DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 19, 2022

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: June 30, 2022

Dear Administrator:

On August 16, 2022, the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Your request for a continuing waiver involving the deficiency cited under K521 at the time of the June 30, 2022 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2022

CMS Certification Number (CCN): 245276

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

Dear Administrator:

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

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

Effective August 10, 2022 the above facility is certified for:

115 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 115 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
July 15, 2022

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: June 30, 2022

Dear Administrator:

On June 30, 2022, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 September 30, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by December 30, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	1900 SHERREN AVENUE MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments From 6/27/22 through 6/30/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS From 6/27/22 through 6/30/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H52762654C (MN83838), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be SUBSTANTIATED: H5276259C (MN81422), with a deficiency cited at F755 and H5276262C (MN74950), with a deficiency cited at F812. The following complaints were found to be UNSUBSTANTIATED: H5276257C (MN76986), H5276258C (MN72019), H5276260C (MN80022), H5276261C (MN77281) and H52762788C (MN84079).	F 000		

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

Electronically Signed | 07/21/2022

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

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate interventions were implemented to reduce the risk of falls for 1 of 1 resident (R37) who had repeated falls and was reviewed for accidents. Findings include: R37's significant change Minimum Data Set (MDS) dated 5/4/22 indicated mildly impaired cognition and diagnoses which included unspecified dementia with behavioral disturbance, repeated falls, reduced mobility,	F 689	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Maplewood Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation.	8/10/22

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F 689	Continued From page 2 unsteadiness on feet, Alzheimer's disease and signs and symptoms involving cognitive functions and awareness. It further indicated a behavior of wandering 1-3 times per week, required supervision with locomotion on the unit, and extensive assistance with all other activities of daily living (ADL's). It also indicated R37 had 2 or more falls without injury and 2 or more falls with injury, since admission. R37's care plan dated 2/16/21, included R37 required assistance of two staff for stand pivot transfers. It further included R37 was at risk for falls related to having a history of falls, weakness, dyskinesia, poor balance, need for staff assistance with performance of most ADLs, frequent incontinence, use of antidepressant medications, and impaired mobility with the following interventions: resident near to staff and reminded resident to call for help before getting up, analyze previous falls to determine whether pattern/trend can be addressed, anticipate and meet needs, place in staff view when restless. R37's Fall Risk Summary dated 5/4/22, included R37 had a Morse Fall Scale completed with a score of 55.0, putting her at a high risk for falling. R37's post incident reviews included: -4/1/22 R37 fell while attempting to self transfer from her bed to her wheelchair with an intervention to put resident near staff and remind her to call for help before getting up. -4/9/22 R37 fell while trying to self transfer from her wheelchair to her bed, with an intervention to put resident near staff and remind her to call for help before getting up. No new interventions were	F 689	POC 689 Free of Accident Hazards/Supervision/Devices Review care plan and care sheet for R37 to ensure up to date information and care for ADLs. Updated care plan with all interventions that have been put in place up to this point. Educate staff on interventions and appropriate care. Will review each individual resident fall in the past 30 days to ensure appropriate interventions are in place. IDT team will review each fall as they occur to ensure root cause analysis and appropriate interventions are put in place. Fall data collection policy and protocol, will be reviewed and revised as needed by IDT. Staff education will be completed by 8/5/2022. The Director of Nursing or designee will conduct routine audits 5x per week for two weeks, and 2x per week for 2 weeks, then weekly for 4 weeks for falls and appropriate interventions. Results of audits will be reviewed at QAPI to determine need for continuation. Completion date: 8/10/2022	

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F 689	Continued From page 3 added. -4/12/22 R37 fell out of her wheelchair, with an intervention to put resident near staff and remind her to call for help before getting up. No new interventions were added. -4/22/22 indicated R37 fell while self propelling in her wheelchair, with an intervention to put resident near staff and remind her to call for help before getting up. No new interventions were added. -4/25/22, indicated R37 fell while attempting to self transfer from wheelchair to bed, with an intervention to put resident near staff and remind her to call for help before getting up. No new interventions were added. During observation on 6/28/22, at 12:53 p.m. R37 was in the hallway in her wheelchair, attempting to enter another residents room. Nursing assistant (NA)-C reminded her which room was her's by pointing out the bluebird decals on the wall by her door. NA-C then pushed R37 in her wheelchair to her room, assisted her into bed and exited the room, leaving R37's wheelchair next to the bed. R37 sat up on the side of her bed and then stood up and took a few steps toward the door and hung onto it. The door was moving back and forth and R37 was unsteady. R37 looked at surveyor and stated "Ma ' am, I can't push this chair." as she was trying to use one hand to push her wheelchair so she could sit down. Surveyor asked "Are you supposed to be getting up by yourself?" Memory Support Director (MDS) came around the corner and shook her head no to me. She went into R37's room and assisted her to sit down in her wheelchair, brought her into the	F 689		

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F 689	Continued From page 4 common area, and walked away. R37 self propelled her wheelchair over to a row of chairs against the wall in the common area and transferred herself from the wheelchair to the chair in the dining area. Licensed practical nurse (LPN)-B was standing a few feet away at the medication cart but didn't appear to notice the resident. At 1:13 p.m., R37 transferred herself from the chair to her wheelchair. Recreational Therapist (RT)-A was in the common area but didn't notice because she was trying to turn on the television (TV). During observation on 6/29/22, at 8:05 a.m. R37 was self propelling her wheelchair in the hallway. RT-A walked up to R37 and stated "let me push you" as she brought her to her room and then went to get a nursing assistant (NA). NA-B stated when he went into R37's room she was in her bed, so he assisted her back into her wheelchair and left the room. R37 sat on her bed. She stood up and took a few steps around her room while hanging onto the door. The door swung back and forth and R37 was unsteady. Surveyor went to get help in order to prevent R37 from falling. The director of nursing (DON) and Administrator were standing by the nurses station and went to assist R37 to sit down in her wheelchair. The DON then brought R37 out into the common area. During observation on 6/29/22, at 1:13 p.m. R37 self-propelled her wheelchair into the common area and started talking to another resident. R37 stood up from her wheelchair and as she was standing, NA-B walked into the common area, looked at R37, and walked away. NA-B didn't assist R37 to sit down or transfer into the chair. R37 transferred herself into the chair next to the other resident.	F 689		

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F 689	Continued From page 5 During an interview on 6/29/22, at 8:05 a.m. NA-B stated R37 "always tries to stand and transfer on her own especially when she's alone, she's very quick but she's supposed to get help." During an interview on 6/30/22, 11:16 a.m. NA-C stated R37 frequently moves around the unit, going in others residents rooms. NA-C further stated R37 often self transfers but she requires the assistance of 2 staff when transferring. During an interview on 6/30/22, at 9:12 a.m. RN-G was asked what interventions they've tried to prevent R37 from falling. RN-G stated they monitor her and had Occupational Therapy (OT) evaluate her for a new wheelchair. She further stated the nursing assistant's shouldn't be leaving her in her room alone. "That would be atypical for them to do that." During an interview on 6/30/22, at 10:05 a.m. the director of nursing (DON), stated R37 had just started self transferring again and they really hadn't had a chance to implement or educate staff on interventions. The DON further stated the facility has had OT evaluate R37 for a new wheelchair (which she received) and they've tried several things in order to figure out why R37 had a change in condition (pain assessment, blood sugar checks, medication review, etc.), however none of these things addressed interventions that were put in place to prevent R37 from self-transferring. The facility's policy titled Fall Data Collection Policy and Protocol last reviewed 2/16/19, included in step 10 under the heading "Procedure" once the cause and contributing	F 689		

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F 689	Continued From page 6 factors are identified, identify a new intervention that will eliminate or minimize the cause and contributing factors. It further included in step 11 the interdisciplinary team will meet daily and as needed (PRN) to review accident/incidents and determine if investigation of incident is need and will assist with assessing for further interventions.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, documentation, and interview, the facility failed to ensure the tube feeding bag was changed every 24 hours for 1 of 1 resident (R30) who utilized tube feedings to	F 693	POC F963 Tube Feeding Mgmt/Restore Eating Skill Tube feeding bag was changed as soon as management was notified the day of	8/10/22

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F 693	Continued From page 7 meet their nutritional needs. Findings include: R30's quarterly Minimum Data Set (MDS) dated 4/21/22, included R30 was rarely/never understood and diagnoses of dysphagia following cerebral infarction, diabetes, vascular dementia without behavioral disturbance, epilepsy, and respiratory failure with hypoxia. It further included R30 had a feeding tube and required total dependence on staff with eating. R30's doctor's order dated 3/10/22, included "Enteral Feed Order every day shift change tube feeding tubing, bag, kit, syringe, and graduate daily and date and initial on change." During observation on 6/27/22, at 2:48 p.m. R30 was laying in bed and her tube feeding was connected. The bag containing her tube feeding was dated 6/26/22, 0800 (8:00 a.m.). The bag could hold 1200 milliliters (ml) of formula (Diabetisource) and there was approximately 350 ml left in the bag. The pump had stopped running and the monitor indicated dose done. Registered nurse (RN)-D verified she had not changed the bag and had added the formula to the bag from the day before. RN-D stated she was unaware how often R30's bag should be changed and she directed surveyor to licensed practical nurse (LPN)-B to answer any further questions. LPN-B verified R30's tube feeding bag should be changed every day. During an interview on 6/29/22, at 1:30 p.m. RN-G stated R30's tube feeding bag needed to be changed every 24 hours.	F 693	6/27/2022 for R30. The MAR was updated for a specific time for bag change every morning at 10:00AM. No other residents require tube feeding at this time. Policy and procedure for tube feeding will be reviewed and revised as needed by IDT. Staff education will be completed by 8/5/2022. The Director of Nursing or designee will conduct audits on changing of the tube feeding bag 5x per week for two weeks, and 2x per week for 2 weeks, then weekly for 4 weeks. Results of audits will be reviewed at QAPI to determine need for continuation. Completion date: 8/10/2022	

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F 693	Continued From page 8 During an interview on 6/30/22, at 10:05 a.m. the director of nursing (DON) stated R30's tube feeding bag should be changed every morning shift. A facility skills checklist titled "Enteral tube feeding, continuous, gastrostomy and jejunosteomy" dated 7/9/21 included label the enteral administration set with the date and time that it was first hung. Change an open-system administration set every 24 hours. Change a closed-system administration set according to the manufacturer's instructions.	F 693		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately and comprehensively monitor the pre-and post-treatment condition or access site for 1 of 1 resident (R188) receiving hemodialysis. R188's admission Minimum Data Set (MDS) dated 6/22/22, indicated R188 was cognitively intact and was receiving dialysis. R188's medical diagnoses included hydronephrosis with renal and ureteral calculous obstruction (excess fluid in kidneys due to stones in the kidneys and ureters), end stage renal disease and dependence on renal dialysis.	F 698	POC F698 Dialysis R188 was assessed to ensure dialysis site was not bleeding, thrill and bruit were felt and heard. All other dialysis patients have been identified and will be reassessed per facility protocol. The Dialysis Data Collection Protocol will be reviewed and revised as needed by IDT. Staff education on Dialysis Data Collection Protocol will be completed by 8/5/2022. The Director of Nursing or designee will conduct audits on pre and post dialysis	8/10/22

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F 698	Continued From page 9 R188's dialysis care plan dated 6/16/22, indicated R188 required hemodialysis due to acute kidney failure, had a right chest catheter site and received dialysis three times a week. The care plan directed staff to "observe for complications following dialysis: hypotension, febrile reaction [fever], bleeding, infection." R188's physician order dated 6/16/22, instructed staff to open and complete a pre- and post-dialysis data collection form every evening shift Monday, Wednesday and Friday. R188's physician order dated 6/20/22, instructed staff to check right chest for tunneled catheter placement and make sure it was intact without bleeding. R188's Dialysis Data Collection Pre and Post Appointment (DDCPPA) form dated 6/20/22, indicated an assessment (mental, skin, edema, lungs, GI, cardiac, access condition) and vital signs (VS), blood pressure (BP), temperature (T), pulse (P) and respirations (R) in the post dialysis section but lacked a pre dialysis assessment and VS. R188's DDCPPA assessment dated 6/22/22, indicated a pre dialysis assessment and VS but lacked a post dialysis assessment with VS for the post assessment documented as collected on 6/22/22, at 7:33 a.m. R188's DDCPPA dated 6/27/22, indicated a pre and post dialysis assessment with VS for the post assessment documented as collected on 6/26/22, at 8:56 a.m. (BP and P), 6/26/22, at 9:18 a.m. (T) and 6/25/22, at 21:41 p.m. (R).	F 698	data collection 5x per week for two weeks, and 2x per week for 2 weeks, then weekly for 4 weeks. Results of audits will be reviewed at QAPI to determine need for continuation. Completion Date: 8/10/2022	

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F 698	Continued From page 10 R188's DDCPPA for dialysis on 6/29/22, was completed by registered nurse (RN)-H on 6/30/22 after being questioned by state surveyor. During interview on 6/28/22, at 9:14 a.m. R188 stated staff never look at her access site after dialysis and sometimes check her oxygen level, BP, and T. R188 further stated staff have never used a stethoscope to listen to her heart, lungs, or chest. During interview on 6/30/22, at 8:30 a.m. RN-H stated an assessment should be done on all dialysis residents before and after dialysis. RN-H stated some of the things to assess were VS, medications due, and the access site for bleeding. RN-H further stated it was important to check the resident's BP and blood glucose after dialysis and observe for nausea. RN-H stated she did not complete the DDCPPA for R188 the day before (6/29/22) even though she did document in the treatment administration record (TAR) that it had been completed. RN-H stated she remembered at the end of her shift she had not completed the DDCPPA for R188 and had planned to complete it today (6/30/22) but stated it should be completed the same day as the dialysis appointment. During interview on 6/30/22, at 8:47 a.m. licensed practical nurse (LPN)-C stated the nurses were supposed to complete a pre and post dialysis assessment using the DDCPPA form in the electronic health record (EHR) and that it should be completed timely. LPN-C further stated it was not appropriate for DDCPPA to be completed a day later as the assessment must be done before and after each dialysis appointment.	F 698		

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F 698	Continued From page 11 During interview on 6/30/22, at 9:49 a.m. director of nursing (DON) stated an assessment should be done pre and post each dialysis appointment by the nurse and they should complete the DDCPPA in the EHR. DON stated there was a reason those forms were in the EHR and that they should be completed accurately with up-to-date VS and assessments. The facility policy Dialysis (Program Guidelines), dated 2006, instructed staff to assess the resident for complications post dialysis therapy. The policy indicated hypotension (low BP) as the most common complication. The policy listed other possible complications such as fever, pulmonary edema, nausea and vomiting.	F 698		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700		8/10/22

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F 700	Continued From page 12 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the use of bed rails prior to their initiation and failed to establish a process for ongoing monitoring of bed rails for 2 of 2 residents (R74 and R188) reviewed who utilized bed rails. Findings include: R74's significant change Minimum Data Set (MDS) dated 6/6/22, indicated moderately impaired cognition. R74 required supervision and one staff to physically assist with bed mobility. R74 was independent with transfers after set-up. The MDS indicated R74 had a diagnosis of lymphoma (a type of cancer.) R74's Physical Device Data Collection Evaluations (PDDCE) dated 2/4/22, and 5/23/22, lacked notation of any physical devices such as grab bars or bed rails. R74's Activity of Daily Living (ADL) care plan dated 8/10/21, lacked mention of use of grab bars. R74's medical record lacked assessment for the use of bed rails (including grab bars), a review of risks including entrapment, that the bed was appropriate for the resident and lacked information that the bed rails were properly installed and maintained.	F 700	POC F700 Bedrails R74 was assessed for appropriate use of bed rail and bed rails were removed on 7/27/2022 as she did not meet criteria. R188 was assessed and orders were obtained. Bedrail safety checklist was completed by maintenance for R188. The physical device data collection was completed in PCC. All other residents with bed rails have the potential to be affected. Bed rail procedure will be reviewed and revised as needed by IDT. Education with staff will be completed by 8/5/2022 on bed rail policy. Any bed change will be reviewed to ensure bed rails are removed or added per resident assessment/physician order. Any discharged room will have the bed assessed to have the bed rails removed or disabled. The Director of Nursing or designee will conduct audits on beds with bed rails/assessments/orders on residents with bed rails 5x per week for two weeks, and 2x per week for 2 weeks, then weekly for 4 weeks. Results of audits will be reviewed at QAPI to determine need for continuation. Completion date: 8/10/2022	

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F 700	Continued From page 13 During an observation and interview 6/27/22, at 12:20 p.m. R74 was in bed with a grab bar on the right and left side of the bed. R74 stated she had a concern with her grab bars being loose. R74 shook her left grab bar which was able to be moved back and forth about four inches. The right grab bar was loose also, and able to be moved back and forth about one inch. R74 had a folded napkin she had wedged into the left grab bar to try and make it more stable. R74 stated she did not remember if any of the staff knew, but the grab bars had been this way since she moved into the room. During an interview on 6/28/22, at 2:57 p.m. nursing assistant (NA)-A shook R74's grab bars after being prompted to, and verified they were loose. NA-A stated the grab bars were not safe and R74 could fall. NA-A stated they would check grab bars periodically during cares, however, R74 was independent with transfers so they had not been checked. During an interview on 6/28/22, at 3:05 p.m. maintenance staff (M)-A stated his department did not have a list of residents with bed rails to monitor routinely. M-A stated he thought scheduled inspections were done by nursing for the use of bed rails. M-A stated they had tried giving R74 other rails in the past. M-A entered R74's room, moved the grab bars and verified the grab bars were loose. During an interview on 6/29/22, at 9:45 a.m. registered nurse (RN)-F stated residents should be assessed for bed rails or grab bars before use and as scheduled. RN-F looked in R74's medical record and verified the physical device assessment had not been completed, did not	F 700		

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F 700	Continued From page 14 include the evaluation of grab bars and should have. During an observation on 6/29/22, at 10:15 a.m. R74 no longer had any bed rails or grab bars on her bed. During a follow up interview on 6/29/22, at 1:30 p.m. M-A stated he took the grab bars off R74's bed. M-A stated when R74 moved to her current room, the bed in the room had existing grab bars that were left on the bed without an order and should not have been. R188's admission MDS dated 6/22/22, indicated R188 was cognitively intact and required extensive two plus person assist with bed mobility and transfers. R188's medical diagnoses included end stage renal disease and morbid obesity. R188's PDDCE dated 6/18/22, indicated R188 did not currently use any physical device. R188's PDDCE dated 6/29/22, indicated R188 used a left and right half side rail. R188's falls care plan dated 6/16/22, indicated R188 was at risk for falls. R188's falls care plan did not include side rails as an intervention. R188's physical device care plan dated 6/29/22, indicated R188 required the use of a physical device for positioning to prevent falls and increase independence. R188's Informed Choice Consent for Physical Devices (ICCPD) dated 6/18/22, indicated R188 was informed of the risks of using bed rails due to "100% risk of falling."	F 700		

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F 700	Continued From page 15 R188's ICCPD dated 6/29/22, indicated R188 was informed of the risks of using bilateral side rails to aide in independence with repositioning due to muscle weakness and chronic pain. R188's physician order dated 6/18/22, indicated two half side rails in bed to aide in independence with reposition. During observation and interview on 6/28/22, at 8:46 a.m. R188's bed had bilateral half side rails. R188 stated the right bed rail was very loose and that the side rails had been installed shortly after she was admitted to the facility. R188 pulled on the right side rail and demonstrated the loose side rail which moved back and forth several inches. During interview on 6/29/22, at 9:16 a.m. M-A stated he installed new side rails on R188's bed the previous day (6/28/22) because she got a new bed and that her old bed had side rails that he had installed previously on 6/18/22. During interview on 6/29/22, at 9:56 a.m. health unit coordinator (HUC)-A stated she normally entered the order for side rails and initiated a work order for maintenance to install them. HUC-A further stated it was the nurse's responsibility to ensure the consent (ICCPD) and assessment (PDDCE) was completed. During interview on 6/29/22, at 10:11 a.m. licensed practical nurse (LPN)-C stated not being aware of R188's side rails until that day. LPN-C stated the process for side rails included an order, consent indicating risks and benefits, and an assessment to ensure the resident could safely use the side rails.	F 700		

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F 700	Continued From page 16 During interview on 6/29/22, at 10:22 a.m. RN-B stated she worked with R188 on 6/18/22, and was aware R188 requested side rails be placed on her bed. RN-B stated she told LPN-C who then initiated the ICCPD form in which she (RN-B) had R188 review and sign on 6/18/22. During interview on 6/29/22, at 11:23 a.m. LPN-C stated RN-B completed the PDDCE on 6/18/22, prior to the side rail installation but should have waited until after they were installed since she (RN-B) was aware of the new order for side rail placement. LPN-C further stated she could see that there was a breakdown in that process. During interview on 6/29/22, at 12:54 p.m. LPN-C stated R188's second PDDCE was completed that day (6/29/22) since it was brought to her attention it had not been completed accurately previously. LPN-C further stated R188's ICCPD was updated with an appropriate reason for use and re-signed by R188 on 6/29/22. During interview on 6/30/22, at 9:42 a.m. DON stated due to the survey, the facility reviewed all residents and found some residents with side rails had not been assessed for the safe use of side rails. DON further stated the PDDCE should have been completed for R188 when they were first installed to ensure appropriateness and her ability to use them safely. During interview on 6/30/22, at 10:59 a.m. maintenance director (M)-B stated there was no formal schedule for checking or maintaining side rails. Facility policy Physical Device Data Collection	F 700		

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F 700	Continued From page 17 and Evaluation dated 7/2018, indicated a physical device data collection tool would be completed on admission, quarterly, annually and with the initiation of any physical device by a licensed nurse and reviewed by the IDT (interdisciplinary team) to ensure the safety of the resident utilizing a physical device. All physical devices would have a medical symptom to warrant the use along with a physician's order. The device would then be listed on the resident's care plan.	F 700		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		8/10/22

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F 755	Continued From page 18 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were provided as ordered for 2 of 5 residents (R23 and R10); and failed to ensure staff were aware of appropriate disposal of fentanyl patches (a controlled narcotic medication) to prevent potential drug diversion for 1 of 1 residents (R10) reviewed for medication administration. Findings include: R23's quarterly Minimum Data Set (MDS) dated 4/8/22, identified intact cognition. R23 had a diagnosis of anxiety. R23's care plan dated 8/2/19, indicated R23 took psychotropic meds to include an antianxiety related to obsessive compulsive disorder and anxiety. R23 was followed by a outside psychiatrist and in house psychologist. R23's Medication Administration Record (MAR) for June 2022 included the following: 1. An order for Clonazepam tablet 0.5 milligrams (mg) by mouth one time daily at 1500 (3:00 p.m.) related to anxiety disorder. The MAR indicated R23 had missed two doses: one on 6/27/22 and one on 6/28/22 and to refer to progress notes. 2. An additional order for Clonazepam tablet 0.5 mg by mouth two time daily at 0600 (6:00 a.m. and 1900 (7:00 p.m.) related to anxiety disorder.	F 755	POC 755 Pharmacy Services R10 and R23 medications were received on 6-29-2022 and given per order. All residents have the potential to be affected including residents who receive Fentanyl. Facility policy and procedure, Medication not received protocol and med destruction, have been reviewed and revised as needed. Facility developed and implemented a new medication not received protocol. Omnicare prior authorization policy was also reviewed. Nurses will be educated on the above policies and protocols. Staff education will be completed by 8/5/22. DON or designee will conduct audits on missed medications including those needing prior authorization and medication destruction. Audits will be completed 5x week for two weeks, and 2x per week for 2 weeks, then weekly for 4 weeks. Audits will be reviewed by QAPI to determine further need. Completion date 8/10/22.	

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F 755	Continued From page 19	F 755		

The MAR indicated R23 had missed one dose on 6/27/22, at 7:00 p.m. and to refer to progress notes.

R23's progress notes dated 6/27/22, at 16:19 (4:19 p.m.) indicated the Clonazepam was not available and pharmacy was notified. A new script (prescription) was needed from the doctor first.

During an observation and interview on 6/27/22, at 6:08 p.m. registered nurse (RN)-A prepared R23's evening medications. RN-A looked through the narcotics drawer on the medication cart and stated the scheduled Clonazepam was empty and she had already notified the clinical manager. RN-A stated the facility had an emergency supply of medication in the Omnicell (an automated medication dispensing cabinet) but she did not think Clonazepam was included in the supply. RN-A went to find R23 to give her the other evening medications. R23 stated she had not slept well and stated she felt like "going out of my mind" and did not know why.

The Omnicell stock list, provided on 6/28/22, included Clonazepam 0.5 mg.

During an observation and interview on 6/28/22, at 3:10 p.m. licensed practical nurse (LPN)-A prepared R23's afternoon medications. LPN-A stated she was not able to give the Clonazepam as ordered because the prescription was out. LPN-A brought the other scheduled medications to R23, administered them, exited the room and started preparing the next resident's medications. When LPN-A was asked if she could obtain the Clonazepam from the Omnicell machine, LPN-A stated she did not have access but could go see if the nurse manager would obtain R23's

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F 755	Continued From page 20 medications from the Omnicell. R10's quarterly MDS dated 3/15/22, identified intact cognition. R10 had a diagnosis of chronic pain syndrome and gastro-esophageal reflux disease (GERD). R10's Pain Care Plan dated 3/29/22, indicated an alteration in comfort related to (r/t) chronic pain syndrome and GERD. Staff were directed to administer medications as ordered. R10's MAR for June 2022, included the following: 1. An order for Protonix (pantoprazole) tablet delayed release 40 mg one time daily by mouth related to GERD. From 6/25/22 through 6/30/22, the MAR indicated the medication was not administered which resulted in six doses of the medication not being administered 2. An order for fentanyl patch 75 micrograms/hour (mcg/hr) apply one patch transdermally (on the skin) every 48 hours for pain and remove per schedule with an order 3. An order to check for patch placement and removal every shift for fentanyl patch 4. An order for famotidine tablet 20 mg by mouth two times a day at 0600 (6:00 a.m.) and 1600 (4:00 p.m.) related to GERD. During an interview on 6/28/22, at 8:34 a.m. R10 stated his pantoprazole for GERD had not been administered for four days. R10 stated medications were sometimes not ordered until the last minute or when they ran out. During a follow up interview at 2:16 p.m. R10 stated he felt heartburn as a result of his missed pantoprazole. R10's progress notes from 6/25/22 through 6/28/22 lacked rationale why the pantoprazole	F 755		

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F 755	Continued From page 21 was not provided or follow up attempts to obtain the medication. During an observation on 6/28/22, at 3:33 p.m. LPN-A removed R23's used fentanyl patch, folded it and set it to the side. LPN-A applied the new patch as ordered. LPN-A exited the room, placed the used patch in a small freestanding sharps container on the nurse's cart in the hallway. LPN-A stated fentanyl patches were placed in the sharps bins and verified the bin was not secure. During an interview on 6/28/22, at 3:43 p.m. RN-A also stated she would put used fentanyl patches in the small freestanding sharps disposal container located on her medication cart in the hallway. During an observation on 6/29/22, at 7:25 a.m. RN-B was preparing R10's morning medications. RN-B picked up one card of the famotidine 20 mg tablets and punched out one pill into a pill cup. RN-B picked up a second bubble pack of the famotidine 20 mg tablets and punched out another pill into the pill cup. This would give R10 double the amount of medication that he was prescribed. RN-B stated the pantoprazole was not available in the medication cart and she would need to check the Omnicell. RN-B went to the Omnicell and the machine displayed a message that the med was not stocked in this cabinet. RN-B was not able to provide the pantoprazole. As RN-B prepared to go into R10's room, she was advised to recheck her medications. RN-B located the extra tablet of famotidine and removed it from the pill cup. During an interview on 6/29/22, at 10:25 a.m. RN-C stated there was an issue with medications	F 755		

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F 755	Continued From page 22 not being reordered timely and running out of the supply, and medications should be re-ordered when there is one week's worth remaining to ensure they don't run out. RN-C stated nurses were additionally expected to either get a back up medication from the Omnicell and/or call the pharmacy to ensure a prescription refill had been ordered. Lastly, Fentanyl patches should be disposed of in the facility "Drug Buster" containers and not in the sharps containers. RN-C showed the Drug Buster units which are available in the medication storage unit room. During an interview on 6/30/22, at 9:53 a.m. the director of nursing (DON) stated she expected medications to be administered as ordered and reordered when the supply ran low. The DON also stated fentanyl patches should be folded in half and disposed of in the Drug Buster. Facility policy General Dose Preparation and Medication Administration dated 1/1/22, indicated facility staff should verify each time a medication is administered that it was the correct dose. Facility policy Reordering, Changing and Discontinuing orders, dated 1/1/22, indicated facilities were encouraged to reorder medications electronically or by fax whenever possible. Additionally, facility staff should review the transmitted re-orders for status and potential issues and pharmacy response. Facility policy, Prescribing, Administration and Disposal of Fentanyl Transdermal Systems dated 1/1/22, indicated patches should be disposed of my folding in half and placed in commercially available disposal kit. The policy noted fentanyl patches are not biohazard waste and should not	F 755		

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F 755	Continued From page 23 be placed in sharps containers.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		8/10/22

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F 758	Continued From page 24 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure provide appropriate side effect monitoring for signs of tardive dyskinesia (TD) [involuntary movements caused by antipsychotic use] with antipsychotic medication consumption for 1 of 4 (R16) residents reviewed for unnecessary medications and utilized antipsychotic medications. Further, the facility failed to ensure orders for as needed (PRN) antianxiety and antipsychotic medication were reassessed or ceased after 14 days, for 1 of 1 residents (R16) reviewed who had orders for as needed psychotropic medication. Findings include: R16's significant change Minimum Data Set (MDS), dated 3/22/22, identified R16 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs). Further the MDS outlined R16 experiences no hallucinations, delusions or other alteration in mood or behavior during the assessment period. R16's diagnoses included, schizoaffective disorder, major depressive	F 758	POC F758 Free from Unnecessary Psychotropic Meds/PRN Use On 6/29/2022 orders for PRN psychotropic medications were discontinued for R16 by hospice due to lacking rational and need as the PRN medications were not being used consistently. AIMS was completed 6/29/2022 for R16. All residents who are on PRN psychotropic medications or scheduled psychotropic medications have the potential to be affected. Psychotropic medication use protocol, will be reviewed and revised as needed by IDT. PRN psychotropic medications will be reviewed by prescribing physicians and appropriate documentation that supports the 14 day extension will be scanned into resident chart. AIMS side effect monitoring will be completed every 6 months. Licensed nurses will be reeducated on the psychotropic medication use protocol.	

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F 758	Continued From page 25 disorder, and adjustment disorder with mixed anxiety and depressed mood. R16's Medication Administration Record (MAR) dated June 2022, included: Seroquel tablet [an antipsychotic medication] 75 mg (milligrams) by mouth two times a day and give 100 mg one time a day for hallucinations and delusions. Haldol [an antipsychotic medication] 2 mg/ml (milliliter) give 0.25 ml by mouth every 1 hours as needed for agitation related to schizoaffective disorder with a start date of 5/27/22 and no documented stop date. R16 received this medication 1 time during the month of June. Seroquel tablet give 50 mg by mouth as needed for hallucinations and delusions related to schizoaffective disorder with a start date of 4/21/22 and no documented stop date. R16 had not received this medication during the month of June. Lorazepam [an antianxiety medication] 2 mg/ml give 0.25 ml by mouth every 2 hours as needed for anxiety with a start date of 5/27/22 and no documented stop date. R16 has used this medication 2 times during the month of June. R16's care plan dated 7/1/21 included, "I take psychotropic meds due to depression, anxiety and schizophrenia. A corresponding intervention dated 3/2/22, instructed, "complete AIMS per order" and "monitor for adverse effects of medication." R16's Pharmacy Consult Report dated 3/23/22, recommended adding 14 day stop dates to PRN orders for antipsychotic and anxiolytic medications and reassess use.	F 758	Education will be completed by 8/5/2022. The Director of Nursing or designee will conduct audits on PRN psychotropic medication to ensure rational for continuation, completion of AIMS every 6 months 5x per week for two weeks, and 2x per week for 2 weeks, then weekly for 4 weeks. Results of audits will be reviewed at QAPI to determine need for continuation. Completion Date: 8/10/2022	

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F 758	Continued From page 26 R16's Pharmacy Consultation Report dated 4/27/22, noted an Abnormal Involuntary Movement Scale (AIMS) [an assessment of the mental and physical effect of antipsychotic medications] or other appropriate assessment to identify symptoms of Tardive Dyskinesia (TD) was not documented in R16's medical record within the previous 6 months. Additionally, the Consultation Report included a recommendation to "monitor for involuntary movements now and at least every 6 months or per facility protocol." An additional Pharmacy Consultation Report dated 4/27/22 recommended adding a 14 day stop as required by regulation. R16's Pharmacy Consultation Report dated 6/22/22, noted, "REPEATED RECOMMENDATION from 4/27/22," and included a recommendation to discontinue the PRN orders, or assess and add a 14 day stop as required by regulation. R16's medical record showed the most recent AIMS was completed 9/21/21, and indicated a score of 5 out of 28 [the higher the score the great the impact of observed movements on resident]. R16's physician progress note dated 5/10/22, included, "Rather severe movement disorder of tardive dyskinesia with tremor with intention of both upper extremities." On 6/27/22, at 3:10 p.m. surveyor observed R16 with a noticeable tremor in his hands. During an interview on 6/29/22, at 10:45 a.m. the director of nursing (DON) stated an AIMS should be completed every 6 months for any resident taking an antipsychotic medication to ensure that	F 758		

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F 758	Continued From page 27 medication does not cause any irreversible negative effects such as TD. Additionally, the DON stated hospice providers don't want to provide stop dates for as needed medications. During a follow-up interview on 6/29/22, at 1:54 p.m. the DON stated R16's PRN psychotropic medications have not been appropriately reassessed or stopped after 14 days. The facility policy, Psychoactive Medication Use and Gradual Dose Reduction, dated 2010, instructed, "Abnormal Involuntary Movement (AIMS) will be performed on residents receiving antipsychotic medications to screen for tardive dyskinesia every 6 months." Additionally, the policy included, "For PRN psychotropic drugs the physician/prescribing practitioner must document their rationale in the resident medical record if he/she believes it is appropriate to extend the order beyond 14 days. PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication."	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure they were free	F 759	POC 759 Free of Medication Error Rts 5 Prcnt or More	8/10/22

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F 759	Continued From page 28 of a medication error rate of five percent or greater. The facility had a medication error rate of 16% with 4 errors out of 25 opportunities involving 2 of 4 residents (R23 and R10) who were observed during medication administration. Findings include: R23's quarterly Minimum Data Set (MDS) dated 4/8/22, identified intact cognition. R23 had a diagnosis of anxiety. R23's Medication Administration Record (MAR) for June 2022 included the following orders: 1. clonazepam tablet 0.5 milligrams (mg) by mouth one time daily at 1500 (3:00 p.m.) related to anxiety disorder. 2. clonazepam tablet 0.5 mg by mouth two times daily at 0600 (6:00 a.m. and 1900 (7:00 p.m) related to anxiety disorder. During an observation and interview on 6/27/22, at 6:08 p.m. registered nurse (RN)-A prepared R23's evening medications. RN-A looked through the narcotics drawer on the medication cart and stated the scheduled clonazepam was empty and she had notified the clinical manager. RN-A gave R23 other scheduled medications. RN-A had not administered the scheduled clonazepam. During an observation and interview on 6/28/22, at 3:10 p.m. licensed practical nurse (LPN)-A prepared R23's afternoon medications. LPN-A stated she was not able to give the clonazepam as ordered because the prescription was out. LPN-A gave R23 other scheduled medications. LPN-A had not administered the scheduled clonazepam.	F 759	R10 and R23 medications were received on 6-29-2022 and given per order. All residents have the potential to be affected. Facility policy and procedure, for Rights of Medication administration have been reviewed and revised as needed by IDT. Facility developed and implemented a new medication not received protocol. Omnicare prior authorization policy was also reviewed. Nurses and TMAs will be educated on the Rights of Medication Administration and medication not received protocol. Staff education will be completed by 8/5/22. DON or designee will conduct audits on missed medications including those needing prior authorization and medication administration. Audits will be completed 5x week for two weeks, and 2x per week for 2 weeks, then weekly for 4 weeks. Audits will be reviewed by QAPI to determine further need. Completion date 8/10/22.	

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F 759	Continued From page 29	F 759		

R10's quarterly MDS dated 3/15/22, identified intact cognition. R10 had a diagnosis of gastro-esophageal reflux disease (GERD) and chronic pain syndrome.

R10's MAR for June 2022, included the following orders:
1. Protonix (pantoprazole) tablet delayed release 40 mg one time daily by mouth related to GERD
2. famotidine tablet 20 mg by mouth two times a day at 0600 (6:00 a.m. and 1600 (4:00 p.m.) related to GERD.

During an observation on 6/29/22, at 7:25 a.m. RN-B was preparing R10's morning medications. RN-B picked up one card of the famotidine 20 mg tablets and punched out one pill into a pill cup. RN-B picked up a second bubble pack also of famotidine 20 mg tablets and punched out another pill into the same pill cup. This would give R10 double the amount of medication that he was prescribed. Next, RN-B stated the pantoprazole was not available in the medication cart because the medication ran out. As RN-B prepared to go into R10's room, she was advised to recheck her medications. RN-B located the extra tablet of famotidine and removed it from the pill cup. RN-B gave R10 other scheduled medications. RN-B had not administered the scheduled pantoprazole.

During an interview on 6/30/22, at 9:53 a.m. the director of nursing (DON) stated she expected medications to be administered as ordered and reordered when the supply ran low.

Facility policy General Dose Preparation and Medication Administration dated 1/1/22, indicated facility staff should verify each time a medication

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F 759	Continued From page 30 is administered that it was the correct dose. Facility policy Reordering, Changing and Discontinuing orders, dated 1/1/22, indicated facilities were encouraged to reorder medications electronically or by fax whenever possible. Additionally, facility staff should review the transmitted re-orders for status and potential issues and pharmacy response.	F 759		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to store and label food to prevent potentially degraded food from being served to residents. This had the potential to affect all 80 of the 81 residents who received food	F 812	POC Food Procurement, Store/Prepare/Serve-Sanitary Dietary director and Dietitian threw everything away in the kitchen that was not dated, labeled, or past date of	8/10/22

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F 812	Continued From page 31 from the kitchen. Findings included: On 6/27/22 at 12:05 p.m. surveyor conducted a kitchen tour with the director of dietary services (DDS) and observed the following in the walking coolers: - A large partially used bag of cut lettuce tapped shut with masking tape - illegible writing on the tape. DDS stated she was unable to read the handwriting, could not identify the date the protect had been opened. - A serving bowl of prepared 3-bean salad - undated - A partially used bag of French toast - undated - 2 small serving bowls of ground beef - undated - 3 large partially used, plastic containers of Reliance salad dressing. Each container displayed a handwritten date which indicated when the product was opened - 5/30, 6/7, and 6/8 - A large partially used plastic container of thousand island salad dressing - dated 5/21/22 - A large partially used plastic container of coleslaw - date 5/1. There were multiple small spots of furry blue/gray matter on the outside of the container. DDS identified the matter as mold. - 1 large partially used plastic container of honey mustard salad dressing - dated 4/4. There were multiple small spots of furry blue/gray matter on the outside of the container. DDS stated the matter appeared to be mold. - 4 individually wrapped meat and cheese sandwiches - undated - A partially used container of beef base - undated - A partially used container of vegetable base - dated 5/13/22 - A large partially used jug of salsa - dated 6/16	F 812	expiration. Reeducation was completed on 6/27/2022 and ongoing with new kitchen staff. All residents have the potential to be affected. Policy and procedure, Food Production and Food Safety, will be reviewed and revised as needed by IDT. Education on labeling and dating/food storage has been completed 6/27/2022 and ongoing with new staff. Dietary Director or designee will audit storage of food for labeling and dating and removal of expired food 5x per week for two weeks, and 2x per week for 2 weeks, then weekly for 4 weeks. Results of audits will be reviewed at QAPI to determine need for continuation. Completion date: 8/10/2022	

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F 812	Continued From page 32 - A large partially used container of pickle relish - dated 6/7 - A full tray of individually dished chocolate pudding with whipped cream - dated 6/13 - 2 serving bowls of prepared ham pasta salad - undated - A serving bowl of cubed turkey - undated - A partially used stick of butter - undated - A partially used block of pre-sliced American cheese - undated - A partial tray of individually dished apple crisp with whipped cream - undated - A partially used bag of shredded mozzarella cheese - undated - A Styrofoam to-go container containing grapes and sliced watermelon - undated - 2 small bowls of light brown pudding-like food. DDS identified the item as, "something pureed" but was unable to provide additional identification - undated - A serving bowl of crushed pineapple - dated 6/22 - A serving bowl of chocolate pudding dated - 6/16 - A partially used bag of flour tortillas - dated 3/8/22 and another partially used bag of flour tortillas - undated - 3 containers of partially used egg salad - undated - A large partially used container of Italian salad dressing - dated 6/15 - A partially used package of pancakes - undated - A partially used carton of liquid whole eggs - undated - A serving bowl of diced peaches - dated 6/21/22 When interviewed during the tour, DDS stated when a food item has been opened or prepared staff should clearly label with the date. All food	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	1900 SHERREN AVENUE MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 33 items should be used or disposed of within 7 days of that date. DDS was unable to state when the observed undated food had been opened or prepared. DDS stated all open undated food or food prepared more than 7 days ago will need to be discarded. The facility policy, Food Storage, dated 2021, included, "All stock must be rotated with each new order received. Rotating tock is essential to assure the freshness and highest quality of all foods." The policy goes on to inform, "Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. Leftover food must be used within 7 days or discarded as per the 2017 Federal Food Code."	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE** **MAPLEWOOD, MN 55109**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/29/2022. At the time of this survey, Maplewood Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000		

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

Electronically Signed | 07/21/2022

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
	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

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MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE** **MAPLEWOOD, MN 55109**

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K 000	Continued From page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Maplewood Care Center is a 3-story building was constructed in 1969 and was determined to be of Type II(222) construction. It has a full basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 115 beds and had a census of 81 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE** **MAPLEWOOD, MN 55109**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install an HVAC system per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1 and 9.2, and NFPA 90A (2012 edition), section 4.3.12.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/29/2022, between 9:00 AM and 12:00 PM, it was revealed by observation that the egress corridors, which were built in 1969, were being used as a portion of the supply air system serving the 1st, 2nd, and 3rd floors, and the return air was being exhausted through the resident room bathrooms. An interview with the Maintenance Director revealed that the HVAC in the corridors supplies air and is exhausted through the resident room bathroom fans at the time of discovery.	K 521	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Maplewood Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. POC K521 HVAC Maintenance director in process of filling out and submitting waiver CMS – 2786R for using the hallways as plenum. All residents have the potential to be affected. Building was built in 1969, prior to 1972 codes that associate with this waiver. Completion date: 8/10/2022	8/10/22
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923		8/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

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MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE** **MAPLEWOOD, MN 55109**

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K 923	Continued From page 3 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE** **MAPLEWOOD, MN 55109**

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K 923	Continued From page 4 Based on observation and staff interview, the facility failed to maintain a medical gas storage room per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/29/2022, between 9:00 AM and 12:00 PM, it was revealed by observation that the Oxygen Room door did not close properly into the door frame. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 923	K923 Gas Equipment – Cylinder and Container Storage Maintenance Director and Maintenance assistant remounted door frame to oxygen room so door now functions properly as of 6/30/2022. All residents have the potential to be affected. Maintenance Director or designee will audit the oxygen room door for compliance weekly by adding to maintenance weekly task list. Completion date: 8/10/2022	

Name of Facility Maplewood Care Center

2012 LIFE SAFETY CODE

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K521	Based on observation and staff interview, the facility failed to install an HVAC system per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1 and 9.2, and NFPA 90A (2012 edition), section 4.3.12.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/29/2022, between 9:00 AM and 12:00 PM, it was revealed by observation that the egress corridors, which were built in 1969, were being used as a portion of the supply air system serving the 1st, 2nd, and 3rd floors, and the return air was being exhausted through the resident room bathrooms. A continuing waiver is requested for K521 Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated 8-9-2022 for a complying HVAC system is $625,746.00 2. Existing non complying HVAC systems can be allowed to continue in use. Ther will be no adverse effect on the builing occupants safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13 1999 edition. 2. The corridors are equiped with a complying smoke detection system. 3. The facility has obtained an approval plan of correction for any other fire safety deficiencies that were cited.

Surveyor *(Signature)*	Title	Office	Date
Roy M Kingsley	Deputy State Fire Marshal	Minnesota Deprtment of Public Safety	07/19/22
Fire Authority Official *(Signature)*	**Title**	**Office**	**Date**
William Abderhalden 37009	Minnesota State Fire Marshal Division	Minnesota State Fire Marshal Division	08/09/22

APEX MECHANICAL	**Apex Mechanical** Minneapolis, MN	Bid Number

Date of Proposal: 8/9/22

Customer Name	Job Address
Maplewood Care Center	1900 Sherren Ave E Maplewood, MN 55109
Todd Bruns	
tabruns@voa.org	

Scope of work:

- Shut down and isolate the make up air
- Remove and add a new make up air we will hang it in the same place
- Add another section to the chiller for more cooling BTU's
- Re pipe the air handler with heat and cooling
- Remove all ductwork from the shaft and hallways
- Install new ductwork and smoke dampers to all the rooms
- We will get the ducts balanced to the specs
- We will run electrical to all the smoke dampers
- Fier contractor will replace the main panel and weir all safeties in from the smokes
- Test the mua set it to manufacturers specs

Includes:

- New MUA Trane
- Smoke dampers for every room
- New section for the chiller for more capacity
- All wiring/electrical
- Engineered plans
- Permit/inspection
- Mechanical drawings/as builts
- New fire main panel and wiring

Total Amount :	$625,746.00

Project Manager or Technician Signature	Customer Signature*

APEX MECHANICAL	**Apex Mechanical** Minneapolis, MN	Bid Number

*I have read the disclosures and agree to the payment schedule for the work described above.

Payment Schedule		
Payment Number	Amount	Milestone Activity
1	$312,873.00	Acceptance of bid (down payment)
2	$104,291.00	Shipping of equipment
3	$104,291.00	When units are set in place
4	$104,291.00	Completion of job
Total	$625,746.00	N/A

Disclosures:

Apex Mechanical agrees to perform the work described in the attached proposal subject to the following provisions:

1. This proposal is good for a period of up to 30 days from the date of the proposal.
2. The cost of any changes to the scope of work will be priced individually and agreed to, in writing by both parties, before additional work is performed. The cost will be added to the original project price.
3. Work is normally scheduled to begin 7 to 10 business days after the proposal has been signed and the deposit has been paid depending on parts and equipment availability.
4. Until written verification of available funds is received from the lender, no work will commence on the project.
5. We reserve the right to file a mechanic's lien at any time.
6. All material is guaranteed to be as specified. All work to be completed in a workmanlike manner according to standard practices. Any alteration or deviation from the above specifications involving extra costs will be executed only upon written orders and will become an extra charge over and above the estimate. All agreements contingent upon strikes, accidents or delays beyond our control. Owner to carry fire, tornado, and other necessary insurance.