 had been seeing the facility ' s physician and had a successful reduction in her Seroquel dose in August 2015. In October 2015, the facility attempted to decrease R71's Seroquel dose but family "was not on board." She further stated at that time family started taking R71 back to her previous physician.

A review of a psychiatric Mental Health Progress Note dated 2/22/16, indicated R71 was "generally doing fairly well." Her mood was described as "positive." The note further indicated R71 had dementia and her memory seems to be fading gradually. No "psychotic symptomatology noted." The note further indicated "continue her current regimen," "she tolerates these medications well." However, the psychiatrist did not provide a clinical rationale for continued use of the medications.

A facility form titled Review of Medication, dated 2/26/16, indicated Seroquel 25 mg in a.m. and 50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 15 mg at night. The review indicated a date of prior reduction 8/3/15, and a result of "stable, no new behaviors noted." The review further indicated, due to history of psychosis and depression, "family is resistant to changing medication." R71 had a decrease in her Seroquel dose in August of 2015 which did not cause her to suffer any adverse effects as indicated by the MDS and RN-D ' s interview on 3/10/16. R71 was not afforded another dose reduction attempt and the medical record lacked evidence of justification for the use the Seroquel. A policy was requested but not provided.	F 329		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean environment for 6 of 7 residents (R236, R151, R179, R19, R68, R69) whose rooms were inspected. In addition, the facility failed to identify one ripped wheelchair bolster that had an uncleanable surface for 1 of 1 resident (R77) reviewed with a bolster in the wheelchair. Findings include: On 3/10/16, at 10:00 a.m. to 10:20 a.m. the environmental tour was conducted with the	F 465	Resident (R236)'s carpet was cleaned and stain was removed. Resident (R151)'s bathroom was painted. Resident (R179)'s bathroom shelving unit was repaired and bathroom was painted. Resident (R19)'s bathroom was painted. Resident (R77)'s bathroom was painted. Resident (R68)'s wheelchair armrest was repaired. Resident (R69)'s wall was repaired and painted. Work orders were submitted for R236, R151, R179, R19, R77, R68 and R69. All repairs were completed on 3/10/16.	4/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 16 administrator and the environmental services director (ESD). During the tour the following concerns that had been identified and were verified: On 3/7/16, at 4:11 pm it was observed that R236's carpet at the foot of his bed was stained. On 3/10/16, at 10:02 a.m. the administrator and ESD verified the carpet was stained and explained to R236 that the carpet would be cleaned and they would arrange a time with him. R236's Admission Record dated 3/10/16, indicated resident was admitted on 2/20/16 with diagnoses of falls, hypertension and diabetes. On 3/7/16, at 7:12 pm it was observed that the long wall in R151's bathroom had a black mark on the wall board, approximately four feet long. On 3/10/16, during environmental tour the administrator and ESD verified the black line on the wall and that it should have been reported by staff and then repaired and painted. R151's quarterly MDS dated 2/3/16, indicated R151 required extensive assist with bed mobility and transfers. On 3/8/16, at 8:53 a.m. a black line was observed on the wall in R179's bathroom near the floor and the bottom shelf of shelving unit in the bathroom was not securely attached to the frame. On 3/10/16, during environmental tour the administrator and ESD verified the black line on the wall and that it should have been reported by staff and then repaired and painted. ESD lined the bottom shelf of the shelving unit up and stated it needed a screw.	F 465	All resident rooms were audited for necessary work orders. Work orders were submitted as needed. Work order policy and procedure was reviewed and is current. Staff education was done regarding the process for identifying necessary work orders and appropriately submitting to the maintenance department. Random audits of resident room condition will be completed weekly for one month and monthly thereafter to ensure compliance by the Environmental Services Director or designee. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as needed. The Administrator is responsible for ongoing compliance. The completion date for certification purposes will be 4/19/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 17	F 465		

R179's MDS dated 12/4/15, indicated R179 required extensive assist with bed mobility and transfers.

On 3/8/16, at 9:56 a.m. R19's bathroom had a two foot black line on the wall approximately six inches above the floor. On 3/10/16, at 10:00 a.m. the administrator and ESD verified the black line on the wall and that it should have been reported by staff and then repaired and painted.

R19's quarterly MDS dated 12/30/15, indicated R19 required extensive assist with bed mobility and transfers.

On 3/8/16, at 10:23 a.m. a black streak in the wall board about one and a half feet long was observed in the bathroom of R77 on the long wall. On 3/10/16, during environmental tour the administrator and ESD verified the black line on the wall and that it should have been reported by staff and then repaired and painted.

R77's quarterly MDS dated 2/4/16, indicated R77 required extensive assist with bed mobility and transfers.

On 3/10/16, at 11:47 a.m. R68 was sitting in a wheel chair in the dining room. The right arm rest was covered with a black foam bolster. The black cloth that covered the bolster was torn with foam sticking out. Registered Nurse (RN)-D verified that the foam was sticking out and that the bolster was no longer cleanable. RN-D stated would obtain a new bolster.

R68's quarterly MDS dated 1/29/16, indicated R68 required extensive assist with bed mobility and was dependent on staff for transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 18 On 3/8/16 R69 pointed out the multiple gouges in wall next to right side of bed, and paint scrapes present on opposite wall when asked do you have problems with anything in the building that effects your comfort. On 3/10/16 at 12:20 p.m. ESD verified the gouges and missing paint next to the foot of the bed and that the wall across from the bed had a black mark on the wall. ESD stated would put in a work order. R69's quarterly MDS dated 2/10/16, indicated R69 required extensive assist with bed mobility and transfers. During interview on 3/10/16 at 10:20 a.m. ESD said "The house keepers have a form to fill out if they notice an issue and that will generate a work order. If a floor staff member notices a problem they can fill out the form in the computer or on the paper form. If it is an emergency the staff can contact maintenance by the walkie-talkie." The administrator and ESD verified there was no work orders for any of the issues noted on tour and that the issues should have been identified earlier. Facility Task/Work Order Requests and Charges for Services policy /procedure revision date 2/2016, instructed, "Requests by residents, staff and families for engineering services should be made via Outlook Tasks (Please do not stop them in the hall for work or use paper written requests (hand written), use electronic Outlook task requests only)." A facility policy was requested but none received.	F 465		
F 492	483.75(b) COMPLY WITH	F 492		4/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492 SS=D	Continued From page 19 FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to suspend billing for services for 1 of 3 residents (R189) reviewed for demand billing who was charged for services. Findings include: R189 received a notice of Medicare non-coverage on 11/10/15, which indicated the last day of Medicare A covered service was 11/17/15. On 11/16/15, R189 requested to have the decision appealed to the Medicare A Contractor (MAC). The facility sent bills to R189 on 12/1/15, 1/1/16, 2/1/16, and 3/1/16. Medicare determination had not been made at the time of billing for services. The billing statements indicated R189 was not being billed for the first 30 days of room and board charges awaiting a determination from Medicare, however, each bill received after 12/1/15, continued to include a previous balance which included charges for 11/18/15 to 12/17/15. During an interview on 3/10/16, at 1:49 p.m., the administrator stated the demand bill was submitted on 1/8/16. She stated, "My	F 492	Resident (R189)'s billing for services was suspended pending a response from CMS. No other residents in the facility had requested a demand bill; therefore, no other residents were affected. The policy and procedure regarding demand bills was reviewed and updated to reflect suspension of all billing for the first 30 days or until a response is received from CMS. Education was provided to the billing department regarding the updated policy and procedure and is ongoing. Residents who request a demand bill will have monthly audits completed on their billing statements to ensure billing is suspended according to facility policy. Information gathered by these audits will be used for review by the QA Committee to ensure ongoing compliance. Action plans will be developed as needed. The Administrator is responsible for ongoing compliance. The completion date for certification purposes will be 4/19/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 20 understanding was billing was only suspended for the first 30 days. A facility policy was requested, but none received.	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **02 - MAIN BULIDING** B. WING _____	**03/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 9, 2016. At the time of this survey, Maranatha Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/03/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **02 - MAIN BULIDING** B. WING _____	**03/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Maranatha Care Center is 2 buildings constructed in 2013. Main Building 02 is a 3-story building with no basement and was determined to be of Type II (222) construction. The building is fully fire sprinkler protected with UL 300 systems protecting the kitchen hoods on each floor. The building has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. There is a 16-bed locked memory care unit on the first floor. The building is attached to the Kitchen and Chapel 03 building which is of non-conforming construction and separated by a 2-hour fire wall. The Kitchen and Chapel 03 building is a 1-story building with no basement and was determined to be of Type V (111) construction. The building is fully fire sprinkler protected with a UL 300 system protecting the kitchen hood. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to the Main	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **02 - MAIN BULIDING** B. WING _____	**03/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 Building 02 building which is of non-conforming construction and separated by a 2-hour fire wall. Due to the non-conforming construction, Maranatha Care Center is surveyed as 2 buildings with (2) CMS-2786R forms completed. The facility has a capacity of 97 beds and had a census of 91 at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) NOT MET as evidenced by:	K 000		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has failed to inspect and maintain the sprinkler system in accordance with NFPA 13 and NFPA 25. This deficient practice could affect all 91 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on March 9, 2016, record review revealed that the fire sprinkler system had not been flow tested for the 2nd and 3rd quarter of 2015. The Director of Environmental Services identified the deficiency and has contracted Simplex Grinnell to conduct quarterly flow tests as of November of 2015. This deficient practice was verified by the Director of Environmental Services at the time of the inspection.	K 062	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also notr to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency. The facility will inspect and maintain the	4/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **02 - MAIN BULIDING** B. WING _____	**03/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 3	K 062	sprinkler systems in accordance with NFPA 13 and NFPA 25 by conducting quarterly inspections. The Environmental Services Director had previously identified this issue and entered into a contractual agreement with Simplex Grinnell in November of 2015 to establish a re-occurring schedule for performing the quarterly sprinkler testing. A quarterly sprinkler test was scheduled for and occurred on 3/10/16, one day after the Deputy State Fire Marshal inspection on 3/9/16. The Safety Committee will review the results of the quarterly sprinkler inspections for accuracy and timeliness. The Environmental Services Director is responsible for ongoing compliance. The completion date for certification purposes will be 4/19/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **03 - KITCHEN AND CHAPEL** B. WING _____	**03/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 9, 2016. At the time of this survey, Maranatha Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/03/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **03 - KITCHEN AND CHAPEL** B. WING _____	**03/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Maranatha Care Center is 2 buildings constructed in 2013. Main Building 02 is a 3-story building with no basement and was determined to be of Type II (222) construction. The building is fully fire sprinkler protected with UL 300 systems protecting the kitchen hoods on each floor. The building has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. There is a 16-bed locked memory care unit on the first floor. The building is attached to the Kitchen and Chapel 03 building which is of non-conforming construction and separated by a 2-hour fire wall. The Kitchen and Chapel 03 building is a 1-story building with no basement and was determined to be of Type V (111) construction. The building is fully fire sprinkler protected with a UL 300 system protecting the kitchen hood. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to the Main	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **03 - KITCHEN AND CHAPEL** B. WING _____	**03/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 Building 02 building which is of non-conforming construction and separated by a 2-hour fire wall. Due to the non-conforming construction, Maranatha Care Center is surveyed as 2 buildings with (2) CMS-2786R forms completed. The facility has a capacity of 97 beds and had a census of 91 at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) NOT MET as evidenced by:	K 000		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has failed to inspect and maintain the sprinkler system in accordance with NFPA 13 and NFPA 25. This deficient practice could affect all 91 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on March 9, 2016, record review revealed that the fire sprinkler system had not been flow tested for the 2nd and 3rd quarter of 2015. The Director of Environmental Services identified the deficiency and has contracted Simplex Grinnell to conduct quarterly flow tests as of November of 2015. This deficient practice was verified by the Director of Environmental Services at the time of the inspection.	K 062	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency. The facility will inspect and maintain the	4/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **03 - KITCHEN AND CHAPEL** B. WING _____	**03/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 3	K 062	sprinkler systems in accordance with NFPA 13 and NFPA 25 by conducting quarterly inspections. The Environmental Services Director had previously identified this issue and entered into a contractual agreement with Simplex Grinnell in November of 2015 to establish a re-occurring schedule for performing the quarterly sprinkler testing. A quarterly sprinkler test was scheduled for and occurred on 3/10/16, one day after the Deputy State Fire Marshal inspection on 3/9/16. The Safety Committee will review the results of the quarterly sprinkler inspections for accuracy and timeliness. The Environmental Services Director is responsible for ongoing compliance. The completion date for certification purposes will be 4/19/16.	

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
March 25, 2016

Ms. Anne O'Connor, Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5462029 and H5462059

Dear Ms. O'Connor:

The above facility was surveyed on March 7, 2016 through March 10, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5462059. 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.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Ruleis 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 Gloria Derfus, Unit Supervisor, at (651) 201-3792.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On March 7-10, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. An investigation of complaint, H5462059 was completed. The complaint was not substantiated.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan to include interventions for pain management for 1 of 1 resident (R39) assessed to have pain with activities of daily living and range of motion. In addition, the facility failed to develop an admission plan of care for 1 of 3 residents (R234) who had been admitted to the facility recently and was identified at risk for falls.	2 555	Corrected	4/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 3 Findings include: R39's admission Minimum Data Set (MDS) dated 1/11/16, indicated R39 was severely cognitively impaired, required extensive assistance with all activities of daily living, and had limited mobility in all extremities. An admission Pain Evaluation dated 1/5/16, indicated R39 had a history of pain and diagnosis which indicate a potential for discomfort or risk for pain. Behavioral indicators of pain included aggressive behaviors, striking out and protecting area. The Pain summary indicated "Resident is on scheduled oxycodone [narcotic]." "Noted striking, protecting areas and aggressive at time [of] care." A subsequent pain assessment dated 1/16/16, also indicated R39 was noted to strike, protect areas and display aggression at time of care. The assessment identified these behaviors as non-verbal indicators of pain. R39's care plan dated 1/22/16, identified risk for pain related to contractures and neuralgia, but did not address interventions to decrease pain with activities of daily living, even though R39 had been assessed to have pain with cares on two separate assessments. A review of the March 2016 Medication Administration Record indicated R39 received scheduled pain medication at 9:00 a.m., 2:00 p.m., and 8:00 p.m., but no medication was administered prior to morning cares even though he was assessed to have pain with cares. During an observation on 3/10/16, at 8:19 a.m., nursing assistant (NA)-B and NA-C were observed performing morning cares for R39.	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 4	2 555		

When staff lifted R39's left arm to wash underneath, R39 said "OW." Resident again called out while NA-B and NA-C applied compression hose to his lower extremities. R39 appeared comfortable throughout the remainder of his morning cares until staff transferred him into his wheel chair. At that time, R39 could be heard yelling out across the hall and through two closed doors.

During an observation on 3/10/16, at 2:46 p.m., R39 was observed during a transfer and displayed no signs of pain or discomfort.

During an interview on 3/10/16, at 11:53 a.m. NA-C stated it was normal for R39 to yell out during care, especially in the morning." He stated in the evening, "not as much." He stated it happens at least a couple of times a week.

During an interview on 3/10/16, at 11:53 a.m., licensed practical nurse (LPN)-A stated NA's have not reported pain during transfers but stated, "screaming out during transfer is typical" for R39. LPN-A stated R39 had pain with transfer when he was admitted but he was "not sure" if he had since then. LPN-A further stated R39 had scheduled pain medication, but did not receive the medication prior to morning cares.

During an interview on 3/10/16, at 12:00 p.m., registered nurse (RN)-D stated she had not observed R39 having any pain but stated he does have behaviors with cares. She stated she was aware he was resistive with care but was not aware if they were related to pain.

During an interview on 3/10/16, at 12:44 p.m. occupational therapist (OT)-E stated a range of motion program was trialed for R39 but was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 5 initiated due to not tolerating. OT-E stated R39 was " combative" and would "grimace" during range of motion. During an interview on 3/10/16, at 3:14 p.m., NA-D stated R39 displays behaviors. She stated, "He fights in the evening at bedtime." She stated R39 calls out "ouch, ouch." She stated she was unsure if R39 was having pain but stated, "All the time he makes the noise." During a subsequent interview on 3/10/16, at 2:36 p.m., RN-D stated, "we got orders for pain medication prior to morning cares now that you brought it to our attention." New orders for pain management include: scheduled pain medication prior to morning cares and pain monitoring five times daily. A facility policy titled Care Plan Policy and Procedure, dated August 2014, directed staff to gather information to provide data for the resident care plan specific to the resident's needs. "The care plan will ensure the resident has the appropriate care required to maintain or attain the resident's highest level of practicable function possible." R234 was observed on 3/8/16, at 3:24 p.m. lying in bed on top of the covers with the lights off and the television on. R234's call light was within reach. A white dressing observed on R234's right knee. R234's wheel chair was across from the bed. R234 stated she did not really fall on 3/5/16. R234 stated was transferring from bed to wheelchair and had forgotten to lock the brakes, so the wheelchair started to roll away and she went down on her right knee.	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 6 The Fall Risk Data Collection dated 2/24/16, indicated, "Pt [patient] is AOx3 [alert and oriented times three] and able to make needs known. Pt transferred to the TCU [transitional care unit] following hospitalization at ABNW [Abbott North Western] for a R [right] TKA [total knee arthroplasty] (replacement). Pt transferred to the TCU via Medivan at 1730 [5:30 p.m.]. Pt is at risk for falls r/t [related/to] assistance needed with transferring and ADLs [activities of daily living] due to R TKA and pain. Pt also has a hemovac [drain for blood] in place and needs assistance with managing the tubing connected." The Individual Resident Care Plan dated 2/24/16, did not identify fall risk as a problem for R234. R234's admission Minimum Data Set (MDS) dated 3/1/16, indicated R234 was moderately cognitively impaired and required extensive assistance with transfers. The Progress Note dated 3/7/16, indicated R234 fell on 3/5/16, while transferring from bed to wheelchair and bleeding observed at incision site. The Fall Care Area Assessment dated 3/8/16, indicated R234 was at risk for falls. R234 was working with therapy with goal of improvement. The Admission Record dated 3/10/16, noted R234 was admitted to the facility on 2/24/16. R234's diagnoses were listed as right artificial knee joint following replacement surgery, osteoarthritis of both knees, with knee contractures and difficulty walking. The care plan did not indicate R234 had fallen on 3/5/16, or what interventions had been put in place. During interview on 3/9/16, at 2:26 p.m.	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 7	2 555		

registered nurse (RN)-A nurse manager stated, "Her fall risk and her fall are not on her care plan because I did not put it there. I should have done it."

During interview on 3/10/16, at 9:38 a.m. director of nursing (DON) stated, "The temporary care plans are to be kept up to date. Yes, if a resident is identified as at risk for falls it should be care planned. If a resident falls that should be added to the care plan and what the intervention is."

On 3/10/16, at 10:56 a.m. DON verified the fall risk and fall were not care planned for R234.

The Care Plan Policy and Procedure modified August 2014 instructed staff, "It is the policy of Presbyterian Homes to initiate a temporary care plan within 24 hours of admission and complete and [sic] comprehensive care plan prior to the initial care conference. The care plan will ensure the resident has the appropriate care required to maintain or attain the resident's highest level of practicable function possible." 10. "The care plan is to be changed and updated as the care changes for the resident and as the resident changes occur it will be written on the paper care plan in the resident's medical record. It is to be current at all times. It is recommended that the care plan is printed annually."

SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop a system to ensure a care plan is developed to reflect each residents' current care needs. The DON or designee could educate all appropriate staff on the system, and monitor to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 8 (21) days.	2 555		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately assess to identify and implement appropriate interventions for pain for 1 of 3 resident (R39) reviewed for pain. This caused actual harm for R39 who experienced pain during care. Findings include: R39 was observed on 3/9/16, at 8:17 a.m. sitting in a reclining wheel chair. His left leg was extended out with the foot slightly inverted. A pillow was in place under his knees and calves. During an observation on 3/10/16, at 8:19 a.m., nursing assistant (NA)-B and NA-C were observed performing morning cares for R39. The	2 830	Corrected.	4/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 NAs provided R39 a pillow to hold during cares. When staff lifted R39's left arm to wash underneath, R39 yelled out loudly "OW" and pulled away from the NAs as they provided upper extremity cares. The resident displayed facial grimacing as he yelled. The resident again yelled out "Ow, Ow, Ow!" while NA-B and NA-C applied compression hose to his lower extremities. The licensed practical (LPN)-A was in the room at the time of the observation and did not intervene or ask the NAs to stop cares so pain relief could be provided. The NAs did not suggest to the nurse that R39 needed pain relief. LPN-A left the room before the resident was transferred into the wheelchair. When the NAs initiated transferring R39 to the wheelchair, they had R39 hold a pillow to prevent the resident from striking out during the care. The surveyor stepped out of the room during the transfer at 8:37 a.m. R39 could be heard screaming out loudly across the hall and through two closed doors during the transfer to the wheelchair. Another surveyor who was in the dining room when R39 screamed out. That surveyor said R39's screaming was heard all the way to the dining room. R39's room was approximately the third room from the dining room. An admission Pain Evaluation dated 1/5/16, indicated R39 had a history of pain, and potential for discomfort or risk for pain. Behavioral indicators of pain included aggressive behaviors, striking out and protecting area. The summary on the Pain Evaluation indicated "Resident is on scheduled oxycodone [narcotic]." "Noted striking, protecting areas and aggressive at time [of] care." R39's admission Minimum Data Set (MDS) dated 1/11/16, indicated he was severely cognitively impaired, required extensive assistance with all	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 ADLs, and had limited mobility in all extremities. In addition, the MDS did denote R39 had behaviors of hitting and kicking out during cares one to three times a week, but no refusals of care were noted. Another pain assessment dated 1/16/16, indicated R39 was noted to strike, protect areas and display aggression at time of care. The assessment identified these behaviors as non-verbal indicators of pain. R39's care plan dated 1/22/16, identified a potential for pain related to decreased mobility, contractures, and neuralgia. A review of the March 2016 Medication Administration Record indicated R39 received scheduled pain medication at 9:00 a.m., 2:00 p.m., and 8:00 p.m.. There was no evidence medications were administered prior to morning cares, even though R39 had been assessed to have pain with cares. An undated and untitled Nursing Assistant Assignment sheet, indicated R39 experienced behaviors of striking out, but did not indicate R39 had indicators of pain. The Assignment sheet identified direction to provide R39 with a pillow to hold to prevent hitting and striking out at staff during cares. During an interview on 3/10/16, at 11:53 a.m. NA-C stated it was normal for R39 to yell out during care, especially in the morning." He stated in the evening, "not as much." He stated it happens at least a couple of times a week. During an interview on 3/10/16, at 11:53 a.m., licensed practical nurse (LPN)-A stated the NA's	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 had not reported pain during transfers but stated, "screaming out during transfer is typical" for R39. LPN-A stated R39 had expressed pain with transfers when he was admitted but he was "not sure" whether R39 continued to have pain. LPN-A further stated R39 had scheduled pain medication, but verified R39 did not receive pain medication prior to morning cares. During an interview on 3/10/16 at 12:00 p.m., registered nurse (RN)-D stated she had not observed R39 having any pain, but stated he did have behaviors during cares. RN-D stated she was aware he was resistive with care but was not aware whether the behaviors were related to pain. During an interview on 3/10/16, at 12:42 p.m., the physical therapist (PT)-E stated R39 had been evaluated for transfers but was combative with treatment. During an interview on 3/10/16, at 12:44 occupational therapist (OT)-E stated a range of motion program had been trialed for R39 but was not initiated due to R39's inability to tolerate it. OT-E said R39 was "combative" and would "grimace" during range of motion. During an interview on 3/10/16, at 1:34 p.m., the director of nursing (DON) stated the facility tries to monitor pain. He stated the nursing assistants chart when pain was noted would alert the nurse in the electronic record to assess. The DON stated R39 was not currently having any specific daily or every shift pain monitoring conducted by a licensed nurse. During an interview on 3/10/16, at 3:14 p.m., NA-D verified R39 displays behaviors. She	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12 stated, "He fights in the evening at bedtime and calls out ouch, ouch." NA-D stated she was unsure whether R39 was having pain but stated, "All the time he makes the noise." NA-D stated she charted R39's calling out and resistance to cares as behaviors and not pain. During a subsequent interview on 3/10/16, at 2:36 p.m., RN-D stated, "we got orders to provide pain medication prior to morning cares now that you brought it to our attention." Review of the 3/10/16 orders for pain management included, scheduled pain medication prior to morning cares and pain monitoring five times daily. A facility policy titled Pain Assessment and Management Policy, dated March 2015, indicated: "It is the right that all residents have the appropriate pain assessment and pain management," and to aid residents in maintaining a comfortable level of function in activities of daily living. The policy directed staff to assess the resident that cannot consistently verbalize pain by interviewing staff regarding nonverbal indicators as pain, symptoms of pain, specific times and activities that appear to cause the resident pain. The policy further directed staff to update the physician in order to start or change a pain management program. While R39's pain assessment indicated he displayed nonverbal indicators of pain during cares and staff had reported pain with range of motion and activities of daily living, there was no indication of pain management interventions utilized to reduce discomfort with morning cares. In addition, there had been no assessment to determine whether the behaviors R39 displayed were related to pain. In addition, although R39 was receiving scheduled pain medication, the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13 medications were not being administered until after R39's morning cares were completed. SUGGEST METHOD FOR CORRECTION: The director of nursing or designee could direct staff to comprehensively assess residents, and implement interventions to ensure residents are provided care in a manner to promote their highest well-being without pain. A monitoring program could be established in order to assure patients are provided pain relief in accordance with their needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is	21535		4/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 14 available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility to implement a gradual dose reduction of an antipsychotic for 1 of 5 residents (R71) reviewed for unnecessary medications. Findings include: During an observation on 3/8/16, at 2:55 p.m., R71 was involved in a group activity in the common area of the unit. She was playing a musical instrument and singing. During an observation on 3/9/16 at 8:33 a.m., R71 was in bed sleeping. During an observation at 12:00 p.m., she was sitting at a table in the dining room with her head resting on her arm. A review of R71's Physicians Orders dated 9/15, indicated R71 received quetiapine (Seroquel-an anti-psychotic medication) 25 milligrams (mg) every morning and 50 mg every evening. A review of R71's Physician's Orders indicated on 10/2/15, noted an order to reduce R71's Seroquel from 25 mg every morning to 12.5 mg every morning and to reduce her evening Seroquel dose from 50 mg to 25 mg. A subsequent order dated the same day indicated, "Cancel previous order." There was no clinical rationale to support the discontinuation of the order. However, a facility Progress Note dated 10/6/15, indicated, "Pt [patient] family wishes to change back to her primary Dr. [doctor]."	21535	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 15 A review of the pharmacy consultants Record of Medication Regimen Review dated 10/8/15, indicated an order to reduce Seroquel was refused by family. There was no indication of continued efforts decrease R71's Quetiapine dose until 12/21/15. On 1/5/16, the facility received a faxed response from R71's primary physician which indicated, dementia with past psychosis and delirium, gets increased anxiety as Seroquel decreased. However, there was no indication of anxiety, nor was there a diagnosis of anxiety in the medical record. R71's quarterly Minimum Data Set (MDS) dated 12/21/15, indicated she was severely cognitively impaired and displayed no behaviors. The MDS indicated R71 had delusions however, a review of facility Progress Notes dated August 2015 through March 2016 indicated she had one episode on 1/20/16, and she was started on an antibiotic for a urinary tract infection on 1/22/16. R71's previous MDS indicated no delusions and no behaviors. R71's diagnosis included major depressive episode with past psychosis, dementia without behavioral disturbance, recurrent major depression and insomnia. During an interview on 3/10/16, registered nurse (RN)-D stated R71 had not currently been having behaviors. She further stated R71's family was concerned R71 would not take care of herself and stated that happened a few years ago when R71's husband passed away. RN-D stated R71 had been seeing the facility's physician and had a successful reduction in her Seroquel dose in August 2015. In October 2015, the facility attempted to decrease R71's Seroquel dose but family "was not on board." She further stated at that time family started taking R71 back to her	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 16 previous physician. A review of a psychiatric Mental Health Progress Note dated 2/22/16, indicated R71 was "generally doing fairly well." Her mood was described as "positive." The note further indicated R71 had dementia and her memory seems to be fading gradually. No "psychotic symptomatology noted." The note further indicated "continue her current regimen," "she tolerates these medications well." However, the psychiatrist did not provide a clinical rationale for continued use of the medications. A facility form titled Review of Medication, dated 2/26/16, indicated Seroquel 25 mg in a.m. and 50 mg at night. The review indicated a date of prior reduction 8/3/15, and a result of "stable, no new behaviors noted." The review further indicated, due to history of psychosis and depression, "family is resistant to changing medication." R71 had a decrease in her Seroquel dose in August of 2015 which did not cause her to suffer any adverse effects as indicated by the MDS and RN-D's interview on 3/10/16. R71 was not afforded another dose reduction attempt and the medical record lacked evidence of justification for the use the Seroquel. A policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could review the use of psychoactive medications with the licensed staff to meet the requirements of the state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 17	21685		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean environment for 7 of 7 residents (R236, R151, R179, R19, R68, R69) whose rooms were inspected. In addition, the facility failed to identify one ripped wheelchair bolster that had an uncleanable surface for 1 of 1 resident (R77) reviewed with a bolster in the wheelchair. Findings include: On 3/10/16, at 10:00 a.m. to 10:20 a.m. the environmental tour was conducted with the administrator and the environmental services director (ESD). During the tour the following concerns that had been identified and were verified: On 3/7/16, at 4:11 pm it was observed that R236's carpet at the foot of his bed was stained. On 3/10/16, at 10:02 a.m. the administrator and ESD verified the carpet was stained and explained to R236 that the carpet would be cleaned and they would arrange a time with him. R236's Admission Record dated 3/10/16,	21685	Corrected.	4/3/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 18 indicated resident was admitted on 2/20/16 with diagnoses of falls, hypertension and diabetes. On 3/7/16, at 7:12 pm it was observed that the long wall in R151's bathroom had a black mark on the wall board, approximately four feet long. On 3/10/16, during environmental tour the administrator and ESD verified the black line on the wall and that it should have been reported by staff and then repaired and painted. R151's quarterly MDS dated 2/3/16, indicated R151 required extensive assist with bed mobility and transfers. On 3/8/16, at 8:53 a.m. a black line was observed on the wall in R179's bathroom near the floor and the bottom shelf of shelving unit in the bathroom was not securely attached to the frame. On 3/10/16, during environmental tour the administrator and ESD verified the black line on the wall and that it should have been reported by staff and then repaired and painted. ESD lined the bottom shelf of the shelving unit up and stated it needed a screw. R179's MDS dated 12/4/15, indicated R179 required extensive assist with bed mobility and transfers. On 3/8/16, at 9:56 a.m. R19's bathroom had a two foot black line on the wall approximately six inches above the floor. On 3/10/16, at 10:00 a.m. the administrator and ESD verified the black line on the wall and that it should have been reported by staff and then repaired and painted. R19's quarterly MDS dated 12/30/15, indicated R19 required extensive assist with bed mobility and transfers.	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 19 On 3/8/16, at 10:23 a.m. a black streak in the wall board about one and a half feet long was observed in the bathroom of R77 on the long wall. On 3/10/16, during environmental tour the administrator and ESD verified the black line on the wall and that it should have been reported by staff and then repaired and painted. R77's quarterly MDS dated 2/4/16, indicated R77 required extensive assist with bed mobility and transfers. On 3/10/16, at 11:47 a.m. R68 was sitting in a wheel chair in the dining room. The right arm rest was covered with a black foam bolster. The black cloth that covered the bolster was torn with foam sticking out. Registered Nurse (RN)-D verified that the foam was sticking out and that the bolster was no longer cleanable. RN-D stated would obtain a new bolster. R68's quarterly MDS dated 1/29/16, indicated R68 required extensive assist with bed mobility and was dependent on staff for transfers. On 3/8/16 R69 pointed out the multiple gouges in wall next to right side of bed, and paint scrapes present on opposite wall when asked do you have problems with anything in the building that effects your comfort. On 3/10/16 at 12:20 p.m. ESD verified the gouges and missing paint next to the foot of the bed and that the wall across from the bed had a black mark on the wall. ESD stated would put in a work order. R69's quarterly MDS dated 2/10/16, indicated R69 required extensive assist with bed mobility and transfers.	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 20 During interview on 3/10/16 at 10:20 a.m. ESD said the house keepers have a form to fill out if they notice an issue and that will generate a work order. If a floor staff member notices a problem they can fill out the form in the computer or on the paper form. If it is an emergency the staff can contact maintenance by the walkie-talkie. The administrator and ESD verified there was no work orders for any of the issues noted on tour and that the issues should have been identified earlier. Facility Task/Work Order Requests and Charges for Services policy /procedure revision date 2/2016, instructed, "Requests by residents, staff and families for engineering services should be made via Outlook Tasks (Please do not stop them in the hall for work or use paper written requests (hand written), use electronic Outlook task requests only)." A facility policy was requested but none received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop a maintenance program to ensure damaged walls and wheelchairs are repaired to maintain a safe, clean, homelike environment. The DON or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21685		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GBI311

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00226

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245462**

2. STATE VENDOR OR MEDICAID NO. (L2) **731342000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MARANATHA CARE CENTER**
(L4) **5409 69TH AVENUE NORTH**
(L5) **BROOKLYN CENTER, MN** (L6) **55429**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **3/24/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) 04/30

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

12.Total Facility Beds **92** (L18)

13.Total Certified Beds **92** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

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

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

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	92			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : Fatty Momodou, HFE NE II 04/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 04/28/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

24-5462

On March 24, 2016, a Minimum Data Set (MDS) 3.0/Staffing Focused Survey was completed to verify compliance with Federal certification regulations. This survey found most serious to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

Post Certification Revisit (PCR) to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

AMENDED LETTER

Electronically delivered
April 26, 2016

Ms Anne O'Connor, Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

RE: Project Number S5462030

This letter amends and should replace the letter dated April 19, 2016.

Dear Ms. O'Connor:

On March 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on March 10, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 24, 2016, the Minnesota Department of Health completed a Minimum Data Set (MDS) 3.0/Staffing Focused Survey to verify that 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 to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 10, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 10, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 10, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Maranatha Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 10, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

Your plan of correction for the deficiencies issued at the time of the March 24, 2016 Minimum Data Set (MDS) 3.0/Staffing Focused Survey has been approved.

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0970
Telephone: (651) 201-3792
Fax: (651) 201-3790

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,

- Include electronic acknowledgement signature of provider and date.

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

- 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental

Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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

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 September 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Minimum Data Set (MDS) 3.0/Staffing Focused Survey was conducted. The following deficiency(ies) is/are issued. The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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, if your ePoC for the respective deficiencies (if any) is acceptable.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		4/22/16

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

Electronically Signed | 04/22/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 10 residents (R10, R8) who required assistance with activities of daily living (ADL's) and reviewed for urinary tract infection (UTI). Findings include: EATING: The facility failed to ensure R10's admission MDS reflected the nursing services provided for eating. R10's admission MDS dated 2/26/16, was inaccurately coded for eating assistance. The Admission record dated 2/20/16, indicated R10 diagnoses included diabetes mellitus type 2, gout and muscle weakness. Review of R10's admission MDS, revealed R10 was cognitively intact and independent with physical assist of one with eating. R10's care plan dated 3/10/16, indicated R10 was independent after set up with eating. Review of the 7-day observation data collection tool for assessment reference date (ARD) of 2/26/16, revealed R10 required extensive	F 278	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency. Resident (R10 and R8) MDS assessments were modified to reflect assistance for eating and UTI as identified. The care plan for each resident was updated to reflect current assistance needed. MDS nurses were re-educated regarding the correct coding for UTI and eating assistance and verbalized understanding. Education for nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 2 assistance of one staff otherwise R10 was independent in eating on all days of the assessment review dates, 2/20/16 through 2/26/16. On 3/34/16 at 9:55 a.m. RN-E, verified R10's the admission MDS was not accurate and stated, "It was an error and should have double check with what the computer coded and change the computer score and write a note of what was change. She added, "It should have been coded supervision with physical assist of one." On 3/24/16, at 1:55 p.m. the clinical administrator (CA) was interviewed and the CA indicated, he would expect staff to code according to Resident Assessment Instrument (RAI). Further stated, they use RAI manual for coding. R8's quarterly MDS reflected the nursing services provided for eating. The Admission Record dated 7/23/15, indicated R8 diagnoses included dysphagia, dementia and muscle weakness. Review of R8's quarterly MDS, revealed R8 was independent with physical assist of one with eating. R8's care plan dated 8/12/15, indicated, "EATING: I am able to feed myself after my meals are set up." R8's quarterly MDS dated 1/21/16, was miscoded for eating assistance as the MDS noted R8 needed assist for eating. On 3/24/16, at 12:28 p.m. nursing assistant (NA)-A stated, "Resident [R8] is and was	F 278	assistants on the definitions of eating assistance and how to code in POC is ongoing. All resident records were reviewed related to eating assistance and care plans and MDSs are accurate to reflect current assistance levels. The policy and procedure for MDS was reviewed and is current. All current residents who have symptoms of UTI were reviewed for possible coding implications and are current. All residents are assessed, a MDS is completed and care plan is revised/updated upon admission, with change of condition and quarterly as part of the RAI process. Random audits will be completed (weekly x 1 month and monthly thereafter to ensure compliance) by the MDS nurse or designee. Completion of the audits and the results will be turned into the Clinical Administrator. Information gathered by these audits will be used for review at Quality Assurance meetings for action plans to be developed as needed. The Clinical Administrator is responsible for ongoing compliance. Date certain for compliance is April 24, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 3 independent with setup with eating." On 3/24/16, at 12:34 p.m. registered nurse (RN)-D was interviewed and acknowledged the quarterly MDS dated 1/21/16, indicated independent with physical assist of one staff. RN-D mentioned, "It looks like it was a mistake on my side coding eating as independent with physical assist of one staff for the quarterly MDS dated 1/21/16." UTI: R8's discharge return anticipated MDS dated 1/25/16, was inaccurately coded for UTI. The 1/25/16, discharge return anticipated MDS indicated R8 had not experienced UTI within the last 30 days. The Progress Notes were reviewed from 1/25/16, going back 30 days and the following was noted: - On 1/22/16, at 10:27 p.m. stated, "Resident was started on antibiotic, Bactrim DS for UTI, temp 97.4 resident was lethargic this evening, sleeping during meal time..." - On 1/23/16, at 1:58 p.m. revealed, "UC [urine culture] results available, resident resistant to Bactrim DS, MD [medical doctor] on call ordered Nitrofurantoin 100 mg [milligram] BID [twice a day] for 7 days..." The Physician Order Summary Report dated January 2016, revealed, Bactrim DS tablet 800-160 mg (Sulfamethoxazole-Trimethoprim) Give 1 tablet by mouth two times a day for UTI for 7 days. Start date of 1/22/16, and end date of 1/29/16. North Memorial Medical Center's Urinalysis Microscopy and Culture-Urine results dated	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 4	F 278		

1/20/16 reads, "BACTERIA Present (A), greater than 100,000 cfu/ml of Gram Negative Bacilli (A)".

The Medication Administration Record indicated, R8 had Bactrim DS on 1/22/16 and 1/23/15. Also had Nitrofurantoin on 1/23/15 through 1/26/16.

The care plan dated 1/20/16, revealed R8 had "Recurrent UTI."

On 3/24/16, at 1:09 p.m. RN-D reviewed R8's record with the surveyor and verified both of the MDS had been inaccurately coded. RN-D stated the UTI should have been coded on both of the MDS. RN-D added, "I miss it by not coding UTI because she was taking antibiotic link to UTI (Nitrofurantoin started 1/21/16)."

On 3/24/16, at 1:53 p.m. the CA was interviewed and the CA stated, he would expect staff to code according to RAI.

According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated October 2015, UTIs can only be coded on the MDS when all of the following criteria are met:

1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnose a UTI in last 30 days,
2. Signs or symptoms attributed to UTI, may or may not include but are not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g., pyuria),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 5 3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and 4. Current medication or treatment for a UTI in the last 30 days.	F 278		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 329	Resident (R7)'s medication was reviewed	4/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 6 review, the facility failed to ensure Risperdal (Risperidone-anti-psychotic medication) had an adequate indication for continued use for 1 of 4 residents (R7) reviewed for antipsychotic medications. Findings include: On 3/24/16, at 1:08 p.m. R7 was observed seated on the wheelchair in the doorway to the room with the eyes closed. A staff member approached R7 and wheeled her to the room. At 1:15 p.m. R7 was observed lying in bed asleep. On 3/24/16, at 1:24 p.m. registered nurse (RN)-C stated R7 was pleasant, took her medications and had never heard of any behaviors. RN-C stated R7 was a retired nurse and at time would be frustrated if she had to wait to get help and had attempted to self-transfer and because she had a fracture and mobility issues, had two falls already at the facility. RN-C stated R7 had been reminded to use the call light and wait for assistance. RN-C further stated R7 had no noted problems with mood. On 3/24/16, at 2:36 p.m. R7 was observed lying in bed eyes open. When approached and asked about medications she took, R7 stated the nurses give all medications to her. R7 also stated she felt tired most of the time and had dizziness when she changed positions. R7 briefly talked about being a nurse and her life. During conversation, R7 had a flat affect but maintained eye contact. During review of Physician Orders dated 2/21/16, 3/1/16, and Medication Administration Record (MAR) dated March 2016, it was revealed R7 had the following orders:	F 329	for appropriate indication for continued use and diagnosis provided by NP. A reduction in the Risperidone dose and a discontinuation of PRN Trazadone was initiated. Resident has since discharged from facility. All residents who are receiving psychotropic medications are reviewed monthly by the Pharmacist Consultant and IDT team for indications of use and recommendations for reductions. All resident care plan and orders are current for medication needs. Education to nursing staff is being conducted regarding non-pharmacological interventions prior to the use of PRN's and for appropriate use and documentation of psychotropic medication. All residents are assessed for appropriate medications upon admission, monthly with drug reviews and as part of IDT as indicated in conjunction with the RAI process. The policy and procedure for unnecessary medications was reviewed and is current. Audits of the use of unnecessary meds will continue to be conducted for 100% of residents monthly by the Pharmacist Consultant and random audits of 10% of residents receiving psychotropic medications for indications of use and GDR will be conducted monthly by the IDT team members. Completion of the audits and the results will be turned into the Clinical Administrator. Information gathered by these audits will be used for review at Quality Assurance meetings for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 7 -Risperidone 0.5 milligram (mg) take by mouth daily with supper for antipsychotic. -Trazodone 25 mg by mouth every bedtime (HS) as needed (PRN). Review of hospital History and Physical Notes dated 2/18/16, indicated R7 had no psychiatry concerns and had dementia. The notes indicated R7 was off hospice, had no behaviors and no indication for Risperidone were documented. During review of Physician Progress Notes dated 2/24/16, 2/25/16, 3/1/16, 3/3/16, 3/8/16, 3/10/16, 3/15/16, 3/17/16, and 3/22/16, indicated R7 had dementia, was disoriented and had no behaviors. All the notes indicated R7 was on risperidone and directed staff to monitor the mood and behaviors. Throughout all the notes, no clear indication documented for the use of risperidone. R7's diagnoses included dementia, depression, hypertension and hip fracture obtained from the admission Minimum Data Set (MDS) dated 2/28/16. The MDS also indicated R7 had both short and long-term memory problems and had severely impaired cognitive impairment. In addition, the MDS indicated R7 had no psychosis, behavioral symptoms and did not refuse care during the assessment period. Review of the facility Psychoactive Medication Informed Consent Form dated 2/29/16; revealed R7 was taking Risperdal for "Antipsychotic." The psychotropic medication care plan dated 3/11/16, identified R7 used psychotropic medications related to dementia (behavioral), depression and insomnia. The care plan directed administer medications as ordered, educate	F 329	action plans to be developed as needed. The Clinical Administrator is responsible for ongoing compliance. Date certain for compliance is April 24, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 8	F 329		

resident, family and care givers about risks, benefits and side effects of psychoactive medications drugs being given.

During review of the March 2016, MAR it was revealed R7 had received Trazodone on 3/23/16, with no non-pharmacological interventions were documented prior to medication given.

When interviewed on 3/24/16, at 2:17 p.m. the consultant pharmacist (CP) stated at the time R7 was admitted to the facility, a monthly medication review had been completed on 2/25/16, which indicated R7 had active orders Risperidone and Zyprexa (Antipsychotic) with diagnoses of agitation, hallucination or sleep and he used that diagnose for Risperidone. When asked if he expected the facility to clarify the indication for Risperidone after the Zyprexa had been discontinued on 3/1/16, CP stated, "I will talk to [RN-B] and get back with answers."
- At 2:43 p.m. RN-B acknowledged the diagnosis for the "Antipsychotic" was not a clear indication for continued use of Risperidone for R7. When asked about R7's behaviors, RN-B stated, "She is very pleasant." When asked about non-pharmacological interventions prior to psychotic medication use, RN-B stated nurses were supposed to use non-pharmacological interventions prior and document and then use medication.
-At 2:45 p.m. CP came to RN-B office both acknowledged the listed diagnosis "Antipsychotic" was not a clear indication for medication. Both also acknowledged even though R7 had a diagnosis of dementia still that was not an indication for medication. CP also indicated to his recollection, R7 had been on hospice before and thought R7 had been on both Risperidone and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 9	F 329		

Zyprexa which was prior to admission to the facility.
-At 3:12 p.m. the CP approached stated the clinical administrator and administrator were in the process of getting the Physician Notes which he thought may have the indication for use for the Risperidone. The CP stated he would expect the staff to use non-pharmacological interventions prior to medications.
- At 3:19 p.m. nursing assistant (NA)-A stated R7 did not have any behaviors, was pleasant and was able to verbalize her needs. NA-A stated when R7 was admitted to the facility she was confused and since had stabilized.
- At 3:33 p.m. the primary nurse practitioner (NP) was interviewed via telephone and stated the Risperidone was being used for dementia and at the time R7 was admitted to the facility she was confused and staff was monitoring her for behaviors. NP indicated the facility was in the process of discontinuing the medications slowly. NP acknowledged the indication for using Risperidone was not justifiable and would be reviewed.
- At 3:40 p.m. the clinical administrator stated non-pharmacological interventions were supposed to be used first prior to medication use and indicated the indication for risperidone was being looked at the time by the NP and CP. Clinical administrator acknowledged "antipsychotic" was not a clear indication for using medication.
- At 4:17 p.m. RN-A reviewed the Face sheet, March 2016, MAR and TAR, MDS's completed and verified resident had both dementia and depression listed however RN-A acknowledged dementia without behavioral disturbance was not an appropriate diagnosis for risperidone which had been coded as administrated for R7 during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 10 the assessment period for both the admission MDS dated 2/28/16, and the 14 day MDS dated 3/6/16. The Psychotropic Medication and Unnecessary Medication Use Policy modified February 2016, informed staff that unnecessary drugs were any drugs when used without adequate indications for its use. The policy also directed if a drug was used outside the guidelines a justification for the use of such drug must include a Physician's Note indicating why it was clinically appropriate and that the physician had carefully considered the risk/benefit to the resident.	F 329		