

Protecting, Maintaining and Improving the Health of Minnesotans

Independent Informal Dispute Requested

This facility has requested an Independent Informal Dispute on the tag(s) identified below.

Exit Date Being	Tag# -
Disputed	Scope/Severity
	Disputed
09/12/2014	F314 revised to a D
	F278 was removed
	F282 was upheld to a D
	Disputed



Protecting, maintaining and improving the health of all Minnesotans

February 6, 2015

Rebecca K. Coffin Voigt, Rode, and Boxeth LLC 2550 University Avenue West Suite 190 South St. Paul, MN 55114 sent via fax: February 6, 2015 (651) 209-6160

RE: OAH Docket 66-0900-31984

Dear Ms. Coffin:

This letter is in response to the Independent Informal Dispute Resolution (IIDR) requested by Haven Homes, Maple Plain, regarding two deficiencies issued as a result of a standard licensing and recertification survey, exit date, September 12, 2014. Haven Homes requested a review of Tags F278, F282, F314 and F353. Based on information provided to the Minnesota Department of Health (MDH) prior to the IIDR, the MDH rescinded Tag F278. Prior to the IIDR Haven Homes withdrew its dispute of Tag F353. The IIDR was held before Administrative Law Judge Thomas Wexler. The Department received Judge Wexlers's recommended decision on January, 6, 2015.

Decision

After careful review of Judge Wexler's recommendation and the material submitted to the Judge in support of each party's position, I do not concur with Judge Wexler's recommendation on Tag F314 that the tag be rescinded. The finding that Resident #56 was not repositioned every two hours as assessed by the facility to be required, is a deficient practice. This deficient practice created the potential for harm, and F314 is valid at a scope and severity of Level D. I also disagree with the recommendation that Tag F282 be rescinded for Resident #56. The care plan for Resident #56 directed staff to reposition the resident every two hours, and the resident was not. The tag is valid as written a scope and severity of Level E.

Rationale

Tag F314 requires that, based on the comprehensive assessment of a resident, a nursing facility must ensure that (1) a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. F314 further defines avoidable pressure ulcers to be those in which the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

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Resident #56 had no cognitive impairment, required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for developing pressure ulcers, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed.

Resident #56 was on a turning and repositioning program and per physician order was to be repositioned at no greater than two hour intervals. The resident's Skin Observation Reports dated 1/2/14 through 6/5/14 indicated the resident's skin was intact and had no pressure ulcers. A 6/17/14 Skin Injury/Wound Report indicated Resident #56 developed a pressure ulcer in the right gluteal fold. This pressure ulcer had worsened by 9/10/14. A second pressure ulcer was identified on a Skin Injury/Wound Report dated 7/27/14, also located on the right buttock.

Current physician orders dated 9/5/14 instructed staff to reposition every two hours instead of every three hours. Nursing notes dated 6/2/14 indicated that Resident #56 was being seen at a wound clinic for two stage 4 pressure ulcers on the right and left heel. There was no evidence the wound clinic assessed or treated any of the pressure areas on Resident #56's buttocks/sacral area.

During survey on 9/10/14 it was observed from 7:18 a.m. to 9:46 a.m. that Resident #56 was sitting in a wheelchair, on a cushion, unable to shift his weight independently, and was not approached by staff to reposition after a two hour interval had passed. During interviews on 9/10/14 and 9/11/14 staff was not aware of Resident #56's worsening pressure ulcers. An interview with Resident #56 at 7:20 a.m. on 9/10/14 noted the resident stated he had pain in his buttocks. At that time Resident #56 clarified he had been in the wheelchair since 6:00 a.m.

On 6/17/14 Resident #56's primary physician was notified of the new pressure ulcer and sent an order for skin care. On 6/19/14 facility nursing staff requested a change from the physician to use an alternative dressing with a border, the physician approved. Resident #56's physician was notified the same day as a second pressure ulcer was noted. On 7/27/14 a new pressure ulcer was identified on Resident #56's right buttocks. Treatment was prescribed and followed. Facility progress notes reflect continuing attention to the cares of the buttock area ulcers. The facility performed numerous tissue tolerance evaluations, predisposing disease risk evaluations, and Braden scale assessments. There were at least 55 days recorded in the nurses' notes where there was at least one communication with a doctor and many of those communications related to the ulcers on the buttocks, requesting advice and change orders in the cares.

There is undisputed evidence that the facility did not reposition Resident #56 for more than two hours on September 10, 2014. This is a lapse in following the care plan, however, it is the only lapse observed. During interview with NA-A, she stated the facility was short staffed and they were not always able to complete resident cares as scheduled. Simultaneous review of F353 supports the nursing assistant's interview that staffing was an issue contributing to consistently completing resident cares according to the plan of care. Further, although there was discussion of refusals of care during the IIDR meeting, the concern was never identified or reported by facility staff during the survey. Careful review of facility documentation identified behavioral assessments cited no behaviors further documenting no refusal of cares. The facility pressure ulcer assessment failed to identify any behavioral issue related to noncompliance with interventions. Review of the care plan provided by the facility as the current care plan, identified no concern with behaviors and therefore no interventions were in place to address the refusal of cares. In addition, although the wound clinic regularly reviewed the heel pressure ulcers, there was no evidence in the record of the wound clinic addressing any other pressure ulcers. If the wound clinic had

Rebecca K. Coffin February 6, 2015 Page 3

provided services for any other areas, there would have been documentation of the service(s) provided in the consultation documentation.

Without consistently providing the services required to minimize the risk for pressure ulcers, the facility is unable to demonstrate the pressure ulcers on the buttocks/sacral area were unavoidable. This lapse creates a potential for harm, however, given other interventions and cares were provided to Resident #56, it cannot be determined that it caused actual harm. The deficiency remains; however, it is reduced in severity from a Level G to a Level D.

Tag F282 requires that the services provided by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Resident #56's plan of care clearly directed staff to reposition him no greater than every two hours. This direction was supported by a physician order.

There is undisputed evidence that the facility did not reposition Resident #56 for more than two hours on September 10, 2014. This is a lapse in following the care plan, however, it is the only lapse observed. During interview with NA-A, she stated the facility was short staffed and they were not always able to complete resident cares as scheduled. Simultaneous review of F353 supports the nursing assistant's interview that staffing was an issue in consistently completing resident cares according to the plan of care.

This lapse creates a potential for harm. This is a valid deficiency. This deficiency is appropriately cited at the scope and severity Level E.

This concludes the IIDR process. As noted in the Department of Health's Information Bulletin 04-07, the final decision of the Department is not binding on the Centers for Medicare and Medicaid Services.

Sincerely,

Edward P. Ehlinger, M.D., MSPH

Commissioner P.O. Box 64975

Saint Paul, Minnesota 55164-0975

cc:

Judge Thomas Wexler Jan M. Suzuki, CMS Region V Deb Holtz Darcy Miner Christine Campbell Monica Larson

Olson, Cynthia (MDH)

From:

rcoffin@vrb-law.com

Sent:

Friday, October 10, 2014 1:52 PM

To:

*MDH_FPC-IDR

Subject:

IDR Form

PROVIDER - 00950, HAVEN HOMES OF MAPLE PLAIN

IDR Type - IIDR

Tags: FF278, F282, F310, F314, F317, F318, F353 Survey Date(Exit Date): September 12, 2014

Review will be conducted - In person

Dates when facility cannot participate: To be determined

Will attorney for facility be attending: Yes

No of persons attending: 6-7 Submitter Name: Rebecca Coffin Email:rcoffin@vrb-law.com

STATE OF MINNESOTA OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of Haven Homes (IIDR)

RECOMMENDED DECISION

This matter came before Administrative Law Judge Thomas W. Wexler for an informal dispute resolution meeting on December 22, 2014. The meeting concluded on that date.

Christine Campbell appeared on behalf of the Minnesota Department of Health (MDH). Mary Cahill also attended on behalf of MDH. Holly Kranz, the compliance survey team leader, testified on behalf of MDH.

Rebecca Coffin, Voight, Rode & Boxeth LLC, appeared on behalf of Haven Homes (Facility or Home). Jessica Sellner, Sue Boyd, Diane Lynch and Renee Anderson also attended on behalf of the Facility. Angie Tormanen, the Nursing Supervisor, and Brenda Anderson, an LPN at the Home, testified on behalf of the Facility.

Based upon the testimony and exhibits submitted at the resolution meeting, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

- 1. The Commissioner of Health (Commissioner) should further recommend that tag F282 be set aside as the evidence does not establish a deficient practice.
- 2. The Commissioner should further recommend that tag F314 be set aside because the evidence does not establish a deficient practice and the outcome was unavoidable.

Dated: January 6, 2014

s/Thomas W. Wexler

THOMAS W. WEXLER Administrative law Judge

Reported: Digital Recording; no transcript prepared

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) (2014), this recommended decision is not binding upon the Commissioner of Health. Pursuant to Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility, indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge, within ten (10) calendar days of receipt of this recommended decision.

MEMORANDUM

General Statutory and Regulatory Background

This matter arises out of a state compliance survey conducted at the Facility between September 8 and 12, 2014.¹

Participation requirements for skilled nursing and long-term care facilities in the Medicare program are set forth in 42 C.F.R. pt. 483, subp. B (2014). Provisions governing the surveying of such entities and compliance enforcement are set forth in 42 C.F.R., pt. 488, especially subp. E, F (2014).

Compliance with participation requirements is monitored by periodic surveys by state agencies such as the MDH. The state agency reports any deficiencies on a form called a "Statement of Deficiencies and Plan of Correction" (form CMS 2567).²

A "deficiency" is a failure to meet a participation requirement in 42 C.F.R. 483, subp. B.³ Deficiencies are designated by alpha-numeric "tags" corresponding to a regulatory requirement in Part 483 (2014).

The survey findings also include a determination as to the severity of each deficiency.⁴ The seriousness of a deficiency depends on both its "scope" and its "severity."⁵

When citing deficiencies, the state surveyors use the CMS Guidance on Deficiency Categorization. There are four levels of severity and three columns of scope. The range of deficiencies is set out on a grid. Each square on the grid has a letter designation. "A" is the least serious and "L" is the most serious. On the bottom row of the grid are the least serious deficiencies and the top row are most serious in terms of harm or threatened harm to the resident.

If a facility is not in substantial compliance, CMS may either terminate the facility's provider agreement or allow the facility the opportunity to correct the deficiency

¹ MDH Ex.J.

² Centers for Medicare and Medicaid Services (CMS).

³ See 42 C.F.R. § 488.301 (2014)

⁴ See 42 C.F.R. § 488.404.

⁵ See 42 C.F.R. § 488.404(b).

⁶ MDH Ex. D.

pursuant to a plan of correction.⁷ Depending upon the severity of the deficiency, CMS may also impose intermediate remedies, such as monetary penalties, for each day the facility was not in substantial compliance with the participation agreement.⁸

A facility may request an informal opportunity to dispute condition-level survey findings.⁹

On October 10, 2014, MDH issued a statement of deficiencies (form CMS 2567) following survey of the Facility. The statement designated certain "F-Tags." Only two of those F-Tags were in dispute at this resolution meeting. Both of the disputed F-Tags relate to the care of resident number 56 (R56). The disputed F-Tags are F282 and F314.

F282 relates to failure to ensure the care plan for repositioning of resident R56. This tag was issued at a severity level E,¹¹ which means a pattern deficiency that results in no immediate jeopardy and no actual harm, but has potential for more than minimal physical, mental and/or psychological discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.¹²

F314 relates to failure to ensure interventions as assessed and to re-evaluate to prevent new pressure ulcers from developing. This tag was issued at a severity level G, ¹³ which means an isolated deficiency that results in actual harm that has compromised the resident's ability to maintain and/or reach his highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. ¹⁴

MDH had also cited tag F278, failure to ensure accuracy of the Minimum Data Set, resident status assessment, for R56, but MDH has agreed that citation is to be withdrawn.

As to F282, the Facility contends that it had qualified staff who knew of the policy to provide repositioning of R56 every two hours and that was routinely done, although it was exceeded on the day of observation, September 10, 2014. The Facility also alleges that R56 often resisted repositioning when offered. The Facility requests that references to R56 be removed from F282 because it was in substantial compliance with the regulations.

⁷ See 42 C.F.R. §§ 488.400, subp. F et seq.

[°] Id.

⁹ See 42 C.F.R. § 488.745; Minn. Stat. § 144A.10, subd. 16 (2014).

¹⁰ MDH Ex. J.

¹¹ *Id.* at J-13.

¹² Facility Exs. C, D, G-J.

¹³ *Id.* at J-25.

¹⁴ Facility Exs. C, D, G-J.

As to F314, the Facility contends that the pressure ulcers that R56 developed were "unavoidable" and that it was in substantial compliance with the regulations in assessing, monitoring, and providing appropriate interventions to address R56's pressure ulcers. The Facility requests that this F314 be rescinded.

"Substantial compliance" is a term of art. 42 C.F.R. § 488.301 defines substantial compliance as follows:

Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

"Minimal harm" is not specifically defined. However, 42 C.F.R. § 488.404(b) establishes guidelines to determine the seriousness of a deficiency, as follows:

- (b) Determining seriousness of deficiencies. To determine the seriousness of the deficiency, CMS considers and the state must consider at least the following factors:
 - (1) Whether a facility's deficiencies constitute-
 - (i) No actual harm with a potential for minimal harm;
 - (ii) No actual harm with a potential for more than minimal harm, but not immediate jeopardy;
 - (iii) Actual harm that is not immediate jeopardy; or
 - (iv) Immediate jeopardy to resident health or safety.
 - (2) Whether the deficiencies-
 - (i) Are isolated:
 - (ii) Constitute a pattern; or
 - (iii) Are widespread.

Seriousness of a deficiency thus involves two components: level of harm to the resident and scope of the conduct in the facility.

There are voluminous studies and writings addressing pressure sores (commonly referred to as pressure ulcers). The writings address evaluation of susceptibility to ulcers, care practices to avoid ulcers (especially frequency of repositioning), periodic reevaluations as may be required to modify care practices for a particular resident, bed and chair devices, off-loading practice, and wound cares. Pressure ulcers are one of the principal concerns of hospital and nursing facility care, and thus, are specifically

addressed in the C.F.R. and extensively addressed in the survey regulations. 42 C.F.R. § 483.25(c) provides as follows:

- (c) *Pressure sores.* Based on the comprehensive assessment of a resident, the facility must ensure that—
- (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were <u>unavoidable</u>; and
- (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(emphasis added)

What is "avoidable" and "unavoidable" is defined as follows:

"Avoidable" means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

"Unavoidable" means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.¹⁵

Nursing facilities and skilled nursing facilities are not unconditional guarantors of favorable outcomes, but the regulations on quality of care impose a duty to provide services designed to achieve those outcomes to the highest degree practicable. 16

The surveying agency has the burden of setting forth the factual basis for its determination that the facility was not in substantial compliance. It must also produce evidence related to any disputed statement of fact. This does not appear to be a burden of proof, but rather a burden of production. When that showing is made, then the burden shifts to the facility to show that the alleged

¹⁶ Florence Park Care Center v. CMS, HHS departmental Appeals Board, Appellate Division, July 13, 2004 (MDH Exhibit E. at E-9).

¹⁷ *Id.* at p. E-12.

¹⁵ State Operations Manual (SOM), MDH Exhibit G-2. The SOM is actually a federal document that includes regulations for facilities enrolled in the Medicare/Medicaid program.

deficiencies were isolated and did not increase the risk for the affected resident to potentially cause more than minimal harm. ¹⁸

Course of Treatment for Resident Number 56

Resident 56 (R56) is a male born January 21, 1923. He was admitted to the Facility on December 10, 2013. He was then 90 years of age, was 5' 9" tall and weighed 133.2 pounds. He had multiple diagnoses upon admission including the following:

- A. Benign prostatic hyperplasia/bladder outlet obstruction.
- B. Hypertension.
- C. Diabetes mellitus type II.
- D. Foot drop.
- E. Hyperglycemia
- F. Mild leukocytosis.
- G. Weakness.
- H. Bilateral pressure ulcers on his heels.
- I. A pressure ulcer on his coccyx.
- J. He was alert and oriented.
- K. His speech was clear. 19

A comprehensive care plan was developed upon admission.²⁰

The tags in this case relate primarily to the alleged failure of the Facility to properly address the requirements directed to avoidance of pressure ulcers. Thus the findings and discussion here will focus on those allegations.

The coccyx ulcer, that was present on admission was 1.3×0.3 cm, was an open ulcer within a larger red rash area. The ulcer resolved by January 2, 2014, and the Facility continued to monitor the area thereafter. 21

The bilateral heel ulcers never resolved.²² There is no contention that the Facility did not adequately monitor and care for the heel ulcers. It appears that they were well cared for and that these vulnerable ulcers never became infected. The care and

¹⁸ *Id.*at p. E-13 and 42 C.F.R. § 488.301.

¹⁹ Facility Exs. 1, 34 (p. 1).

²⁰ Facility Ex. 34.

²¹ Facility Ex. 2.

²² Facility Ex. 3.

treatment of the heel condition is relevant here. It shows the regularity of doctor visits, the doctors' primary concerns for patient welfare, and that it likely required bed positioning with feet elevated, a regimen that heightened stress to the buttock area. The Facility records reflect regular attention to and treatment of the heel ulcers. R56 was seen on approximately a monthly basis by Dr. Jennifer Rysso at Ridgeview Medical Center for treatment of his heel ulcers. The Rysso was R56's primary care doctor.

R56 was seen on or about March 14, 2014 by Dr. Dawn Stapleton at the Lakeview Clinic, who performed a wound debridement on the heel ulcers.²⁵

R56 was also being seen for the heel ulcers by a Wound, Ostomy and Continence Nurse (WOC or WOCN). On May 13, 2014, the WOC felt that she did not have anything further to offer R56 with respect to his heel ulcers and recommended referral to a formal wound clinic.²⁶

R56 was also seen by Dr. Matthew Melin, a vascular surgeon, on June 2 and again on June 25, 2014. Dr. Melin diagnosed probable peripheral arterial disease, he viewed the heel ulcers, did not recommend revascularization, but did discuss the option of hospice care. He specified cares for the foot ulcers.²⁷

Dr. Rysso's exam records reflect approximate monthly visits from March 2014 through June 2014, after which R56 was seen more frequently. He was seen three times in July and again on August 1, 2014. None of these progress notes mention pressure sores on his gluteal area, sacrum or coccyx, although Dr. Rysso was notified of these developments by the Facility as they appeared and as hereafter noted.

On June 17, 2014, the Facility first noted two areas of skin breakdown on R56's gluteal folds. There was a red raised area on his left gluteal fold²⁹ and an open area on his right gluteal fold.³⁰ The left gluteal fold condition resolved by July 9, 2014. The right gluteal fold condition was consistently monitored, but did not heal. Dr. Rysso was promptly informed on June 17 of the of the gluteal fold issues and she sent an order for that skin care.³¹

On June 19 nursing requested a change from the doctor for treatment of the right gluteal fold to use an alternative dressing with border.³²

²³ Facility Exs. 4-10, 18, 46.

²⁴ Facility Exs. 11-17, nursing visit summaries.

²⁵ Facility Ex. 31.

²⁶ Facility Ex. 17.

²⁷ Facility Exs. 29, 30.

²⁸ Facility Exs. 20 to 28.

²⁹ Facility Ex. 41.

³⁰ Facility Ex. 42.

Facility Ex. 43, nurses note on June 17, 2014.

³² Facility Ex. 43, p. 8.

The progress notes reflect continuing attention to the cares of the gluteal fold and other buttock area ulcers.³³

On June 21, 2014, R56 complained about his Stimulite chair cushion because it felt like he was sitting in a hole.³⁴ The nurse consulted with physical therapy and it was decided to provide a vector pressure redistribution cushion.³⁵ The nursing staff then did a sitting tissue tolerance assessment on 6/23/2014 and a new Braden scale evaluation on that same day.³⁶

Dr. Rysso's report of July 18, 2014 opines that R56 has experienced significant gradual decline in overall medical status and suggested that the code status be changed to comfort care status.³⁷

On July 27, the Facility noted a new open wound on R56's right buttocks.³⁸ The doctor was notified, prescribed treatment and the Facility implemented the treatment.³⁹ The new open area was not likely due to repositioning issues. It was likely the result of trauma from the adhesive edge of the right gluteal fold dressing.⁴⁰ The Facility then requested permission from the doctor to change the wound dressing to prevent further fragile skin trauma.⁴¹

On August 24, 2014 nursing noted a new reddened area on R56's sacrum/coccyx region, requested a treatment order, and on August 25, 2014, Dr. Rysso was notified of the reddened area.⁴² Dr. Rysso observed the reddened area on September 5.⁴³ The Facility again notified the doctor, received and carried out care instructions, and completed a new tissue tolerance assessment which concluded that the same repositioning schedule was appropriate.⁴⁴

R56 was vulnerable to skin issues. In addition to his foot, sacrum and buttock skin issues, he had skin issues with his scrotum, elbows, finger, left bunion, bottom side of penis, both hands, and right lateral foot.⁴⁵ Some of these issues resolved with Facility

³³ Facility Ex. 43 on dates of June 19, 20, 21, 22; July 9, 12, 14, 16, 18, 27, 28, 31; August 1, 12, 24, 25; and September 1, 3, 5, 6.

³⁴ Facility Ex. 43, nurse's note 6/21/2014.

Facility Ex. 43, note 6/21/2014, Exs. 7-10; Testimony of Brenda Anderson.

³⁶ Facility Exs. 35; 38.

³⁷ Facility Ex. 22.

³⁸ Facility Ex. 43.

³⁹ Facility Exs. 8-10.

⁴⁰ Facility Ex. 43, nurse's note 7/31/2014.

⁴¹ Id.

⁴² Facility Ex. 32; Ex. 43, 8/25/14.

⁴³ Facility Ex. 43, 9/5/14.

⁴⁴ Facility Exs. 9, 10, 35, 43.

⁴⁵ Facility Ex. 43, skin injury notes of: Buttocks 8/28/14, 9/5/14; Scrotum 5/12/14, 5/27/14, 6/21/14, 8/1/14 (resolved); Right hand 5/18/14, 5/19/14, 6/23/14 (resolved); General 5/28/14; Elbows 6/8/14 (resolved), 6/20/14 (new elbow injury), 6/23/14, 7/20/14 (resolved); Clipped finger 6/24/14, 6/25/14, 7/3/14 (resolved); Bunion 6/29 - 7/1/14, 7/21/14, 7/23/14; Right lateral foot 7/7/14 (resolved); Penis 7/14/14, 7/16/14, 7/18/14; Back of left hand 8/28/14.

care as noted in the footnote below. A few of the skin issues resulted from what appear to be mild traumas.

R56 was not always cooperative with attempts to reposition him. 46 On at least two occasions, June 21, 2014 and July 12, 2014, he was counselled about the importance of repositioning. 47 As part of his repositioning regimen, R56 was scheduled for bedrest in the A.M. and the P.M. 48 R56's wife, who also resides in the Facility and was regularly attendant with R56, agrees that R56 did not always want to be repositioned. 49 On other occasions, when R56 was resistant to repositioning, Facility staff would off-load him. 50

The Facility regularly followed physician orders, WOC recommendations, and their own assessments. ⁵¹

The Facility performed tissue tolerance evaluations, predisposing disease risk evaluations, and Braden scale assessments of R56. 52 There were seven tissue tolerance evaluations between January 10, 2014 and August 25, 2014. 53 There were three Braden evaluations—in March, May and June 2014—which indicated mild risk for ulcers, but the Facility treated him as "high risk" notwithstanding the lower Braden score. 54

The facility was implementing a variety of cares to address R56's multiple needs, including turning and repositioning, elbow protectors, elevating his legs, creams, sheep skin on wheelchair arms, changing ulcer dressings and applying medications, pressure guard air mattress, cushion for the wheel chair or room chair, and diabetic diet with protein supplement to assist with wound healing.⁵⁵

Dr. Rysso was concerned about R56's diet. Based upon Dr. Rysso's order, the facility performed a dietary assessment. The assessment recommended that they continue with the current diet which included nightly snacks and protein supplements. R56's weight had remained stable. 56

R56 has recently been moved to hospice care. 57

⁴⁶ Facility Exs. 51, 52; Test. of B. Anderson.

⁴⁷ Id.

⁴⁸ Facility Exs. 5-10.

⁴⁹ Facility Ex. 50.

Test. of B. Anderson.

⁵¹ Facility Exs. 4-10.

⁵² Facility Exs. 35-40.

Facility Ex. 35. The CMS 2567 notes some apparent inconsistencies in the evaluations with respect to ability to reposition independently in the lying position. However, the care plan did not change and continued to require repositioning intervals not to exceed two hours.

⁵⁴ Facility Ex. 36; Test. of B. Anderson.

Facility Exs. 4-10, 34 (care plan and p. 10).

⁵⁶ Facility Exs. 21, 43 (note of 8/12/2014).

⁵⁷ Advice at the meeting.

It is undisputed that on one survey day, September 10, 2014, R56 was not repositioned or off-loaded within two hours. However, that appears to be an exception to the common practice at the Facility and there is no evidence that one occasion caused R56 any harm.

Analysis

None of the literature that has been presented or researched by the undersigned states that frequent repositioning of a resident assures that pressure ulcers will not occur. It appears that a pressure ulcer can begin within two to six hours. ⁵⁸ Typically the ulcer commences below the epidermis, in the dermis, and progresses outward due to bony pressure on the skin. The appearance of the ulcer may not become apparent for days after it begins. An ulcer can also be precipitated by shear and friction forces, which can occur when a resident is moved on bed sheets. ⁵⁹ A white paper publication of the National Pressure Ulcer Advisory Panel (NPUAP) states that pressure ulcers occurring at the end of life are often not preventable, because of the frail condition and comorbidities. ⁶⁰

The determination that an ulcer is a pressure ulcer cannot be made based merely on its location over a pressure point. It could also be precipitated by a shear event.⁶¹

Of course, the resident's failing condition would not justify failure to implement appropriate cares to minimize pressure ulcer risk. However, the preponderance of the evidence in this case is that the Facility regularly repositioned R56 to minimize the risk of pressure ulcers. That conclusion is supported by the following:

- 1. That the sacrum ulcer present upon admission resolved.
- 2. There were no new pressure ulcers for six months after admission.
- 3. The left side gluteal fold ulcer, that appeared on June 17, 2014, resolved by July 9, 2014.
- 4. The Facility was devoting regular attention to skin issues by performing tissue tolerance tests and Braden Scale assessments and considered R56's status to be high risk in spite of the Braden scale score.
- 5. R56 was frequently resisting repositioning, staff had to counsel R56 about the importance of repositioning.

⁵⁸ MDH Ex. G-6.

⁵⁹ MDH Ex. G-2.

⁶⁰ "Pressure Ulcers in Individuals Receiving Palliative Care: A National Pressure Ulcer Advisory Panel White Paper," Advances in Skin and Wound Care, February 2010. CMS acknowledges NPUAP as an authoritative agency, MDH Exhibit M-32.

⁶¹ MDH Ex. M-32.

- 6. Doctors were promptly notified of the presence of new ulcers and orders obtained and implemented.
- 7. The treatment of ulcers was effective to prevent infection.
- 8. R56 was provided with a special air mattress for his bed.
- 9. R56 was provided with a therapeutic chair cushion and months later, when R56 reported it to be uncomfortable, the Facility provided him with a new therapeutic cushion which R56 found to be comfortable. MDH argues that there was no appropriate evaluation of the new chair cushion by Occupational Therapy, but R56 found it comfortable and Physical Therapy recommended it.
- 10. The medication administration records reflect consistent attention to all of the cares prescribed in those records, some of which were prescribed to prevent skin breakdown and to assist with healing.
- 11. The primary healing concern from admission onwards was always the open heel wounds, and they were well cared for. Though they never healed, they did not become infected. No one contends that there was any deficiency in the Facility care of the heel pressure ulcers.
- 12. The records reflect that there were many doctors visits and constant communication to and from the doctors relating to many aspects of R56's care. There were at least 55 days recorded in the nurses' notes where there was at least one communication with a doctor and there was more than one such communication on many of those days. Many of those communications related to the ulcers on the sacrum and gluteal fold, requesting advice and change orders in the cares.
- 13. The Facility had a repositioning policy and a wound care policy. Each of those policies assigned qualified staff to those responsibilities. 62

All of these facts support the conclusion that the Facility paid careful attention to the risk of pressure ulcers, and to the cares required to prevent pressure ulcers.

There is admitted evidence that the Facility did not reposition R56 for more than two hours on September 10, 2014, perhaps for much more than two hours on that day. No actual harm is shown to be related to that incident. The best evidence is that the September 10 incident was an isolated occurrence, and MDH has classified it as an isolated occurrence.

⁶² Facility Exs. 48, 49.

R56 was not always in the care of the Facility at times possibly relevant to the development of the gluteal fold pressure ulcers on June 17, 2014. On June 2, 2014, R56 was taken by transport to the Methodist Hospital Wound Clinic. He left the Facility at 9:15 A.M. and returned at 12:30 P.M.⁶³ It is foreseeable that the beginning of pressure ulcers could happen during that time.

R56 was also transported to the hospital on May 6, 2014, during which time he was gone from 10:45 A.M. to 4:00 P.M. 64

Another ulcer appeared on July 27, 2014, but this appears to be related to trauma caused by removal of a bandage/dressing from one of the gluteal ulcers. The Facility promptly contacted the doctor to request approval for use of a different dressing and that request was approved. This was not a pressure ulcer.

One other pressure ulcer appeared on the sacrum on August 25, 2014.

The requirement that the heels had to be elevated in bed likely made repositioning more complicated to avoid backside pressure. Without minimizing the need to relieve backside pressure, it is undeniably true that the heel ulcers were always the primary concern, and that the potential of serious infection and leg amputation was avoided by the attentive care provided.

R56's wife also resided in the Facility⁶⁵ and was regularly involved with R56 and with his care. She signed a statement that should be fairly interpreted to mean that repositioning was commonly provided at appropriate intervals, and that R56 sometimes declined repositioning when offered. She also acknowledges that the Facility advised of the risk of not repositioning every two hours.

A CNA was interviewed by the survey team and was understood to say that sometimes they could not get to R56 for repositioning every two hours. That CNA provided a statement, however, that when she was on duty she always repositioned R56 every two hours. However, the CNA also appears to state that R56 sometimes refused to be repositioned.

There are very few, if any, chart reports of pain complaints by R56 associated with the gluteal fold and sacrum pressure ulcers. It appears the Facility was appropriately managing the comfort level of R56 related to the pressure ulcers. On September 10, 2014, R56 did tell the survey interviewer that he had pain in the buttocks at that time.

The Facility contends that R56's co-morbidities, especially his diabetes, impaired circulation and low prealbumin levels, ⁶⁶ made the pressure ulcers on his sacrum and buttocks unavoidable. All of these conditions are well known to impair skin health. The

⁶³ Facility Ex. 43.

⁶⁴ Id

⁶⁵ Facility Ex. 34, p. 6 of 16.

⁶⁶ Facility Ex. 25.

prealbumin levels were in the range of 8 to 9, which indicates malnutrition and in turn relates to the ability of skin cells to regenerate. The doctors were informed of the lab results and ordered diet supplements which were provided by the Facility. R56's weight was stable.

Fecal incontinence is known to exacerbate vulnerability to skin ulcers.⁶⁷ R56 suffered from such incontinence.

R56 received necessary treatment and services to promote healing. Individualized procedures were observed in the care and treatment of R56 and of his susceptibility to pressure ulcers. R56's ulcers were treated appropriately and consistent with doctor recommendations. Doctors were kept informed. R56 did not experience significant discomfort associated with the pressure ulcers and was generally comfortable.

The evidence and exhibits reflect that R56's condition and multiple comorbidities were well-evaluated upon admission, and that his pressure ulcer risk factors were noted and an appropriate care plan developed and implemented consistent with R56's needs. He was evaluated as at high risk for pressure ulcers and placed on two hour repositioning from the inception of his residence. The preponderance of the evidence is that the care plan was appropriate and consistent with the standards of practice.

Conclusion

The Administrative Law Judge recommends that the Commissioner further recommend that the "G" level deficiency issued under F314, and the "E" level deficiency issued under tag F282 be set aside.

T. W. W.

⁶⁷ MDH Ex. G-8.

⁶⁸ Facility Ex. 4 at entry of 1/9/14.



Protecting, Maintaining and Improving the Health of Minnesotans

CERTIFIED MAIL # 7003 2260 0000 9987 7248 March 25, 2015

Ms. Diane Lynch, Administrator Haven Homes of Maple Plain 1520 Wyman Avenue Maple Plain, Minnesota 55359

Re:

Haven Homes Of Maple Plain Independent Informal Dispute Resolution

Provider # 245497 Project # S5497023

Dear Ms. Lynch:

In a request dated October 10, 2014, Haven Homes Of Maple Plain requested removal of deficiencies cited at F282 and F314 as a result of a survey completed on September 12, 2014 by the Licensing and Certification program of the Minnesota Department of Health. The Statement of Deficiencies, CMS 2567, has been revised to reflect the Commissioner's decision as delineated in the letter dated February 6, 2015. The revised CMS 2567 is enclosed.

Also, corresponding State licensing orders cited at MN Rule 4658.0525 Subp. 3 has been reviewed and revised. The revised Minnesota Department of Health order form is enclosed.

This concludes the Minnesota Department of Health Independent Informal Dispute Resolution Process.

Sincerely,

Christine Campbell

Christin Campbell

CC: Office of Ombudsman for Long-Term Care

Mary Absolon, Program Manager

Pam Kerssen, Assistant Program Manager Maria King, Assistant Program Manager Kris Lohrke, OHFC Assistant Director

Licensing and Certification File

Haven Homes IIDR

MDH L&C 32	01 ON DELIVERY
SENDER: COMPLETE THIS SECTION Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits.	A. Signature X
Article Addressed to:	PLEASE DATE
Ms. Diane Lynch, Administrator Haven Homes Of Maple Plain 1520 Wyman Avenue Maple Plain, MN 55359	3. Service Type Certified Mail
2003 2260 0000 9987 7248	4. Restricted Delivery (Extra 102595-02-M-1540) Return Receipt

PRINTED: 03/25/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245497	B. WING			09/12/2014	
	PROVIDER OR SUPPLIER	_AIN		. 1	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	ΓS	F	000			
F 156 SS=D	surveyors of this De above provider and orders are issued. completed, please these orders and re Minnesota Departm Compliance Monito Certification Prograsuite 212, St Cloud 483.10(b)(5) - (10), RIGHTS, RULES, St Cloud 483.10(b)(6) - (10), RIGHTS, RULES, RULES, RULES, RULES, RULES, RULES, RU	ım, 3333 West Division St,	F	156	REVISED		10/22/14
		nt when changes are made to	NATURE		TITLE		(Y6) DATE

(X6) DATE

10/10/2014

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.

LAND PLAN OF CODDECTION LIDENTIFICATION NUMBER.		(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING	;		09/	12/2014
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F 156	the items and servic (i)(A) and (B) of this (i)(A) and (B) of this The facility must infat the time of admist the resident's stay, facility and of chargincluding any chargunder Medicare or the facility must fur legal rights which in A description of the funds, under paragram A description of the for establishing eligithe right to request 1924(c) which deternon-exempt resourcinstitutionalization as pouse an equitable cannot be considered toward the cost of the medical care in his down to Medicaid elemants of all pertingroups such as the agency, the State licombudsman program advocacy network, a unit; and a statemer complaint with the Sagency concerning misappropriation of	ces specified in paragraphs (5) is section. corm each resident before, or usion, and periodically during of services available in the es for those services, es for services not covered by the facility's per diem rate. consist a written description of cludes: manner of protecting personal raph (c) of this section; requirements and procedures ibility for Medicaid, including an assessment under section raines the extent of a couple's ces at the time of a dattributes to the community eshare of resources which ed available for payment the institutionalized spouse's per her process of spending	F	156			

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′		E CONSTRUCTION	COMPLETED		
		245497	B. WING			09/1	2/2014	
	PROVIDER OR SUPPLIER	LAIN	•	15	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE IAPLE PLAIN, MN 55359			
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F 156	The facility must in name, specialty, ar physician responsion. The facility must province information applicants for adminformation about Medicare and Medicare	•		156				
	by: Based on interview facility failed to ensemble R57) reviewed for required Notice of Centers for Medica (CMS) Form 1012; to an appeal and embedicare coverage discontinuation of Findings include:							
	medicare coverage facility determined coverage criteria a non-coverage on connection non-covered day lidid not have record	e on 2/13/14. On 4/22/14, the R11 no longer met medicare and issued a notice of medicare continued stay, with the first sted as 4/25/14. The facility d R11 received the CMS ner of her rights for an						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245497	B. WING			09/12/2014	
	PROVIDER OR SUPPLIER	_AIN		15	REET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	medicare coverage letters contained or R57's last covered records did not con medicare coverage remained in the factorerage was discoverage denial letter DON provided copi Medicare Assessm medicare coverage these did not address to inform residents	to the facility with skilled on 1/17/14. R57's denial hly the CMS 10123, indicating day was 3/19/14. R57 tain the required notice of on continued stay. R57 cility after her medicare	F	156			
F 241 SS=E	INDIVIDUALITY The facility must prepare and in an elementary each restricted full recognition of home and the second full recognition and the second full rec	CAND RESPECT OF Tomote care for residents in a senvironment that maintains or sident's dignity and respect in its or her individuality. NT is not met as evidenced tion, interview, and document failed to ensure 4 of 4 residents ning who required staff R52, R66 and R7), were e in a dignified manner.	-	241			10/22/14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		COMPLETED				
		245497	B. WING			09/	12/2014	
	PROVIDER OR SUPPLIER	_AIN		1	STREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE MAPLE PLAIN, MN 55359			
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F 241	R12's quarterly min 6/18/14, indicated If impairment and recassistance with din R52's quarterly MD R52 had severe corequired extensive R66's quarterly MD had severe cognitive extensive staff ass R7's quarterly MDS had severe cognitive extensive staff ass During dining obseapproximately 5:40 was observed sittindining room at a tarm R7. After the resident to resident and then rolling on next resident. NA-of food, set the fore	nimum data set (MDS) dated R12 had severe cognitive quired extensive staffing. S dated 8/20/14, identified gnitive impairment and staff assistance with dining. S dated 8/6/14, identified R66 ve impairment and required istance with dining. S dated 8/27/14, identified R7 ve impairment and required istance with dining. rvation on 9/8/14, at p.m. nursing assistant (NA)-P ng on a rolling stool in the ble with R12, R52, R66 and ents received their food, NA-P able on the stool going from t giving them a bite of food, the stool using her feet, to the P would give a resident a bite or spoon down, and		241		RIATE	· ·	
		er to the next resident, and round the table on the stool the						
	stated she was red at a time, and need she was able to go ensure they all red there was not enough	n 9/8/14, at 6:01 p.m. NA-P quired to feed multiple residents ded to use the rolling stool so from resident to resident to eived their meal. NA-P stated ugh staff to ensure all the ng fed timely, so the NA's do						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER	_AIN		1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE MAPLE PLAIN, MN 55359	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		BE	(X5) COMPLETION DATE
F 241	what they have to s meals.	ge 5 o the residents receive their residents was requested but	F 2	241			
F 253 SS=D	not provided. 483.15(h)(2) HOUS MAINTENANCE SE		F2	253			10/22/14
	maintenance service	ovide housekeeping and ses necessary to maintain a and comfortable interior.					
	by: Based on observative review, the facility for residents (R46) batequipment in good failed to ensure 2 o	NT is not met as evidenced tion, interview, and document ailed to ensure 1 of 48 throoms had bathroom repair. In addition, the facility f 48 residents (R46, R24) quate water pressure to their					
		num data set (MDS) dated e resident had no cognitive					
	stated her bathroor had very little water sink. She stated sh staff about both iss and no one did any low water pressure	19/8/14, at 4:30 p.m. R46 m sink was cracked and she pressure in her bathroom he had talked to several of the ues with her bathroom sink, thing about it. R46 stated the and cracked sink had been idmission to the facility which o.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		SURVEY PLETED
		245497	B. WING			09/*	12/2014
	PROVIDER OR SUPPLIER	LAIN		1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE JAPLE PLAIN, MN 55359	-	
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F 253	During a tour of the p.m. maintenance: R46's sink had two from the faucet know to the drain, and a of the sink. MS-F ain R46's bathroom water trickled out of had not been inform he stated had the president, and he was pressure in R46's rounds of the facilitie equipment, however resident rooms or linspection. He stated	e facility on 9/12/14, at 1:00 supervisor (MS)-F verified large cracks, one extending ob down the entire sink almost second crack on the left edge also verified the water pressure sink was very low and the of the faucet. MS-F stated he med of the cracked sink, which cotential to, "Scratch" the as not aware of the low water froom. MS-F stated he did daily by looking for damaged er, he did not go into any of the bathrooms during the ted it was the expectation in him of broken items so	F	253			
	resident had sever required extensive personal cares. During observation 9/11/14, at 11:00 at the bathroom sink time for the tempe get warm. During the tour of p.m. MS-F verified pressure was very aware of the R24's and it was an easy the problem for his	OS dated 6/24/14, identified the re cognitive impairment and assistance of two staff for as on 9/8/14, at 7:14 p.m. and .m. R24's water flowed out of faucet slowly and took a long rature of the water to heat up to the facility on 9/12/14, at 1:00 I R24's bathroom sink water low. MS-F stated he was not as low water pressure until now, of fix if he had been informed of a department to address the dinursing staff are to notify him					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245497	B. WING			09/12/2014	
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN		LAIN		15	FREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	of any maintenance	_	F2	253			
F 282 SS=E	483.20(k)(3)(ii) SEI	RVICES BY QUALIFIED ARE PLAN	F:	282			10/22/14
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of					
	by: Based on observa review, the facility f was implemented f residents (R56), re 1 of 1 residents ba who required assis of 5 residents ROM	tion, interview, and document failed to ensure the care plan for repositioning for 1 of 2 viewed for pressure ulcers, for thing needs (R11), reviewed stance with bathing, and for or 2 of motion services.					
	Findings include:						
	identified R56 had required extensive mobility, extensive repositioning in the ulcer development	nimum data set dated 6/11/14, no cognitive impairments, assistance of two staff for bed assistance of one staff for e chair, was at risk for pressure, and currently had one stage ressure ulcer that was present unhealed.					
	a unstageable pres	ated 8/16/14, identified R56 had ssure ulcer measuring 1.3 x 0.3 are plan instructed R56 to be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/	12/2014	
	PROVIDER OR SUPPLIER	_AIN		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 282	During continuous of from 7:18 a.m. throwas not repositione weight independent. During interview on stated he had pain up in his chair since morning. During interview on practical nurse (LPI repositioned at leas lie down after break assistance to lay RS NA-B and LPN-B tradown on 9/10/14, at care plan instructed two hours, the residual of 2 hours and repositioned. R31's quarterly MDR R31 had no current motion (contracture extremities. R31s care plan date to receive passive renees, and ankles,	preater than 2 hour intervals. Deservation of R56 on 9/10/14, ugh 9:46 a.m. the resident d and was unable to shift his ly in the wheelchair. 9/10/14, at 7:20 a.m. R56 in his buttocks and had been approximately 6:00 a.m. that 9/10/14, at 9:54 a.m. licensed N)-B stated R56 should be it every two hours, and should fast. LPN-B requested	F 2	82				
	the resident recieve	oM documentation indicated at range of motion services 12 onth (8/12/14 through 9/14/14).						

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245497	B. WING	·		09/	12/2014
	PROVIDER OR SUPPLIER	_AIN		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	R31's restorative do not documented as 31 days. During interview on assistant (NA)-E st any range of motion dressing activities. During interview or stated he had a str walk anymore, but complete leg exerce R11 quarterly MDS required extensive dressing and person provide partial phys. The care plan date needed the assist of preferred to have a was directed to to and provide care in During interview or stated recently she weeks without a bahave any bath aids. R11's point of care received a tub bath was a partial bath later. During interview or stated.	being completed for 28 out of 09/11/14, at 9:45 a.m. nursing ated R31 did not ever receiven services other than routine 19/11/14, at 3:18 p.m. R31 oke a while back and did not would like to use his legs and ises. dated 8/27/14, identified R11 assistance from staff for onal hygiene and was able to sical help with bathing. d 9/4/14, identified R11 of one staff for bathing and a bath versus a shower. Staff nonor resident's preferences a timely manner.		282			
	a bath because the residents with bath	ere is not enough staff to assist					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245497	B. WING _			09/	12/2014
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN				15	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B		BE	(X5) COMPLETION DATE
F 282		ge 10 dated 6/25/14, indicated R1 ation in range of motion (ROM)	F 28	82			
	to one side of the u R1 care plan dated receive passive ran	pper and lower extremities. 7/2/14, identified R1 was to ge of motion (PROM) daily, ral shoulders, elbows, wrists,					
	reviewed from April There was no docu	tive nursing sheets were 2014 - September 2014. mentation to determine if R1 M as directed by the care					
	1:25 p.m. NA-B state restorative aid, and	9/10/14, at approximately ted the facility no longer had a the NAs are not able to M as directed by the care					
F 310 SS=G	non-verbally indicat forth motion with he when asked if staff on a daily basis. W the PROM being do on her communicat	9/11/14, at 9:25 a.m. R1 ed by motioning in a back and er hand to indicate 'so-so,' were assisting her with PROM hen asked for a frequency of one, R1 spelled out, "monthly," ion board. DO NOT DECLINE UNLESS	F 3 ⁷	10			10/22/14
	resident, the facility abilities in activities unless circumstand condition demonstra	rehensive assessment of a must ensure that a resident's of daily living do not diminish es of the individual's clinical ate that diminution was ncludes the resident's ability					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245497	B. WING			09/1	2/2014
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN				1	STREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE MAPLE PLAIN, MN 55359	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 310	to bathe, dress, an ambulate; toilet; ea or other functional This REQUIREME by: Based on observareview, the facility is services to prevent residents (R47 and assistance with am reassessed upon a	d groom; transfer and t; and use speech, language, communication systems. NT is not met as evidenced tion, interview, and document failed to provide ambulation to loss of function for 2 of 4 in R7) who required physical abulation, and were not a decline in ambulation. The ambulate resulted in actual	F	310	,		
	R47's quarterly Mir 7/2/14, indicated R impairment, neede staff for transfers a wheelchair or a war R47's balance was and walking and slower function range R47's Care Area A 10/9/13, identified had clear speech, able to understance gait, was able to be wheelchair behind the restorative wall During interview of stated she was conher ability to walk I	nimum Data Set (MDS) dated 47 had no cognitive de extensive assistance of one and ambulation, and used a alker to aid her ambulation. It is not steady during transfers the had no loss of upper and ge of motion (contractures). It is sessments (CAA) dated R47 was alert and oriented, and she was understood and I others. R47 had an unsteady ear weight, and required a her when she was involved in king program. In 9/8/14, at 7:11 p.m. R47 incerned she was going to lose because staff had not been inbulate. She stated she was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/1	2/2014	
	NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 310	Continued From pasupposed to be wanot enough staff to was, "Very rarely be Another interview vil:00 a.m. R47 stanot being walked to shortage. She staft to walk me." R47 in therapy and the walked. Because to walk, R47 stated was not able to morecent past. She is remember she was ago. R47's care plan dato be ambulated por The restorative proplan of care. R47's nursing assidirected nursing as resident 57 feet to	lked twice a day but there was do this. She indicated she eing walked." vas completed on 9/11/14, at ted she was, "upset, " about wice a day due to staff ted, "They just don't have time stated she had been involved therapist recommended she be staff had not been assisting her difference has a easily as she had in the stated the last time she could be walked was about 7-10 days atted 7/9/14, indicated R47 was ter the "Restorative program." begram was not specified in the staff, a transfer belt, rolling		310	DEFICIENCY)			
	indicated the resid	rapy note dated 8/7/14, ent was able to ambulate up to ng walker and contact guard					·	
	department from 7 considered to be a directions. R47's indicated she tran	he occupational therapy (OT) 7/14/14 to 8/14/14. R47 was alert and able to follow discharge from OT on 8/14/14, sferred with contact guard the therapist would hold a						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245497	B. WING		09	/12/2014
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN				STREET ADDRESS, CITY, STATE, ZIP 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 310	transfer belt for star for greater than thr maintained a safe wheeled walker, had endurance while performing her exemperforming	bilization), tolerated standing ee minutes while she balance while using a 4 ad an increase in her erforming her activities of daily I no increase in fatigue while ercises. I no increase in fatigue while ercises. I ders dated 9/5/14, directed he resident 57-115 feet twice hair behind, using a rolling relation belt. I ursing sheets (which the swhere resident restorative imented and tracked), titled has, located in the restorative erceivewed from April 2014, to 14 identified the following: I a 2014, R47 was ambulating as walked 15 feet consistently. I as walked 15 times on the day the evening shift. The last R47 being ambulated was walked 115 feet. I eptember 11 2014, there was regarding R47 ambulating. In 9/11/14, at 9:44 a.m. nursing that the was aware R47 was to be a day, however, he had never inbulate. NA-J stated staff does omplete R47 ambulation				

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NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN				1520	ET ADDRESS, CITY, STATE, ZIP CODE WYMAN AVENUE LE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 310	During interview on therapy assistant (I with R47 from 7/14 physical therapy or recommended R47 57-111 feet. PTA-E walked," and was a feet when discharg During interview or registered nurse (Fi the person in charg Services), stated the fforts to walk R47 ambulate R47 twic sure if this was bei R47 had declined i stated there was no completed of R47's ensure it was apprias ordered. RN-A her that they were ambulation related however, NA-A ver were not reassess made with the programment of the programment	determine if R47 was being a there was no documentation. 9/11/14, at 2:39 p.m. physical PTA)-E stated she had worked /14, until her discharge from a 8/12/14. PTA-E had be ambulated twice a day, E stated R47, "loved to be able to consistently walk 80 ed from PT on 8/12/14. 19/11/14, at 3:24 p.m. RN)-A (who was identified as ge of Rehab/Restorative here was no record of staff. RN-A stated staff was to be a day, however, she was not ng done, and was unsure if an her ability to ambulate. RN-A to formal nursing assessment as ambulation program to opriate and being implemented stated NA's had complained to unable to assist residents with to being short staffed, iffied the ambulation programs ed and no changes had been gram to ensure it was being	F3	10			
	R47's current amb	I to sit down. PTA-E stated ulation ability was a decline ident was discharged from n 8/12/14.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVE	
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	PROVIDER OR SUPPLIER	_AIN	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359				
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F 310	being ambulated as did not reassess ar to ensure the reside to ambulate. R47's related to the lack of ambulation program actual harm for R4'. R7's annual MDS of had severe cognitive (contracture) to one required extensive transfers and walking able to stabilize who assistance, and walking able to stabilize who assistance, and walking, transfer as walking, transfer as During observation was lying in bed on were bent and raise. R7's Physical Ther Summary dated 3/4 ambulate 20-30 fee with assist of two sable to hang onto the and did not need the services. PT also motion (ROM) was extension, and 22 december 20 feet and 22 dece	was aware R47 was not assessed by PT, the facility of put interventions into place ent did not decline in the ability of the facility completing the massessed resulted in 7. Idated 8/27/14, identified R7 we impairment, had impairment eside of the upper extremity, two person assistance withing in the corridor, was only en standing with staff alking in the resident room, it had not occurred during the ck period of the MDS 8/27/14. Idated 8/27/14, did not address R7's collity, or current contractures. On 9/9/14, at 2:50 p.m. R7 in her back and both knees		310			
	9/5/14, instructed s	staff to walk the resident 29-57					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245497	B. WING			09/	12/2014	
	PROVIDER OR SUPPLIER	LAIN		15	REET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE APLE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 310	feet with assistance using a walker. R7's restorative nu identified as where are documented as Medications, locate book, from April 20 instructed two staffeet, two times dail documentation ide R7 from 4/2014- 9/ R7's care plan date pushed R7 to all do and transferred with belt and walker. R the resident was a instruct staff on R7 program. When interviewed stated the restorat shambles right now revamp the prograr receiving their prognot aware R7 had decline in transfer RN-A stated NA's	rsing sheets (which the facility resident restorative programs and tracked), titled Routine and in the restorative nursing 14 - September 2014, If to walk the resident 29-57 y. There was no ntifying if staff was ambulating 1/2014. The definition of two with a transfer assist of two with a transfer assist of two with a transfer assessed ambulation on 9/9/14, at 9:46 a.m. RN-A ive/ ambulating program was in w, and she was trying to a mot been ambulating or had a ability or ambulation, however, had complained to her they		310	DEFICIENCY)			
	During interview o stated R7 had a ditransfers, and staffer, however, R7 not have time to swalking prior. NA-	omplete residents ambulation e of short staffing. n 9/11/14, at 1:42 p.m. NA-F ecline in ambulating as well as if was supposed to be walking no longer walks, and staff did pend to try to assist her in -F stated recently she had to for R7 because she could no						

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		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER	_AIN		15	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETION DATE
F 310	longer raise her fee when staff were purificated she had obstransferring a few in the point," of being walker, so staff was using a hand in har had done no forma ambulation prograr ambulation prograr as assessed and R her ability to transfer. On 9/11/14, at 1:20 PTA-E and COTA-I and had some combilateral knees. PTR7 from the wheeled transfer, R7 did noweight on her feet, heavy assist. During "ouch," on multiple staff was attempting knees. PTA-E and would benefit from referred back to the resident was declinated ambulating. COTA expressed concern. Although the facility program was not be and the resident whad a decline in training.	et up when in the wheelchair shing her to destinations. 9/11/14, at 1:57 p.m. RN-D erved R7 ambulating and nonths ago, and R7, "got to unable to bear weight on the stransferring the resident and method. RN-D stated she I assessment of R7's method when it was noted R7's method was not being implemented to was noted to be declining in the er and ambulate. 1 p.m. R7 was evaluated by D, and stated R7 was resistive tractures in her left hand and TA-E and COTA-D transferred thair to her bed. During the take any steps, bear any and was lifted into bed withing the evaluation, R7 stated, occasions and grimaced when g to straighten the resident's COTA-D both verified R7 therapy and should have been erapy when staff noted the ening in transfers and no longer A-D stated residents have as with not being ambulation eing completed as assessed, as no longer ambulating and ensfers, the facility failed to the resident back to therapy.	F 3	10			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
•		245497	B. WING	·		09/	12/2014
	PROVIDER OR SUPPLIER HOMES OF MAPLE P	LAIN		1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE JAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312 F 312 SS=D	483.25(a)(3) ADL (DEPENDENT RES A resident who is udaily living receives	CARE PROVIDED FOR		312 312			10/22/14
	by: Based on interview the facility failed to	NT is not met as evidenced w and documentation review, provide bathing assistance for 11) reviewed who was for bathing.		,			
	8/27/14, identified assistance from st	mum data set (MDS) dated R11 required extensive aff for dressing and personal able to provide partial physical					
	needed assist of o preferred to have a the goal was to res	ed 9/4/14, indicated R11 ne staff for bathing and a bath versus a shower, and spect the resident's wishes and y, and provide care in a timely					
	stated she had red weeks without a b	n 9/8/14, at 4:23 p.m. R11 cently gone for a couple of ath because the facility didn't s to provide bathing assistance.					
	nursing assistants	re Bathing Record (where the (NA) document when a a bath/shower), identified R11					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			245497	B. WING			09/1	2/2014
		ROVIDER OR SUPPLIER OMES OF MAPLE P	LAIN		15	REET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE APLE PLAIN, MN 55359	-	
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	F 312	record of R11 rece	age 19 bath on 7/31/14. The next iving assistance with bathing completed on 8/28/14, 28 days	F 3	12			
		During interview or stated there were residents with bath completed regularl R11 could have go bath due to the lac with bathing. During interview or stated the facility up to the stated the facility up to the stated the	n 9/11/14, at 10:13 a.m. NA-H not enough staff to assist s and they were not being y. NA-H stated it was possible ne almost a month without a k of staff available to assist n 9/12/14, at 9:34 a.m., NA-B used to have a bath aid to					
		ago the bath aid le were not being cor was possible R11 a month because During interview o registered nurse (I up concerns regar residents baths du RN-A stated the fa	aths, however, a few months off the facility, so resident baths impleted timely. NA-B stated it had not been bathed in almost of the lack of staffing. In 9/11/14, at 10:30 a.m. RN)-A stated NA's had brought ding not being able to complete the to lack of staff, however, acility was still working on a ensure resident cares are being					
	F 314 SS=D	not provided. 483.25(c) TREATI PREVENT/HEAL Based on the com resident, the facili who enters the fac	MENT/SVCS TO PRESSURE SORES Aprehensive assessment of a ty must ensure that a resident cility without pressure sores pressure sores unless the	F	314			10/22/14

Event ID: JMZ111

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/·	12/2014
	PROVIDER OR SUPPLIER	_AIN		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
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F 314	individual's clinical of they were unavoidad pressure sores recesservices to promote prevent new sores of this REQUIREMENT by: Based on observator review, the facility for (R56) who was admitted was provided intervore-evaluated to prevent developing. Findings include: R56's quarterly Min 6/11/14, identified Form impairment, require staff for bed mobility staff for repositioning developing pressure one stage IV (unstage)	condition demonstrates that ble; and a resident having eives necessary treatment and healing, prevent infection and	F3	:14	,		
	dated 6/23/14, rever pressure ulcer deversand repositioning producer care with dress pressure reducing of R56 was identified a pressure ulcers bot R56's care plan data.	ed 8/16/14, identified R56 had					
		able pressure ulcer on the epositioned at no greater than					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING					E SURVEY PLETED		
		245497	B. WING	·		09/	12/2014
	PROVIDER OR SUPPLIER HOMES OF MAPLE PI	_AIN		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359	-	
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F 314	2 hour intervals, ha mattress on the ber redistribution wheel R56's Skin Observathrough 6/5/14, indi intact and had no pressure ulcer risk) resident had a mild ulcers. The Brader R56 had recently groushion related to trulcers. R56's Tissue Tolerato determine skins dated 6/17/14, iden at the three hour may unable to charm the evaluation inditing one, two or three position and was unindependently. The assessment. R56's Tissue Toleration independently. The was blanchable redwhile sitting and the independently. The R56's Tissue Toleration in the wheeled in the wheele	d a pressure redistribution d, and a pressure lichair cushion. Action Reports dated 1/2/14, cated the resident's skin was ressure ulcers. The (a tool used to assess a dated 6/8/14, indicated the risk of developing pressure in scale assessment indicated otten a new wheelchair he risk of developing pressure ance Evaluation (assessment ability to withstand pressure) tified non-blanchable redness ark in the lying position, and age position independently. Cated R56 had no redness at the hour mark in the sitting mable to change position		314			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	_AIN		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359			
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F 314	evaluation. R56's Skin Injury/Mindicated R56 deveright gluteal fold med 0.8 cm with a pink opressure ulcer (parpresenting as a shapink wound bed, wicleansed and a prophysician was faxed Measurements of the documented weekly Report. Review of 6/17/14, through 9/ ulcer had worsened developing into an (full thickness tissuulcer is covered by green or brown, an black tissue, in the pressure ulcer was slough yellow wour Another pressure ulcer was slough yellow wour Another pressure ulcer was slough yellow wour Another pressure ulcer was slough yellow wour the area ulcer," on the Skin it was located on a the facility identified stage 2. The docuulcer on 9/10/14, ic worsened to an unincreased in size with the skin it was located on a the facility identified stage 2. The docuulcer on 9/10/14, ic worsened to an unincreased in size with the skin it was located on a the facility identified stage 2. The docuulcer on 9/10/14, ic worsened to an unincreased in size with the skin it was located on a the facility identified stage 2. The docuulcer on 9/10/14, ic worsened to an unincreased in size with the skin it was located on a the facility identified stage 2. The docuulcer on 9/10/14, ic worsened to an unincreased in size with the skin it was located on a the facility identified stage 2.	of the tissue tolerance /ound Report(s) dated 6/17/14, loped a pressure ulcer in the easuring 0.5 centimeter (cm) x wound bed, and was a stage 2 tial thickness loss of dermis allow open ulcer with a red thout slough). The area was tective cream applied, and the	F3	314				

245497 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	09/12/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HAVEN HOMES OF MAPLE PLAIN 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE COMPLÉTION
yellow slough wound bed, and was currently unstageable. R56's current physician orders dated 9/5/14, instructed staff to apply Tegaderm with foam dressing to reddened area on the sacrum, check every shift, and change every three days and as needed (PRN). Tegaderm with a foam dressing was to be applied to the right buttock, sacrum, and gluteal fold every 3 days and as needed (PRN). The physician orders also instructed staff that R56 was not appropriate to have three hour intervals ordered for repositioning programs due to skin issues, therefore, needed to be repositioned at no greater than every two hours. R56's Nurses notes dated 6/2/14. indicated the resident was admitted with two, stage 4 pressure ulcers on the right and left heel. R56 was being seen at the wound clinic for these wounds, and they had been debrided by the surgeon in the past. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m., R56 was slitting in his wheelchair on a cushion, and was unable to shift his weight independently. Throughout the 2 hour and 28 minute observation, R56 was not approached by staff to reposition as assessed. During interview on 9/10/14, at 7:20 a.m., R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short staffed and NAs did their best to assist residents	

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		245497	B. WING_		09/	12/2014
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F 314	aware of R56's preand, "They were posend, "They were posended R56 was to hours. During interview of practical nurse (LF repositioned after after breakfast. Lifter from staff to lay Reference of the was 2 hours constant observation of the standing lift and resident of the wound nurse, re-assignment of delegating them of the currently had three LPN-B was not clithe pressure ulce	essure ulcers on his buttocks retty open," right now. NA-A to be repositioned every 2 n 9/10/14, at 9:54 a.m. licensed PN)-B stated R56 should be 2 hours and should lie down PN-B requested assistance 56 down. n on 9/10/14, at 10:05 a.m. It's room to reposition him, as and 47 minutes after the initial ion began, and 4 hours and 5 as tated he had been up in his R56 out of his chair using a emoved his brief. R56's It's red in color and had a foam	F 3	14		
	because the residence he was sitting in a	dent had complained he felt like a hole. LPN-B stated OT did not dent to ensure the wheelchair				

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	OVIDER OR SUPPLIER	_AIN	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE IAPLE PLAIN, MN 55359		
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concess of the second s	alcers on 9/10/14, a nursing (DON) and pen areas on his by pen are	oriate. of R56's current pressure at 1:58 p.m. the director of LPN-B verified R56 had two outtocks, one on the upper was whitish at the wound base eable pressure ulcer with 90% which currently measured 1.5 cond pressure ulcer was on d had 60-70% slough that was ne wound base and measured was also unstageable. pressure ulcers had increased nce the last time she had seen N-B was unable to verify the bserved R56 pressure ulcers. 19/10/14, at 2:17 p.m. certified by assistant (COTA)-D stated nvolved in assessing R56 for air positioning or the		3314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245497	B. WING		09	/12/2014	
	OF PROVIDER OR SUPPLIER N HOMES OF MAPLE P	LAIN		STREET ADDRESS, CITY, STATE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359			
(X4) PREF TAC	IX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	00000 000000000	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE	
F	R56's medical doc be reached to disc be reached to disc be reached to disc. The facility policy, indicated it was the place a system to for each resident a hours or more free resident's conditioned may be imple repositioning (i.e. warranted for indivulcer development therapy department weight distribution pressure redistribution pressure redistribution/mattress coordination with the facility policy last revised 12/01, who sits too long of prone to get ischia 483.25(e)(1) NO FUNAVOIDABLE Based on the commercial resident, the facility who enters the facility of the facility who enters the facility who enters the facility motion does not emotion unless the	ssure ulcers. 9 p.m., a call was placed to tor (MD)-C who was unable to uss R56's pressure ulcers. titled Repositioning, undated, e policy of the facility to have in identify repositioning programs and repositioning every two quently depending upon the n and tolerance of the tissue mented, and more frequent off loading hourly) may be viduals at high risk for pressure to the policy indicated the nassessed postural alignment, sitting balance, stability, and ution along with recommendations in the nursing department. titled Wound/Skin Care Policy, 1/97, indicated an at-risk resident on a static surface may be more		317		10/22/14	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/1	2/2014
	PROVIDER OR SUPPLIER	LAIN		152	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 317	by: Based on observareview, range of m provided for 2 of 4 reviewed for ROM. harm with a reduct Findings include: R55's quarterly Mir 6/4/14, identified R functional limitation was totally depend toileting, dressing, During interview or registered nurse (Fixed stretch of a muscle utilize any splint deany formal ROM p R55's care plan, laidentify the present instruct staff on the completed by staff R55's restorative restorative nursing 6/30/14, and instruct daily restorative nursing 6/30/14, and instructed of the following leading the following metals are documented to the following metals are documented by staff R55's restorative nursing 6/30/14, and instructed of the following following metals are documented by staff R55's restorative nursing 6/30/14, and instructed of the following fo	tion, interview, and record otion (ROM) services were not residents (R55 and R7) R55 and R7 sustained actual ion in functional ROM. nimum Data Set (MDS) dated 55 did not walk, had no as in ROM (contractures), and ent on staff for transferring, and all activities of daily living. 10 9/8/14, at 5:55 p.m. 11 RN)-A stated R55 had 11 high resistance to passive 12 in both knees only, did not evices, and was not receiving rogram. 12 st updated 6/9/14, did not ce of any contractures nor did it 12 type of ROM exercises to be 13 the swhere resident restorative 14 the swhere resident restorative 15 unursing sheets (which the 16 swhere resident restorative 17 unursing sheets (which the 18 swhere resident restorative 18 unursing sheets (which the 19 book dated 1/1/14, through 19 ucted staff R55 was to receive 19 ursing treatments which 10 ving: 10 range of motion (PROM) 10-15 exion/extension		317			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245497	B. WING_		09	/12/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 317	restorative treatment opportunities. The facility was unursing sheets for or 9/2014. The fare ROM was done for was unable to verificate was started, and intime to determine. Review of R55's Effrom 7/1/14, to 9/17 received any ROM assessment to enappropriate for R55. During observation was observed being would not full and the residents assistant (NA)-B was above her head to needed to slide the stretch it over her up her arms or street.	15 reps bilateral 15 reps bilateral 15 reps bilateral 15 reps bilateral 5 reps bilateral ative nursing sheet identified 3 ents were provided out of the 31 ents were provided any restorative R55 for the months of 8/2014, cility had no documentation any r R55 for 2 months. The facility fy when R55's ROM program if it had been reassessed at any if it was appropriate for R55. Electronic Point Of Care Record 2/14, did not identify R55 if services, nor was there any sure the ROM program was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245497	B. WING			09/-	12/2014
	PROVIDER OR SUPPLIER	LAIN		152	REET ADDRESS, CITY, STATE, ZIP CODE 10 WYMAN AVENUE PLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 317	Continued From pa	age 29	F3	317			
	stated R55's ROM completed because to spend time com stated R55 only recommend.	n 9/10/14, at 11:50 a.m. NA-B exercises were not being e they didn't have enough staff pleting the exercises. NA-B ceived about 10% of the ROM e resident had been assessed					
	stated when restor provided to the res document in Point completed. RN-C further documenta ROM services, and	n 9/10/14, at 12:45 p.m., RN-C ative services or ROM was idents, the NAs should of Care when it was was unable to provide any tion that R55 was receiving any d verified there was no Point of Care R55 was			-		
	practical nurse (LF responsible for confor the residents a completed in the residents are completed in the residents are completed in the residents.)	n 9/11/14, at 9:38 a.m. licensed PN)-B stated the NAs were mpleting the ROM treatments is well as charting when it was esidents electronic point of care is not aware R55's ROM was ed.					
	dated 9/6/11, indic passive stretching and 25 degrees of to be pain free and	erapy Discharge Summary ated R55 demonstrated of the right knee to 22 degrees the left knee. R55 was noted d would be discharged to ower extremity ROM program					
	dated 7/17/12, ind hip/knee/ankle alig	al Therapy Discharge Summary icated R55 exhibited proper gnment while in the wheelchair. not note the presence of any					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245497	B. WING			09/1	12/2014
	PROVIDER OR SUPPLIER	_AIN		1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE IAPLE PLAIN, MN 55359	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 317	upper extremity conductive or occupational therapy examined R55's uppersonant total RON completely assess wrist, and finger conducated R55 appersonant appears with a respective of prior. COTA-D sidentification of prior. COTA-D side	J. Contract of the contract of	F3	317			

	OF DEFICIENCIES OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		245497	B. WING			09/	12/2014		
	PROVIDER OR SUPPLIER	LAIN		152	EET ADDRESS, CITY, STATE, ZIP CODE O WYMAN AVENUE PLE PLAIN, MN 55359				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE		
F 317	back, as well as land better. During interview or stated range of more completed and R5-result. NA-H stated her arms and legs the resident dresses the resident's famiculating. During another interested the resident's famiculating. During another interested the resident in place current restorative implemented as as program is adequate in ROM. RN-A state concerns about not complete resident stated the facility has resorative nursing be completed. The facility failed to program was reas program was bein adequate to prever Although the facility further difficulty with in ROM, the facility in ROM, the facility in ROM, the facility in stated in ROM, the facility in ROM and the ROM.	age 31 for shirts that opened in the reger pants, to make it slide on a 9/11/14, at 10:13 a.m. NA-Hotion services were not being 5 was becoming stiff as a 4 R55 wasn't able to stretch out like before which made getting and more difficult, so staff asked by member to bring in different derview on 9/11/14, at 11:10 a.m. are was no formal ROM are was no formal ROM are was no formal ROM are was no formal review on 9/11/14, at 11:10 a.m. are was no formal ROM are was being assessed, nor to ensure the are to prevent further decrease atted the NA's had brought up of having enough staff to ROM programs, however, she had not reviewed the current programs to ensure they could an one of the program and was not further decline in ROM. By was aware R55's restorative sessed to ensure the ROM grimplemented and was not further decline in ROM. By was aware R55 was having the dressing related to decrease of failed to provide further reassessment which resulted in		317	DEFICIENCY				
	had severe cognit	dated 8/27/14, indicated R7 ive impairment and had ROM acture) to one side of the upper							

	UD STANTOS CORRECTION DE DENTISICATION NUMBER.		LE CONSTRUCTION	I COMPLI		
		245497	B. WING		09/1	2/2014
	PROVIDER OR SUPPLIER	LAIN	-	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 317	Continued From pa	age 32	F 317	,		
	resident had a chrowhich was released	ted 3/21/14, indicated the onic right hand contracture d with surgery, had no pain, muscular function back in the			·	
	During observation was lying in bed or was in a fist.	n on 9/9/14, at 2:50 p.m. R7 n her back and her left hand				
	During observation was sitting in her wand her left hand v	n on 9/10/14, at 6:53 a.m. R7 wheelchair in the activities room was closed in a fist.				
	During observation was sitting in the a closed in a fist.	n on 9/11/14, at 9:40 a.m. R7 activity room with her left hand				
	was sitting in the d	n on 9/12/14, at 8:40 a.m. R7 lining room with her left hand her fingers bent inward.				
	R7 was not observ	n of R7 from 9/9/14- 9/12/14, yed to release the fist of her left attempt to use her left hand.		r		
	3/4/14, indicated the	and Discharge Summary dated he resident was able to hang thout hand support, and was to				
	September 2014,	ician Orders sheets for instructed staff the resident was wing restorative nursing	,			
	· Ankle PROM	0-15 reps bilateral				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/1	2/2014
	PROVIDER OR SUPPLIER	_AIN		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE IAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 317	flexion/extension 1: Elbow PROM 1 flexion/extension 1: Hip PROM 10- flexion/extension, a Knee PROM 1 flexion/extension 1: Shoulder PRO flexion/extension 1 Walk 29-57 fee wheelchair behind roller walker transfe Wrist PROM 1 flexion/extension 1 R7's restorative nu identified as where are documented as Medications, locate book, indicated the contracture. The re reviewed from Apr noted the following R7 on the day shift Ankle PROM 0 dorsiflexion/extension 1 Elbow PROM flexion/extension 1 flexion/extension, Knee PROM 1 flexion/extension, Knee PROM 1 flexion/extension, Knee PROM 1	1x 0-15 reps bilateral x 10-15 reps bilateral x 15 reps bilateral abduction/adduction 1x 0-15 reps bilateral x M 10-15 reps bilateral x et two times daily with stand by assistance of two er belt x2 0-15 reps bilateral x ersing sheets (which the facility e resident restorative programs and tracked), titled Routine ed in the restorative nursing e resident had a right hand estorative nursing sheets il 2014, - September 2014, g program to be completed for t: 0-15 reps bilateral 1x 10-15 reps bilateral 1x 10-15 reps bilateral 1x 10-15 reps bilateral abduction/adduction 1x 10-15 reps bilateral abduction/adduction 1x 10-15 reps bilateral	F	317			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245497	B. WING			09/1	2/2014
	PROVIDER OR SUPPLIER	LAIN		1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE JAPLE PLAIN, MN 55359	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 317	flexion/extension 1 Walk 29-57 fee wheelchair behind roller walker transfe. Wrist PROM 1 flexion/extension 1 R7's restorative nu September 2014, rprogram to be comhowever, there wa receiving any ROM R7's care plan date right hand contract On 9/11/14, at 1:20 PTA-E and COTA-resistive and had shand and bilateral R7 grimaced and soccasions when Pattempting ROM. OR would benefit fsplint or cone for thand. During interview of stated R7 had a contract thand to state R7 had a contract thand to state R7 should be she was trying to restated R7 should be as had been asse aware of R7's left contractures.	et two times daily with stand by assistance of two er belt x2 0-15 reps bilateral x rsing sheets for April 2014 - noted the restorative nursing apleted for R7 on the day shift, s no documentation R7 was 1.	F	317			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		NSTRUCTION	(X3) DATE COMF	SURVEY
		245497	B. WING			09/1	2/2014
	PROVIDER OR SUPPLIE			1520 W	TADDRESS, CITY, STATE, ZIP CODE JYMAN AVENUE E PLAIN, MN 55359	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 317	able to complete feel sorry for the range of motion." have any extra tir ambulation. During interview of stated R7 had a complete which was repaired contracture identification. During interview of stated R7 had a complete with the state of the state	A-A who stated staff was not ROM for residents and stated, "I residents because they need the NA-A stated staff just does not me to provide any ROM or on 9/11/14, at 1:57 p.m. RN-D contracture to the right hand, ed via surgery, and was the ified on the resident's MDS. eral months ago R7 got to the able to hang onto the walker with aff was ambulating the resident N-D stated R7 was noted at that ecline in ROM in her left hand unable to hang onto the walker, storative program was not the resident was not referred event further decline in ROM. It to ensure R7's restorative assessed to ensure the ROM ing implemented and was vent further decline in ROM. If the walker to ambulate, the provide further interventions and hich resulted in actual harm to be used to the facility had the right to do in his/her own care and to have ilable to him/her to reach their		317			
	nighest possible psychosocial lev	, practicable physical and rel. Restorative nursing is a					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245497	B. WING	; 		09/1	2/2014
	PROVIDER OR SUPPLIER	LAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 317	builds on strengths criteria: 1. Measurable ob must be document clinical record 2. Evidence of penurse must be presonant assistant the techniques that in the activity 4. Restorative ac supervised by mer	age 36 c, organized program that and must meet the following edictives and interventions ed in the care plan and in the eriodic evaluation by licensed sent in the clinical record ants/aides must be trained in t promote resident involvement tivities must be carried out or mbers of the nursing staff we programs must be provided	F	317	7		
	a minimum of 6 da 6. Each Restorat a minimum of 15 m. The policy further management posimaintaining the organization of the summary of the summary of the summary of the summary of the following, "Restora OBRA [Omnibus E 1987, as a means highest possible posychosocial level enhances dignity a primary reason for restorative nursing organized programidentify restorative	ays/week ive program must be provided ininutes in a 24 hour period identified nurses in tions were responsible for ganization of the restorative itoring the delivery of restorative itoring the programs consistently and as planned. The policy documented the ative nursing was mandated by itorian itoria					
	restorative service	sure residents receive the es as planned and document to nent record of the entire					

			PLETED				
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER	LAIN		15	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 317 F 318 SS=D	process. It does not Loss of function de and one's ability to of life. An organize delivers systematic individual needs in and enhances well 483.25(e)(2) INCR	of feel good to lose function. creases a person's self-worth experience and enjoy quality d restorative program that care based on the resident's creases self-esteem and worth being." EASE/PREVENT DECREASE	F3	317			10/22/14
	resident, the facility with a limited range appropriate treatm	orehensive assessment of a y must ensure that a resident e of motion receives ent and services to increase ad/or to prevent further of motion.					
	by: Based on observative review the facility fand/ or ambulation maintain current learnesidents (R31, R6)	NT is not met as evidenced ation, interview, and document ailed to ensure range of motion a services were provided to evel of functioning for 3 of 5 of 5, and R1) reviewed for range ambulation services.					
	6/11/14, indicated	nimum data set (MDS) dated R31 had no current functional motion in the upper or lower					
	to receive 10-15 re	ated 8/20/14, indicated R31 was epetitions daily, passive range to hips, knees, bilateral	3		·		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		E SURVEY PLETED
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER	_AIN		1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE //APLE PLAIN, MN 55359	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	shoulders, elbows, R31's restorative not from 7/2014, to 9/1/1 range of motion set month of 7/2014, at (8/12/14, through 9) During observation was sitting in his whobserved on 9/10/1 receiving any ROM During interview on therapy assistant (Fourrent functional follower extremities, in for development of not receive the assistant (NA)-E strange of motion sed dressing activities for related to lack of stream of the lack of stream of the lack of stream of the complex of the last few months. R64's quarterly MD R64 had severe controlled.	writs, fingers, and ankles. ursing PROM documentation 4/14, indicated R31 received vices 3 out of 31 days for the nd 12 days in the last month /14/14). on 9/10/14, at 9:39 a.m. R31 neelchair. R31 was not 4, 9/11/14, and 9/12/14, services. 9/10/14, at 2:00 p.m. physical PTA)-E stated R31 had no pss of range of motion in his nowever, would be at high risk contractures if he continued to essed range of motion 1 09/11/14, at 9:45 a.m. nursing ated R31 did not receive any rvices other than routine for the last several months affing. 1 9/11/14, at 3:18 p.m., R31 oke a while back and did not would like to use his legs if he nce. R31 stated he would be leting leg exercises, however, ompleting them at the facility in s. 2S dated 8/13/14, indicated gnitive impairment, required	F	318			
	extensive assistan	ce for all ADL's including bed ig, and walking. R64 was not					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER	LAIN		15	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	steady, and was or assistance. R64 h. or lower extremity or lower extremity of R64's Physical therestoration of the could ambulate up discharged on a reprogram. R64's occupational dated 5/16/14, instruction on the resprogram. During a review of R64 was to have or moves their own journed by the company of the could are the composite of the could be company of the	anly able to stabilize with staff and no impairment to his upper range of motion. Trapy discharge summary dated R64 had significant discharge and pivot transfers, to 230 feet, and was storative nursing ambulation. If therapy discharge summary ructed the resident was to storative nursing ambulation. R64's care plan dated 8/15/14, ervical (neck) active (subject point) range of motion per per per and occupational therapy tions. The care plan also was to ambulate with the care Sheet (which staff used as individual care needs) dated at taff to ambulate R64, 115-230 in the day shift, with assist of 1 fer belt and a walker. Table time log in the electronic which identified if the resident M or ambulation), lacked	F3	318			
	received any PRO evidence any nurs PROM) was comp 8/14, or 9/14. During interview o	M or ambulation), lacked ing rehab (ambulation or letted for the months of 7/14, or 9/10/14, at 1:00 p.m. nursing					
	8/14, or 9/14. During interview o						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245497	B. WING		09	/12/2014
	PROVIDER OR SUPPLIER	_AIN		STREET ADDRESS, CITY, STATE, ZIP C 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 318	During interview on physical therapy as had contractures of walked and receive contractures don't of During observation was assisted by PT in the hallway. R64 time to get up from	ident ROM program for R64 hort staffed. 9/11/14, at 10:45 a.m. sistant (PTA)-E stated R64 f his knees and needed to be the PROM to ensure the get worse. on 9/11/14, at 1:50 p.m. R64 TA-E and COTA-D to ambulate needed encouragement and his recliner, but did ambulate	F 3	18		
	COTA-D stated R6 "About the same," from services on 5, decline in ROM or During an interview registered nurse (Fassistants should to fpassive range or residents electronic RN-C verified R64' blank for 7/14, 8/14 was no way for the receiving PROM or stated there current responsible for assistants."	on 9/12/14, at 11:00 a.m. RN)-C stated the nursing be documenting the completion of motion and ambulation in the comedical record program. It is nursing rehab time log was at and 9/14, therefore, there facility to identify if R64 was beeing ambulated. RN-C of the restriction of the restorative restorative.				
	R1 Quarterly MDS had functional limit to one side of the u	ensure it was being appropriate for the residents. dated 6/25/14, indicated R1 ration in range of motion (ROM) apper and lower extremities. ded 7/2/14, indicated R1 was to			·	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		i		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/1	2/2014
	PROVIDER OR SUPPLIER		<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 318	receive daily passi 10-15 reps, to bilat and fingers. R1's restorative nu resident was to rec Ankle PROM dorsiflexion/flexion Digits PROM flexion/extension Elbow PROM flexion/extension Hip PROM 0- flexion/extension Knee PROM flexion/extension Shoulder PRO flexion/extension	ve range of motion (PROM) teral shoulders, elbows, wrists, ursing program identified the ceive the following daily: 10-15 reps bilateral 1x 10-15 reps bilateral 1x 15 reps bilateral 1x 15 reps bilateral 1abduction/adduction 1x 10-15 reps bilateral 1x 0M 10-15 reps bilateral 1x 1x 10-15 reps bilateral	F	318			
	nursing program f September 2014, ROM program had months. When interviewed licensed practical no longer a restor facility, so the NA' supposed to be prambulation for the have enough staff completed. LPN-	ocumentation of the restorative from April 2014, through were all blank, indicating the d not been completed for 5 If on 9/10/14, at 7:10 a.m. nurse (LPN)-A stated there was rative NA employed by the staffed on the floor are roviding the ROM and e residents, however, they don't for to ensure this is being A stated residents have the walking or receiving their ROM e lost strength.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY PLETED
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER	LAIN		152	REET ADDRESS, CITY, STATE, ZIP CODE 10 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 318	Continued From pa	age 42	F3	318			
	stated ROM and an being done due to	on 9/10/14, at 9:18 a.m. NA-Embulation of residents was not being short staffed, and rative nursing was not being					
	non-verbally respo and forth motion w "so-so," when aske ROM and ambulat was asked how oft	n 9/11/14, at 9:25 a.m. R1 nded by motioning in a back ith her hand to indicate, ed if staff was assisting her with ion on a daily basis. When R1 ten staff was assisting, R1 nly" on her communication					
	COTA-D stated R1 contractures if PR being done, however	on 9/12/14, at 9:49 a.m. I would be at risk for increased OM and ambulation was not yer, COTA-D was not aware of slines in ROM or ambulation.					
	Nursing identified individual admitted become involved i the services availa highest possible, psychosocial level planned, systematically builds on strength criteria: 1. Measurable of must be document clinical record 2. Evidence of program of the present admits a control of program of the present admits a control o	d policy titled Restorative the philosophy was each I to the facility had the right to In his/her own care and to have able to him/her to reach their bracticable physical, and I. Restorative nursing is a cic, organized program that Is and must meet the following bjectives and interventions ted in the care plan and in the eriodic evaluation by licensed esent in the clinical record tants/aides must be trained in					

	F CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
		245497	B. WING			09/1	12/2014
	PROVIDER OR SUPPLIER	LAIN		15	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 318 F 323 SS=D	supervised by men 5. Two Restorativa minimum of 6 da 6. Each Restoratian minimum of 15 m. The policy identifies positions were responsization of the monitoring the delivoutine basis to assemble followed consistent 483.25(h) FREE OHAZARDS/SUPERTHE facility must elenvironment remains is possible; and	tivities must be carried out or obers of the nursing staff re programs must be provided sys/week ve program must be provided ninutes in a 24 hour period d nurses in management ponsible for maintaining the restorative program and very of restorative care on a sure the programs are being thy and as planned.		3318			10/22/14
	by: Based on observareview, the facility were thoroughly as appropriate/pertine implemented or re R3), with multiple facility. Findings include: R64 admission facility.	ent interventions could be vised, for 2 of 2 residents (R64,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245497	B. WING		09/	12/2014		
	PROVIDER OR SUPPLIER	LAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
F 323	quarterly Minimum 8/13/14, indicated impairment, require activities of daily live mobility, transfer, was not steady, and staff assistance. R64's care plan dated at high risk for falls admission to the transicipate R64's to mat on the floor which safety alarm systems ocks while in bed R64's wheelchair.	Data Set (MDS) dated R64 had severe cognitive ed extensive assistance for all ving (ADL), including bed valking, and toilet use. R64 d only able to stabilize with ated 8/19/14, indicated R64 was and had falls prior to and after he facility. Staff were directed to ileting needs, place the floor hen in bed, have the call light m on while in bed, wear gripper, ensure safety alarm was on chair, and ensure an e was on the residents	F 32	3				
	dated 5/20/14, indifalls risk; [six] 6 fall attempts self trans delusional revertin pastor Gripper s [wheelchair] alarm system remain appears and fall on 7/27/14. At R64's alarm sound observed sitting of had no injuries. R6 wanted to go to so told staff he needed staff assisted the furinated. Staff was	estraint Evaluation Review icated, "Resident remains high Is in [three] 3 months. Resident if the sters frequently. Confused and ig to his days of being a ocks when in bed; W/C; motion sensor; Bed alarm propriate. Floor mat added." It is indicated the resident had a coording to the progress notes, ded, and the resident was in the floor at his bedside and 64 was alert, and reported his chool and rolled out of bed. R64 and to go to the bathroom and resident to the bathroom and he is unable to provide any further restigation of the fall to						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/1	2/2014		
	PROVIDER OR SUPPLIER	LAIN		1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE IAPLE PLAIN, MN 55359				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 323	determine if current appropriate, new ir if R64's toileting plas was appropriate to R64's progress not another fall on 8/24 progress notes, R6 was observed on toinjuries were noted clip his nails. Staff further assessment determine if current appropriate, if their residents falls, or in needed to prevent. During interview or registered nurse (If of conducting post there was no furth regarding these fawere not complete caused the fall, if the current interventions in stated, "We are with known he [R64] had although R64's faindicated the resident prior three months the facility was unincident reports, or intervents, or incident reports, or intervents in the sacility was unincident reports.	at interventions were atterventions were needed, and an was being implemented and prevent further falls. Ites indicated the resident had 4/14. According to the 64/18 alarm sounded, and he he floor on his buttocks. No 1. R64 indicated he needed to was unable to provide any at or investigation of the fall to at interventions were e were any trends with the flow interventions were further falls. In 9/12/14, at 10:00 a.m., RN)-B stated she was in charge afall investigations. RN-B stated er information available and post fall assessments and to determine what may have there were any trends noted, if ntions were appropriate, or if needed to be modified. RN-B orking on thatI didn't even		323					
·	R3's diagnoses lis	sted on the undated facesheet ss, spasm of muscle, abnormal			·				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	LAIN		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE WAPLE PLAIN, MN 55359	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 323	involuntary movem dementia, and free R3's quarterly MD5 was severely cogn extensive assistant steady when stand During an interview stated R3 had three 8/22/14, and 9/4/14 impulsive and learn often rolled out of long in the injured during the nurses station. Dack of her blouse anti-rollback devicatempted to stand members attempted to stand members attempted to stand members attempted to seat and read calmly in minutes paging the about each picture.	nents, lack of coordination, quency of urination. S dated 7/2/14, indicated R3 itively impaired, required ce with all ADL's, and was not ling or transferring. V on 9/8/14, at 4:20 p.m., RN-A re recent falls, on 8/20/14, 4. RN-A stated R3 was need forward in her chair and her chair. RN-A stated R3 was these falls. Servations on 9/10/14, R3 was relchair, in the area in front of R3 had a alarm clipped to the equal and her wheelchair. R3 dimany times and multiple staffed to redirect R3 and assisted was able to self propel her build often lean forward in her would sound the alarm which er. On one occasion, a staffed a magazine, which R3 sat her wheelchair for several rough the magazine and talking	F 323				
	risk for additional falls. Staff were di practices and to a toileting needs. The to offer activities to for folding, cloths	falls due to a history of frequent rected to observe for unsafe nticipate R3's needs, especially ne care plan also directed staff o keep her busy, to offer towels to wipe surfaces she could o dress and undress.					

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION .	COMI	PLETED
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER	LAIN		15	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE IAPLE PLAIN, MN 55359	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	R3's progress note included the follow On 8/20/14, R3 sto outside of her room were no injuries no going to get to her increased confusio toileted and laid do provide any further determine the caus interventions were on 08/22/2014, R3 observed slowly faroom. No injuries wattempting to get uroom when she fel her wheelchair and restroom to be toild provide any further determine if currer appropriate, or if n On 9/5/14, R3's als witnessed her stardesk in the main pstanding to reach front of her at the cinto her wheelchaic closer to her. Staff further assessmer current intervention interventions were During an interview registered nurse (I charge of conduct RN-B stated there	es related to her recent falls, ing: bod up from her wheelchair in and fell to her knees. There of ted. R3 indicated she was appointment. Staff noted on after lunchtime and R3 was own for nap. Staff was unable to assessment of the fall to se of the fall, if current appropriate, or if new needed. B's alarm sounded and she was lling to the floor in the activity were noted. R3 stated she was up and walk out of the activity were noted. R3 stated she was up and walk out of the fall to detend. Staff was unable to rassessment of the fall to interventions were ew interventions were ew interventions were needed. The arror R3 stated she was for the watermelon that was in desk. R3 was assisted back of the fall to determine if of the fall to determine if on the fall to determine if on the ware appropriate, or if new		323			

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 ` ′			COMF	PLETED
		245497	B. WING			09/1	2/2014
	PROVIDER OR SUPPLIER	LAIN		15	FREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE IAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ì	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	assessments were what may have cau any trends noted, ir appropriate, or if the followed.	age 48 not completed to determine used R3's falls, if there were f the current interventions were ne plan of care was being	F3	323			
F 353 SS=F	and Risk/Restraint Fall Evaluation will [director of nursing hours after a resident 483.30(a) SUFFIC	Evaluation included, "The Post be completed by the DON or her/his designee within 72 ent fall." IENT 24-HR NURSING STAFF		353			10/22/14
	provide nursing an maintain the highe and psychosocial v	ave sufficient nursing staff to ad related services to attain or set practicable physical, mental, well-being of each resident, as ident assessments and care.					
	numbers of each of personnel on a 24	rovide services by sufficient of the following types of -hour basis to provide nursing ts in accordance with resident					
		ed under paragraph (c) of this nurses and other nursing			•		
	section, the facility	ed under paragraph (c) of this must designate a licensed a charge nurse on each tour of					
	This REQUIREME	ENT is not met as evidenced					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COM	PLETED
		245497	B. WING	i		09/	12/2014
	PROVIDER OR SUPPLIER		J	1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE IAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	by: Based on observareview, the facility nursing staff was a accordance with e 48 residents (R7, R12, R52, R66, armembers (FM-B) cares were not be This practice had residents who resid	ation, interview, and document failed to ensure sufficient available to provide services in ach resident's needs for 11 of R47, R1, R31, R55, R56, R11, and R7) and 1 of 4 family who had concerns resident ing met related to lack of staff. the potential to affect all 48 ded in the facility. walked according to the ive nursing orders. During 14, at 1:42 p.m. NA-F stated the e enough staff to walk R7, and lt R7 had a decline in possibly range of motion. NA-F lifficulty with transferring now, or raise her feet up while in the num Data Set (MDS) dated she had severe cognitive firment (contractures) to one extremity, and required son assistance with Her balance was impaired and and with staff assistance. The dephysician orders dated staff to walk the resident 29-57 ce of two staff, twice daily using ursing documentation from April 2014, lacked documentation walked/ambulated by staff from the province of the staff from walked/ambulated by staff from walked/ambulated by staff from the province of the staff from walked from the province of the staff from walked from the province of the staff from the province of the staff from the province of the pr		353			

	OF DEFICIENCIES OF CORRECTION	A. BUILDING 245497 B. WING WIES OF MAPLE PLAIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IDENTIFICATION NUMBER: A. BUILDING B. WING 1520 WYMAN AVENUE MAPLE PLAIN, MN PROVIDER: PREFIX (EACH CORRE CROSS-REFERE					E SURVEY IPLETED
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER	_AIN		STREET ADDRESS, CITY, STATE, ZIF 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359	, CODE		12/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFI)	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
F 353	When interviewed of stated the restorative right now, and she program. She verift R7 was being walked. An interview on 9/1 completed with NA-ambulate residents happen because of stated staff was not residents either, and residents because motion." NA-A stated extra time to provide R47 stated during in p.m., there was not time. She stated shand all the way up to her call light and acceptable. She all shortage, she had it is cold. During a second interviewed her food and it is cold. During a second interviewed her food and it is cold. During a second interviewed her food and it is cold. She stated she wood bathroom as staff of light. She stated she was she was stated she was stated she was stated she was she was stated she was she w	on 9/9/14, at 9:46 a.m. RN-A ve program was in shambles was trying to revamp the ied there was no evidence that ed. 0/14, at 1:00 p.m. was		53			
	because of previou wait for staff over 2 reported the nursin	s falls, however, she can not 0 minutes for assistance. She g assistants are aware she off shortage. R47 stated she is					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	_AIN		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	supposed to be ass however, staff is no don't have time, and been walked for ab	isted with walking twice a day, it able to do this as they just d she didn't think she had out 10 days. TM)-B of R47 was interviewed	F3	353			
	on 9/10/14, at 1:15 to staff a "couple of being walked and h lose strength. FM-E twice each day, but stated R47 had falle was not willing to be assistance from stanswered for long p stated there were ti call light was on for	p.m. and stated he had talked times" that R47 was not e was concerned she would a stated R47 was to be walked it seldom happened. FM-B en a couple of times as she incontinent while waiting for aff when her call light was not periods of time. FM-B also mes when he visited and the over 15 minutes and he ut to the hall and try to find					
	was cognitively inta of delirium. She ne two staff with bed nof one staff for tran personal hygiene.	S dated 7/2/14, indicated R47 ct with no signs or symptoms reded extensive assistance of nobility, extensive assistance sfers, dressing, toilet use and R47 needed extensive rtaff with ambulation.					
	directed nursing as resident 57 feet to	stant care sheet dated 9/9/14, sistants to ambulate the 115 feet twice per day with staff, a transfer belt, rolling hair behind.					
	complete passive rankles, digits, kneed daily. In addition, to	igned 9/5/14, directed staff to ange of motion to wrists, s, elbows, shoulder and hips ne physician ordered that R47 eet twice a daily with a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245497	B. WING		09	/12/2014		
	PROVIDER OR SUPPLIER	LAIN		STREET ADDRESS, CITY, STATE, ZIP (1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		8		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE	(X5) COMPLETION DATE		
F 353	wheelchair behind, transfer belt. R47's restorative n	age 52 using a rolling walker and ursing sheets for August, 2014 4 were reviewed and there was	F 3	353				
	no documentation range of motion to An interview with li (LPN)-C was compand she stated she walked twice a day stated there was nestorative nursing	that R47 received any passive extremities or ambulation. censed practical nurse pleted on 9/11/14, at 11:15 a.m. e was aware R47 was to be with staff assistance. LPN-C o documentation on the sheets to identify if R47 had ambulation or any PROM in						
	feel there were sur incontinent because answered fast end she had not been asked how often s	9/14, at 1:10 p.m. she did not fficient staff and she has been se the call light was not being bugh. R1 also was concerned receiving ROM, and when the had been receiving ROM tout, "monthly," using her pard.						
	R1 had moderate or symptoms of de behavioral issues,	S completed 6/25/14, indicated cognitive ability, had no signs elirium/ psychosis, had no and had limitations to one side ower extremity (contractures).						
	nursing sheets fro	ted 7/2/14, and restorative om 4/2014- 9/2014, directed assive range of motion daily to bows, wrists, and fingers.						
		ursing sheets for April 2014, to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245497	B. WING		09	/12/2014	
	PROVIDER OR SUPPLIED			STREET ADDRESS, CITY, STATE, ZIP COL 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 353	that passive rang R1. During an intervie licensed practical not have time to residents due to have time to residents due to have time to residents and ambula done due to being During an intervie stated the restoraseveral months a not have time to residents. When interviewe stated there was this time, and NA residents with an NA's had brough having enough s and assist reside program. R31 reported on stroke a while bathe stated he wo not get the chanstaff to help him.	ew on 9/10/14, at 7:10 a.m. I nurse (LPN)-A stated NAs did do restorative nursing for being short staffed. I/10/14, at 9:18 a.m. with nursing was completed and she stated ation of residents were not being g short staffed. I/10/14, at 1:25 p.m. NA-B ative aide position had been cut ago, and nursing assistants did provide ROM and ambulation to d on 9/11/14 at 10:30 a.m., RN-F no formal restorative program at a swere directed to assist inbulation and ROM. RN-F stated at up concerns to her about not taff to complete resident cares ents with the restorative nursing 9/11/14, at 3:18 p.m. he had a ack and did not walk anymore. uld like to use his legs, but does ce because there are not enough		3			
	on two staff for a	vely impaired, totally dependent all transfers, and needed ance of one staff for all					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	COMPLETED		
		245497	B. WING	G		09/1	2/2014
	PROVIDER OR SUPPLIEF			1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE /IAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	R31's care plan d	ated 8/20/14, indicated R31 was		353			
	to receive PROM ankles 10-15 repe bilateral shoulders	motion to hips, knees, and etitions daily as well as to s, elbows, wrists and fingers.	i,				
	8/12/14, through 9 PROM only 12 tin						
	RN-A stated the f formalized restoratime due to lack of	acility did not currently offer ative programs at the present of staffing.					
	During interview of assistant (NA)-E any range of mot	on 09/11/14, at 9:45 a.m. nursing stated R31 did not ever receive ion services.	3				
	R55 was not recesstaff shortage.	eiving range of motion due to					
	did not walk, had	IDS dated 6/4/14, identified R55 no functional limitations in stally dependent on staff for ting, dressing and all activities or					
	dated 1/1/14-6/30 R55 received da included the follo shoulder, wrist, a The 7/2014 MAF were provided ou facility was unab	the restorative nursing book 0/14, instructed staff to ensure ily restorative treatments which owing passive range of motion to ankle, finger, elbows and knees. It identified 3 restorative services at of the 31 opportunities. The le to provide evidence that R55 assive range of motion from 8/14,					
		on 9/10/14, at 11:50 a.m., NA-B					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/1	2/2014
	PROVIDER OR SUPPLIER			15	REET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	stated R55's ROM because they didn'time completing the only received about which the resident needing. During interview of stated range of mompleted and R result. NA-H states her arms and legithe resident dress asked the resident different clothing. R56 stated on 9/8 the facility had entowait a long time. During interview stated he had paup sitting in his with 6:00 a.m. that moment in the different clothing in his with 6:00 a.m. that moment is sistance of one chair, and was a ulcers. He curre (Unstageable) pron admission over R56's admission over R56's admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission over R56's admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission over R56's admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission over R56's admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission over R56's admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission over R56's admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission over R56's admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission over R56's admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission dated 12/17/13, repositioned at new complete and sistence of the curre (Unstageable) pron admission dated 12/17/13, repositione	M exercises were often not done n't have enough staff to spend ne exercises. NA-B stated R55 ut 10% of the ROM exercises t had been assessed as on 9/11/14, at 10:13 a.m., NA-H notion services were not being 55 was becoming stiffer as a ed R55 wasn't able to stretch out is like before which made getting sed more difficult so facility staff ants family member to bring in		353			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/1	12/2014
	PROVIDER OR SUPPLIEF			1	STREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 353	in his wheelchair a weight independe by staff to assist to assessed.	page 56 rough 9:46 a.m., R56 was sitting and was unable to shift his ntly, and was not approached he resident to reposition as	F	353			
	assistant (NA)-Assistaffed and NA's of to reposition as assunable to do so, repositioned ever	stated the facility was short did their best to assist residents assessed but at times were NA-A verified R56 had not been by two hours as assessed cility not having sufficient					
	p.m. she had gon a bath because the aids to provide bath R11 stated she has for staff to resport to go to go to the happened a lot, a call light on for over bathroom, no sta	an interview on 9/8/14, at 4:23 e for a couple of weeks without the facility didn't have any bath athing assistance. In addition, and to wait 40 minutes to an hour and to her call light when she had bathroom. She stated this and a few nights ago she had her ver 40 minutes to go to the ff came to help her to the had to, "Poop in my diaper."					
	had moderate co extensive assista R11's Point of Ca nursing assistant receives cares), bath on 7/31/14.	IDS dated 8/27/14, identified R11 gnitive impairment and required ince from staff for toileting. Bare Bathing Record (where the se document when a resident identified R11 had received a tub The next record of R11 receiving pathing was a partial bath on later.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/1	2/2014
	PROVIDER OR SUPPLIE			15	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	During interview stated there are residents a bath. able to complete the facility being sresidents complete they put on their chad transferred in able to respond to being short staffed. During interview stated it was posing for weeks with the facility does recomplete all the nanother staff calls replace them. Note the administration knew resident calls resident baths and NA-H stated it was accommodate by resident baths and NA-H stated it was almost a month staff available to buring interview stated resident by timely. NA-B stated in a lack of staffing. During interview registered nurse up concerns registered resident staff available to concerns registered nurse up concerns registered nurse up concerns registered nurse and the staff available to concerns registered nurse up concerns registered nurse and the staff available to concerns registered nurse up concerns registered nurse up concerns registered nurse and the staff available to concerns registered nurse up concerns registered nur	on 9/9/14, at 3:03 p.m. NA-K ot enough staff to provide NA-K stated she often is not all the resident cares because of short staffed. NA-K stated in of the long wait times when call light, and some residents adependently when staff is not mely to their call light due to d. on 9/10/14, at 2:23 p.m., NA-F stable that some residents had without getting a bath because not have enough staff to resident cares. NA-F stated if is in sick, the facility does not A-F stated she had complained tion about this because she res were being neglected. on 9/11/14, at 10:13 a.m., NA-H not enough staff to aths for the residents, and e not being completed regularly. The possible R11 could have gone without a bath due to the lack of		353			

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245497 B. WING	09/12/2014
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN STREET ADDRESS, CITY, 1520 WYMAN AVENUE MAPLE PLAIN, MN 5	
(X4) ID SOMMAN ON CHIEF OF THE PRECEDED BY FULL PREFIX (EACH CORRECT PREFIX OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREN	S PLAN'OF CORRECTION (X5) CTIVE ACTION SHOULD BE COMPLETION NCED TO THE APPROPRIATE DEFICIENCY)
F 353 facility is still working on the staffing concerns. During dining observation on 9/8/14, at approximately 5:40 p.m. NA-P was observed sitting on a rolling stool in the dining room at a table with R12, R52, R66 and R7. After the residents received their food, NA-P rolled around the table on the stool going from resident to resident giving them a bite of food, and then rolling on the stool using her feet to the next resident. NA-P would give a resident a bite of food, set the fork or spoon down, and immediately roll over to the next resident, and continued rolling around the table on the stool the entire meal. R12's quarterly MDS dated 6/18/14, indicated R12 had severe cognitive impairment and required extensive staff assistance with dining. R52's quarterly MDS dated 8/20/14, identified R52 had severe cognitive impairment and required extensive staff assistance with dining. R66's quarterly MDS dated 8/6/14, identified R66 had severe cognitive impairment and required extensive staff assistance with dining. R7's quarterly MDS dated 8/27/14, identified R7 had severe cognitive impairment and required extensive staff assistance with dining. During interview on 9/8/14, at 6:01 p.m. NA-P stated she was required to seed multiple residents at a time, and needed to use the rolling stool so she was able to go from resident to resident to ensure they all received their meal. NA-P stated there was not enough staff to ensure all the residents were being fed timely, so the NA's do	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245497	B. WING	;		09/12/2014		
	PROVIDER OR SUPPLIER	LAIN	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359					
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	O BE	(X5) COMPLETION DATE	
F 353	Continued From payments they have to meals. When interviewed LPN-A stated som wait for help becaute LPN-A stated they assisting residents during the survey, LPN-A stated residents and residents and residents and feel the call lights not be cares provided. Lambulation for the completed, and rewalking and feel the stated on the wee with behavioral isson the nurse to presupervision, which the resident cares. When interviewed stated there were shift and staff was necessary care for residents have be 60 minutes for he sick call, the staff short, and there he	age 59 so the residents receive their on 9/10/14, at 7:10 a.m. etimes the residents needed to use the facility is short staffed. managers are not typically s with dining, however, the week they have been helping out. dents have voiced concerns of peing answered and not having PN-A stated restorative nursing, residents is not being sidents have complained of not ney are losing strength. LPN-A kends, the staff brings residents sues to the lobby and this falls ovide additional makes it difficult to complete all which need to be completed. If on 9/10/14, at 6:50 a.m. NA-L not enough staff on the night struggling to provide the or over 2 months. NA-L stated then complaining of waiting 45 - Ip. NA-L stated when there is a is not replaced and they work have been nights the facility had orking to take care of all the	F	353	DEFICIENCY)			
	When interviewed stated residents having enough state had reported multiple times. No changed with sta	d on 9/10/14, at 6:57 a.m. NA-M have voiced concerns about not raff to complete the cares and this to the charge nurse on duty IA-M stated nothing had ffing, even after reporting receiving the cares they require	/					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/1	12/2014
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE IAPLE PLAIN, MN 55359		
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F 353	Continued From p	age 60	F3	353			
	stated the night shand they often wo						
	stated residents a they need and des restorative service aid and bath aid p months ago, and staffing. She state the dining room to management had room, which neve NA-H stated resid are not receiving to not have time to constated some resident shift to use the batter of the state of the stat	on 9/10/14 at 7:46 a.m. NA-H re not getting the quality care serve, and there had been no es for 3 months. The restorative ositions were eliminated several staff had quit due to short ed residents not being helped in eat, and during survey been helping in the dining r happens on a regular week. ents have voiced concerns they their baths because staff does to this extra task. NA-H also lents are only assisted twice per throom due to staffing, and getting walked so they get try to walk alone.					
	stated she did not and nursing assist all cares, includin ambulation. NA-tomplained of the	I on 9/10/14, at 9:18 a.m. NA-E teel there were enough staff tants were not able to provide g baths, shaving, ROM, and stated residents have a call lights not being answered, ned of having less strength due g done.					
	NA-F stated the N stated the NA's a ambulation, and I	ew on 9/10/14, at 1:15 p.m., NA's constantly feel rushed. She re supposed to do ROM, paths for residents, and the NA's amplete this because of short					

Event ID: JMZ111

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER			15	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE IAPLE PLAIN, MN 55359		
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F 353	When interviewed 1:25 p.m. NA-B si sufficient staff to chad tears in her eyunable to complete bathing, ROM, din When interviewed stated it is difficult to being short staff On 9/11/14, at 9:0 light times was restated they did no out the report. She the facility was us response times. When interviewed verified there is not this time. RN-A complaints from N staff to complete ambulation. RN-A do ROM on reside them, and verified and did not meet nursing program. During interview of stated the facility resident cares we stated ROM was residents, specific stiffer as a result. enough staff to ac residents and the stated the NA's he state	on 9/10/14, at approximately tated the facility did not have omplete resident cares. NA-B yes as she stated they are e resident cares, especially ing, and ambulation. on 9/10/14, at 2:07 p.m. NA-O to provide resident cares due	F	353			

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/12	2/2014
	ROVIDER OR SUPPLIE			15	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 353	when interviewed staffing coordinated was a sick call, recomber of staff scall resulted in statestablished minimus the director of number is no policy. When interviewed DON and adminition census, not not levels. The goal assistants on both the enursing assistants on both ree nursing assistants on the enursing assistants on the enursing assistant if it would not been lay replace staff if somet the right staff acility was significated the year. They stated they on being more exares. They NA complete all of the staff and they feat on the complete restorative nursing with the place staff and they feat on the place staff and	wever, nothing had been done to g issue. d on 9/12/14, at 10:34 a.m., the or (MR)-J stated when there eplacement depended on the cheduled. She reported if a sick aff working a shift with less than nums, she would consult with rsing (DON). She indicated on staffing. d on 9/12/14, at 11:04 a.m. the strator stated staffing was based ecessarily on resident care was to have six nursing the the day and evening shift, and sistants on the night shift. If they have not been replacing the equire overtime. They stated uced the hours of staff, and there offs, however, they would not be meone left or retired, until they first they flet the ficantly overstaffed, and did not an issue with lack of staffing. If had been trying to educate staff efficient in providing residents is should have been able to the duties necessary with less lit the NA's were making a choice things such as baths or ng services. DON stated they he NA's working at a time and six, because having nine, "Just d business sense."		853			10/22/14
F 43′ SS=F		e) DRUG RECORDS, DRUGS & BIOLOGICALS	} 	431	·		10/22/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245497	B. WING	i		09/12/2014		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359					
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F 431	a licensed pharma of records of rece controlled drugs in accurate reconciliarecords are in ord controlled drugs is reconciled. Drugs and biological labeled in accordary professional princial appropriate access instructions, and trapplicable. In accordance with facility must store locked compartment controls, and permanently affix controlled drugs in the facility must store locked compartment controls, and permanently affix controlled drugs in the facility must germanently affix and germanently affix drugs in the facility must germanently affix and germanently affix and germanently	employ or obtain the services of acist who establishes a system of the analysis and disposition of all a sufficient detail to enable an action; and determines that drug er and that an account of all a maintained and periodically cals used in the facility must be ance with currently accepted iples, and include the accepted iples, and include the accepted iples, and cautionary the expiration date when The State and Federal laws, the all drugs and biologicals in the ents under proper temperature mit only authorized personnel to be keys. The provide separately locked, the drugs and other drugs subject to the and other drugs subject to the facility uses single unit tribution systems in which the minimal and a missing dose car		431				
	by: Based on observ	ENT is not met as evidenced vation, interview, and document y failed to establish a system to						

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245497	B. WING			09/1	2/2014
	PROVIDER OR SUPPLIER			STI 152	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE APLE PLAIN, MN 55359	1 03/1	212014
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	medication storage in the storage area addition, the facility multi-dose vial in 1 in the medication is potential to affect a residing in the faci admitted residents. Findings include: During observation room on 9/12/14, a nursing (DON)-A a (LPN)-A, the refrigundated, vial of Tutesting for tubercuverified the vial was opened, and long the vial had be DON-A stated on Minimum Medicat Omnicare, Inc. dashould have, "Dat portion after 30 dathe tuberculin propadmitted resident in the refrigerator, the refrigerator in also contained a length (medication used (milligram/millilite with an opened disticker that direct LPN-A stated R2 order for the medication distillustration available for the medication available for the medication and the sticker that direct LPN-A stated R2 order for the medication available for the medicat	dications were removed from e in 2 of 2 medication carts and in the east hallway. In a failed to date an open, of 1 medication refrigerators storage room. This had the fall 48 residents currently lity, as well as any newly	d /	431			

SIMILITIES DEL TOTAL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245497	B. WING	i		09/1	2/2014
	PROVIDER OR SUPPLIER	LAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 431	were responsible for storage areas to clum and proper labeling. During observation LPN-A, the locked the end of the East unopened stock by Coated Aspirin 328 8/14. LPN-A state available for use behave been removed. During an observation with LPN-A, the Nicontained Aspir-locan expiration date been using chewal stated the Aspir-locan expiration.	all staff giving medications or going through medication neck for expired medications of medications. I on 9/12/14, at 8:50 a.m. with medication storage cabinet at thallway, contained four ottles of Geri Care Enteric of mg, with an expiration date of the bottles of Aspirin were ut were expired and should	F	431			
	LPN-B, the South stock bottle of Ge 325 mg, with an e stated the Aspirin and were expired from the medicati also contained Acunits per gram, fo 8/14. R55's physincluded a curren used PRN. Anoth Cream 100,000 uthe medication cacurrent physician	n on 9/12/14, at 9:20 a.m. with medication cart contained a ri Care Enteric Coated Aspirin expiration date of 8/14. LPN-B were available for resident use and should have been removed on cart. The medication cart stavis Nystatin Cream, 100,000 or R55, which had expired on ician orders, dated 9/14, torder for Nystatin cream to be ner tube of Actavis Nystatin nits per gram, for R17 was in art and expired 8/14. R17's orders, dated 9/14, included a Nystatin cream to be used PRN.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245497	B. WING			09/1	2/2014
	PROVIDER OR SUPPLIER	LAIN		15	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441 SS=D	for R40 had an exp 5/14, however, the prescription was fil disposed of 14 day of R40's current phesched evidence of LPN-B verified the but remained avail all staff giving medicated a system to completed. Review of the facil Medications, Biolopolicy, dated 12/1/ensure that medication or biologicy, dated 12/1/ensure that medication or biologicallines with resopened medication the date opened owhen the medication the date opened owhen the medication deteriorated medication areas for proper some regularly schedule 483.65 INFECTIC SPREAD, LINENS	ortisone Butyrate 0.1% cream biration date on the tube of pharmacy sticker indicated the led on 5/31/13, and was to be is after being filled. A review sysician orders, dated 9/14, an order for this medication. See medications were expired able for use. LPN-B reported ications were responsible to ates, however, the facility assure this was being ity's Storage and Expiration of gicals, Syringes and Needles 07, included, "Facility should ations and biologicals: Have an the label; Have not been an recommended by upplier guidelinesOnce any orgical package is opened, by manufacturer/supplier spect to expiration dates for ins. Facility staff should record in the medication container on has a shortened expiration Facility should destroy or included, outdated/expired, or cations or biologicalsFacility inspect nursing station storage torage compliance on a ed basis."		441			10/22/14
	IIIIection Control I	rogram acoignou to provide a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE IAPLE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 441	to help prevent the of disease and inf (a) Infection Contr. The facility must of Program under who (1) Investigates, or in the facility; (2) Decides what should be applied (3) Maintains a reactions related to (b) Preventing Sp (1) When the Infedetermines that a prevent the spreasisolate the reside (2) The facility must be communicable different contact will (3) The facility must be facility m	comfortable environment and endevelopment and transmission ection. Fol Program establish an Infection Control nich it - controls, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections. Fread of Infection control Program resident needs isolation to ad of infection, the facility must not. First prohibit employees with a sease or infected skin lesions but with residents or their food, if transmit the disease. First staff to wash their direct resident contact for which indicated by accepted stice.		441				
	This REQUIREM by: Based on obser	iso as to prevent the spread of as to prevent the spread of a specific spec						

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/1	2/2014
	OVIDER OR SUPPLIE			15	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
	personal cares for observed during. Findings include: R55's quarterly No. 6/4/14, identified mpairment and vall activities of dapersonal hygiene. During observation of the was wet an incontinence carbrief was wet an it. NA-B remove with multiple displayers, NA-B players and gloves, NA-B players and gloves, NA-B the pulling up R55's R55 out of bed a R55 was in the value bathroom and washing completion of R gloves should how ashing completion of the R55's incontined done that. During interview director of nursi	nygiene following providing for 1 of 3 residents (R55) personal cares. Minimum Data Set (MDS) dated R55 had severe cognitive was totally dependent on staff for aily living, bed mobility, and		141			

NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN STREET ADDRESS, CITY, STATE, ZIP CO 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 69 The facility policy titled Hand Hygiene, undated,	09/12/2014 ODE	1
HAVEN HOMES OF MAPLE PLAIN (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 69 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SECONDS) CROSS-REFERENCED TO THE ADEFICIENCY)	ODE	1
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Titl Contained Ton page 55	SHOULD BE COMPLETING	ON
identified according to the Centers for Disease Control, hand hygiene is the most effective, single procedure for preventing infections. The policy directed staff to complete hand hygiene before and after gloving, and also before and after providing resident cares. 483.75(o)(1) QAA SS=F COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS F 520	10/22/1	4
A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced		
This REQUIREMENT is not met as evidenced by:		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER	_AIN		1	STREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE MAPLE PLAIN, MN 55359	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Based on interview facility failed to ens and assurance (QA required. In addition and implement appidentified areas of care concerns in the	and document review, the ure the quality assessment A) committee met quarterly as n, the facility failed to develop ropriate action plans for concern related to resident e facility. This had the II 48 residents who currently	F t	520			
	accuracy of the mir assessment for 1 c for pressure ulcers pressure sores, fa mobility status was residents (R20, R5 services and failed	of 5 residents (R7, R55)					
	ambulation service 2 of 4 residents (Raphysical assistance not reassessed upon	ne facility failed to provide s to prevent loss of function for 47 and R7) who required with ambulation, and were on a decline in ambulation. ty to ambulate resulted in 7 and R7.					
	appropriate bathing 1 of 3 residents (R dependent on staff (ADL's). Refer to F314 as the resident (R56), who ulcer was provided	ne facility failed to provide g and grooming assistance for 11) reviewed, who were for activities of daily living ne facility failed to ensure 1 of 1 o was admitted with a pressure interventions as assessed, ted to prevent further pressure					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	BUILDING			COMPLETED		
		245497	B. WING	i		09/1	2/2014		
NAME OF PROVIDER C				-	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359				
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ulcers from harm for multiple facility. Refer to range of for 2 of ROM. For reduction Refer to range of provided for 3 of for range of for range of sufficier services needs, R55, R54 family resident of staff, all 48 resister as the i	F317 as to motion (F318 as to motion and to maintage of motion F353 as to motion and to maintage of motion F353 as to motion F353 as to motion and to motion F353 as to motion	ping, which resulted in actual ed to the development of ulcers after admission to the he facility failed to ensure ROM) services were provided (R55 and R7) reviewed for 7 sustained actual harm with a conal ROM. The facility failed to ensure end/ or ambulation services were end/ or ambulation services were end/ or ambulation services. The facility failed to ensure end/ or ambulation services. The facility failed to ensure estaff was available to provide ence with each resident's residents (R7, R47, R1, R31, 12, R52, R66, and R7) and 1 of (FM-B) who had concerns re not being met related to lack estice had the potential to affect the resided in the facility.	F	520	,				
intervie been br and had meeting dates o the adn docume adminis been he	wed. The according to the second was also be a conducted on 6/6/14 and a conducted meets are the strator acknowled the conducted of the conduc	administrator stated she had so the new administrator in 1/14, and her first QAA committee 4. When asked to provide the QAA meetings for the last year, was only able to find one other string on 5/10/13. The nowledged that the facility hadn' required quarterly meetings.	t						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245497	B. WING	***************************************		09/1	2/2014	
	PROVIDER OR SUPPLIER	LAIN		STREET ADDRESS, CITY, STATE, Z 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359	IP CODE		I mar da V I T	
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F 520	resident census. R concerns had not he meeting because there was enough care. The administrator of residents were not had brought this condition administrator recall discussed R56's purposed R56's pur	ver, staffing was based on N-B stated the staffing been discussed at the QA he facility management felt staff to provide the necessary stated she was aware being bathed because staff oncern up to her. The led QAA committee had ressure ulcers at the QAA nable to to recall anything ut into place as a result of the ministrator stated specific were not discussed in QA. 19/12/14, at 12:05 p.m., A was unaware of the facility's hether the committee was an any quality improvement unfamiliar with the purpose/ee. H-A stated it would be nice and know what was going on in the felt the housekeeping staff in information.	F 5					
	any current quality	improvement projects/action by the QAA committee, and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/1	2/2014
NAME OF PROVID				152	REET ADDRESS, CITY, STATE, ZIP CODE O WYMAN AVENUE PLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
state the f The Assu facili that as th com Furt impl defic revis	facility QA meet facility's policy urance Commenty was to have would meet a ne facility deer mittee function ner, the policy ement action ciencies which	at aware what was discussed at etings. y Quality Assessment and ittee dated 5/14, indicated the e an ongoing QAA committee t least quarterly, or more often med necessary, to fulfill ns and operate effectively. y identified that the facility would plans to address quality a would include processes to were not achieving or sustaining		520			

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 00950 09/12/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1520 WYMAN AVENUE** HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 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:** The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.

Minnesota Department of Health

STATE FORM

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

Upon receipt of an acceptable POC an on-site

TITLE

(X6) DATE

10/10/14

If continuation sheet 1 of 63

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Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 2 000 Continued From page 1 revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 10/22/14 2 255 MN Rule 4658.0070 Quality Assessment and 2 255 Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required. In addition, the facility failed to develop and implement appropriate action plans for identified areas of concern related to resident care concerns in the facility. This had the potential to affect all 48 residents who currently resided in the facility. Findings include: Refer to F278 as the facility failed to ensure

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00950	B. WING	·	09/12	2/2014
NAME OF P	ROVIDER OR SUPPLIER			TATE, ZIP CODE		
HAVEN H	OMES OF MAPLE PI	ΔIN	IAN AVENUE LAIN, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	assessment for 1 of for pressure ulcers pressure sores, fa mobility status was residents (R20, R5 services and failed contractures for 2 or reviewed for range Refer to F310 as the ambulation service 2 of 4 residents (Rephysical assistance not reassessed up The decline in ability actual harm for R4 Refer to F312 as the appropriate bathing 1 of 3 residents (Rependent on staff (ADL's). Refer to F314 as the resident (R56), who ulcer was provided and was re-evaluated ulcers from development for R56 relation multiple pressure of acility. Refer to F317 as the resident of R55 and Richard Rom. R55 and Richard R55 and Richard R55 and R55 a	nimum data set (MDS) If 2 residents (R56) reviewed who had multiple unhealed illed to ensure transfer and accurately coded for 2 of 2 If 2 residents (R7 rehabilitation to accurately code of 5 residents (R7, R55) of motion. In a facility failed to provide to prevent loss of function for to ambulation, and were on a decline in ambulation. It to ambulate resulted in to and R7. In a facility failed to provide g and grooming assistance for to a manufacture of a dily living the facility failed to ensure 1 of 1 to was admitted with a pressure to the development of ulcers after admission to the the facility failed to ensure to the development of ulcers after admission to the the facility failed to ensure to M) services were provided to (R55 and R7) reviewed for to sustained actual harm with a				

Minnesota Department of Health

PRINTED: 03/25/2015 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 00950 09/12/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 255 2 255 Continued From page 3 for range of motion and/ or ambulation services. Refer to F353 as the facility failed to ensure sufficient nursing staff was available to provide services in accordance with each resident's needs, for 11 of 48 residents (R7, R47, R1, R31, R55, R56, R11, R12, R52, R66, and R7) and 1 of 4 family members (FM-B) who had concerns resident cares were not being met related to lack of staff. This practice had the potential to affect all 48 residents who resided in the facility. On 9/12/14, at 11:31 a.m., the administrator and registered nurse (RN)-B who had recently served as the interim director of nursing, were interviewed. The administrator stated she had been brought in as the new administrator in 1/14, and had conducted her first QAA committee meeting on 6/6/14. When asked to provide the dates of all of the QAA meetings for the last year, the administrator was only able to find one other documented meeting on 5/10/13. The administrator acknowledged that the facility hadn't been holding the required quarterly meetings. RN-B stated they were aware of the concerns with staffing, however, staffing was based on resident census. RN-B stated the staffing concerns had not been discussed at the QA meeting because the facility management felt there was enough staff to provide the necessary care.

The administrator stated she was aware residents were not being bathed because staff had brought this concern up to her. The administrator recalled QAA committee had discussed R56's pressure ulcers at the QAA meeting, but was unable to to recall anything specific that was put into place as a result of the

PRINTED: 03/25/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 255 2 255 Continued From page 4 discussion. The administrator stated specific staffing concerns were not discussed in QA. During interview on 9/12/14, at 12:05 p.m., housekeeping (H)-A was unaware of the facility's QAA committee, whether the committee was currently working on any quality improvement projects, and was unfamiliar with the purpose/ role of the committee. H-A stated it would be nice to have meetings and know what was going on in the facility, and she felt the housekeeping staff were missing out on information. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility had a QAA committee or what the purpose/role of the committee was. When interviewed on 9/11/14, at 10:30 a.m. RN-A who also served as the assistant director of nursing, confirmed there had been complaints from NA's about not having enough staff to complete resident cares. RN-A was unaware of any current quality improvement projects/action plans put into place by the QAA committee, and stated she was not aware what was discussed at the facility QA meetings. The facility's policy Quality Assessment and Assurance Committee dated 5/14, indicated the facility was to have an ongoing QAA committee that would meet at least quarterly, or more often as the facility deemed necessary, to fulfill

desired outcomes.

committee functions and operate effectively. Further, the policy identified that the facility would

implement action plans to address quality deficiencies which would include processes to revise plans that were not achieving or sustaining

(X3) DATE SURVEY

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		00950	B. WING		09/1	2/2014
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE -		
HAVEN F	IOMES OF MAPLE PL	ΔΙΝ	IAN AVENUE _AIN, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 255	Continued From pa	ge 5	2 255			
	The administrator of designee, medical update polices and develop improveme committee meets quand DON could aud needs are met, aud restorative and range.	THOD OF CORRECTION: could work with the DON or director, and governing body to procedures, identify issues, ent plans, and ensure the uarterly. The administrator dit cares to ensure resident dit charts for completion of ge of motion programs, and e quality committee.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			10/22/14
	Subp. 3. Use. A c must be used by al care of the residen	omprehensive plan of care I personnel involved in the t.				
	by: Based on observate review, the facility was implemented for residents (R56), real of 1 residents based who required assist of 5 residents ROM	ent is not met as evidenced ion, interview, and document failed to ensure the care plan for repositioning for 1 of 2 viewed for pressure ulcers, for thing needs (R11), reviewed stance with bathing, and for or 2 // programs (R31, R11) of motion services.				
	Findings include:			·		
	R56's quarterly Mir identified R56 had	nimum data set dated 6/11/14, no cognitive impairments,				

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00950		B. WING		09/12/2014			
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359						
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2 565	Continued From parequired extensive mobility, extensive repositioning in the ulcer development, IV (unstageable) pron admission and unstageable presente coccyx. The carepositioned at no compare the coccyx. The carepositioned at no compare the coccyx and the coccyx. The carepositioned at no compare the coccyx. The carepositioned at no compare the coccyx. The carepositioned at no compare the coccyx and the coccyx. The carepositioned at least the coccyx are positioned at least the coccy and the coccy are positioned at least the coccy and the coccy are positioned at least the coccy	assistance of two staff for bed assistance of one staff for chair, was at risk for pressure and currently had one stage ressure ulcer that was present unhealed. Ited 8/16/14, identified R56 had sure ulcer measuring 1.3 x 0.3 are plan instructed R56 to be greater than 2 hour intervals. Observation of R56 on 9/10/14, bugh 9:46 a.m. the resident ed and was unable to shift his tily in the wheelchair. In 9/10/14, at 7:20 a.m. R56 in his buttocks and had been e approximately 6:00 a.m. that an 9/10/14, at 9:54 a.m. licensed N)-B stated R56 should be st every two hours, and should kfast. LPN-B requested	2 565				
	NA-B and LPN-B to down on 9/10/14, a care plan instructe two hours, the resi	ransfered R56 to his bed to lay at 10:05 a.m. Although R56's d staff to reposition R56 every dent had been in his chair for a d 47 minutes without being					
-	R31 had no curren	OS dated 6/11/14, indicated it functional losses of range of es) in the upper or lower	-				

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PRFFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 565 Continued From page 7 2 565 R31s care plan dated 8/20/14, identified R31 was to receive passive range of motion daily to hips, knees, and ankles, 10-15 repetitions, as well as to bilateral shoulders, elbows, wrists and digits daily. Review of R31s ROM documentation indicated the resident recieved range of motion services 12 days in the last month (8/12/14 through 9/14/14). R31's restorative documentation for 7/2014, was not documented as being completed for 28 out of 31 days. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not ever receive any range of motion services other than routine dressing activities. During interview on 9/11/14, at 3:18 p.m. R31 stated he had a stroke a while back and did not walk anymore, but would like to use his legs and complete leg exercises. R11 quarterly MDS dated 8/27/14, identified R11 required extensive assistance from staff for dressing and personal hygiene and was able to provide partial physical help with bathing. The care plan dated 9/4/14, identified R11 needed the assist of one staff for bathing and preferred to have a bath versus a shower. Staff was directed to to honor resident's preferences and provide care in a timely manner. During interview on 9/8/14, at 4:23 p.m. R11 stated recently she had gone for a couple of weeks without a bath because the facility didn't have any bath aids.

R11's point of care bathing record indicated R11

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED. IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRFFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 565 Continued From page 8 2 565 received a tub bath on 7/31/14, and the next entry was a partial bath on 8/28/14, which was 28 days During interview on 9/12/14, at 9:34 a.m. NA-B stated it was possible R11 went for weeks without a bath because there is not enough staff to assist residents with bathing. R1's quarterly MDS dated 6/25/14, indicated R1 had functional limitation in range of motion (ROM) to one side of the upper and lower extremities. R1 care plan dated 7/2/14, identified R1 was to receive passive range of motion (PROM) daily, 10-15 reps to bilateral shoulders, elbows, wrists, and digits. R1's PROM restorative nursing sheets were reviewed from April 2014 - September 2014. There was no documentation to determine if R1 was recieving PROM as directed by the care plan. During interview on 9/10/14, at approximately 1:25 p.m. NA-B stated the facility no longer had a restorative aid, and the NAs are not able to complete R1's PROM as directed by the care plan. During interview on 9/11/14, at 9:25 a.m. R1 non-verbally indicated by motioning in a back and forth motion with her hand to indicate 'so-so.' when asked if staff were assisting her with PROM on a daily basis. When asked for a frequency of the PROM being done, R1 spelled out, "monthly," on her communication board.

SUGGESTED METHOD OF CORRECTION:

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(X3) DATE SURVEY

Minnesota Department of Health

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED	
		00950	B. WING	·	09/12	2/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE MAPLE PLAIN, MN 55359							
(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 SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE		
2 565	Continued From page 9		2 565				
	The facility could de ensures that reside that all staff are del care plan and educ managers. The factorie for accurate dinterventions and dirack ongoing complete.	evelop a system which ent care plans are current and ivering care according to the eate all care givers and nurse cility could monitor resident elivery of care plan evelop and auditing system to					
2 800	MN Rule 4658.051 Staffing requirement	0 Subp. 1 Nursing Personnel; nts	2 800			10/22/14	
	home must have o number of qualified registered nurses, nursing assistants residents at all nur- in all buildings if me	g requirements. A nursing n duty at all times a sufficient d nursing personnel, including licensed practical nurses, and to meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends, cements.					
1.	by: Based on observative review, the facility nursing staff was a accordance with each of the state of the st	tion, interview, and document failed to ensure sufficient available to provide services in ach resident's needs, for 11 of R47, R1, R31, R55, R56, R11, and R7) and 1 of 4 family who had concerns residenting met related to lack of staff. the potential to affect all 48 ded in the facility.					

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER.		(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:		COMIT			
00950		00950	B. WING		09/12/2014			
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HAVEN HOMES OF MAPLE PLAIN 1520 WYMAN AVENUE								
		MAPLE PI	LAIN, MN 55	3359				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULI		(X5) COMPLETE DATE		
2 800	Continued From page 10		2 800					
	R7 was not being wassessed restorative interview on 9/11/14 facility did not have as a result, she felt ambulation and posteroported R7 had different control of the contro	valked according to the ve nursing orders. During 4, at 1.42 p.m. NA-F stated the enough staff to walk R7, and R7 had a decline in ssibly range of motion. NA-F fficulty with transferring now, raise her feet up while in the						
	8/27/14, identified s impairment, impair side of the upper extensive two perso transfers/walking. I	um data set (MDS) dated she had severe cognitive ment (contractures) to one xtremity, and required on assistance with Her balance was impaired and and with staff assistance.						
	9/5/14, instructed s	d physician orders dated staff to walk the resident 29-57 e of two staff, twice daily using						
	2014 - September	rsing documentation from April 2014, lacked documentation valked/ambulated by staff from						
	stated the restorati	on 9/9/14, at 9:46 a.m. RN-A ve program was in shambles is trying to revamp the fied there was no evidence that ed.						
	completed with NA ambulate residents happen because o stated staff is not a	10/14 at 1:00 p.m. was L-A who stated staff tries to s, but it does not always f the lack of staffing. NA-A able to complete ROM for d stated, "I feel sorry for the						

Minnesota Department of Health

FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 800 2 800 Continued From page 11 residents because they need the range of motion." NA-A stated staff just does not have any extra time to provide any ROM or ambulation. R47 stated during interview on 9/8/14, at 3:57 p.m., there was not sufficient staff at the present time. She stated she waited for over 20 minutes and all the way up to an hour for staff to respond to her call light and did not feel that was acceptable. She also reported that due to staffing shortage, she had to wait a long time to be served her food and by the time she gets her food it is cold. During a second interview on 9/8/14, at 7:02 p.m. R47 stated would transfer herself to the bathroom as staff does not respond to her call light. She stated she, "Refuses," to be incontinent of urine or stool because of having to wait for staff, and as a result will transfer herself. She stated she is aware she is not supposed to transfer herself to the bathroom because of previous falls, however, she can not wait for staff over 20 minutes for assistance. She reported the nursing assistants are aware she does this due to staff shortage. R47 stated she is supposed to be assisted with walking twice a day, however, staff is not able to do this as they just don't have time, and she didn't think she had been walked for about 10 days. A family member (FM)-B of R47 was interviewed on 9/10/14, at 1:15 p.m. and stated he had talked to staff a, "couple of time" that R47 was not being walked and he was concerned she would

lose strength. FM-B stated R47 was to be walked twice each day, but it seldom happened. FM-B stated R47 had fallen a couple of times as she was not willing to be incontinent while waiting for assistance from staff when her call light is not answered for long periods of time. FM-B also

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ____ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 800 2 800 Continued From page 12 stated there were times when he visited and the call light was on for over 15 minutes and he would have to go out to the hall and try to find staff to assist her. R47's quarterly MDS dated 7/2/14, indicated R47 was cognitively intact with no signs or symptoms of delirium. She needed extensive assistance of two staff with bed mobility, extensive assistance of one staff for transfers, dressing, toilet use and personal hygiene. R47 needed extensive assistance of one staff with ambulation. R47's nursing assistant care sheet dated 9/9/14, directed nursing assistants to ambulate the resident 57 feet to 115 feet twice per day with assistance of one staff, a transfer belt, rolling walker and wheelchair behind. Physician orders, signed 9/5/14, directed staff to complete passive range of motion to wrists, ankles, digits, knees, elbows, shoulder and hips daily. In addition, the physician ordered that R47 be walked 57-115 feet twice a daily with a wheelchair behind, using a rolling walker and transfer belt. R47's restorative nursing sheets for August, 2014 to September, 2014 were reviewed and there was no documentation that R47 received any passive range of motion to extremities or ambulation. An interview with licensed practical nurse (LPN)-C was completed on 9/11/14 at 11:15 a.m. and she stated she was aware R47 was to be walked twice a day with staff assistance. LPN-C stated there was no documentation on the restorative nursing sheets to identify if R47 had been assisted with ambulation or any PROM in the prior months.

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 800 2 800 Continued From page 13 R1 reported on 9/9/14 at 1:10 p.m., she did not feel there were sufficient staff and she has been incontinent because the call light was not being answered fast enough. R1 also was concerned she had not been receiving ROM, and when asked how often she had been receiving ROM services, she spelt out,"monthly," using her communication board. R1's quarterly MDS, completed 6/25/14, indicated R1 had moderate cognitive ability, had no signs or symptoms of delirium/ psychosis, had no behavioral issues, and had limitations to one side of her upper and lower extremity (contractures). R1's care plan dated 7/2/14, and restorative nursing sheets from 4/2014- 9/2014, directed staff to provide passive range of motion daily to both shoulders, elbows, wrists, and fingers. R1's restorative nursing sheets for April, 2014 to September 12, 2014 lacked any documentation that passive range of motion was being done for During an interview on 9/10/14, at 7:10 a.m. licensed practical nurse (LPN)-A stated a NA's did not have time to do restorative nursing for residents due to being short staffed. An interview on 9/10/14, at 9:18 a.m. with nursing assistant (NA)-E was completed and she stated ROM and ambulation of residents were not being done due to being short staffed. During an interview on 9/10/14, at 1:25 p.m. NA-B stated the restorative aid position had been cut several months ago, and nursing assistants did not have time to provide ROM and ambulation to

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: ___ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 800 2 800 Continued From page 14 residents. When interviewed on 9/11/14 at 10:30 a.m., RN-F stated there was no formal restorative program at this time, and NA's were directed to assist residents with ambulation and ROM. RN-F stated NA's had brought up concerns to her about not having enough staff to complete resident cares and assist residents with the restorative nursing program. R31 reported on 9/11/14, at 3:18 p.m. he had a stroke a while back and did not walk anymore. He stated he would like to use his legs, but does not get the chance because there are not enough staff to help him. R31's quarterly MDS dated 6/11/14, indicated R31 was cognitively impaired, totally dependent on two staff for all transfers, and needed extensive assistance of one staff for all locomotion. R31's care plan dated 8/20/14, indicated R31 was to receive PROM motion to hips, knees, and ankles 10-15 repetitions daily as well as to bilateral shoulders, elbows, wrists and fingers. A review of R31's restorative nursing sheets from 8/12/14, through 9/14/14, indicated R31 received PROM only 12 times. RN-A stated the facility did not currently offer formalized restorative programs at the present time due to lack of staffing. During interview on 09/11/14, at 9:45 a.m. nursing assistant (NA)-E stated R31 did not ever receive

any range of motion services.

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		00950	B. WING		09/1	2/2014
	PROVIDER OR SUPPLIER	1520 WYN	DRESS, CITY, S IAN AVENUE LAIN, MN 55		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 800	Continued From pa	age 15	2 800			
	R55 was not receiv staff shortage.	ring range of motion due to				
	did not walk, had n ROM, and was tota	OS dated 6/4/14, identified R55 of functional limitations in ally dependent on staff for ang, dressing and all activities of				
	dated 1/1/14-6/30/ R55 received daily included the follow shoulder, wrist, and The 7/2014 MAR is were provided out facility was unable	ne restorative nursing book 14, instructed staff to ensure restorative treatments which ing passive range of motion to kle, finger, elbows and knees. dentified 3 restorative services of the 31 opportunities. The to provide evidence that R55 ive range of motion from 8/14,				
	stated R55's ROM because they didn' time completing th only received about	n 9/10/14, at 11:50 a.m., NA-B exercises were often not done it have enough staff to spend e exercises. NA-B stated R55 at 10% of the ROM exercises had been assessed as				
	stated range of mo completed and R5 result. NA-H stated her arms and legs the resident dress	n 9/11/14, at 10:13 a.m., NA-H otion services were not being 5 was becoming stiffer as a d R55 wasn't able to stretch out like before which made getting ed more difficult so facility staff ts family member to bring in				
	the facility had end	/14, at 3:50 p.m. he did not feel ough staff. He reported having to have his call light answered.				·

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE S COMPL	
		00950	B. WING	· ·	09/12	2/2014
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
HAVEN F	HOMES OF MAPLE P	AIN	IAN AVENUE LAIN, MN 55			
(X4) ID PREFIX TAG	- (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 800	Continued From pa	age 16	2 800			
	stated he had pain up sitting in his who 6:00 a.m. that more	n 9/10/14, at 7:20 a.m. R56 in his buttocks and had been eelchair since approximately ning without repositioning.				
	was cognitively into assistance of two s assistance of one s chair, and was at r ulcers. He current (Unstageable) pres	dated 6/11/14, identified R56 act and he required extensive staff for bed mobility, extensive staff for repositioning in the isk for developing pressure ly had one stage IV ssure ulcer, that was present a year ago, and was unhealed.				
	dated 12/17/13, ide	are area assessment (CAA) entified R56 was to be greater than two hour intervals.				
	from 7:18 a.m. throin his wheelchair a weight independer	observation of R56 on 9/10/14, ough 9:46 a.m., R56 was sitting and was unable to shift his ontly, and was not approached he resident to reposition as				
	assistant (NA)-As staffed and NA's do reposition as as unable to do so. It repositioned every	n 9/10/14, at 9:46 a.m. nursing tated the facility was short lid their best to assist residents sessed but at times were NA-A verified R56 had not been two hours as assessed cility not having sufficient resident cares.				
-	p.m. she had gone a bath because th	an interview on 9/8/14, at 4:23 e for a couple of weeks without e facility didn't have any bath thing assistance. In addition,				

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING_ 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 800 Continued From page 17 2 800 R11 stated she had to wait 40 minutes to an hour for staff to respond to her call light when she had to go to go to the bathroom. She stated this happened a lot, and a few nights ago she had her call light on for over 40 minutes to go to the bathroom, no staff came to help her to the bathroom so she had to, "Poop in my diaper." R11's quarterly MDS dated 8/27/14, identified R11 had moderate cognitive impairment and required extensive assistance from staff for toileting. R11's Point of Care Bathing Record (where the nursing assistants document when a resident receives cares), identified R11 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath on 8/28/14, 28 days later. During interview on 9/9/14, at 3:03 p.m. NA-K stated there are not enough staff to provide residents a bath. NA-K stated she often is not able to complete all the resident cares because of the facility being short staffed. NA-K stated residents complain of the long wait times when they put on their call light, and some residents had transferred independently when staff is not able to respond timely to their call light due to . being short staffed. During interview on 9/10/14, at 2:23 p.m., NA-F stated it was possible that some residents had gone for weeks without getting a bath because the facility does not have enough staff to complete all the resident cares. NA-F stated if another staff calls in sick, the facility does not replace them. NA-F stated she had complained to the administration about this because she knew resident cares were being neglected.

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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2 800	During interview on stated there was no accommodate bath resident baths are NA-H stated it was almost a month wit staff available to as During interview or stated resident batt timely. NA-B state been bathed in alm lack of staffing. During interview or registered nurse (Fup concerns regard residents baths due	9/11/14, at 10:13 a.m., NA-H of enough staff to us for the residents, and not being completed regularly. possible R11 could have gone hout a bath due to the lack of	2 800		
	approximately 5:40 sitting on a rolling stable with R12, R5 residents received the table on the storesident giving the rolling on the stool resident. NA-P wo food, set the fork of immediately roll ov continued rolling a entire meal. R12's quarterly MER12 had severe corequired extensive	rvation on 9/8/14, at p.m. NA-P was observed stool in the dining room at a 2, R66 and R7. After the their food, NA-P rolled around ool going from resident to m a bite of food, and then using her feet to the next ould give a resident a bite of or spoon down, and round the table on the stool the possible of the next resident, and round the table on the stool the observative impairment and staff assistance with dining.			

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2 800	required extensive R66's quarterly MD had severe cognitive extensive staff assions R7's quarterly MDS had severe cognitive extensive staff assions During interview or stated she was required at a time, and need she was able to go ensure they all receiter was not enouresidents were being	staff assistance with dining. S dated 8/6/14, identified R66 re impairment and required istance with dining. S dated 8/27/14, identified R7 re impairment and required	2 800			
	LPN-A stated some wait for help becau LPN-A stated the rassisting residents during the survey, LPN-A stated resident the call lights not be cares provided. Lambulation for the completed, and rewalking and feel the stated on the weel with behavioral isson the nurse to prosupervision, which the resident cares	on 9/10/14, at 7:10 a.m. etimes the residents needed to use the facility is short staffed. managers are not typically with dining, however, the week they have been helping out. Itents have voiced concerns of using answered and not having PN-A stated restorative nursing, residents is not being sidents have complained of not ney are losing strength. LPN-A kends, the staff brings residents uses to the lobby and this falls by out additional makes it difficult to complete all which need to be completed. on 9/10/14, at 6:50 a.m. NA-L not enough staff on the night.	,			

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2 800	necessary care for residents have bee 60 minutes for help sick call, the staff is short, and there ha only one nurse wor residents in the face. When interviewed stated residents had having enough staff she had reported the multiple times. NA changed with staffi residents are not residents are not residents are not restorative services aid and bath aid por months ago, and staffing. She state the dining room to management had room, which never NA-H stated residents are not receiving the not have time to do stated some residents are not residents and then the staff in th	struggling to provide the over 2 months. NA-L stated n complaining of waiting 45 - 0. NA-L stated when there is a sonot replaced and they work we been nights the facility had king to take care of all the illity. on 9/10/14, at 6:57 a.m. NA-M eve voiced concerns about not fit to complete the cares and his to the charge nurse on duty -M stated nothing had ng, even after reporting eceiving the cares they require. on 9/10/14, at 7:01 a.m. NA-N expected in the fit, sick calls are not replaced, k short staffed. on 9/10/14 at 7:46 a.m. NA-H e not getting the quality care erve, and there had been no so for 3 months. The restorative ositions were eliminated several taff had quit due to short diresidents not being helped in eat, and during survey been helping in the dining happens on a regular week. Ents have voiced concerns they her baths because staff does on this extra task. NA-H also ents are only assisted twice per throom due to staffing, and getting walked so they get try to walk alone.				
	When interviewed	on 9/10/14, at 9:18 a.m. NA-E				

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verified there is no formal restorative program at this time. RN-A confirmed there have been complaints from NA's about not having enough staff to complete resident cares or ROM and ambulation. RN-A stated the NA's were asked to do ROM on residents while assisting to dress

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 800 2 800 Continued From page 22 them, and verified this was not a formal program and did not meet the intention of a restorative nursing program. During interview on 9/11/14, at 10:13 a.m., NA-H stated the facility was short staffed and the resident cares were not being completed. NA-H stated ROM was not being completed for residents, specifically R55 who was becoming stiffer as a result. NA-H stated there were not enough staff to accommodate baths for the residents and they were often skipped. NA-H stated the NA's had complained to the administration staff at the nurse meetings about short staffing, however, nothing had been done to correct the staffing issue. When interviewed on 9/12/14, at 10:34 a.m., the staffing coordinator (MR)-J stated when there was a sick call, replacement depended on the number of staff scheduled. She reported if a sick call resulted in staff working a shift with less than established minimums, she would consult with the director of nursing (DON). She indicated there is no policy on staffing. When interviewed on 9/12/14, at 11:04 a.m. the DON and administrator stated staffing was based on census, not necessarily on resident care levels. The goal was to have six nursing assistants on both the day and evening shift, and three nursing assistants on the night shift. If there is a call in, they have not been replacing the staff if it would require overtime. They stated they had not reduced the hours of staff, and there had not been layoffs, however, they would not replace staff if someone left or retired, until they met the right staff . They stated they felt the facility was significantly overstaffed, and did not

believe their was an issue with lack of staffing.

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FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: __ B. WING _ 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 800 2 800 | Continued From page 23 They stated they had been trying to educate staff on being more efficient in providing residents cares. They NA's should have been able to complete all of the duties necessary with less staff and they felt the NA's were making a choice to not complete things such as baths or restorative nursing services. DON stated they used to have nine NA's working at a time and now they have six, because having nine, "Just didn't make good business sense." SUGGESTED METHOD OF CORRECTION: The facility could work with the Administrator to develop a system to ensure staffing levels are adequate to meet resident care needs. The facility could develop auditing tools to ensure the required resident care is being provided and report results to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 10/22/14 2 830 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.

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING_ 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 830 | Continued From page 24 This MN Requirement is not met as evidenced Based on observation, interview, and document review, the facility failed to ensure resident falls were thoroughly assessed to ensure appropriate/pertinent interventions could be implemented or revised, for 2 of 2 residents (R64, R3), with multiple falls. Findings include: R64 admission face sheet, dated 2/24/12, indicated the resident had diagnoses including weakness, dementia, and incontinence. R64's quarterly Minimum Data Set (MDS) dated 8/13/14, indicated R64 had severe cognitive impairment, required extensive assistance for all activities of daily living (ADL), including bed mobility, transfer, walking, and toilet use. R64 was not steady, and only able to stabilize with staff assistance. R64's care plan dated 8/19/14, indicated R64 was at high risk for falls and had falls prior to and after admission to the the facility. Staff were directed to anticipate R64's toileting needs, place the floor mat on the floor when in bed, have the call light safety alarm system on while in bed, wear gripper socks while in bed, ensure safety alarm was on R64's wheelchair/chair, and ensure an anti-rollback device was on the residents wheelchair. R64's Fall Risk/Restraint Evaluation Review dated 5/20/14, indicated, "Resident remains high falls risk; [six] 6 falls in [three] 3 months. Resident attempts self transfers frequently. Confused and delusional reverting to his days of being a pastor... Gripper socks when in bed; W/C

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2 830	[wheelchair] alarm; system remain app R64's progress not fall on 7/27/14. Acc R64's alarm sound observed sitting on had no injuries. R6-wanted to go to schold staff he needed staff assisted the reurinated. Staff was assessment or invedetermine if current appropriate, new in if R64's toileting pla	motion sensor; Bed alarm ropriate. Floor mat added." es indicated the resident had a cording to the progress notes, ed, and the resident was the floor at his bedside and 4 was alert, and reported he nool and rolled out of bed. R64 d to go to the bathroom and he sunable to provide any further estigation of the fall to	2 830			
	another fall on 8/24 progress notes, R6 was observed on the injuries were noted clip his nails. Staff further assessment determine if current appropriate, if there	es indicated the resident had ./14. According to the 4's alarm sounded, and he he floor on his buttocks. No . R64 indicated he needed to was unable to provide any tor investigation of the fall to to interventions were en were any trends with the new interventions were further falls.				
	registered nurse (F of conducting post there was no further regarding these fall were not complete caused the fall, if the the current interver the interventions no	n 9/12/14, at 10:00 a.m., RN)-B stated she was in charge fall investigations. RN-B stated or information available ls, and post fall assessments d to determine what may have nere were any trends noted, if at intions were appropriate, or if needed to be modified. RN-B orking on that! didn't even				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE

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		MAPLE PI	LAIN, MN 55		T	
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2 830	Continued From pa	ge 26	2 830			
	know he [R64] had	a fall last week."				
	indicated the reside prior three months the facility was una incident reports, or	assessment dated 5/20/14, ent had fallen six times in the while a resident in the facility, ble to provide progress notes, any documentation regarding lentified in the fall assessment.				
	included visual loss	ed on the undated facesheet s, spasm of muscle, abnormal ents, lack of coordination, uency of urination.				
	was severely cogni	6 dated 7/2/14, indicated R3 tively impaired, required ce with all ADL's, and was not ing or transferring.				
	stated R3 had three 8/22/14, and 9/4/14 impulsive and lean	on 9/8/14, at 4:20 p.m., RN-A e recent falls, on 8/20/14, l. RN-A stated R3 was ed forward in her chair and her chair. RN-A stated R3 was hese falls.				
	seated in her whee the nurses station. back of her blouse anti-rollback device attempted to stand members attempted her to sit down. R3 wheelchair and wo wheelchair which was attached to he member offered R3	servations on 9/10/14, R3 was elchair, in the area in front of R3 had a alarm clipped to the and had a Safe-T-Mate on her wheelchair. R3 many times and multiple staffed to redirect R3 and assisted was able to self propel her uld often lean forward in her would sound the alarm which or. On one occasion, a staff a magazine, which R3 sat her wheelchair for several				

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PRINTED: 03/25/2015 FORM APPROVED Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 8 3 0 2 830 Continued From page 27 minutes paging through the magazine and talking about each picture. R3's care plan dated 7/8/14, indicated R3 was at risk for additional falls due to a history of frequent falls. Staff were directed to observe for unsafe practices and to anticipate R3's needs, especially toileting needs. The care plan also directed staff to offer activities to keep her busy, to offer towels for folding, cloths to wipe surfaces she could reach, and dolls to dress and undress.

R3's progress notes related to her recent falls, included the following:

On 8/20/14, R3 stood up from her wheelchair outside of her room and fell to her knees. There were no injuries noted. R3 indicated she was going to get to her appointment. Staff noted increased confusion after lunchtime and R3 was toileted and laid down for nap. Staff was unable to provide any further assessment of the fall to determine the cause of the fall, if current interventions were appropriate, or if new interventions were needed.

On 08/22/2014, R3's alarm sounded and she was observed slowly falling to the floor in the activity room. No injuries were noted. R3 stated she was attempting to get up and walk out of the activity room when she fell. R3 was assisted back into her wheelchair and promptly assisted to the restroom to be toileted. Staff was unable to provide any further assessment of the fall to determine if current interventions were appropriate, or if new interventions were needed. On 9/5/14, R3's alarm sounded and staff witnessed her standing and then falling by the desk in the main parlor. R3 stated she was standing to reach for the watermelon that was in front of her at the desk. R3 was assisted back into her wheelchair and the food was placed

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
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2 830	Continued From pa	nge 28	2 830			
	further assessment	was unable to provide any t of the fall to determine if is were appropriate, or if new needed.				
	registered nurse (R charge of conducting RN-B stated there available regarding assessments were what may have causely trends noted, if	on 9/12/14, at 10:00 a.m., RN)-B indicated she was in no post fall investigations. was no further information R3's falls. Post fall not completed to determine used R3's falls, if there were if the current interventions were see plan of care was being				
	and Risk/Restraint Fall Evaluation will	d policy titled Fall Prevention Evaluation included, "The Post be completed by the DON] or her/his designee within 72 ent fall."				
	The DON or design Committee to update assessing causative could also perform documentation to the commentation to the commenta	THOD OF CORRECTION: ee could work with the QA ate policies and procedures for ve factors for falls. The facility a audits of post-fall ensure interventions were put ential contributing factors were				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 890	MN Rule 4658.052 Motion	25 Subp. 2 A Rehab - Range of	2 890			10/22/14
	Subp. 2. Range o	f motion. A supportive program				

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staff for transfers and ambulation, and used a wheelchair or a walker to aid her ambulation. R47's balance was not steady during transfers and walking and she had no loss of upper and lower function range of motion (contractures).

R47's Care Area Assessments (CAA) dated 10/9/13, identified R47 was alert and oriented,

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R47's physical therapy note dated 8/7/14,

indicated the resident was able to ambulate up to

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During interview on 9/11/14, at 9:44 a.m. nursing assistant (NA)-J stated he was aware R47 was to

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Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 890 Continued From page 32 2 890 be ambulated twice a day, however, he had never assisted R47 to ambulate. NA-J stated staff does not have time to complete R47 ambulation program because of short staff. During interview on 9/11/14, at 11:15 a.m. licensed practical nurse (LPN)-C stated R47 was to be ambulated twice a day, however, she stated there was no way to determine if R47 was being ambulated because there was no documentation. During interview on 9/11/14, at 2:39 p.m. physical therapy assistant (PTA)-E stated she had worked with R47 from 7/14/14, until her discharge from physical therapy on 8/12/14. PTA-E had recommended R47 be ambulated twice a day, 57-111 feet. PTA-E stated R47, "loved to be walked." and was able to consistently walk 80 feet when discharged from PT on 8/12/14. During interview on 9/11/14, at 3:24 p.m. registered nurse (RN)-A (who was identified as the person in charge of Rehab/Restorative Services), stated there was no record of staff efforts to walk R47. RN-A stated staff was to ambulate R47 twice a day, however, she was not sure if this was being done, and was unsure if R47 had declined in her ability to ambulate. RN-A stated there was no formal nursing assessment completed of R47's ambulation program to ensure it was appropriate and being implemented as ordered. During observation on 9/11/14, at 3:55 p.m. PTA-E assisted R47 to ambulate. R47 was able to walk 45-60 feet before becoming short of breath and needed to sit down. PTA-E stated R47's current ambulation ability was a decline

from when the resident was discharged from

physical therapy on 8/12/14.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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2 890	Continued From pa	age 33	2 890			
	being ambulated a did not reassess at to ensure the resid to ambulate. R47's related to the lack	y was aware R47 was not s assessed by PT, the facility and put interventions into place ent did not decline in the ability decline in ambulation ability of the facility completing the mas assessed resulted in 7.				
	had severe cognitive (contracture) to on required extensive transfers and walk able to stabilize whas sistance, and walk unit, and off the unit.	dated 8/27/14, identified R7 ve impairment, had impairment e side of the upper extremity, two person assistance with ing in the corridor, was only nen standing with staff alking in the resident room, with had not occurred during the ick period of the MDS 5 8/27/14.				
	R7's CAAs dated 8 walking, transfer a	3/27/14, did not address R7's bility, or current contractures.				
	1	n on 9/9/14, at 2:50 p.m. R7 n her back and both knees sed off the bed.				
	Summary dated 3/ ambulate 20-30 fe with assist of two s able to hang onto and did not need t services. PT also motion (ROM) was	rapist Progress & Discharge /4/14, indicated R7 was to et, using a four wheeled walker staff, two times a day. R7 was the walker without hand suppor he platform walker on even indicated R7's knee range of s 26 degrees of left knee degree of right knee extension	t			
	R7's current signe 9/5/14, instructed	ed physician orders dated staff to walk the resident 29-57				

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING _ 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 8 9 0 2 890 Continued From page 34 feet with assistance of two staff, two times daily using a walker. R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, from April 2014 - September 2014, instructed two staff to walk the resident 29-57 feet, two times daily. There was no documentation identifying if staff was ambulating R7 from 4/2014- 9/2014. R7's care plan dated 9/3/14, indicated staff pushed R7 to all destinations in the wheelchair and transferred with assist of two with a transfer belt and walker. R7's care plan did not address if the resident was able to ambulate, nor did it instruct staff on R7's assessed ambulation program. When interviewed on 9/9/14, at 9:46 a.m. RN-A stated the restorative/ ambulating program was in shambles right now, and she was trying to revamp the program to ensure residents were receiving their programs as assessed. RN-A was not aware R7 had not been ambulating or had a decline in transfer ability or ambulation. During interview on 9/11/14, at 1:42 p.m. NA-F stated R7 had a decline in ambulating as well as transfers, and staff was supposed to be walking her, however, R7 no longer walks, and staff did not have time to spend to try to assist her in walking prior. NA-F stated recently she had to order foot pedals for R7 because she could no longer raise her feet up when in the wheelchair when staff were pushing her to destinations. During interview on 9/11/14, at 1:57 p.m. RN-D

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Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 890 2 890 Continued From page 35 stated she had observed R7 ambulating and transferring a few months ago, and R7, "got to the point," of being unable to bear weight on the walker, so staff was transferring the resident using a hand in hand method. RN-D stated she had done no formal assessment of R7's ambulation program when it was noted R7's ambulation program was not being implemented as assessed and R7 was noted to be declining in her ability to transfer and ambulate. On 9/11/14, at 1:20 p.m. R7 was evaluated by PTA-E and COTA-D, and stated R7 was resistive and had some contractures in her left hand and bilateral knees. PTA-E and COTA-D transferred R7 from the wheelchair to her bed. During the transfer, R7 did not take any steps, bear any weight on her feet, and was lifted into bed with heavy assist. During the evaluation, R7 stated, "ouch," on multiple occasions and grimaced when staff was attempting to straighten the resident's knees. PTA-E and COTA-D both verified R7 would benefit from therapy and should have been referred back to therapy when staff noted the resident was declining in transfers and no longer ambulating. COTA-D stated residents have expressed concerns with not being ambulated. Although the facility was aware R7's ambulation program was not being completed as assessed, and the resident was no longer ambulating and had a decline in transfers, the facility failed to reassess and refer the resident back to therapy. This resulted in actual harm for R7. SUGGESTED METHOD OF CORRECTION: The facility could work with the QA Committee and therapy department to identify and develop programming for residents in need of range of

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00950	B. WING		09/12/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
HAVEN H	IOMES OF MAPLE PL	A I N I	MAN AVENUE LAIN, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 890	Continued From pa	ge 36	2 890		
	facility could develor motion services for QA Committee.	those at risk for decline. The op systems to audit range of completion and report to the			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one			
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895		10/22/14
	that is directed town through positioning implemented and n comprehensive res of nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the sident assessment, the director must coordinate the nursing care plan which			
	receives appropriate	th a limited range of motion te treatment and services to motion and to prevent further of motion.			
	by: Based on observate review, range of metalen provided for 2 of 4 reviewed for ROM. harm with a reduct Findings include:	tion, interview, and record otion (ROM) services were not residents (R55 and R7) R55 and R7 sustained actual ion in functional ROM.			
	6/4/14, identified R functional limitation	nimum Data Set (MDS) dated 55 did not walk, had no ns in ROM (contractures), and ent on staff for transferring,			

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E_CONSTRUCTION	COMPLETED
		00950	B. WING		09/12/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE .	
HAVEN H	OMES OF MAPLE PL	VIVI	/IAN AVENUE LAIN, MN 55	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
2 895	Continued From pa	ge 37	2 895		
	toileting, dressing,	and all activities of daily living.			
	registered nurse (R contractures (fixed	9/8/14, at 5:55 p.m. N)-A stated R55 had high resistance to passive			
) in both knees only, did not vices, and was not receiving ogram.			
	identify the present	st updated 6/9/14, did not ce of any contractures nor did it type of ROM exercises to be			
·	facility identified as programs are docu Routine Medication restorative nursing 6/30/14, and instru	ursing sheets (which the where resident restorative mented and tracked), titled as, was located in the book dated 1/1/14, through cted staff R55 was to receive rsing treatments which ing:			
	REPS-bilateral flex -Wrist PROM 10-1 flexion/extension -Ankle PROM 10-1 dorsiflexion/flexion -Digits PROM 10-1 flexion/extension -Elbow PROM 10-1 flexion/extension -Knee PROM 10-1 flexion/extension	5 reps bilateral 5 reps bilateral 5 reps bilateral 15 reps bilateral 5 reps bilateral			
	The 7/2014 restoral restorative treatment opportunities.	ative nursing sheet identified 3 ents were provided out of the 3°			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE S	
. r		00950	B. WING		09/12	2/2014
	PROVIDER OR SUPPLIER	ΔIN 1520 WYN	DRESS, CITY, S IIAN AVENUE LAIN, MN 55	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 895			2 895			
	nursing sheets for I or 9/2014. The fac ROM was done for was unable to verify was started, and if	able to provide any restorative R55 for the months of 8/2014, ility had no documentation any R55 for 2 months. The facility when R55's ROM program it had been reassessed at any it was appropriate for R55.				
	from 7/1/14, to 9/12 received any ROM	ectronic Point Of Care Record 2/14, did not identify R55 services, nor was there any ure the ROM program was				
	was observed being legs would not fully and the residents k assistant (NA)-B was above her head to needed to slide the stretch it over her hup her arms or stra	on 9/10/14, at 7:18 a.m. R55 g assisted with dressing. R55's extend and rest on the bed, nees stayed bent. Nursing as unable to raise R55's arms put on her shirt, and instead shirt up R55's arms and then lead. R55 was not able to lift lighten her arms from the lead R55 was becoming more				
	stated R55's ROM completed because to spend time completed R55 only reconstanted R55 onl	exercises were not being they didn't have enough staff pleting the exercises. NA-B exercised about 10% of the ROM exercised about had been assessed	-			
	stated when restor provided to the res document in Point completed. RN-C	n 9/10/14, at 12:45 p.m., RN-C ative services or ROM was idents, the NAs should of Care when it was was unable to provide any tion that R55 was receiving any				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

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HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359							
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Minnesota Department of Health

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DATE S COMPL	
		00950	B. WING		09/1:	2/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HAVEN H	HOMES OF MAPLE PL	ΔIN	IAN AVENUE LAIN, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 40	2 895			
	PTA-E stated when physical therapy dis 9/6/11, R55's knee PTA-E stated the riworsened to 55 deg before, and the left compared to 25 deg PTA-E both verified ROM as had been been referred back R55's knees were and noted a decline move the upper extwith dressing. During interview on (FM)-A stated receipurchase larger paso it would be easier R55 was becoming her arms and straig	n of R55's lower extremities. compared to the most recent scharge summary dated contractures had worsened. If the contractures had grees compared to 22 degrees knee was now at 35 degrees grees prior. COTA-D and R55 should be receiving assessed, and should have to OT/PT when staff noted becoming more contracted, in the resident's ability to cremities when being assisted as 9/11/14, at 9:09 a.m. family ntly staff had asked him to not and different types of shirts for to dress R55. FM-A stated as o stiff she was not able to lift ighten her knees so it was a dressed every day. FM-A				
	stated staff asked f	or shirts that opened in the ger pants, to make it slide on				
	stated range of mo completed and R55 result. NA-H stated her arms and legs the resident dresse	9/11/14, at 10:13 a.m. NA-H tion services were not being 5 was becoming stiff as a R55 wasn't able to stretch out like before which made getting and more difficult, so staff asked by member to bring in different				
	confirmed there wa in place for R55 to	n 9/11/14, at 11:10 a.m. RN-A as no formal ROM assessment ensure the current restorative g implemented as assessed,				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
		00950	B. WING		09/12	2/2014
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
HAVEN F	OMES OF MAPLE PL	AIN	/IAN AVENUE LAIN, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE .	(X5) COMPLETE DATE
2 895	Continued From pa	ge 41	2 895			
	nor to ensure the property further decrease in	rogram is adequate to prevent ROM.				
	program was reass program was being adequate to preven Although the facility further difficulty with in ROM, the facility	ensure R55's restorative dessed to ensure the ROM implemented and was at further decline in ROM. It was aware R55 was having in dressing related to decrease failed to provide further deassessment which resulted in				
	had severe cognitive	lated 8/27/14, indicated R7 /e impairment and had ROM cture) to one side of the upper				
	resident had a chrowhich was released	ed 3/21/14, indicated the onic right hand contracture d with surgery, had no pain, muscular function back in the				
		on 9/9/14, at 2:50 p.m. R7 her back and her left hand				
		on 9/10/14, at 6:53 a.m. R7 heelchair in the activities room vas closed in a fist.				
	During observation was sitting in the a closed in a fist.	on 9/11/14, at 9:40 a.m. R7 ctivity room with her left hand				
	was sitting in the d	n on 9/12/14, at 8:40 a.m. R7 ining room with her left hand her fingers bent inward.				

Minnesota Department of Health

PRINTED: 03/25/2015 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 895 2 895 Continued From page 42 During observation of R7 from 9/9/14- 9/12/14. R7 was not observed to release the fist of her left hand, nor did she attempt to use her left hand. R7's PT Progress and Discharge Summary dated 3/4/14, indicated the resident was able to hang onto the walker without hand support, and was to receive ROM. R7's current Physician Orders sheets for September 2014, instructed staff the resident was to receive the following restorative nursing program: Ankle PROM 0-15 reps bilateral dorsiflexion/flexion 1x Digits PROM 10-15 reps bilateral flexion/extension 1x Elbow PROM 10-15 reps bilateral flexion/extension 1x Hip PROM 10-15 reps bilateral flexion/extension, abduction/adduction 1x Knee PROM 10-15 reps bilateral flexion/extension 1x Shoulder PROM 10-15 reps bilateral flexion/extension 1x Walk 29-57 feet two times daily with wheelchair behind stand by assistance of two roller walker transfer belt x2 Wrist PROM 10-15 reps bilateral flexion/extension 1x

R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, indicated the resident had a right hand contracture. The restorative nursing sheets reviewed from April 2014, - September 2014,

(X3) DATE SURVEY

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	LETED
		00950	B. WING		09/1	2/2014
	PROVIDER OR SUPPLIER	ΔIN 1520 WY	DRESS, CITY, ST MAN AVENUE LAIN, MN 553			
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2 895	R7 on the day shift: Ankle PROM 0 dorsiflexion/flexion Digits PROM 1 flexion/extension 12 Hip PROM 10- flexion/extension, a Knee PROM 10 flexion/extension 12 Shoulder PROM 10 flexion/extension 12 Walk 29-57 fee wheelchair behind roller walker transfe Wrist PROM 10 flexion/extension 12 R7's restorative nu September 2014, r program to be come however, there was receiving any ROM	program to be completed for -15 reps bilateral 1x 0-15 reps bilateral 30-15 reps bilateral 40-15 reps bilateral	2 895	DEFICIENCY)		
	right hand contract					
	PTA-E and COTA- resistive and had s hand and bilateral R7 grimaced and s occasions when P attempting ROM. O R7 would benefit fr	D.p.m. R7 was evaluated by D, who both verified R7 was ome contracture(s) in her left knees. During the evaluation stated, "Ouch" on multiple TA-E and COTA-D were COTA-D and PTA-E both stated om therapy and possibly a ne new contracture in her left				

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE S	
			A. BUILDING:			
		00950	B. WING		09/12	2/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HAVEN I	OMES OF MAPLE P	ΙΔΙΝ	AAN AVENUE			
0.4.1.15	CUMMADV ST/	ATEMENT OF DEFICIENCIES	LAIN, MN 55	PROVIDER'S PLAN OF CORRECT	ION	(X5) ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 895	Continued From pa	age 44	2 895			
	stated R7 had a cohad surgery to rele RN-A stated the rebeing completed for she was trying to restated R7 should bas had been assess aware of R7's left hontractures. An interview on 9/1 completed with NA able to complete R feel sorry for the regrange of motion."	n 9/9/14, at 9:46 a.m. RN-A entracture to her right hand and ase part of the contracture. Storative program was not or residents as assessed, and evamp the program. RN-A are receiving the ROM services used by PT. RN-A was not hand or bilateral knee. 10/14, at 1:00 p.m. was and the companies of the stated staff was not companies and stated, "I esidents because they need the NA-A stated staff just does not e to provide any ROM or				
	stated R7 had a co which was repaired contracture identifi RN-D stated sever point of being unal her hands, so staff hand in hand. RN- time to have a dec related to being un however, R7's rest reassessed, and the back to PT to prevability.	n 9/11/14, at 1:57 p.m. RN-D ontracture to the right hand, d via surgery, and was the ed on the resident's MDS. ral months ago R7 got to the ble to hang onto the walker with f was ambulating the resident -D stated R7 was noted at that sline in ROM in her left hand hable to hang onto the walker, torative program was not he resident was not referred tent further decline in ROM on ensure R7's restorative sessed to ensure the ROM				
	program was being adequate to preve	sessed to ensure the ROM g implemented and was nt further decline in ROM. ty was aware R7 was no longer				

Minnesota Department of Health

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING _ 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 8 9 5 Continued From page 45 2 895 able to hang onto the walker to ambulate, the facility failed to provide further interventions and reassessment which resulted in actual harm to R7. The facility policy titled Restorative Nursing, undated, identified the philosophy was each individual admitted to the facility had the right to become involved in his/her own care and to have the services available to him/her to reach their highest possible, practicable physical and psychosocial level. Restorative nursing is a planned, systematic, organized program that builds on strengths and must meet the following criteria: 1. Measurable objectives and interventions must be documented in the care plan and in the clinical record 2. Evidence of periodic evaluation by licensed nurse must be present in the clinical record 3. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity 4. Restorative activities must be carried out or supervised by members of the nursing staff Two Restorative programs must be provided a minimum of 6 days/week Each Restorative program must be provided a minimum of 15 minutes in a 24 hour period The policy further identified nurses in management positions were responsible for maintaining the organization of the restorative program and monitoring the delivery of restorative care on a routine basis to assure the programs are being followed consistently and as planned. The summary of the policy documented the following, "Restorative nursing was mandated by OBRA [Omnibus Budget Reconciliation Act] in

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0950

Minnesota Department of Health

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING

O9/12/2014

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5							
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2 895	Continued From page 46	2 895					
	1987, as a means to keep residents at their highest possible practicable physical, mental and psychosocial level. Maintaining function enhances dignity and self-esteem. It is the primary reason for implementing effective restorative nursing programs. A comprehensive organized program guides staff to accurately identify restorative needs, implement restorative programs that assure residents receive the restorative services as planned and document to maintain a permanent record of the entire process. It does not feel good to lose function. Loss of function decreases a person's self-worth and one's ability to experience and enjoy quality of life. An organized restorative program that delivers systematic care based on the resident's individual needs increases self-esteem and worth and enhances well being."						
	SUGGESTED METHOD OF CORRECTION: The facility could work with the QA Committee and therapy department to identify and develop programming for residents in need of range of motion services or those at risk for decline. The facility could develop systems to audit range of motion services for completion and report to the QA Committee.						
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.						
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers	2 900		10/22/14			
	Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:						

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED. AND PLAN OF CORRECTION A. BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 Continued From page 47 2 900 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R56) who was admitted with a pressure ulcer was provided interventions as assessed, and was re-evaluated to prevent further pressure ulcers from developing. Findings include: R56's quarterly Minimum Data Set (MDS) dated 6/11/14, identified R56 had no cognitive impairment, required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for developing pressure ulcers, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed. R56's most recent Care Area Assessment (CAA) dated 6/23/14, revealed R56 was at risk for pressure ulcer development, was on a turning and repositioning program, receiving pressure ulcer care with dressing application, and had a pressure reducing device for the chair and bed. R56 was identified as being admitted with

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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		00950	B. WING		09/1:	2/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	•	
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HAVEN	IOMES OF MAPLE PL	MAPLE P	LAIN, MN 55	359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 48	2 900			
	pressure ulcers bot	h heels.				
	a 1.3 x 0.3 unstage coccyx, should be r					
		ation Reports dated 1/2/14, icated the resident's skin was ressure ulcers.				
	pressure ulcer risk) resident had a mild ulcers. The Brader R56 had recently g	e (a tool used to assess) dated 6/8/14, indicated the risk of developing pressure a scale assessment indicated otten a new wheelchair the risk of developing pressure				
	to determine skins dated 6/17/14, ider at the three hour m was unable to char The evaluation indithe one, two or three	ance Evaluation (assessment ability to withstand pressure) ntified non-blanchable redness mark in the lying position, and make position independently. It is a cated R56 had no redness at the end of the sitting mable to change position ere was no further				
	identified no redne in the lying positior independently. The was blanchable red while sitting and the	ance Evaluation dated 6/23/14, ss at the one or two hour mark n, and able to reposition e evaluation indicated there dness at the two hour mark at R56 could reposition ere was no further assessment.				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMPI	
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2 900	R56's Tissue Tolera identified blanchable mark in the wheelc unable to reposition further assessment evaluation. R56's Skin Injury/Windicated R56 deveright gluteal fold module of the control of the co	ance Evaluation dated 8/25/14, le redness at the two hour hair and the resident was in independently. There was not of the tissue tolerance Vound Report(s) dated 6/17/14, eloped a pressure ulcer in the easuring 0.5 centimeter (cm) x wound bed, and was a stage 2 tial thickness loss of dermis allow open ulcer with a red ithout slough). The area was elective cream applied, and the d for further orders. The pressure ulcer were by on the Skin Injury/ Wound the weekly monitoring from 10/14, indicated the pressure d increasing in size and unstageable pressure ulcer ulcer le loss in which the base of the slough, yellow, tan, gray, ad/or eschar, tan, brown or wound bed). On 9/10/14, the s 1.5 cm x 2 cm, with a 70% and base and was unstageable. Lulcer was identified on a Skin ort(s) dated 7/27/14, on the curing 0.5 cm x 0.4 cm was as, "trauma from the adhesive ed on the gluteal fold." Was identified as a "pressure"	2 900			
	it was located on a the facility identifie stage 2. The docu	Injury/Wound Report because a pressure area. On 8/29/14, d the pressure ulcer was a umentation of the pressure ulcer had				

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED. IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1520 WYMAN AVENUE** HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 2 900 Continued From page 50 worsened to an unstageable pressure ulcer, and increased in size with a description of the pressure ulcer as 2.5 cm x 2 cm, with 50% white/ yellow slough wound bed, and was currently unstageable. R56's current physician orders dated 9/5/14, instructed staff to apply Tegaderm with foam dressing to reddened area on the sacrum, check every shift, and change every three days and as needed (PRN). Tegaderm with a foam dressing was to be applied to the right buttock, sacrum, and gluteal fold every 3 days and as needed (PRN). The physician orders also instructed staff that R56 was not appropriate to have three hour intervals ordered for repositioning programs due to skin issues, therefore, needed to be repositioned at no greater than every two hours. R56's Nurses notes dated 6/2/14. indicated the resident was admitted with two, stage 4 pressure ulcers on the right and left heel. R56 was being seen at the wound clinic for these wounds, and they had been debrided by the surgeon in the past. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m., R56 was sitting in his wheelchair on a cushion, and was unable to shift his weight independently. Throughout the 2 hour and 28 minute observation, R56 was not approached by staff to reposition as assessed. During interview on 9/10/14, at 7:20 a.m., R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 Continued From page 51 2 900 staffed and NAs did their best to assist residents to reposition as assessed. NA-A stated she was aware of R56's pressure ulcers on his buttocks and, "They were pretty open," right now. NA-A verified R56 was to be repositioned every 2 hours. During interview on 9/10/14, at 9:54 a.m. licensed practical nurse (LPN)-B stated R56 should be repositioned after 2 hours and should lie down after breakfast. LPN-B requested assistance from staff to lay R56 down. During observation on 9/10/14, at 10:05 a.m. NA-B entered R56's room to reposition him, which was 2 hours and 47 minutes after the initial constant observation began, and 4 hours and 5 minutes since R56 stated he had been up in his chair. NA-B lifted R56 out of his chair using a standing lift and removed his brief. R56's buttocks were dark red in color and had a foam dressing on the right buttock. During interview on 9/10/14, at 11:23 a.m. registered nurse (RN)-A stated LPN-B had been the wound nurse, however, there was a recent re-assignment of wound duties and she was delegating them out to the staff. RN-A was unsure of the current condition of R56's ulcers. During interview on 9/10/14, at 11:35 a.m. LPN-B stated R56 had gotten a new wheelchair cushion when the buttock pressure ulcers developed around 6/21/14, and she though the resident currently had three pressure ulcers, however, LPN-B was not clear on the current condition of the pressure ulcers. LPN-B stated nursing decided to get R56 a new wheelchair cushion because the resident had complained he felt like he was sitting in a hole. LPN-B stated OT did not

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Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1520 WYMAN AVENUE** HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 Continued From page 52 2 900 evaluate the resident to ensure the wheelchair cushion was appropriate. During observation of R56's current pressure ulcers on 9/10/14, at 1:58 p.m. the director of nursing (DON) and LPN-B verified R56 had two open areas on his buttocks, one on the upper gluteal cleft which was whitish at the wound base and was an unstageable pressure ulcer with 90% slough wound bed which currently measured 1.5 cm x 2 cm. The second pressure ulcer was on the right buttock and had 60-70% slough that was whitish in color at the wound base and measured 2.5 cm x 2 cm, and was also unstageable. LPN-B stated both pressure ulcers had increased in size and stage since the last time she had seen them, however, LPN-B was unable to verify the last time she had observed R56 pressure ulcers. During interview on 9/10/14, at 2:17 p.m. certified occupational therapy assistant (COTA)-D stated she had not been involved in assessing R56 for adequate wheelchair positioning or the wheelchair cushion. During interview on 9/11/14, at 1:07 p.m. director of nursing (DON) stated she was not aware of R56's worsening pressure ulcers. DON stated R56 repositioning schedule of every two hours should have been re-evaluated after the pressure ulcers developed and worsened to ensure the schedule was individualized and adequate to promote healing of the pressure ulcers. During interview on 9/11/14, at 1:10 p.m. RN-B stated she was not aware of R56's worsening pressure ulcers so she had not discussed interventions with OT, nor had she reassessed the current interventions in place to ensure they were being implemented and were adequate to

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2 900	Continued From pa	age 53	2 900			
	prevent further pres	ssure ulcers.				
	R56's medical doct	p.m., a call was placed to tor (MD)-C who was unable to uss R56's pressure ulcers.				
	indicated it was the place a system to i for each resident a hours or more freq resident's condition load may be imple repositioning (i.e. of warranted for individucer development therapy department weight distribution, pressure redistribution/mattress in coordination with the system of the syst	recommendations in he nursing department.				
	last revised 12/01/	itled Wound/Skin Care Policy, '97, indicated an at-risk resident on a static surface may be more al ulcerations.				
	The Director of Nu interdisciplinary to pressure sores to necessary treatmes sores from develor. The Director of Nu Assurance Commmonitoring of the ensure that pressures the resider	THOD OF CORRECTION: ursing could assign the eam to review all residents with assure they are receiving the ent/services to prevent pressure ping and to promote healing. ursing could assign the Quality littee to provide on-going delivery of care to residents to sure sores do not develop at's clinical condition they were unavoidable.				

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ B. WING _ 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1520 WYMAN AVENUE** HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 Continued From page 54 2 900 TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 10/22/14 2 920 2 920 MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced Based on interview and documentation review, the facility failed to provide bathing assistance for 1 of 3 residents (R11) reviewed who was dependent on staff for bathing. Findings include: R11 quarterly Minimum data set (MDS) dated 8/27/14, identified R11 required extensive assistance from staff for dressing and personal hygiene, and was able to provide partial physical help for bathing. R11 care plan dated 9/4/14, indicated R11 needed assist of one staff for bathing and preferred to have a bath versus a shower, and the goal was to respect the resident's wishes and maintain autonomy, and provide care in a timely manner. During interview on 9/8/14, at 4:23 p.m. R11 stated she had recently gone for a couple of weeks without a bath because the facility didn't

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED. **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: ___ B. WING _ 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 920 Continued From page 55 2 920 have any bath aids to provide bathing assistance. R11's Point of Care Bathing Record (where the nursing assistants (NA) document when a resident received a bath/shower), identified R11 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath completed on 8/28/14, 28 days later. During interview on 9/11/14, at 10:13 a.m. NA-H stated there were not enough staff to assist residents with baths and they were not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist with bathing. During interview on 9/12/14, at 9:34 a.m., NA-B stated the facility used to have a bath aid to provide resident baths, however, a few months ago the bath aid left the facility, so resident baths were not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staff, however. RN-A stated the facility was still working on a staffing pattern to ensure resident cares are being completed. A policy on resident bathing was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could provide education

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: • B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 9 2 0 2 920 Continued From page 56 on the performance of providing activities of daily living and follow up with audits/observation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21426 10/22/14 21426 MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R37), who was reviewed for tuberculosis screening,

received a two-step mantoux or a baseline

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21426 Continued From page 57 21426 tuberculosis symptom screen. Findings include: R37 was admitted to the facility on 5/22/14. R37's medical record lacked any documentation of a tuberculosis symptom screen or baseline mantoux testing. Copies of any further information were requested from the DON on 9/12/14, at 10:12 a.m., none were provided. DON verified there was no record of R37 receiving a tuberculosis symtpom screen or baseline mantoux testing. A facility policy on resident tuberculosis testing was requested but not provided. SUGGESTED METHOD OF CORRECTION: The facility could develop an auditing system to ensure all residents receive a baseline tuberculosis symptom screen and appropriate testing. The facility could report findings to the QA Committee to develop a system for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 10/22/14 21695 21695 MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.

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Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21695 Continued From page 58 21695 This MN Requirement is not met as evidenced Based on observation, interview, and document review, the facility failed to ensure 1 of 48 residents (R46) bathrooms had bathroom equipment in good repair. In addition, the facility failed to ensure 2 of 48 residents (R46, R24) were provided adequate water pressure to their bathroom sink. Findings include: R46's annual minimum data set (MDS) dated 8/6/14, identified the resident had no cognitive impairment. During interview on 9/8/14, at 4:30 p.m. R46 stated her bathroom sink was cracked and she had very little water pressure in her bathroom sink. She stated she had talked to several of the staff about both issues with her bathroom sink, and no one did anything about it. R46 stated the low water pressure and cracked sink had been like this since her admission to the facility which was over a year ago. During a tour of the facility on 9/12/14, at 1:00 p.m. maintenance supervisor (MS)-F verified R46's sink had two large cracks, one extending from the faucet knob down the entire sink almost to the drain, and a second crack on the left edge of the sink. MS-F also verified the water pressure in R46's bathroom sink was very low and the water trickled out of the faucet. MS-F stated he had not been informed of the cracked sink, which he stated had the potential to, "Scratch" the resident, and he was not aware of the low water pressure in R46's room. MS-F stated he did daily rounds of the facility looking for damaged

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21695	Continued From pa	ge 59	21695			
	resident rooms or binspection. He state	er, he did not go into any of the pathrooms during the red it was the expectation him of broken items so pair them.				
	resident had severe	S dated 6/24/14, identified the e cognitive impairment and assistance of two staff for				
	9/11/14, at 11:00 a. the bathroom sink	s on 9/8/14, at 7:14 p.m. and m. R24's water flowed out of faucet slowly and took a long rature of the water to heat up to				
	p.m. MS-F verified pressure was very aware of the R24's and it was an easy the problem for his	he facility on 9/12/14, at 1:00 R24's bathroom sink water low. MS-F stated he was not low water pressure until now, fix if he had been informed of department to address the d nursing staff are to notify him e problems.				
	A facility maintence provided.	e policy was requested but not				
	The administrator review, and/or review, ensure resident rofunctional working designee could ed the policies and prodesignee could deensure ongoing control of the policies and prodesignee could deensure ongoing control of the policies and prodesignee could deensure ongoing control of the policies and prodesignee could deensure ongoing control of the province of th	THOD OF CORRECTION: or designee could develop, se policies and procedures to oms and bathrooms are in order. The administrator or ucate all appropriate staff on ocedures. The administrator or velop monitoring systems to impliance. R CORRECTION: Twenty-one				

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Minnesota Department of Health

by:

vulnerable adults.

to patients, residents, their quardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to

This MN Requirement is not met as evidenced

Minnesota Department of Health

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21800	Continued From pa	ige 61	21800			
	Based on interview facility failed to ens R57) reviewed for I required Notice of Centers for Medica (CMS) Form 10123	and document review, the ure 2 of 3 residents (R11, iability notices, received the Medicare Non-Coverage re and Medicaid Services 3, informing them of their right expedited review of their expedited r				
	Findings include:					
	medicare coverage facility determined coverage criteria and non-coverage on conon-covered day list did not have record	to the facility with skilled on 2/13/14. On 4/22/14, the R11 no longer met medicare nd issued a notice of medicare ontinued stay, with the first sted as 4/25/14. The facility IR11 received the CMS er of her rights for an				
	medicare coverage letters contained or R57's last covered records did not commedicare coverage remained in the factorerage was discoverage interview or 10:00 a.m. director	n 9/11/14, at approximately of nursing (DON) stated the				
	issue medicare del no other denial lett DON provided cop Medicare Assessm medicare coverage	e a policy specific to how to nials, and verified there were ers on file for R11 or R57. ies of a Haven Homes nent Tool and a blank notice of e on continued stay, however, ess the facility process on how				

Minnesota Department of Health

PRINTED: 03/25/2015 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED 00950 B. WING 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 21800 Continued From page 62 21800 to inform residents of medicare appeal rights or for required denial letters the residents must receive. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure residents receive proper documentation regarding liability and demand bill notices in a timely manner. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: JMZ1

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COMPLETED BY THE STATI								Facility ID: 00950
MEDICARE/MEDICAID PROVIDER 10 (L1) 245497 2.STATE VENDOR OR MEDICAID NO. (L2) 064742000	LI) 245497 TATE VENDOR OR MEDICAID NO. (L3) HAVEN HOMES (L4) 1520 WYMAN AV					L6)	55359	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) 10/01/2004		7. PROVIDER/SUI	PPLIER CATEGORY 05 HHA	09 ESRD	<u>-02</u> ((L7) 22 CI	LIA	7. On-Site Visit 8. Full Survey After C	9. Other omplaint
6. DATE OF SURVEY 12/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	08/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	E		FISCAL YEAR ENDING	G DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 52 (L37) (L38) 16. STATE SURVEY AGENCY REMAR	19 SNF (L39)	B. Not in Com Requirement ICF (L42)	nce With requirements be Based On: Acceptable POC pliance with Programents and/or Applied W IID (L43)		2. T3. 24. 75. I * Code:	Fechnical Per 24 Hour RN 7-Day RN (R Life Safety C	sonnel ural SNF) ode	Following Requirements: 6. Scope of Serv 7. Medical Direc 8. Patient Room 9. Beds/Room (L12)	ctor
See Attached Remarks					40.000.000				
	17. SURVEYOR SIGNATURE Date : Marilyn Kaelke, HFE NE II 12/24/2014 (L19) PART II - TO BE COMPLETED BY HCFA REGIONA						, Enfo	rcement Specia	Date: alist 1/9/2015 (L20)
DETERMINATION OF ELIGIBILIT X 1. Facility is Eligible to Pa 2. Facility is not Eligible			IPLIANCE WITH CI	IVIL	:		o/Control In	al Solvency (HCFA-2572) sterest Disclosure Stmt (HCF	'A-1513)
22. ORIGINAL DATE OF PARTICIPATION 10/01/1987 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEMEN ENDING DATE (L25)		26. TERMIN VOLUNTARY 01-Merger, Cl 02-Dissatisfac	Y losure	_00	<u>INVOLUN</u> 05-Fail to M	(L30) TARY Meet Health/Safety feet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44) (L45)		03-Risk of Inv 04-Other Reas			OTHER 07-Provider 00-Active	r Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C	ARRIER NO.	(L31)	30. REMARK		2015	Co	
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION (OF APPROVAL DAT	(L33)	DETERMI				
					I				

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00950

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5497

Continuation of Item #16

Page #2

On 11/14/2014, the Minnesota Department of Health completed a revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on 09/12/2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey completed on 09/12/2014.

As a result of our finding that the facility continues to not be in substantial compliance, this Department imposed the following category 1 remedy:

- State Monitoring effective November 29, 2014. (42 CFR 488.422)

In addition, this department is recommending the follow action related to the remedy imposed in their letter of November 19, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 12, 2014, remain in effect. (42 CFR 488.417 (b))

On 12/8/2014, this department completed a PCR. Findings demonstrate compliance with federal certification deficiencies issued pursuant to the standard survey completed on 09/12/2014. State monitoring is rescinded as of 12/4/2014, previous to DPNA effective date of 12/12/2014. Therefore, this department recommended and CMS concurred with rescinding:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 12, 2014,

Refer to the CMS 2567B for health.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245497 January 9, 2015

Ms. Diane Lynch, Administrator Haven Homes Of Maple Plain 1520 Wyman Avenue Maple Plain, Minnesota 55359

Dear Ms. Lynch:

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 December 4, 2014 the above facility is certified for or recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

December 24, 2014

Ms. Diane Lynch, Administrator Haven Homes of Maple Plain 1520 Wyman Avenue, P.O. Box 369 Maple Plain, Minnesota 55359

Re: Enclosed Reinspection Results - Project Number S5497024

Dear Ms. Lynch:

On December 8, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 12, 2014, with orders received by you on October 4, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

Kate Johnston, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245497	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/8/2014
Name of Facility			Street Address, City, State, Zip Code	
НА	VEN HOMES OF MAPLE PLAIN		1520 WYMAN AVENUE, PO BOX 30	69
			MAPLE PLAIN, MN 55359	

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	F0156		Correction Completed 12/04/2014		ID Prefix	F0278		Correction Completed 12/04/2014		ID Prefix	F0311		Correction Completed 12/04/2014
								12/04/2014			-		
keg. #	483.10(b)(5) - (10),	483.10(D)(1)		LSC	483.20(g) - (j)				Reg. #	483.25(a)(2)		_
				┼─					+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	-		12/04/2014		ID Prefix								_
	483.25(e)(2)				Reg. # LSC					Reg. #			_
				-					+-				_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC				<u> </u>	LSC				┿.	LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_ '
Reg. #					Reg. #					Reg. #			_
LSC				<u> </u>	LSC				ᆚ.	LSC			_
			Compostion					Competion					Composition
			Correction Completed					Correction Completed					Correction Completed
ID Prefix			Completed		ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC				<u> </u>	LSC			_
Reviewed By	Rev	viewed B	у	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	<i>y</i>	JS/K	<u>J</u>	12	/24/20	14		27059				12/08	3/2014
Reviewed By	Rev	viewed B	у	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to Survey Completed on:					-				a Summary of				
9/12/2014					Unco	orrecte	d Deficiencies	(CM	S-2567) Sent	to the Facility?	YES	NO	

State Form: Revisit Report

HAVEN HOMES OF MAPLE PLAIN

(Y1)	Provider / Supplier / CLIA / Identification Number 00950	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/8/2014
Name	of Facility		Street Address, City, State, Zip Code	

1520 WYMAN AVENUE, PO BOX 369

MAPLE PLAIN, MN 55359

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(4) Item	(Y:	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date
		Correction			Correction					Correction
ID Drofiv	20005	Completed	ID Drofiv	20045	Completed 12/08/2014		ID Drofiv	24.426		Completed
ID Prefix	-	12/08/2014	ID Prefix				ID Prefix	-		12/08/2014
	MN Rule 4658.0525 Subp			MN Rule 4658.0525 Subp.				MN St. Statute		
LSC		_	LSC							
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix	21800	12/08/2014	ID Prefix		-					
•	MN St. Statute144.651 St		Reg. #				Reg. #			_
LSC		_	LSC				LSC			
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix				ID Prefix			_
Reg. #		_	Reg. #				Reg. #			
LSC		_	LSC				LSC			
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix				ID Prefix			_
Reg. #			Reg. #				Reg. #			
LSC		_	LSC				LSC			_
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix				ID Prefix			_
Reg. #		_	Reg. #				Reg. #			_
LSC		_	LSC				LSC			
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:	-			Date:	
State Agency	JS	S/KJ	12/24/20	14	27059				12/	08/2014
Reviewed By CMS RO	Reviewed	Ву	Date:	Signature of Surve	yor:				Date:	
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility			-	1				
	9/12/2014			Uncorrecte	d Deficiencie	s (CMS	-2567) Sent	to the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: JMZ1

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PAR	T I - TO BE COM	E SURVEY AG	ENCY	F	acility ID: 00950		
1. MEDICARE/MEDICAID PI (L1) 245497 2.STATE VENDOR OR MEDI (L2) 064742000		3. NAME AND ADD (L3) HAVEN (L4) 1520 WY (L5) MAPLE	HOMES (YMAN AVE	OF M <i>a</i> Enue, i			4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHAN (L9) 10/01/2004		7. PROVIDER/SUR 01 Hospital	05 HHA	09 ESRD	<u>Q2</u> (L7)	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
DATE OF SURVEY ACCREDITATION STATU Unaccredited	11/05/2014 (L34) S: (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)
2 AOA	3 Other							
11LTC PERIOD OF CERTIFI	CATION	10.THE FACILITY	IS CERTIFIED AS:					
From (a): To (b):		A. In Complian Program Re Compliance	equirements		2. Tech:	nical Personnel our RN	Following Requirements: 6. Scope of Service 7. Medical Direct	
12.Total Facility Beds	52 (L18)	1. A	Acceptable POC		4. 7-Da 5. Life	y RN (Rural SNF) Safety Code	8. Patient Room S 9. Beds/Room	Size
13. Total Certified Beds	52 (L17)		pliance with Program ents and/or Applied V			B*	(L12)	
14. LTC CERTIFIED BED BRI	EAKDOWN				15. FACILITY ME	EETS		
18 SNF	18/19 SNF 19 SNF 52	ICF	IID		1861 (e) (1) or 1	861 (j) (1):	(L15)	
(L37)	(L38) (L39)	(L42)	(L43)					
16. STATE SURVEY AGENC	Y REMARKS (IF APPLICABLE	SHOW LTC CANCELL	LATION DATE):	'				
See Attached Remarks								
17. SURVEYOR SIGNATURE	E	Date :			18. STATE SURV	EY AGENCY API	PROVAL	Date:
Holly Kra	anz, HFE NE II	1	1/07/2014	(L19)	Kate John	sTon, Enf	orcement Specia	alist 01/02/2015
	PART II - TO	BE COMPLETE	D BY HCFA RE	EGIONAI	OFFICE OR S	INGLE STAT	E AGENCY	,
19. DETERMINATION OF ELL. _X			IPLIANCE WITH C	IVIL	2. C		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)
2. Facility is n	ot Eligible (L21)							
22. ORIGINAL DATE	23. LTC AGREEM	MENT 2	24. LTC AGREEME	NT	26. TERMINAT	ION ACTION:	(1	L30)
OF PARTICIPATION 10/01/1987	BEGINNING	G DATE	ENDING DATE	Ξ	01-Merger, Closur		05-Fail to Mo	eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction 03-Risk of Involur	W/ Reimbursemen		eet Agreement
25. LTC EXTENSION DATE		VE SANCTIONS n of Admissions:	(L44)		04-Other Reason f		OTHER 07-Provider 00-Active	Status Change
	(L27) B. Rescind St	uspension Date:	(L45)					
28. TERMINATION DATE:	2	9. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)	Posted (01/23/2015	i Co	
31. RO RECEIPT OF CMS-153	(L32)	32. DETERMINATION (11/13/2014	OF APPROVAL DAT	(L33)				
	(L32)			(L33)	DETERMINA	TION APPRO	VAL	

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00950

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5497

Continuation of Item #16 Page #2

CCN: 24-5497

Continuation of Item #16

Page #2

On 11/14/2014, the Minnesota Department of Health completed a revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard, completed on 09/12/2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on 09/12/2014.

The deficiency(ies) not corrected is/are as follows:

F0156 -- S/S: D -- 483.10(b)(5) - (10), 483.10(b)(1) -- Notice Of Rights, Rules, Services, Charges

F0278 -- S/S: D -- 483.20(g) - (j) -- Assessment Accuracy/coordination/certified

F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion

In addition, at the time of this revisit, we identified the following deficiency(ies):

F0311 -- S/S: E -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls

The most serious deficiencies in your facility pursuant to the standard survey were found to isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

As a result of our finding that the cility continues to not be in substantial compliance, this Department imposed the following category 1 remedy:

- State Monitoring effective November 29, 2014. (42 CFR 488.422)

In addition, this department is recommending the follow action related to the remedy imposed in their letter of November 19, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 12, 2014, remain in effect. (42 CFR 488.417 (b))



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0877

November 24, 2014

Ms. Diane Lynch, Administrator Haven Homes Of Maple Plain 1520 Wyman Avenue, P.O. Box 369 Maple Plain, Minnesota 55359

RE: Project Number S5497024

Dear Ms. Lynch:

On October 1, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an standard survey, completed on September 12, 2014. 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 November 14, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on September 12, 2014. Due to health survey compliance not being verified as of our document dated November 19, 2014, we recommended that CMS impose Mandatory Denial of Payment, effective December 12, 2014.

On November 5, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on September 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of . Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our extended survey, completed on September 12, 2014. The deficiency(ies) not corrected is/are as follows:

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F0156 -- S/S: D -- 483.10(b)(5) - (10), 483.10(b)(1) -- Notice Of Rights, Rules, Services, Charges F0278 -- S/S: D -- 483.20(g) - (j) -- Assessment Accuracy/coordination/certified F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion
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In addition, at the time of this revisit, we identified the following deficiency(ies):

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F0311 -- S/S: E -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls
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The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as

Haven Homes Of Maple Plain November 24, 2014 Page 2 evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective November 29, 2014. (42 CFR 488.422)

However, as we notified you in our letter of October 1, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 12, 2014.

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 12, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

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:

Jessica Sellner, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7343

Fax: (320)223-7365

PLAN OF CORRECTION (PoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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

Haven Homes Of Maple Plain November 24, 2014 Page 4

the date confirmed by the acceptable evidence, whichever is sooner.

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 March 12, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

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

PRINTED: 11/21/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION	(X3) DAT		
			A. BOILD	A. BUILDING			R	
		245497	B. WING		·	1.	1/05/2014	
NAME OF P	ROVIDER OR SUPPLIER	<u></u>		STRE	ET ADDRESS, CITY, STATE, ZIP CODE			1
7.001.	TO VIDER ON GOT FEET	,		i	WYMAN AVENUE, PO BOX 369			1
HAVEN H	OMES OF MAPLE PLAIN	Ĺ		ļ	LE PLAIN, MN 55359			
0441.15	CLIMMADY C	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
			-		Facility timely submits this			
{F 000}	INITIAL COMMENTS	3	{F 0	000}	response and plan of correction	n		l
					pursuant to federal and state la	w		
	An onsite resurvey w	vas conducted by surveyors		-	requirements. This response a			
		11/3/14, 11/4/14, and			plan of correction are not			
		compliance with federal				ot .		
	deficiencies issued d	uring a recertification survey			admissions or an agreement th	aı		1
	exited on 9/12/14. Th	e following deficiencies were			a deficiency does exist or that			
	found not corrected.			ļ	the statement of a deficiency			
{F 156}	483,10(b)(5) - (10), 4	83.10(b)(1) NOTICE OF	{F 1	56}	was correctly cited or factually	<i>7</i> :		
SS≍D	RIGHTS, RULES, SE				based and it's also not to be			
					construed as an admission			1
	The facility must infor	m the resident both orally			against interest of the facility,			
	and in writing in a lan	guage that the resident			the administrator, of any		,	
	understands of his or	her rights and all rules and	_		employees, agents or other			
		resident conduct and			individuals who participated in	1		
ĺ		the stay in the facility. The			the drafting or who may be	•		
	•	vide the resident with the			discussed or otherwise identifi	ad		
		State developed under	7			Cu		
		t. Such notification must be	3		in the same.			
		admission and during the		İ	1. R11 and her financial Power			
		ipt of such information, and			of Attorney were contacted on			
	-	t, must be acknowledged in		ŀ	10/20/14 and provided an	1		
	writing.				explanation regarding the		4.0.1	\
	The feeliths access before				facility's failure to provide notic	e /	1/1/1/2	
		m each resident who is enefits, in writing, at the time	1	ļ	of Medicare's denial of coverage		MINN	\vee
		ursing facility or, when the		ŀ	with the Notice of Medicare	11 9	11 m	
		gible for Medicaid of the			Non-Coverage (NOMNC), at			
j		at are included in nursing			least 48 hours prior to the end of	' '	II APIN	1
		the State plan and for			services, per CMS regulations. I	t	7 ° W >	ļ .
		ay not be charged; those			was also explained at that time	10%	, XV.	
ļ		ces that the facility offers			that notice was provided 24	W	111112	1
İ		dent may be charged, and		ļ	hours in advance, but still failed	100	78711 J	
-		s for those services; and			to meet the 48 hour regulation.	١ / ١	X(\),)	
		when changes are made to	,		She was also provided	\ '	\U \	
		s specified in paragraphs (5)		1	one was also provided	/	`	
	(i)(A) and (B) of this s			-	reassurance that, in the future,	/		
	1.717				the facility would be sure to			
	The facility must infor	m each resident before, or			supply them with required			ĺ
. †	y				notices in a timelier manner.		1	l
ORATORY	NRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	ιE		TITLE	\all_1	(X6) DATE	

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.

Event (D: JMZ112

Facility ID: 00950

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB'NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A, BUILDING_ AND PLAN OF CORRECTION 11/05/2014 R. WNG 245497 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG R17 and her financial Power of (F 156) Attorney were contacted on {F 156} Continued From page 1 12/1/14 and were provided an at the time of admission, and periodically during explanation regarding the the resident's stay, of services available in the facility and of charges for those services, facility's failure to provide notice including any charges for services not covered of Medicare's denial of coverage under Medicare or by the facility's per diem rate. with the Notice of Medicare Non-Coverage (NOMNC), at The facility must furnish a written description of least 48 hours prior to the end of legal rights which includes: services, per CMS regulations. It A description of the manner of protecting personal was also explained at that time funds, under paragraph (c) of this section; that notice was provided 24 hours in advance, but still failed A description of the requirements and procedures to meet the 48 hour regulation. for establishing eligibility for Medicaid, including They were provided reassurance the right to request an assessment under section that, in the future, the facility 1924(c) which determines the extent of a couple's would be sure to supply them non-exempt resources at the time of institutionalization and attributes to the community with required notices in a spouse an equitable share of resources which timelier manner. cannot be considered available for payment toward the cost of the institutionalized spouse's R90 was contacted on 11/18/14 medical care in his or her process of spending and provided an explanation down to Medicaid eligibility levels. regarding the facility's failure to provide notice of Medicare's A posting of names, addresses, and telephone denial of coverage with the numbers of all pertinent State client advocacy Notice of Medicare Nongroups such as the State survey and certification Coverage (NOMNC), at least 48 agency, the State licensure office, the State hours prior to the end of services, ombudsman program, the protection and per CMS regulations. It was also advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a explained at that time that notice complaint with the State survey and certification was provided 24 hours in agency concerning resident abuse, neglect, and advance, but still failed to meet misappropriation of resident property in the the 48 hour regulation. They facility, and non-compliance with the advance were provided reassurance that,

manner.

in the future, the facility would be sure to supply them with

required notices in a timelier

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directives requirements.

The facility must inform each resident of the

name, specialty, and way of contacting the

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

R NAME OF PROMDER OR SUPPLIER		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	COMPLETED
AVEN HOMES OF MAPLE PLAIN AVEN HOMES OF MAPLE PLAIN SUMMARY STATEMENT OF DEFICIENCIES	AND PLAN OF	CORRECTION	BENTI TOATION NOMBER	A. BUILDIN	NG	R
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN PRESTY PROVIDER'S PROVIDER'S STREEMENT OF DEPICEMENTS PROVIDER'S PROVIDER'S STREEMENT OF DEPICEMENTS PROVIDER'S PLAN OF CORRECTION (PLAN DEPICEMENT OF LIGHT PROPRIATE OF THE PROPRIATE			245497	B. WING_		11/05/2014
AVEN HOMES OF MAPLE PLAIN PRESIDENCE SUMMARY STATEMENT OF DEFICIENCIES PRESIDENCE AND PROCESS. ASSEMBLE PLAIN, MN 153539	NAME OF D	POVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE	
PATID SIMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX CROSS-REFIRENCE TO THE APPROPRIATE CROSS-REFIRENCE TO THE	NAME OF P	ROVIDER OR BUT LIER			1520 WYMAN AVENUE, PO BOX 368	
Continued From page 2 Physician responsible for his or her care.	HAVEN H	OMES OF MAPLE PLAIN	•		MAPLE PLAIN, MN 55359	
(F 156) Continued From page 2 physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission or all and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility falled to ensure 3 of 6 residents (R 11, R17, and R80) reviewed for liability notices received the Notice of Medicare Non-Coverage (CMs form 10123) within the required timeframe of 48 hours prior to skilled services ending. Findings include: R11's 6-day Medicare Minimum Data Set (MDS) assessment dated 9/30/14, indicated R11's Medicare coverage would be ending on 10/3/14, however, the facility with skilled coverage. R17's 14-day Medicare MDS dated 9/30/14, Indicated R17 was admitted to the facility with skilled coverage beginning 9/17/14, Review of skille	PREFIX	/EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLETION
This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 6 residents (R11, R17, and R90) reviewed for liability notices received the Notice of Medicare Non-Coverage (CMS form 10123) within the required timeframe of 48 hours prior to skilled services ending. Findings include: R11's 5-day Medicare Minimum Data Set (MDS) assessment dated 9/30/14, indicated R11 was admitted to the facility with skilled coverage beginning 9/23/14. R11's Medicare coverage would be ending on 10/3/14, however, the facility did not notify R11 of the non-coverage until 10/2/14, 24 hours prior to the end of skilled coverage. R17's 14-day Medicare MDS dated 9/30/14, indicated R17 was admitted to the facility with skilled coverage beginning 9/17/14. Review of	(F 156)	physician responsible The facility must prom written information, ar applicants for admissi information about how Medicare and Medica receive refunds for pr	for his or her care. Innently display in the facility and provide to residents and ion oral and written to apply for and use id benefits, and how to	(F 15	that all residents being disc from therapy, or otherwise ending coverage for skilled services are at risk of being affected. Residents with the potential to be discontinued of Medicare A will be disc at Medicare Meetings to en at least 48 hour notification given to resident or representative per CMS	harge de de de de de de de de de de de de de d
facility reviewed R17's Medicare coverage and determined her last covered day was 10/3/14. documentation and communication.		by: Based on interview a facility failed to ensure and R90) reviewed fo the Notice of Medicar 10123) within the required for the skilled service Findings include: R11's 5-day Medicare assessment dated 9/3 admitted to the facility beginning 9/23/14. R indicated R11's Medic ending on 10/3/14, ho notify R11 of the non- hours prior to the end R17's 14-day Medical indicated R17 was ad skilled coverage begin R17's Medicare denia facility reviewed R17's	and document review, the e 3 of 6 residents (R11, R17, r liability notices received e Non-Coverage (CMS formulired timeframe of 48 hours is ending. Minimum Data Set (MDS) 30/14, Indicated R11 was with skilled coverage 11's Medicare denial notice care coverage would be swever, the facility did not coverage until 10/2/14, 24 of skilled coverage. The MDS dated 9/30/14, Imitted to the facility with nining 9/17/14. Review of all notices indicated the shedicare coverage and		3. Responsibility for issuan Notice of Medicare Non-Coverage and corresponding documents has been reassigned to the Business Office Man on 11/6/14 due to an audit denial given on 11/5/14 than ot given timely. Back-up responsibilities for issuance Notice of Medicare Non-Coverage and corresponding documents are assigned to Education was provided to Business Office Manager of 12/1/14. Both the DON and Administrator are monitoring process at this time. The fathas restructured the overall process of the Medicare meetings, including whose attendance, process, documentation and	ager ager of a t was e of g DON. the n I the ng this cility

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					IO. 0938-039 [
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		PLE CONSTRUCTION G		E SURVEY MPLETED
		·	-				R
	·	245497	В.\	WING_		1	1/05/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		,
					1520 WYMAN AVENUE, PO BOX 369	1	
HAVEN H	OMES OF MAPLE PLAIN				MAPLE PLAIN, MN 55359		_,
(X4) ID PREFIX - TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 156}	Continued From page Non-Coverage on 10/end of skilled services. R90's 14-day Medical indicated R90 was adskilled coverage beging R90's Medicare denial issued the Notice of Mol/2/14, 24 hours prices. During Interview on 1 assistant director of nwas aware Medicare R11, R17 and R90, hotices in a timely madelicare meeting haland it was better for to "One day than no day was aware the Mediciasued within the 48 houring Interview on 1 director of nursing (Dithe facility had some Medicare Denial Lette worker was on leave the backups for issuir notices until she return 483.20(g) - (j) ASSES ACCURACY/COORD	e 3 /2/14, 24 hours prior to the s. re MDS dated 9/18/14, mitted to the facility with nning 9/5/14. Review of al notices indicated R90 was Medicare Non-Coverage on or to the end of skilled 1/04/2014, at 1:12 p.m. the ursing (ADON) stated she coverage was ending for owever she did not issue the anner. The ADON stated a d not been held that week he notices to be issued, //s," ahead of time. ADON are denial notices were not nour timeframe. 1/05/2014, at 2:36 p.m. the ON) stated she was aware concerns with issuing ers. The facility social and the ADON was one of ong the Medicare denial med. SSMENT DINATION/CERTIFIED at accurately reflect the ust conduct or coordinate		{F 15	R93 and her financial Poly Attorney were also continuously and the facility's factoring the facility's factoring the facility's factoring for facility's factoring for facility's factoring for facility's factoring for facility's factoring for facility's factoring for facility's factoring for factoring for facility's factoring for factoring for factoring for factoring for factoring for factoring for factoring for factoring for factoring for factoring for factoring for factoring for factoring for factoring factoring for factoring for factoring for factoring for factoring factoring for factoring for factoring factoring for factoring factoring for factoring for factoring f	acted on the late and they nation ailure to are's the least 48 Services, was also at notice n to meet They nee that, would with elier rill nts mials nen 3 per alts will mmittee	
	participation of health	professionals.		,	,		

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

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY LETED	
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	1 ' '			ļ		
		0.7.7.7	B. WING			1	R 05/2014	
	245497			_	REET ADDRESS, CITY, STATE, ZIP CODE	1 11/		
NAME OF P	ROVIDER OR SUPPLIER		,		220 WYMAN AVENUE, PO BOX 369			
HAVEN HO	OMES OF MAPLE PLAIN		-	1	APLE PLAIN, MN 55359			
			[D	٠	PROMDER'S PLAN OF CORRECTION	_	(X5) COMPLETION	
(X4) ID PREFIX TAG	/EXCHIDERICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREF	ix	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	DATE	
					1. R31 has been re-assessed for	!		
{F 278}	Continued From page	- 4	{F	278}	functional limitations in range of		·	
[1 41.5]	Oorkiin Look France				motion following the exact steps			
	A registered nurse M	ust sign and certify that the			listed in section G0400: Function			
	assessment is comple	eted.			Limitation in Range of Motion in		'	
					the CMS Long-Term Care			
	Each individual who	completes a portion of the			Resident Assessment Instrument.			
	assessment must sig	n and certify the accuracy of			Assessment findings were then			
	that portion of the ass	sessment.			used as a reference for the modifications of the MDS			
				1	Assessments (ARD of 9/10/14)			
	Under Medicare and	Medicaid, an individual who			that were coded inaccurately.			
	willfully and knowingly certifies a material and false statement in a resident assessment is			-	These assessment modifications			
					were re-submitted on 11/17/14.			
	subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who				Were re-submitted on 11/1//1 !!			
	\$1,000 for each asse			R25 has been re-assessed for				
	willfully and knowingly causes another individual to certify a material and false statement in a				functional limitations in range of			
_	to certify a material a	is subject to a civil money	7	1	motion following the exact steps			
	resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.				listed in section G0400: Function	al		
					Limitation in Range of Motion in		1	
				ļ	the CMS Long-Term Care			
	Clinical disagreement does not constitute a material and false statement.				Resident Assessment Instrument.		1	
				İ	Assessment findings were then			
	Illatoliai alia iaisa si				used as a reference for the			
				į	modifications of the MDS			
	This REQUIREMENT	୮ is not met as evidenced)	Assessments (ARD of 8/27/14)			
	by: Based on interview and document review, the facility failed to ensure accuracy of the Minimum Data Set (MDS) assessment for 2 of 4 residents (R25 and R31) reviewed for range of motion (ROM) and contractures which were not			İ	that were coded inaccurately.			
				i	These assessment modifications			
				i	were re-submitted on 11/18/14.			
							1	
					Resident's with contractures			
					have a potential to be affected for		-	
	accurately coded on	เมือ เมกอา			miscoding on MDS. Residents w			
					be reviewed using the Query tool	·		
	Findings include:			[to determine if they were correct	ly		
	Posts applied MDS d	ated 8/27/14, Identified R25			coded on the MDS for contractur			
·	had no functional lim	itations in ROM			on most recent MDS assessment	to		
	(contractures).	100000000000000000000000000000000000000			verify MDS accuracy.			
	(contractares).	*						
	A physical therapy di	scharge note dated		ļ				

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

CENTERS FOR MEDICARE & MEDICAID SERVICES			0(8) 1(1)	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l i			COMP		
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER	A, BUILL	, DNI		F	٦	
			B, WNG			11/	05/2014	
		245497	B, WING		TREET ADDRESS, CITY, STATE, ZIP CODE	·		
NAME OF PROVIDER OR SUPPLIER					520 WYMAN AVENUE, PO BOX 369		ļ	
	MED OF MADIE DI AIM							
HAVEN HO	OMES OF MAPLE PLAIN			T W	APLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG (CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
				+	3. MDS nurses will receive	-		
			, (12)	278)	education on the accurate method			
{F 278}	Continued From page	9 5	\ r.	2,01	of identifying limitation of			
1	10/17/14, identified R	25 would continue on a		1	functional ROM limitations per th	e		
	nursing rehab ROM p	program, and listed the ROM			RAI manual on 12/1/14.			
	extension of the left k	knee to be -13 degrees, and			Understanding of process will be			
	the right knee at -19	degrees, indicating R25 had			confirmed through supervised			
	contractures in both	(1)CC3.	1		return demonstration for 5 MDSs	•		
	R31's quarterly MDS	dated 9/10/14, identified		Í	by DON.			
	R31 had no functions	al limitations in ROM.			n 11 de will les routewed neiner	•		
					Residents will be reviewed using the Query tool to determine if the	v,		
	A physical therapy di	scharge note dated		}	were correctly coded on the MDS	Š		
	10/29/14 identified R	R31 had ROM extension of		-	for contractures on most recent		,	
	the left knee at -25 de	egrees and the right knee			MDS assessment to verify MDS			
	was -22 degrees, ind	licating R31 had contractures			accuracy. If inaccurate,			
1	in both knees.			ĺ	modifications of MDS will be			
1	During Interview on 1	11/5/14 at 9:06 a.m.	7		completed and resubmitted.			
	registered nurse (RN	I)-A stated some resident						
	MDS's had recently b	been reviewed for accuracy,		l	4. The DON/Designee will run		1	
	but neither she nor th	ne other MDS nurse had		1	Query Tool every month to audit	•		
	reviewed every single	e residents' MDS, RN-A			residents limited ROM scores on	ı S		
	stated the facility con	porate nurses had reviewed		j	previous MDS to determine MD	t		
	all resident MDS's in	the facility for accuracy, but		1	accuracy. Results will be brough to the QA Committee for further			
	was unsure why R25	and R31's MDS had not			to the QA Committee for further review and/or recommendation.			
	been corrected to rea	flect their contractures.		ł	review and/or recommendation			
	Therefore inter-dense are	11/5/14, at 10:06 a.m. the		Ì	5. 12/4/14			
	director of pursing (F	OON) reviewed the electronic			, in the state of			
	charts of R25 and R3	31, and verified the residents						
	both had identified ki	nee contractures, however,						
	neither R25 or R31's	MDS's were coded correctly		1				
	to identify the bilater	al lower contractures.	_	ایرم .			1.	
F 311	483,25(a)(2) TREAT	MENT/SERVICES TO	į	F 311				
SS=E		NADLS		1				
					~		1	
	A resident is given the	ne appropriate treatment and						
	services to maintain	or improve his or her abilities						
	specified in paragrap	ph (a)(1) of this section.				•		
		•		•			<u></u>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPART	WENT OF TILABLETT	MEDICAID SERVICES					J. 0900-000
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION -	(X3) DATE	SURVEY PLETED
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDI	NG			R
		245497	B. WING			· 11	/05/2014
		24040.		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROMDER OR SUPPLIER						
HAVEN H	OMES OF MAPLE PLAIN	ı			20 WYMAN AVENUE, PO BOX 369 APLE PLAIN, MN 55359		
		ī	ID.	-	PROVIDER'S PLAN OF CORRECTI	ON	(X5) COMPLETION
(X4) ID PREFIX TAG	TARL DESIGNATION OF THE PROPERTY OF THE PROPER	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
					1. R94 is offered assistance w	ith	
		- 0	F	311	1. R94 is offered assistance in		
F 311	Continued From pag	еь			walking daily. Resident		
f					frequently refuses to ambulate	tion	1
	This REQUIREMEN	T is not met as evidenced			with care staff, but an ambula	elv	
	by:	to and desument			program is still offered routin	d of	
	Based on observation	on, interview, and document			At times, upon being reminde	u or	
	review, the facility fa	iled to provide assistance			ricks and benefits, resident is		
	with ambulation serv	ices for 4 of 4 residents		1	more willing to participate.	Ine	
	(R94, R89, R93 and	Kea) Muo tedanea		İ	undated program and		1
	assistance from staff	With ambulation.		ł	interventions for refusals hav	e	
					been communicated to the ca	re	
	Findings include:				staff to carry out according to	the the	,
		Doto Set (MDS) dated		-	resident care plan.		1
	R94's Admission Mir	nimum Data Set (MDS) dated					
	10/8/14, identified R	94 had moderately impaired			R89 was admitted to Hospic	e on	
	cognition and require	ed physical assistance of one			11/17/14. Ambulation progr	am	
,	person with ambulat	30n.	7		was discontinued per family	•	
,		ental Communication form		l	request, and ROM has been		
	R94's Interdepartme	and signed by physical			offered daily since to avoid	risk	
[provided to nursing	16/14, indicated R94 was to		1	offered daily since to avoid	ife	
	therapy (PT) on 10/	00 feet with a rolling walker			of increased pain at end of l		
	ambulate daily 50-1	of member			related to contracture		
1					development		
	Identified R94 was t	nt Care sheet dated 11/3/14, o be walked 50-100 feet with	\$		R93 was discharged 11/6/14	1.	
	a rolling walker, tran	sfer belt and assist of one			R69 was referred back to the	erapy	
	staff.				due to refusals to work with	staff.	
					due to relusals to work with	nis	
	Review of the electr	onic point of care restorative			and remains in therapy at the time. Resident is still ambu	lated 1	
	nursing section whi	ich was identified by the			time. Resident is suit almou	.,	
	facility as the docum	nentation of when and how far			daily by nursing staff with	ection	
	a resident ambulate	es, indicated R94 had walked			minimal refusals, in conjui	IOTIOII	
	only four of the twel	nty days from the starting date e review date of 11/4/14.			with therapy.		
	R94 was observed	lying in bed on 11/5/14, at 2:49					
	- m and was interv	iewed. R94 stated he needed					
	assistance to walk i	n the hallway and was not					
	offered the opportu	nity to waik by staff.	1				

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

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	T	-10/ -	CONSTRUCTION	(X3) DATE	SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	PUILDING		COMPLETED	
AND PLAN OF	CORRECTION	IDEN (IFICA) TON NOMBER	A. BUILDI	NG		F	!
		245407	B, WNG			11/0	5/2014
	J	245497		S	FREET ADORESS, CITY, STATE, ZIP CODE		
NAME OF PE	ROVIDER OR SUPPLIER				520 WYMAN AVENUE, PO BOX 369		
HAVEN HO	MES OF MAPLE PLAIN		. :		APLE PLAIN, MN 55359		
HAVENTIN	1		- In		PROVIDER'S PLAN OF CORRECTION	1	(X6) COMPLETION
(X4) ID PREFIX TAG	# ACCUPERIOUS NO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE .	DATE .
			1				
F 311	R89's Admission MD R89 had moderate or required physical ass ambulation. R89's Interdepartmet provided to nursing a 10/16/14, indicated F 25-50 feet with a rolli staff member. R89's Nursing Assist 11/3/14, identified R8 feet with a transfer b of one staff member. R89's electronic poir section indicated the the twenty days from 10/16/14, until the re R89 was observed s the bird aviary on 11 interviewed. R89 staff gesiet the resident was	S dated 10/6/14, identified orgitive impairment, and distance of one staff with and signed by PT on a segment of any walker and assist of one and Care sheet dated segment walker, and assist of care restorative nursing resident had walked nine of	F	311	2. All residents being discharge from therapy with FMP (Functional Maintenance Program) or ambulation programs have potential to be affected. 3. An in-service was provided the Nurses on 11/19/14 and CNAs on 11/21/14 regarding the multitude of risks and comorbidities associated with contractures and immobility, and how that affects the overall health, level of functional mobility, mood and quality of life in the elderly population. Education included how the old culture of nursing homes (alarm psychotropic, etc.) contributes these risks, as well as relating the effect immobility can have on falls, and how the importance of completing ROM/AMB/FMP Programs for all residents who have them.	o ad is, o	
	R93 had severe cog required physical as ambulation in the co						
	provided to nursing	ental Communication form and signed by PT on R93 was to ambulate twice a et with a rolling walker and lember				ntinuation sh	eet Page 8 of 1

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

CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE C	CONSTRUCTION (X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A, BUILDI	NG			R .	
		245497	B. WNG			1	05/2014	
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN				STF 152 MA				
OUNTABLY STATEMENT OF DEFICIENCIES					PLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	·	(X5) COMPLETION	
(X4) ID PREFIX TAG	ACY DESIGNENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE	
F 311			F	311	A Restorative committee meetin was held 11/25/14. The DON, 5 restorative aides, and the	g.		
	R93's Nursing Assiste 11/3/14, identified R9 with a rolling walker, i one staff member.	ant Care sheet dated 3 was to walk 100-200 feet transfer belt, and assist of			Restorative RN were in attendance. Residents with an FMP and/or AMB program was reviewed by committee for	•		
	section indicated R93	t of care restorative nursing that walked 9 of the 38 starting date of 10/16/14, of 11/4/14.			overall effectiveness of the program, resident's compliance with exercises, and possible interventions that might assist with the overall success of the			
	in a wheelchair near in not observed ambula				maintenance program for each resident. Any declines in functional ability and/or consistent refusals were referred			
	R69 had severe coor	dated 10/14/14, identified itive impairment and istance of one person with	The state of the s		back to therapy and/or discontinued after educating about risks associated with regarding refusals to participate			
	provided to nursing a 10/17/14, indicated R day 75-100 feet with	69 was to ambulate twice a a rolling walker and a			in the program. 4. DON/Designee will continue			
	transfer belt, with ass member.				to perform weekly audits of documentation summaries for al residents to ensure	1		
	with a transfer belt, roone staff member.	9 was to walk 75-100 feet olling walker, and assist of			documentation compliance of FMP/AMB program weekly x 6 weeks with results brought to th QA committee for further review.	e		
	section indicated R69	t of care restorative nursing 3 had walked 3 of the 28 0/22/14, through the review			5. 12/4/14			
	During interview on 1	1/5/14, at 1:46 p.m. director I corporate registered nurse						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING_ 11/05/2014 R. WING 245497 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ID PREF**IX** SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG DEFICIENCY) TAG F 311 F 311 Continued From page 9 (CRN)-A stated R69 was receiving PT and OT services from 10/9/14, and was discharged from therapy on 10/31/14. DON and CRN-A were not aware why therapy had assessed R69 to be walked twice a day by staff when she was receiving therapy, However, they had not spoken to therapy about the ambulation assessment therapy had completed on 10/17/14, for R69 to be ambulated twice a day. During interview on 11/05/2014, at 2:23 p.m. physical therapy assistant (PTA)-A and occupational therapy assistant (OTA)-A stated R69 was receiving therapy services with PT and OT from 10/9/14, through 10/31/14, once a day, Monday through Friday. PTA-A and OTA-A stated R69 was referred to nursing on 10/17/14, to be ambulated twice a day by staff, so nursing staff would assist R69 with ambulating in the evenings and on weekends. PTA-A stated R69 had been independent with ambulating in the past, and the goal was to possibly get the resident back to being independent with ambulation. During an observation on 11/5/14, at 2:43 p.m. R69 was lying in her bed. R69 stated she could transfer from the wheelchair to the toilet with no problems, but could not recall the last time she walked in the hallway by staff. R69 stated, "But I love to walk," During interview on 11/4/14, at 10:47 a.m. physical therapist (PT)-A stated they had recently assessed the ambulation and/or range of motion therapy needs of all the residents in the facility. PT-A stated the interdepartmental Communication forms were completed and sent

to nursing to implement. PT-A stated if any resident was assessed to be on an ambulation PRINTED: 11/21/2014 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/21/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			<u> </u>	T	. 0938-0381
STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION `	1	LETED
		245497	B, WING				05/2014
NAME OF P	ROVIDER OR SUPPLIER	,	,		TREET ADDRESS, CITY, STATE, ZIP CODE	~	
	OMES OF MAPLE PLAIN			1	520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	•	
		ATEMENT OF DEFICIENCIES	. ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
(X4) ID PREFIX TAG	/EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	ΉX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
					-		
F 311	Continued From page	e 10	F	311	•		
1 011		cted they be walked at least					
	daily and for some re	esidents twice a day to					
	maintain their ambula	ition ability.	,				
{F 318}	483,25(e)(2) INCREA	SE/PREVENT DECREASE	{F	318}			
SS≍D	LIVE MAC OF MOTH	ON			1. R6 is receiving AAROM at		
					least 2x/week and appropriate		
	Based on the compre	hensive assessment of a			documentation tools were put		ļ
	resident, the facility m	nust ensure that a resident			into place on 11/25/14.		
	with a limited range o	t and services to increase					
	range of motion and/o	or to prevent further			R55 is receiving PROM at least		
	decrease in range of	motion.		-	2x/week and appropriate		
	G00/0000 III (2.1.g)				documentation tools were put		İ
					into place on 11/25/14.		
					o Maria di Albanda	.1	
	This REQUIREMENT	is not met as evidenced			2. All residents being discharge	a	
	by:	- intendey and document			from therapy with FMP		
	Based on observatio	n, interview, and document led to ensure range of			(Functional Maintenance Program) or ambulation		
	motion services (ROM	M) were provided to maintain			programs have potential to be		
	and/or improve curre	nt level of functioning for 2 of			affected.		•
	8 residents (R6 and F	R55) reviewed for range of			affected.		
	motion services.		'		3. The Director of Nursing and		
		· · · · · · · · · · · · · · · · · · ·			the Physical Therapy Assistant		
	Findings include:				met on 11/26/14 and 12/3/14 to		
	Dol. Junio A	ge Minimum Data Set (MDS)			set up a process to ensure that the		
	Ros significant chang	ted R6 had severa cognitive			Interdepartmental		
	impairment and had t	functional limitations of ROM			Communication Forms from	_	,
	to both upper extrem				therapy are given to the Directo		
	, ,				of Nursing to be implemented b		
	R6's Interdepartment	al Communication form			the nursing department in a		
	provided to nursing, a	and signed by physical			timelier, more proactive manne		
	therapy (PT) and occ	supational therapy (OT) on			so all residents discharging from		
ĺ	10/23/14, indicated R	to was to receive 10	.		PT/OT/ST services may have a		
	repetitions twice a We	eek of active assisted range to hips, knees, ankles,			seamless transition into his/her		
	bilateral shoulders, e	lbows, writs, and fingers.	}		maintenance plan.	÷	
			. [1		

Facility ID: 00950

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL		(X3) DATE SURVEY COMPLETED			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			R
		245497	B, WING				11/05/2014
	TOTALLE OF STREET	240491		STR	EET AODRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1520	WYMAN AVENUE, PO BOX 369		
HAVEN H	OMES OF MAPLE PLAIN	•		MA	PLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	/EACH DEFICIENC!	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETION DATE
{F 318}	Continued From page The Functional Mainte Program documentati Identified as the docu resident ROM prograt treatment sheets for a documentation that R Implemented or provict assessed on 10/23/14 During observations of 11/5/14, at 8:30 a.m., 11/5/14, R6 was sittin not observed on to re R55's modified MDS of R55 had severe cognifunctional limitations of lower extremities. R55's Interdepartment provided to nursing an 10/23/14, indicated R repetitions twice a we motion (PROM) to hip shoulders, elbows, we repetitions of cervical stretch. The Functional Mainte Program documentati treatment sheets for a documentation that R implemented or provict assessed on 10/23/14	enance and Restorative on book, which was mentation of completion of ms, which included 10/14, and 11/14, lacked any 6's AAROM plan had been ded to R6 since being 4. on 11/4/14, at 8:29 a.m., and and again at 10:44 a.m. on g in her wheelchair. R6 was eceive any ROM services. dated 10/27/14, identified litive impairment and had of ROM to both upper and tal Communication form nd signed by PT and OT on 55 was to receive 10 tek, of passive range of tes, knees, ankles, bilateral dits, fingers, and 10 neck ROM with a gentle enance and Restorative on book which included 10/14, and 11/14, lacked any 55's PROM plan had been ded to R55 since being 4.	{F 3	318)	While the Restorative Nursing policy remains unchanged, the Functional Maintenance Programation policy was developed. This policy was created to help distinguish the differences between restorative and functional maintenance prograin the context of preventing decline of physical functioning and/or preventing further limitations in functional range motion for residents. An in-service was provided to Nurses on 11/19/14 and CNAs on 11/21/14 regarding the multitude of risks and comorbidities associated with contractures and immobility, a how that affects the overall health, level of functional mobility, mood and quality of life in the elderly population. Education included how the old culture of nursing homes (alar psychotropic, etc.) contributes these risks, as well as relating effect immobility can have on falls, and how the importance completing ROM/AMB/FMP Programs for all residents who have them.	ms of d ms, to the	
	was sleeping in her w	n 11/3/14, at 1:19 p.m. R55 heelchair in her room. R55 11/3/14, to receive any					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		ľ	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG	R
		245497	B. WING		11/05/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFÖRMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
{F 318}	During interview on 1 of nursing (DON) stat range of motion programethe staff were to docucompleted. During interview on 1 therapy assistant (PT worked with R6 and F discharged from therapy assistant to the nursing implement the ongoin for the residents. During interview on 1 therapist (PT)-A stated at that the Communication forms provided to the nursing implement the ongoin for the residents. During interview on 1 therapist (PT)-A stated the prior evening (11/had confusion about which was to start on wanted to be sure R5 since 10/23/14, when therapy and was to be PT-A stated there was During interview on 1 assistant (NA)-D, stated there was During interview on 1 assistant (NA)-D, stated there was During interview which residents who were owas not able to identify programs were not be	1/3/14, at 2:01 p.m. director ed residents who were on a ram would have paper hal Maintenance and documentation book which ment on when ROM was 1/4/14, at 8:40 a.m. physical A)-A stated therapies had R55 until they were apy services on 10/23/14. Ime the interdepartmental is were filled out and graff so they could grunctional ROM program 1/4/14, at 8:56 a.m. physical dhe had reassessed R55 3/14), because nursing staff starting R55's ROM program 10/23/14. PT-A stated they 5 had no decrease in ROM she was discharged from egin ROM with nursing. Is no change or decilne. 1/4/14, at 2:10 p.m. nursing the she carried the carried the care book when working as was used to identify an ROM program. NA-D fry why the resident ROM eing completed.	{F 3	A Restorative committee me was held 11/25/14. The DON restorative aides, and the Restorative RN were in attendance. Residents with at FMP and/or AMB program y reviewed by committee for overall effectiveness of the program, resident's compliant with exercises, and possible interventions that might assis with the overall success of the maintenance program for each resident. Any declines in functional ability and/or consistent refusals were refer back to therapy and/or discontinued after educating about risks associated with regarding refusals to participatin the program. 4. DON/Designee will continue to perform weekly audits of a ROM/AMB/FMP documentation all residents to ensure compliance of FMP/AMB programs weekly x 6 weeks we results brought to the QA committee for further review.	n, 5 nee t e h red ate ll tion
	Nursing identified the	olicy titled Restorative philosophy was each the facility had the right to is/her own care and to have		5. 12/4/14	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILE	TIPLE CO		(X3) DATE SURVEY COMPLETED		
.,		245497	B, WING				11	R /05/2014
	ROVIDER OR SUPPLIER			1520	EET ADDRESS, CITY, STATE, ZIP O WYMAN AVENUE, PO BOX 368 PLE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD B HEAPPROPRI		(X5) COMPLETION DATE
{F 318}	the services available highest possible, prace psychosocial level. Replanned, systematic, obuilds on strengths an criteria: 1. Measurable objects	to him/her to reach their ticable physical, and	{F 3	318}				
	2. Evidence of perionurse must be present. 3. Nursing assistant the techniques that proin the activity. 4. Restorative activity. 5. Two Restorative a minimum of 6 days/v. 6. Each Restorative a minimum of 15 minu. The policy identified nupositions were responsorganization of the resmonitoring the delivery routine basis to assure	s/aides must be trained in omote resident involvement lies must be carried out or resident involvement soft the nursing staff programs must be provided evek program must be provided tes in a 24 hour period urses in management sible for maintaining the torative program and of restorative care on a the programs are being	-	-				
	followed consistently a	nd as pianned.						

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245497	(Y2) Multiple Construction A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 11/14/2014
Name of Facility		Street Address, City, State, Zip Code	
HAVEN HOMES OF MAPLE PLAIN		1520 WYMAN AVENUE, PO BOX 3	69

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
		(Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix		<i>`</i>	10/20/2014		ID Prefix			10/10/2014		ID Prefix			_
Reg. #	NFPA 101				Reg. #	NFPA 101				Reg. #			_
LSC	K0029				LSC	K0130				LSC			_
		(Correction					Correction					Correction
ID Prefix			Completed		ID Profix			Completed		ID Profix			Completed
													_
Reg. #					Reg. # LSC					Reg. #			_
LSC					LSC				<u> </u>	LSC			_
		,	Carraction					Correction					Correction
			Correction Completed					Correction Completed					Correction Completed
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Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
Reviewed By	Revi	ewed B	у	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	,	PS	S/KJ	11	/19/201	4		19251				11/1	4/2014
Reviewed By	Revi	ewed B	•	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed o	on:				Check fo	or anv	Uncorrected I	Defic	iencies. Was	a Summary of	-	
	9/15/2014	1					-				to the Facility?	YES	NO

PRINTED: 11/21/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		NSTRUCTION	COMF	SURVEY
		245497	B. WING			1	R 05/2014
	ROVIDER OR SUPPLIER	N	•	1520	EET ADDRESS, CITY, STATE, ZIP CODE WYMAN AVENUE, PO BOX 369 PLE PLAIN, MN 55359	,	VV.2V. 1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	-	was conducted by surveyors	{F 0	00}			
{F 156}	11/5/14, to determine deficiencies issued o exited on 9/12/14. The found not corrected.	n 11/3/14, 11/4/14, and e compliance with federal during a recertification survey ne following deficiencies were	{F 1	56}			
SS=D	RIGHTS, RULES, SI The facility must info and in writing in a lar understands of his o regulations governin- responsibilities durin facility must also pro notice (if any) of the §1919(e)(6) of the Ac made prior to or upo resident's stay. Rec- any amendments to writing. The facility must info entitled to Medicaid I of admission to the r resident becomes eli items and services th facility services unde which the resident m other items and serv and for which the resi the amount of charge inform each resident the items and service (i)(A) and (B) of this	rm the resident both orally nguage that the resident r her rights and all rules and g resident conduct and g the stay in the facility. The vide the resident with the State developed under ct. Such notification must be n admission and during the eipt of such information, and it, must be acknowledged in rm each resident who is benefits, in writing, at the time tursing facility or, when the ligible for Medicaid of the nat are included in nursing er the State plan and for lay not be charged; those ices that the facility offers sident may be charged, and when changes are made to les specified in paragraphs (5)					
I ABORATORY I	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(X6) DATE

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

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) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245497	B. WING _			R 11/05/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359		11/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
{F 156}	at the time of admissing the resident's stay, of facility and of charger including any charger under Medicare or by The facility must furnilegal rights which income A description of the refor establishing eligibility to request an 1924(c) which determ non-exempt resource institutionalization an spouse an equitable cannot be considered toward the cost of the medical care in his or down to Medicaid eligible. A posting of names, a numbers of all pertinegroups such as the Sagency, the State lice ombudsman program advocacy network, an unit; and a statement complaint with the Stagency concerning remisappropriation of refacility, and non-complicatives requirement.	ion, and periodically during if services available in the stort those services, stort services not covered to the facility's per diem rate. ish a written description of ludes: nanner of protecting personal ph (c) of this section; equirements and procedures illity for Medicaid, including in assessment under section nines the extent of a couple's set at the time of it dietributes to the community share of resources which it available for payment is institutionalized spouse's in her process of spending gibility levels. addresses, and telephone ent State client advocacy state survey and certification ensure office, the State in, the protection and in the Medicaid fraud control is that the resident may file a are survey and certification esident abuse, neglect, and esident property in the pliance with the advance	{F 1	56}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION G	l` '	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			R 11/05/2014	
	ROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	•	11/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 156}	written information, a applicants for admis information about ho Medicare and Medic	e for his or her care. minently display in the facility and provide to residents and	{F 15	6}			
	by: Based on interview facility failed to ensu and R90) reviewed f the Notice of Medica	T is not met as evidenced and document review, the re 3 of 6 residents (R11, R17, or liability notices received are Non-Coverage (CMS form quired timeframe of 48 hours less ending.					
	R11's 5-day Medicar assessment dated 9 admitted to the facili beginning 9/23/14. I indicated R11's Med ending on 10/3/14, h notify R11 of the nor	re Minimum Data Set (MDS) /30/14, indicated R11 was ty with skilled coverage R11's Medicare denial notice icare coverage would be lowever, the facility did not n-coverage until 10/2/14, 24 d of skilled coverage.					
	indicated R17 was a skilled coverage beg R17's Medicare den facility reviewed R17	are MDS dated 9/30/14, dmitted to the facility with linning 9/17/14. Review of ial notices indicated the "s Medicare coverage and covered day was 10/3/14. Notice of Medicare					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245497	B. WING _			R I 1/05/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359		11/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 156}	end of skilled service R90's 14-day Medica indicated R90 was ac skilled coverage begi R90's Medicare denia issued the Notice of I 10/2/14, 24 hours pric services. During interview on 1 assistant director of r was aware Medicare R11, R17 and R90, h notices in a timely ma Medicare meeting ha and it was better for t "One day than no day	re MDS dated 9/18/14, Imitted to the facility with Inning 9/5/14. Review of Included all notices indicated R90 was Medicare Non-Coverage on Increase to the end of skilled Included All 1:12 p.m. the Increase was ending for Incoverage was ending for ending for Incoverage was ending for e	{F 15	56}		
{F 278} SS=D	director of nursing (D the facility had some Medicare Denial Lette worker was on leave the backups for issuin notices until she return 483.20(g) - (j) ASSES ACCURACY/COORE The assessment must resident's status.	SSMENT DINATION/CERTIFIED at accurately reflect the ust conduct or coordinate th the appropriate	{F 27	78}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING		1	R 1/05/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	· ·	1700/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 278}	Continued From page	e 4	{F 278	33}		
	A registered nurse m assessment is compl	ust sign and certify that the eted.				
	I .	completes a portion of the n and certify the accuracy of sessment.				
	willfully and knowingl false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingl to certify a material a	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each				
	Clinical disagreemen material and false sta	t does not constitute a atement.				
	by: Based on interview a facility failed to ensur Data Set (MDS) asse					
	Findings include:					
	R25's annual MDS danad no functional limit (contractures).	ated 8/27/14, identified R25 itations in ROM				
	A physical therapy di	scharge note dated				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X	(X3) DATE SURVEY COMPLETED	
		7 50.125			R	
	245497	B. WING			11/05/2014	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIATE	(X5) COMPLETION DATE	
10/17/14, identified R nursing rehab ROM p extension of the left k the right knee at -19 c contractures in both k R31's quarterly MDS R31 had no functional A physical therapy dis 10/29/14, identified R the left knee at -25 de was -22 degrees, indicin both knees. During interview on 1 registered nurse (RN MDS's had recently be but neither she nor the reviewed every single stated the facility corpall resident MDS's in was unsure why R25 been corrected to refind the properties of R25 and R3 both had identified kneither R25 or R31's	25 would continue on a program, and listed the ROM nee to be -13 degrees, and degrees, indicating R25 had thees. dated 9/10/14, identified I limitations in ROM. scharge note dated 31 had ROM extension of egrees and the right knee cating R31 had contractures 1/5/14, at 9:06 a.m. 1-A stated some resident een reviewed for accuracy, e other MDS nurse had eresidents' MDS. RN-A porate nurses had reviewed the facility for accuracy, but and R31's MDS had not ect their contractures. 1/5/14, at 10:06 a.m. the ON) reviewed the electronic 1, and verified the residents ee contractures, however, MDS's were coded correctly	{F 2				
IMPROVE/MAINTAIN A resident is given the services to maintain of	ADLS e appropriate treatment and or improve his or her abilities	F	311			
	SUMMARY ST. (EACH DEFICIENCY REGULATORY OR INTEGRICATION	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 10/17/14, identified R25 would continue on a nursing rehab ROM program, and listed the ROM extension of the left knee to be -13 degrees, and the right knee at -19 degrees, indicating R25 had contractures in both knees. R31's quarterly MDS dated 9/10/14, identified R31 had no functional limitations in ROM. A physical therapy discharge note dated 10/29/14, identified R31 had ROM extension of the left knee at -25 degrees and the right knee was -22 degrees, indicating R31 had contractures in both knees. During interview on 11/5/14, at 9:06 a.m. registered nurse (RN)-A stated some resident MDS's had recently been reviewed for accuracy, but neither she nor the other MDS nurse had reviewed every single residents' MDS. RN-A stated the facility corporate nurses had reviewed all resident MDS's in the facility for accuracy, but was unsure why R25 and R31's MDS had not been corrected to reflect their contractures. During interview on 11/5/14, at 10:06 a.m. the director of nursing (DON) reviewed the electronic charts of R25 and R31, and verified the residents both had identified knee contractures, however, neither R25 or R31's MDS's were coded correctly to identify the bilateral lower contractures. 483.25(a)(2) TREATMENT/SERVICES TO	ROVIDER OR SUPPLIER DMES OF MAPLE PLAIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 10/17/14, identified R25 would continue on a nursing rehab ROM program, and listed the ROM extension of the left knee to be -13 degrees, and the right knee at -19 degrees, indicating R25 had contractures in both knees. R31's quarterly MDS dated 9/10/14, identified R31 had no functional limitations in ROM. A physical therapy discharge note dated 10/29/14, identified R31 had ROM extension of the left knee at -25 degrees and the right knee was -22 degrees, indicating R31 had contractures in both knees. During interview on 11/5/14, at 9:06 a.m. registered nurse (RN)-A stated some resident MDS's had recently been reviewed for accuracy, but neither she nor the other MDS nurse had reviewed every single residents' MDS. RN-A stated the facility corporate nurses had reviewed all resident MDS's in the facility for accuracy, but was unsure why R25 and R31's MDS had not been corrected to reflect their contractures. During interview on 11/5/14, at 10:06 a.m. the director of nursing (DON) reviewed the electronic charts of R25 and R31, and verified the residents both had identified knee contractures, however, neither R25 or R31's MDS's were coded correctly to identify the bilateral lower contractures. A resident is given the appropriate treatment and services to maintain or improve his or her abilities	ROVIDER OR SUPPLIER DMES OF MAPLE PLAIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 10/17/14, identified R25 would continue on a nursing rehab ROM program, and listed the ROM extension of the left knee to be -13 degrees, and the right knee at -19 degrees, indicating R25 had contractures in both knees. R31's quarterly MDS dated 9/10/14, identified R31 had no functional limitations in ROM. A physical therapy discharge note dated 10/29/14, identified R31 had ROM extension of the left knee at -25 degrees and the right knee was -22 degrees, indicating R31 had contractures in both knees. During interview on 11/5/14, at 9:06 a.m. registered nurse (RN)-A stated some resident MDS's had recently been reviewed for accuracy, but neither she nor the other MDS nurse had reviewed every single residents' MDS. RN-A stated the facility corporate nurses had reviewed all resident MDS's in the facility for accuracy, but was unsure why R26 and R31's MDS had not been corrected to reflect their contractures. During interview on 11/5/14, at 10:06 a.m. the director of nursing (DON) reviewed the electronic charts of R25 and R31, and verified the residents both had identified knee contractures, however, neither R25 or R31's MDS's were coded correctly to identify the bilateral lower contractures. 483.25(a)(2) TREATMENT/SERVICES TO In MRROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	ROVIDER OR SUPPLIER DMES OF MAPLE PLAIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DESICIENCY OR LIST DEPLOYENCES) (EACH DESICIENCY WILLIAM IN 53399 MAPLE PLAIN, MIN 53399 SUMMARY STATEMENT OF DEFICIENCIES (EACH DESICIENCY OR LIST DEPLOYENCES) (EACH DESICIENCY WILLIAM IN FORMATION) Continued From page 5 Continued From page 5 Continued From page 5 Continued From page 5 Continued From page 5 A BUILDING SPREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 5 Continued From page 5 (F 278) 10/17/14, identified R25 would continue on a nursing rehab ROM program, and listed the ROM extension of the left knee to be -13 degrees, and the right knee at -19 degrees, indicating R25 had contractures in both knees. R31's quarterly MDS dated 9/10/14, identified R31 had no functional limitations in ROM. A physical therapy discharge note dated 10/29/14, identified R31 had ROM extension of the left knee at -25 degrees and the right knee was -22 degrees, indicating R31 had contractures in both knees. During interview on 11/5/14, at 9:06 a.m. registered nurse (RN)-A stated some resident MDS's had recently been reviewed for accuracy, but neither she nor the other MDS nurse had reviewed all resident MDS's in the facility for accuracy, but was unsure why R25 and R31's MDS had not been corrected to reflect their contractures. During interview on 11/5/14, at 10:06 a.m. the director of nursing (DON) reviewed the electronic charts of R25 and R31, and verified the residents both had identified knee contractures, however, neither R25 or R31's MDS's were coded correctly to identify the bilateral lower contractures. 483.26(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			R 11/05/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359		11103/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 311	F 311 Continued From page 6 This REQUIREMENT is not met as evidenced		F 3 ⁻	11		
	by: Based on observation review, the facility fail	n, interview, and document ed to provide assistance ces for 4 of 4 residents R69) who required				
	Findings include:					
	10/8/14, identified R9 cognition and required	94's Admission Minimum Data Set (MDS) dated 0/8/14, identified R94 had moderately impaired organition and required physical assistance of one erson with ambulation.				
	provided to nursing at therapy (PT) on 10/16	6/14, indicated R94 was to 0 feet with a rolling walker				
	identified R94 was to	t Care sheet dated 11/3/14, be walked 50-100 feet with fer belt and assist of one				
	nursing section, which facility as the docume a resident ambulates, only four of the twenty	nic point of care restorative in was identified by the entation of when and how far indicated R94 had walked y days from the starting date review date of 11/4/14.				
	p.m. and was intervie	ng in bed on 11/5/14, at 2:49 wed. R94 stated he needed the hallway and was not y to walk by staff.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 50125	_		l f	R
		245497	B. WING			11/	05/2014
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN			1	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE, PO BOX 369 IAPLE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 311	R89 had moderate corequired physical ass ambulation. R89's Interdepartment provided to nursing a 10/16/14, indicated R25-50 feet with a rolling staff member. R89's Nursing Assista 11/3/14, identified R8 feet with a transfer been of one staff member. R89's electronic point section indicated the the twenty days from 10/16/14, until the revent the bird aviary on 11/2 interviewed. R89 staffrom the staff to walk assist the resident with stated staff did not off everyday. R93's Admission MD3 R93 had severe cogning required physical ass ambulation in the core R93's Interdepartment provided to nursing a 10/17/14, indicated R	Signature of one staff with stance of one staff with stance of one staff with stance of one staff with stance of one staff with stance of one staff with stance of one staff with stance of one staff with stance of one staff with stance of one staff with stance of one staff with stance of stance and staff had offered to the walking, however, he fer to assist him with walking stance of one person with ridor.	F	311			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD				R	
		245497	B. WING			1	05/2014	
	ROVIDER OR SUPPLIER DMES OF MAPLE PLAIN	ı	•	1520	ET ADDRESS, CITY, STATE, ZIP CODE WYMAN AVENUE, PO BOX 369 LE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 311	with a rolling walker, one staff member. R93's electronic poin section indicated R93 opportunities from the until the review date of the review d	ant Care sheet dated 3 was to walk 100-200 feet transfer belt, and assist of t of care restorative nursing 3 had walked 9 of the 38 e starting date of 10/16/14, of 11/4/14. In 11/5/14, at 2:42 p.m. sitting the nurses station. R93 was string. dated 10/14/14, identified nitive impairment and sistance of one person with Intal Communication form and signed by PT on a general sistance of one staff	F	311	DEFICIENC!)			
		1/5/14, at 1:46 p.m. director discorporate registered nurse						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245497	B. WING			11/05/2014		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	11/05/2014			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 311	services from 10/9/14 therapy on 10/31/14. aware why therapy havalked twice a day by receiving therapy. Ho to therapy about the atherapy had complete ambulated twice a day by receiving therapy about the atherapy had complete ambulated twice a day occupational therapy R69 was receiving the OT from 10/9/14, throw Monday through Frida R69 was referred to rambulated twice a day would assist R69 with and on weekends. Prindependent with amigoal was to possibly being independent with amigoal was to possibly being independent with amigoal was lying in her transfer from the when problems, but could rawalked in the hallway love to walk." During interview on 1 physical therapist (Prassessed the ambulatherapy needs of all the PT-A stated the Interest Communication formation nursing to implement	was receiving PT and OT I, and was discharged from DON and CRN-A were not ad assessed R69 to be y staff when she was wever, they had not spoken ambulation assessment ed on 10/17/14, for R69 to be y. 1/05/2014, at 2:23 p.m. stant (PTA)-A and assistant (OTA)-A stated erapy services with PT and bugh 10/31/14, once a day, ay. PTA-A and OTA-A stated hursing on 10/17/14, to be y by staff, so nursing staff in ambulating in the evenings TA-A stated R69 had been bulating in the past, and the get the resident back to ith ambulation. In on 11/5/14, at 2:43 p.m. bed. R69 stated she could belchair to the toilet with no not recall the last time she or by staff. R69 stated, "But I 1/4/14, at 10:47 a.m. T)-A stated they had recently tion and/or range of motion the residents in the facility.	F 31					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245497	B. WING	_		R	
NAME OF P	ROVIDER OR SUPPLIER	240491	D. WING	S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/0	05/2014
HAVEN H	OMES OF MAPLE PLAIN			1	520 WYMAN AVENUE, PO BOX 369		
HAVEN H	JWES OF WAPLE PLAIN			N	IAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)		(X5) COMPLETION DATE
F 311 {F 318} SS=D	daily, and for some remaintain their ambulated 483.25(e)(2) INCREATIN RANGE OF MOTION Based on the compressident, the facility math a limited range of	cted they be walked at least esidents twice a day to ation ability. ASE/PREVENT DECREASE ON The ensive assessment of a nust ensure that a resident of motion receives and services to increase or to prevent further	F 3	311			
	by: Based on observatio review, the facility fail motion services (ROM and/or improve currer 8 residents (R6 and F motion services. Findings include: R6's significant chang dated 9/29/14, indicat impairment and had f	is not met as evidenced n, interview, and document led to ensure range of M) were provided to maintain nt level of functioning for 2 of R55) reviewed for range of ge Minimum Data Set (MDS) ted R6 had severe cognitive functional limitations of ROM					
	provided to nursing, a therapy (PT) and occ 10/23/14, indicated R repetitions twice a we of motion (AAROM) to	al Communication form and signed by physical upational therapy (OT) on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245497	B. WING				3
	ROVIDER OR SUPPLIER	I] 5	STREET ADDRESS, CITY, STATE, ZIP COD 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	<u> </u>	11/	05/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
{F 318}	Program documentatidentified as the docuresident ROM prograt treatment sheets for documentation that Rimplemented or proviassessed on 10/23/14 During observations of 11/5/14, at 8:30 a.m., 11/5/14, R6 was sitting not observed on to real R55's modified MDS R55 had severe cognificational limitations lower extremities. R55's Interdepartment provided to nursing a 10/23/14, indicated Riepetitions twice a wear motion (PROM) to his shoulders, elbows, with repetitions of cervical stretch. The Functional Maint Program documentation that Riemplemented or proviassessed on 10/23/14 During observation of was sleeping in her with the street was sleeping in her with the sleeping in her with the sleeping in her with the sleeping in her with the sleeping in her with the sleeping in her with the sleeping in her with the sleeping in her with the sleeping in her with the sleeping in her with the s	enance and Restorative ion book, which was imentation of completion of ms, which included 10/14, and 11/14, lacked any 26's AAROM plan had been ded to R6 since being 4. on 11/4/14, at 8:29 a.m., and and again at 10:44 a.m. on ing in her wheelchair. R6 was eceive any ROM services. dated 10/27/14, identified hitive impairment and had of ROM to both upper and of ROM to both upper and intell Communication form and signed by PT and OT on 255 was to receive 10 eek, of passive range of ions, knees, ankles, bilateral rits, fingers, and 10 in neck ROM with a gentle enance and Restorative ion book which included 10/14, and 11/14, lacked any 255's PROM plan had been ded to R55 since being	{F 3	118}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	11/100/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
{F 318}	of nursing (DON) starrange of motion prog sheets in the Function Restorative Program the staff were to doct completed. During interview on 1 therapy assistant (PT worked with R6 and I discharged from therapy assistant form provided to the nursing implement the ongoing for the residents. During interview on 1 therapist (PT)-A stated the prior evening (11) had confusion about which was to start on wanted to be sure R8 since 10/23/14, when therapy and was to be PT-A stated there was During interview on 1 assistant (NA)-D, star Functional Maintenar the restorative which residents who were considered.	1/3/14, at 2:01 p.m. director ted residents who were on a ram would have paper nal Maintenance and documentation book which ament on when ROM was 1/4/14, at 8:40 a.m. physical rA)-A stated therapies had r855 until they were apy services on 10/23/14. Etime the Interdepartmental is were filled out and registaff so they could region functional ROM program 1/4/14, at 8:56 a.m. physical red he had reassessed R55 resident and reassessed R55 resident and reassessed R55 resident and reassessed R55 resident and reassessed R55 resident and reassessed R55 resident region ROM program region ROM with nursing son change or decline. 1/4/14, at 2:10 p.m. nursing red she carried the rice Book when working as was used to identify on an ROM program. NA-D region ROM program. NA-D region resident ROM	{F 318		
	Nursing identified the individual admitted to	policy titled Restorative philosophy was each the facility had the right to is/her own care and to have			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245497	B. WING			R 11/05/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	'	11/00/2014	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 318}	highest possible, prace psychosocial level. Replanned, systematic, builds on strengths are criteria: 1. Measurable object must be documented clinical record 2. Evidence of perionurse must be preserd. Nursing assistant the techniques that printhe activity 4. Restorative actives upervised by members. Two Restorative a minimum of 6 days. Control of the positions were responding an interest of the remonitoring the deliveres.	e to him/her to reach their cticable physical, and estorative nursing is a organized program that and must meet the following ctives and interventions in the care plan and in the codic evaluation by licensed at in the clinical record ts/aides must be trained in romote resident involvement cities must be carried out or ears of the nursing staff programs must be provided tweek a program must be provided that in a 24 hour period nurses in management asible for maintaining the storative program and by of restorative care on a te the programs are being	{F 31	8}			

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		D	
		00950	B. WING		R 11/05/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HAVEN HO	OMES OF MAPLE PLAIN		MAN AVENUE, F			
			LAIN, MN 5535			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{2 000}	Initial Comments		{2 000}			
	****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correcting pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessments.	ther a violation has been mpliance with all				
	that may result from norders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.				
	was determined that to orders were not corre- orders will remain in e	sit was completed on 11/5/14. During this visit it he following correction cted. This uncorrected effect and will be reviewed at be reviewed for possible				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
					R		
		00950	B. WING		11/05/2014		
NAME OF D	ROVIDER OR SUPPLIER	etheet And	DESC CITY STA	TE ZID CODE			
NAIVIE OF P	ROVIDER OR SUPPLIER		ORESS, CITY, STA				
HAVEN H	OMES OF MAPLE PLAIN		AN AVENUE, F .AIN, MN 5535				
	CLIMMA DV CT		<u> </u>				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE		
{2 895}	Motion Subp. 2. Range of m that is directed toward through positioning all implemented and ma comprehensive reside of nursing services m development of a nur provides that: B. a resident with receives appropriate	sing care plan which a limited range of motion treatment and services to tion and to prevent further	{2 895}				
	This MN Requirement is not met as evidenced by: *Uncorrected based on the following findings. The original licensing order issued on 9/12/14, will remain in effect. Penalty assessment issued. Based on observation, interview, and document review, the facility failed to ensure range of motion services (ROM) were provided to maintain and/or improve current level of functioning for 2 of 8 residents (R6 and R55) reviewed for range of motion services. Findings include: R6's significant change Minimum Data Set (MDS) dated 9/29/14, indicated R6 had severe cognitive impairment and had functional limitations of ROM to both upper extremities.						
	provided to nursing, a	al Communication form and signed by physical upational therapy (OT) on					

Minnesota Department of Health

STATE FORM 5899 JMZ112 If continuation sheet 2 of 14

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00950	B. WING		R 11/05/2014	
	ROVIDER OR SUPPLIER	1520 WYM	RESS, CITY, STA AN AVENUE, F	O BOX 369		
	J20 01 111/11 12 1 12 1111	MAPLE PL	AIN, MN 5535	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
{2 895}	Continued From page	2	{2 895}			
	10/23/14, indicated R repetitions twice a we of motion (AAROM) to bilateral shoulders, el The Functional Mainte Program documentati identified as the docu resident ROM program treatment sheets for 1 documentation that R implemented or provious assessed on 10/23/14 During observations of 11/5/14, at 8:30 a.m., 11/5/14, R6 was sittin not observed to receive R55's modified MDS R55 had severe cogni	6 was to receive 10 ek of active assisted range of hips, knees, ankles, bows, writs, and fingers. enance and Restorative on book, which was mentation of completion of ms, which included 10/14, and 11/14, lacked any 6's AAROM plan had been ded to R6 since being				
	provided to nursing an 10/23/14, indicated R repetitions twice a we motion (PROM) to hip shoulders, elbows, wr repetitions of cervical stretch. The Functional Mainter Program documentation that R	ek, of passive range of os, knees, ankles, bilateral its, fingers, and 10 neck ROM with a gentle enance and Restorative on book which included 10/14, and 11/14, lacked any 55's PROM plan had been ded to R55 since being				

Minnesota Department of Health

STATE FORM 5899 JMZ112 If continuation sheet 3 of 14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
					R
		00950	B. WING		11/05/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
HAVEN H	OMES OF MAPLE PLAIN		MAN AVENUE, P		
		MAPLE P	LAIN, MN 55359)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
{2 895}	Continued From page	: 3	{2 895}		
	was sleeping in her w	n 11/3/14, at 1:19 p.m. R55 heelchair in her room. R55 11/3/14, to receive any			
	of nursing (DON) stat range of motion progr sheets in the Function Restorative Program the staff were to docu completed. During interview on 1 therapy assistant (PT. worked with R6 and F discharged from thera PTA-A stated at that t Communication forms provided to the nursing	nal Maintenance and documentation book which ment on when ROM was 1/4/14, at 8:40 a.m. physical A)-A stated therapies had R55 until they were apy services on 10/23/14. It ime the Interdepartmental is were filled out and			
	During interview on 1 therapist (PT)-A state the prior evening (11/had confusion about which was assessed PT-A stated they wan decrease in ROM since	1/4/14, at 8:56 a.m. physical d he had reassessed R55 (3/14), because nursing staff starting R55's ROM program to have started on 10/23/14. Ited to be sure R55 had no ce 10/23/14, when she was apy and was to begin ROM			
	Nursing identified the individual admitted to become involved in hit the services available highest possible, prac psychosocial level. Replanned, systematic,	the facility had the right to sher own care and to have to him/her to reach their sticable physical, and			

Minnesota Department of Health

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R	
		00950	B. WING		1	5/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			AN AVENUE, F	,		
HAVEN H	OMES OF MAPLE PLAIN		AIN, MN 5535			
(VA) ID	QUMMARV ST	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{2 895}	Continued From page	e 4	{2 895}			
2.015	criteria: 1. Measurable obje must be documented clinical record 2. Evidence of perionurse must be preser 3. Nursing assistanthe techniques that printhe activity 4. Restorative active supervised by members. Two Restorative a minimum of 6 days. 6. Each Restorative a minimum of 15 minimum of 1	ctives and interventions in the care plan and in the odic evaluation by licensed at in the clinical record ts/aides must be trained in romote resident involvement dities must be carried out or ears of the nursing staff programs must be provided fiveek a program must be provided outes in a 24 hour period nurses in management ansible for maintaining the storative program and by of restorative care on a fee the programs are being and as planned.				
2 915	Subp. 6. Activities of comprehensive reside home must ensure th A. a resident is g treatments and service abilities in activities of deterioration is a normal the resident's conditional part, activities of daily resident's ability to: (1) bathe, dress, (2) transfer and (3) use the toilet (4) eat; and	iven the appropriate res to maintain or improve f daily living unless mal or characteristic part of on. For purposes of this v living includes the and groom; ambulate;	2 915			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			231251113.		R	
		00950	B. WING		11/05/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
HAVEN H	OMES OF MAPLE PLAIN		MAN AVENUE, P			
040.15	STIMMADA ST.	ATEMENT OF DEFICIENCIES	PLAIN, MN 5535	PROVIDER'S PLAN OF CORRECTION	d over	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 915	Continued From page	e 5	2 915			
	functional communica	ation systems; and				
	by: *Uncorrected based of The original licensing remain in effect. Pen Based on observation review the facility faile ambulation services a residents (R94, R89, assistance from staff Findings include:	R93 and R69) who required with ambulation.				
	10/8/14, identified R9	mum Data Set (MDS) dated 4 had moderately impaired d physical assistance of one on.				
	provided to nursing at therapy (PT) on 10/16	6/14, indicated R94 was to 0 feet with a rolling walker				
	identified R94 was to	t Care sheet dated 11/3/14, be walked 50-100 feet with fer belt and assist of one				
	nursing section, which facility as the docume	nic point of care restorative n was identified by the entation of when and how far indicated R94 had walked				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00950	B. WING		11	R / 05/2014
		00330				103/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
HAVEN H	OMES OF MAPLE PLAIN		MAN AVENUE, PO			
	1	MAPLE F	PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 915	Continued From page	e 6	2 915			
		y days from the starting date review date of 11/4/14.				
	p.m. and was intervie	ing in bed on 11/5/14, at 2:49 wed. R94 stated he needed the hallway and was not by to walk by staff.				
	R89 had moderate co	S dated 10/6/14, identified ognitive impairment, and istance of one staff with				
	provided to nursing a 10/16/14, indicated R	ntal Communication form nd signed by PT on 89 was to ambulate daily ng walker and assist of one				
		ant Care sheet dated 9 was to walk daily 25-50 elt, rolling walker, and assist				
	•					
	the bird aviary on 11/1 interviewed. R89 star from the staff to walk assist the resident with	eated in the wheelchair near 5/14, at 3:03 p.m. and was ted he required assistance and staff had offered to th walking, however, he fer to assist him with walking				
	R93 had severe cogn	S dated 10/10/14, identified itive impairment and istance of one person with				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R
		00950	B. WING		11/05/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE	
HAVEN HO	OMES OF MAPLE PLAIN		MAN AVENUE, F LAIN, MN 5535		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
2 915	Continued From page	7	2 915		
	ambulation in the corr	idor.			
	provided to nursing an 10/17/14, indicated R day 100-200 feet feet assist of one staff mer R93's Nursing Assista 11/3/14, identified R93 with a rolling walker, tone staff member. R93's electronic point section indicated R93 opportunities from the until the review date of R93 was observed on	93 was to ambulate twice a with a rolling walker and mber. Int Care sheet dated 3 was to walk 100-200 feet ransfer belt, and assist of of care restorative nursing had walked 9 of the 38 starting date of 10/16/14, of 11/4/14.			
	R69 had severe cogn	dated 10/14/14, identified itive impairment and stance of one person with			
	provided to nursing ar	69 was to ambulate twice a a rolling walker and a			
	·	ant Care sheet dated 9 was to walk 75-100 feet Iling walker, and assist of			

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STATE FORM 5899 JMZ112 If continuation sheet 8 of 14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		. ,	(X3) DATE SURVEY COMPLETED	
		00950	B. WING		11	R / 05/2014
	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA MAN AVENUE, P LAIN, MN 5535	O BOX 369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 915	R69's electronic point section indicated R69 opportunities, from 10 date of 11/4/14. During interview on 1 of nursing (DON) and (CRN)-A stated R69 services from 10/9/14 therapy on 10/31/14. aware why therapy had walked twice a day by receiving therapy. Ho to therapy about the atherapy had complete ambulated twice a da During interview on 1 physical therapy assist occupational therapy R69 was receiving the OT from 10/9/14, throw Monday through Frida R69 was referred to rambulated twice a da would assist R69 with and on weekends. Prindependent with aml goal was to possibly goeing independent with models are problems, but could reproblems, but could revalled in the hallway love to walk."	a of care restorative nursing had walked 3 of the 28 of	2 915			

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00950	B. WING		R 11/05/2014
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI	E, ZIP CODE	11/00/2014
HAVEN H	OMES OF MAPLE PLAIN	1520 WY	MAN AVENUE, PO	D BOX 369	
HAVENT	JMES OF MAPLE PLAIN	MAPLE	PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 915	Continued From page	9	2 915		
	therapy needs of all the PT-A stated the Intercommunication forms to nursing to impleme resident was assesse program, it was expect	were completed and sent nt. PT-A stated if any d to be on an ambulation cted they be walked at least sidents twice a day to			
{21426}	MN St. Statute 144A. Prevention And Contr	04 Subd. 4 Tuberculosis ol	{21426}		
	maintain a compreher infection control progreurrent tuberculosis ir issued by the United S Control and Prevention Tuberculosis Eliminat Morbidity and Mortalit This program must incompaid employees, corresidents, and volunted Health shall provide to regarding implemental	am according to the most affection control guidelines States Centers for Disease on (CDC), Division of ion, as published in CDC's by Weekly Report (MMWR). Clude a tuberculosis that covers all paid and contractors, students, eyers. The Department of exchnical assistance tion of the guidelines.			
	by: Uncorrected based or	t is not met as evidenced n the following findings. The or issued on 9/12/14, will			

Minnesota Department of Health STATE FORM

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	l n www		D WING		R
		00950	B. WING		11/05/2014
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA		
HAVEN H	OMES OF MAPLE PLAIN		AN AVENUE, F AIN, MN 5535		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{21426}	Based on interview ar facility failed to ensure screening was comple admission for 2 of 7 re reviewed for TB scree failed to assess the re (TST), within 48-72 he for 1 of 7 residents (Rescreening. Findings include: The Minnesota Depar Regulations for Tuber Health Care Settings, all residents must received the Admit by the facility. R96 received the Admit by the facility. R96 received the TST-1st after admission to the Admit received the TST-1st after admission to the The Minnesota Depar Regulations for Tuber Health Care Settings, results of the TST be hours of being admining the received the TST be hours of the TST be hours of the TST be hours of the TST be hours of the TST be hours of the TST be hours of the TST be hours of the TST be hours of the TST be hours of the TST be hours of t	alty assessment issued. Ind document review, the entitle tuberculosis (TB) eted within 72 hours of esidents (R96 and R98), ening. In addition, the facility esults of tuberculin skin test ours of being administered, 197) reviewed for TB It ment of Health (MDH) eculosis Control in Minnesota dated July 2013, directed eive a baseline TB ours of admission or within 3 ission. It facility on 10/19/14, 1t/Discharge report provided devived the Tuberculin Skin in 10/23/14, four days after ty. It facility on 10/22/14, 1t/Discharge report. R98 Step on 11/3/14, 12 days facility. It ment of Health (MDH) eculosis Control in Minnesota dated July 2013, directed assessed within 48-72	{21426}		
		it/Discharge report. R97			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			_
		00950	B. WING		11	R / 05/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
HAVEN H	OMES OF MAPLE PLAIN		MAN AVENUE, PO	BOX 369		
	 I	MAPLE F	PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
{21426}	Continued From page	e 11	{21426}			
		d Step on 10/31/14, but the essed until 11/3/14, four days red.				
	director of nursing (D	1/05/2014, at 10:29 a.m. ON) stated she was aware or resident TB screening.				
	indicated the facility v place for administerin residents and staff. T	lin Skin Test (TST), undated, would have a procedure in ng and reading the TST for the policy directed staff to n 48-72 hours." No further				
{21800}	MN St. Statute144.65 Residents of HC Fac.		{21800}			
	residents shall, at adrare legal rights for the stay at the facility or the treatment and mainted that these are describused written statement of the responsibilities set for case of patients administratement shall also operson 16 years old	describe the right of a per older to request release as 53B.04, subdivision 2, and nd telephone numbers of sizations that provide services for patients in				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		00950	B. WING		R 11/05/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
HAVEN H	OMES OF MAPLE PLAIN	1520 WYM	AN AVENUE, F	PO BOX 369	
TIAVEN III	SWILD OF WATEL FEAT	MAPLE PL	AIN, MN 5535	9	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{21800}	local health authoritie the written statement to patients, residents, chosen representative to the administrator of person, consistent with Practices Act, and servulnerable adults. This MN Requirement by: *Uncorrected based of The original licensing remain in effect. Penal Based on interview and R90) reviewed for the Notice of Medicar 10123) within the requirement of the Notice of Medicar 10123) within the requirement of the Notice of Medicar 10123) within the requirement of the Notice of Medicar 10123 within the requirement o	ction findings of state and s, and further explanation of of rights shall be available their guardians or their es upon reasonable request r other designated staff th chapter 13, the Data ction 626.557, relating to It is not met as evidenced on the following findings. order issued on 9/12/14, will alty assessment issued. Ind document review, the e 3 of 6 residents (R11, R17, or liability notices received the Non-Coverage (CMS form uired timeframe of 48 hours es ending. Indicated R11 was a with skilled coverage would be coverage would be coverage until 10/2/14, 24 of skilled coverage. In MDS dated 9/30/14, Imitted to the facility with	{21800}		
		nning 9/17/14. Review of all notices indicated the			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		00950	B. WING		11/05/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		1520 WYM	AN AVENUE, F		
HAVEN HOMES OF MAPLE PLAIN			AIN, MN 5535		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{21800}	Continued From page	e 13	{21800}		
{21800}	facility reviewed R17's determined her last or R17 was issued the Non-Coverage on 10/end of skilled services R90's 14-day Medical indicated R90 was ad skilled coverage begin R90's Medicare denial issued the Notice of Nouring interview on 1 assistant director of n was aware Medicare R11, R17 and R90, he the notices in a timely a Medicare meeting hand it was better for the "One day than no day was aware the Medicissued within the 48 he During interview on 1 director of nursing (Dethe facility had some Medicare Denial Letter worker was on leave and of the similar termination of the similar termination of the facility had some Medicare Denial Letter worker was on leave and to the similar termination of the similar ter	s Medicare coverage and overed day was 10/3/14. Notice of Medicare /2/14, 24 hours prior to the s. The MDS dated 9/18/14, Imitted to the facility with nning 9/5/14. Review of al notices indicated R90 was Medicare Non-Coverage on or to the end of skilled 1/04/2014, at 1:12 p.m. the nursing (ADON) stated she coverage was ending for owever, she did not issue manner. The ADON stated and not been held that week the notices to be issued, /s," ahead of time. ADON are denial notices were not nour timeframe. 1/05/2014, at 2:36 p.m. the ON) stated she was aware concerns with issuing ers. The facility social and the ADON was one of ng the Medicare denial	{21800}		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING		R		
		00950	B. WING		11/0	5/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
HAVEN F	OMES OF MAPLE PL	ΔIN	IAN AVENUI LAIN, MN 5	E, PO BOX 369			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPERTY)	D BE	(X5) COMPLETE DATE	
{2 000}	Initial Comments		{2 000}				
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of which is the matter of the Minnesota Department of the	nether a violation has been					
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	the provided at the tag ille number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was					
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.					
	11/3/14, 11/4/14, an was determined that orders were not cor- orders will remain in	visit was completed on and 11/5/14. During this visit it the following correction rected. This uncorrected a effect and will be reviewed at to be reviewed for possible		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00950	B. WING		R 11/05/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
HAVEN H	OMES OF MAPLE PL	AIN	MAN AVENU LAIN, MN 5	E, PO BOX 369 5359	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
{2 000}	Continued From pa	ge 1	{2 000}	The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the surfindings are the Suggested Method Correction and the Time Period Following the STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION SIGNATURES STATUTES/RULES.	Tag." the tute/rule ies" ply" nis s which after the s /eyors d of or DING OF THIS O DN FOR
{2 895}	MN Rule 4658.0528 Motion	5 Subp. 2.B Rehab - Range of	{2 895}		
	that is directed towa through positioning implemented and m comprehensive resi of nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00950	B. WING			R 05/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
HAVEN I	HOMES OF MAPLE PI	ΔIN	MAN AVENUE PLAIN, MN 55	E, PO BOX 369 359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
{2 895}	Continued From pa	ge 2	{2 895}			
	receives appropriat	h a limited range of motion e treatment and services to notion and to prevent further of motion.				
	by: *Uncorrected based The original licensir remain in effect. Pe Based on observati review, the facility fa motion services (RG and/or improve curi	ent is not met as evidenced d on the following findings. In a grader issued on 9/12/14, will enalty assessment issued. It is interview, and document ailed to ensure range of OM) were provided to maintain rent level of functioning for 2 of d R55) reviewed for range of				
	Findings include:					
	dated 9/29/14, indic	inge Minimum Data Set (MDS) cated R6 had severe cognitive d functional limitations of ROM mities.				
	provided to nursing therapy (PT) and or 10/23/14, indicated repetitions twice a of motion (AAROM)	ntal Communication form, and signed by physical ccupational therapy (OT) on R6 was to receive 10 week of active assisted range) to hips, knees, ankles, elbows, writs, and fingers.				
	Program document identified as the docresident ROM prog treatment sheets fo	ntenance and Restorative ation book, which was cumentation of completion of rams, which included or 10/14, and 11/14, lacked any R6's AAROM plan had been				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
00950		B. WING			R 11/05/2014		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE E, PO BOX 369			
HAVEN I	HOMES OF MAPLE PL	AIN	LAIN, MN 55	·			
(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	
{2 895}	Continued From page 3		{2 895}				
	implemented or provided to R6 since being assessed on 10/23/14.						
	During observations on 11/4/14, at 8:29 a.m., and 11/5/14, at 8:30 a.m., and again at 10:44 a.m. on 11/5/14, R6 was sitting in her wheelchair. R6 was not observed to receive any ROM services.						
	R55 had severe cog	S dated 10/27/14, identified gnitive impairment and had s of ROM to both upper and					
	R55's Interdepartmental Communication form provided to nursing and signed by PT and OT on 10/23/14, indicated R55 was to receive 10 repetitions twice a week, of passive range of motion (PROM) to hips, knees, ankles, bilateral shoulders, elbows, writs, fingers, and 10 repetitions of cervical neck ROM with a gentle stretch.						
	Program document treatment sheets fo documentation that	ntenance and Restorative ation book which included r 10/14, and 11/14, lacked any R55's PROM plan had been vided to R55 since being /14.					
	was sleeping in her	on 11/3/14, at 1:19 p.m. R55 wheelchair in her room. R55 in 11/3/14, to receive any					
	of nursing (DON) st range of motion pro sheets in the Functi Restorative Prograr	11/3/14, at 2:01 p.m. director ated residents who were on a gram would have paper ional Maintenance and m documentation book which cument on when ROM was					

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Minnesota Department of Health

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* *	E CONSTRUCTION	(X3) DATE COMP	PLETED
			5 14/10		F	
		00950	B. WING		11/0	5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVENI	HOMES OF MAPLE PL	ΔIN 1520 WYI	MAN AVENUE	E, PO BOX 369		
11/14/214	1011120 01 111711 22 1 1	MAPLE P	LAIN, MN 55	5359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 895}		ge 4	{2 895}			
	therapy assistant (F worked with R6 and discharged from the PTA-A stated at tha Communication for provided to the nurs implement the ongo for the residents. During interview on therapist (PT)-A state the prior evening (1 had confusion about which was assesse PT-A stated they was decrease in ROM s	11/4/14, at 8:40 a.m. physical PTA)-A stated therapies had R55 until they were erapy services on 10/23/14. It time the Interdepartmental ms were filled out and sing staff so they could bing functional ROM program 11/4/14, at 8:56 a.m. physical ted he had reassessed R55 1/3/14), because nursing staff at starting R55's ROM program d to have started on 10/23/14. Intended to be sure R55 had no ince 10/23/14, when she was erapy and was to begin ROM				
	Nursing identified the individual admitted become involved in the services available highest possible, propsychosocial level. planned, systematic builds on strengths criteria: 1. Measurable objust be documented clinical record 2. Evidence of pernurse must be presidented as in the activity 4. Restorative activity	I policy titled Restorative ne philosophy was each to the facility had the right to his/her own care and to have ble to him/her to reach their racticable physical, and Restorative nursing is a c, organized program that and must meet the following fectives and interventions ed in the care plan and in the riodic evaluation by licensed ent in the clinical record ints/aides must be trained in promote resident involvement divities must be carried out or others of the nursing staff				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
			A. BUILDING:			
		00950	B. WING		11/0	5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVEN I	HOMES OF MAPLE PI	ΔIN	MAN AVENUI LAIN, MN 5	E, PO BOX 369 5359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 895}	Continued From pa	ge 5	{2 895}			
	a minimum of 6 day 6. Each Restorati a minimum of 15 m The policy identified positions were resp organization of the monitoring the deliv routine basis to ass followed consistent	we program must be provided inutes in a 24 hour period dinurses in management consible for maintaining the restorative program and very of restorative care on a cure the programs are being by and as planned.				
2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			
	comprehensive reshome must ensure A. a resident is treatments and serabilities in activities deterioration is a nother esident's condipart, activities of daresident's ability to: (1) bathe, dres (2) transfer and (3) use the toil (4) eat; and (5) use speech	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of tion. For purposes of this illy living includes the as, and groom; d ambulate;				
	by: *Uncorrected base The original licensi	ent is not met as evidenced d on the following findings. ng order issued on 11/5/14, will enalty assessment issued.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
			A. BUILDING.			R
		00950	B. WING			05/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVEN I	HOMES OF MAPLE P	ΙΔΙΝ	MAN AVENUI LAIN, MN 5	E, PO BOX 369 5359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 915	Continued From pa	age 6	2 915			
	review the facility fa ambulation service residents (R94, R8 assistance from sta	ion, interview, and document ailed to provide assistance with s as assessed for 4 of 4 9, R93 and R69) who required aff with ambulation.				
	Findings include:					
	10/8/14, identified I	linimum Data Set (MDS) dated R94 had moderately impaired ired physical assistance of one ation.				
	provided to nursing therapy (PT) on 10	nental Communication form and signed by physical /16/14, indicated R94 was to 100 feet with a rolling walker taff member.				
	identified R94 was	ant Care sheet dated 11/3/14, to be walked 50-100 feet with nsfer belt and assist of one				
	nursing section, wh facility as the docu a resident ambulate only four of the twe	cronic point of care restorative nich was identified by the mentation of when and how far es, indicated R94 had walked enty days from the starting date are review date of 11/4/14.				
	p.m. and was intervassistance to walk	lying in bed on 11/5/14, at 2:49 viewed. R94 stated he needed in the hallway and was not unity to walk by staff.				
	R89 had moderate	IDS dated 10/6/14, identified cognitive impairment, and ssistance of one staff with				

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Minnesota Department of Health

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
HAVEN HOMES OF MAPLE PLAIN 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 915 Continued From page 7 2 915			00950	B. WING			
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) MAPLE PLAIN, MN 55359 MAPLE PLAIN, MN 55359 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 915 Continued From page 7 2 915	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 915 Continued From page 7 PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG RECH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) 2 915	HAVEN	HOMES OF MAPLE PI	AIN				
	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETE DATE
R89's Interdepartmental Communication form provided to nursing and signed by PT on 10/16/14, indicated R89 was to ambulate daily 25-50 feet with a rolling walker and assist of one staff member. R89's Nursing Assistant Care sheet dated 11/3/14, identified R89 was to walk daily 25-50 feet with a transfer belt, rolling walker, and assist of one staff member. R89's electronic point of care restorative nursing section indicated the resident had walked nine of the twenty days from the starting date of 10/16/14, until the review date of 11/4/14. R89 was observed seated in the wheelchair near the bird aviary on 11/5/14, at 3:03 p.m. and was interviewed. R89 stated he required assistance from the staff to walk and staff had offered to assist the resident with walking, however, he stated staff did not offer to assist him with walking everyday. R93's Admission MDS dated 10/10/14, identified R93 had severe cognitive impairment and required physical assistance of one person with ambulation in the corridor. R93's Interdepartmental Communication form provided to nursing and signed by PT on 10/17/14, indicated R93 was to ambulate twice a day 100-200 feet feet with a rolling walker and assist of one staff member. R93's Nursing Assistant Care sheet dated 11/3/14, identified R93 was to walk 100-200 feet	2 915	ambulation. R89's Interdepartm provided to nursing 10/16/14, indicated 25-50 feet with a rostaff member. R89's Nursing Assis 11/3/14, identified Feet with a transfer of one staff member. R89's electronic posection indicated the twenty days from 10/16/14, until their R89 was observed the bird aviary on 1 interviewed. R89's from the staff to was assist the resident stated staff did not everyday. R93's Admission MR93 had severe concequired physical as ambulation in the concept of the staff of	ental Communication form and signed by PT on R89 was to ambulate daily olling walker and assist of one stant Care sheet dated R89 was to walk daily 25-50 belt, rolling walker, and assist er. int of care restorative nursing he resident had walked nine of me the starting date of eview date of 11/4/14. seated in the wheelchair near 1/5/14, at 3:03 p.m. and was tated he required assistance lik and staff had offered to with walking, however, he offer to assist him with walking DS dated 10/10/14, identified gnitive impairment and signed by PT on R93 was to ambulate twice a set with a rolling walker and nember.				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00950	B. WING		11/0	? 5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
HAVEN I	HOMES OF MAPLE PL	AIN	MAN AVENUI LAIN, MN 5	E, PO BOX 369 5359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 8	2 915			
	one staff member.					
	section indicated R	int of care restorative nursing 93 had walked 9 of the 38 he starting date of 10/16/14, e of 11/4/14.				
		on 11/5/14, at 2:42 p.m. sitting r the nurses station. R93 was lating.				
	R69 had severe cog	S dated 10/14/14, identified gnitive impairment and ssistance of one person with				
	provided to nursing 10/17/14, indicated day 75-100 feet with	ental Communication form and signed by PT on R69 was to ambulate twice a n a rolling walker and a ssistance of one staff				
	11/3/14, identified R	stant Care sheet dated 869 was to walk 75-100 feet rolling walker, and assist of				
	section indicated R	int of care restorative nursing 69 had walked 3 of the 28 10/22/14, through the review				
	of nursing (DON) at (CRN)-A stated R69 services from 10/9/ therapy on 10/31/14	11/5/14, at 1:46 p.m. director and corporate registered nurse 9 was receiving PT and OT 14, and was discharged from 4. DON and CRN-A were not had assessed R69 to be				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00950	B. WING		11/0	₹ 5/2014
	PROVIDER OR SUPPLIER	ΔIN 1520 WYN		STATE, ZIP CODE E, PO BOX 369		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 915	walked twice a day receiving therapy. It to therapy about the therapy had comple ambulated twice a complete ambulated twice a complete ambulated twice a complete ambulated twice as occupational therapy as occupational therapy as occupational therapy as occupational therapy as occupational therapy as occupational therapy as occupational therapy as occupational therapy as occupational therapy as occupational therapy as occupational therapy as occupational therapy as occupational therapy as occupational therapy as occupational therapy and the ambulated twice a complete would assist R69 was lying in he transfer from the will problems, but could walked in the hallwallove to walk." During interview on physical therapist (fassessed the ambulated therapy needs of all PT-A stated the Interesident was asses program, it was exprogram, it was expression and therapy and the problems are considered to mursing to implement the problems as asses program, it was expression and the problems are considered to the problems are	by staff when she was dowever, they had not spoken ambulation assessment eted on 10/17/14, for R69 to be day. 11/05/2014, at 2:23 p.m. sistant (PTA)-A and by assistant (OTA)-A stated therapy services with PT and arough 10/31/14, once a day, day. PTA-A and OTA-A stated on nursing on 10/17/14, to be day by staff, so nursing staff ith ambulating in the evenings PTA-A stated R69 had been mbulating in the past, and the y get the resident back to with ambulation. Ion on 11/5/14, at 2:43 p.m. r bed. R69 stated she could neelchair to the toilet with no down the recall the last time she ay by staff. R69 stated, "But I at 11/4/14, at 10:47 a.m. PT)-A stated they had recently elation and/or range of motion at the residents in the facility. For each of the properties and sent ment. PT-A stated if any seed to be on an ambulation preceded they be walked at least residents twice a day to	2 915			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						E SURVEY PLETED	
		00950	B. WING			R 05/2014	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
HAVEN I	HOMES OF MAPLE PI	ΔIN	MAN AVENUE PLAIN, MN 55	, PO BOX 369 359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
{21426}	Continued From pa	ge 10	{21426}				
{21426}	MN St. Statute 144 Prevention And Cor	A.04 Subd. 4 Tuberculosis ntrol	{21426}				
	maintain a compret infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volumelith shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines. Ance with this subdivision must be nursing home.					
	by: Uncorrected based original licensing or	ent is not met as evidenced on the following findings. The der issued on 9/12/14, will enalty assessment issued.					
	facility failed to ens screening was com admission for 2 of 7 reviewed for TB scr failed to assess the (TST), within 48-72	and document review, the ure tuberculosis (TB) pleted within 72 hours of 7 residents (R96 and R98), reening. In addition, the facility results of tuberculin skin test hours of being administered, (R97) reviewed for TB					

Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00950	B. WING		11/0	5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAVEN I	HOMES OF MAPLE P	ΙΔΙΝ	MAN AVENUI LAIN, MN 5	E, PO BOX 369 5359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{21426}	Continued From pa	nge 11	{21426}			
	Findings include: The Minnesota Dep Regulations for Tuk Health Care Setting all residents must r screening within 72 months prior to adrive the Active to the Active the facility. R96 Test (TST)-1st Step admission to the facility. R98 was admitted according to the Active the TST-1 after admission to the TST-1 after admission to the TST-1 after admission for Tuk Health Care Setting results of the TST knows of being admission to the Active the TST-2 was admitted according to the Active the TST-2 was admitted according to the Active the TST-2 was admitted according to the Active the TST-2 was admitted to the Active the TST-2 was admitted to the Active the TST-2 was admitted to the Active the TST-2 was admitted to	partment of Health (MDH) perculosis Control in Minnesota gs, dated July 2013, directed eceive a baseline TB hours of admission or within 3 mission. to the facility on 10/19/14, Imit/Discharge report provided received the Tuberculin Skin o on 10/23/14, four days after cility. to the facility on 10/22/14, Imit/Discharge report. R98 st Step on 11/3/14, 12 days the facility. partment of Health (MDH) perculosis Control in Minnesota gs, dated July 2013, directed the assessed within 48-72 ministered. to the facility on 10/20/14, Imit/Discharge report. R97 and Step on 10/31/14, but the sessed until 11/3/14, four days				
	director of nursing of the requirements	11/05/2014, at 10:29 a.m. (DON) stated she was aware s for resident TB screening.				
	Reading the Tubero	tled Administering and culin Skin Test (TST), undated, would have a procedure in				

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00950	B. WING		11/0	R 5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
HAVEN I	HOMES OF MAPLE PL	AIN		E, PO BOX 369		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	LAIN, MN 5	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
{21426}	Continued From pa	ge 12	{21426}			
	residents and staff.	ring and reading the TST for The policy directed staff to n in 48-72 hours." No further ovided.				
{21800}	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	{21800}			
	residents shall, at a are legal rights for stay at the facility of treatment and main that these are described written statement of responsibilities set case of patients and as defined in section statement shall also person 16 years old provided in section shall list the names individuals and orgative advocacy and legal residential program accommodations shall communication impose a language of facility policies, insplication in the written statement to patients, resident to the administrator person, consistent to the side of th	tion about rights. Patients and dmission, be told that there their protection during their rethroughout their course of tenance in the community and ribed in an accompanying of the applicable rights and forth in this section. In the mitted to residential programs in 253C.01, the written of describe the right of a did or older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide services for patients in s. Reasonable hall be made for those with the patients and those who other than English. Current proceeding the part of the available test, their guardians or their ives upon reasonable request or other designated staff with chapter 13, the Data section 626.557, relating to				

Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	E CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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{21800}	Continued From pa	ge 13	{21800}			
	by: *Uncorrected based The original licensir remain in effect. Pe Based on interview facility failed to ensi and R90) reviewed the Notice of Medic	ent is not met as evidenced d on the following findings. In gorder issued on 9/12/14, will inalty assessment issued. and document review, the lure 3 of 6 residents (R11, R17, for liability notices received are Non-Coverage (CMS form equired timeframe of 48 hours ces ending.				
	Findings include:					
	assessment dated sadmitted to the facil beginning 9/23/14. indicated R11's Medending on 10/3/14, notify R11 of the no	are Minimum Data Set (MDS) 9/30/14, indicated R11 was lity with skilled coverage R11's Medicare denial notice dicare coverage would be however, the facility did not n-coverage until 10/2/14, 24 and of skilled coverage.				
	indicated R17 was a skilled coverage be R17's Medicare der facility reviewed R1 determined her last R17 was issued the	care MDS dated 9/30/14, admitted to the facility with ginning 9/17/14. Review of hial notices indicated the 7's Medicare coverage and covered day was 10/3/14. Notice of Medicare 0/2/14, 24 hours prior to the ces.				
	indicated R90 was a skilled coverage be R90's Medicare der	care MDS dated 9/18/14, admitted to the facility with ginning 9/5/14. Review of nial notices indicated R90 was f Medicare Non-Coverage on				

Minnesota Department of Health

7 501251	IG:	COMPLETED
nnasn B. WING		R
00950 B. WING		11/05/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CIT	Y, STATE, ZIP CODE	
HAVEN HOMES OF MAPLE PLAIN 1520 WYMAN AVEI MAPLE PLAIN, MN		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
(21800) Continued From page 14 10/2/14, 24 hours prior to the end of skilled services. During interview on 11/04/2014, at 1:12 p.m. the assistant director of nursing (ADON) stated she was aware Medicare coverage was ending for R11, R17 and R90, however, she did not issue the notices in a timely manner. The ADON stated a Medicare meeting had not been held that week and it was better for the notices to be issued, "One day than no days," ahead of time. ADON was aware the Medicare denial notices were not issued within the 48 hour timeframe. During interview on 11/05/2014, at 2:36 p.m. the director of nursing (DON) stated she was aware the facility had some concerns with issuing Medicare Denial Letters. The facility social worker was on leave and the ADON was one of the backups for issuing the Medicare denial notices until she returned.		

6899

	of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	_		E SURVEY IPLETED
		00950	B. WING	· ·	R 11/05/2014	
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE		
HAVEN HO	MES OF MAPLE PLAIN	•	YMAN AVENUE, PO PLAIN, MN 55359	BOX 369		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			-
	*****ATTEN	ITION*****				
	NH LICENSING C	ORRECTION ORDER	-			
		linnesota Statute, section				
		ion order has been issued If, upon reinspection, it is				
	found that the deficie	ncy or deficiencies cited				
		ted, a fine for each violation eassessed in accordance				
		es promulgated by rule of				
		ther a violation has been				
	corrected requires co	mpliance with all ule provided at the tag	·			}
		e number indicated below.				
	When a rule contains	several items, failure to				
	comply with any of th	e items will be considered _ack_of_compliance_upon				
	re-inspection with any	y item of multi-part rule will				
}		ent of a fine even if the item				
	corrected.	ing the initial inspection was				
	You may request a he	earing on any assessments				
	that may result from r	non-compliance with these				
	the Department within	a written request is made to n 15 days of receipt of a				
	notice of assessment					
	INDITIAL CONMINIENTO					
	INITIAL COMMENTS An onsite follow-up vi					
	11/3/14, 11/4/14, and	11/5/14. During this visit it		r / \	,	'
	was determined that	the following correction		(Landan))	
		ected. This uncorrected effect and will be reviewed at			ud /	
		be reviewed for possible		(I) ALVO MIST	1/	
	penalty assessments			101		
nesota Dep	partment of Health					(X6) DATE
OR ATORY D	DIRECTOR OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	T A 1	TITLE	12/4/	14
100	me_		JAO/U	Z112	if contin	nuation sheet 1 c

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: JMZ1

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COMPLETED BY TI					STATE SURVEY AGENCY Facility ID: 00950			y ID: 00950
1. MEDICARE/MEDICAID PROVIDE (L1) 245497 2.STATE VENDOR OR MEDICAID N (L2) 064742000		3. NAME AND ADDRESS OF FACILITY (L3) HAVEN HOMES OF MAPLE PLAIN (L4) 1520 WYMAN AVENUE, PO BOX 36 (L5) MAPLE PLAIN, MN					4. TYPE OF 1. Initial 3. Terminati 5. Validation 7. On-Site V	2. ion 4. n 6.	2 (L8) Recertification CHOW Complaint Other
5. EFFECTIVE DATE CHANGE OF (L9) 10/01/2004		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 09/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE		FISCAL YEAR		ATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	67 (L18) 67 (L17)	Complianc1. A X B. Not in Con	equirements to Based On:	gram	2. Techni 3. 24 Hou	cal Personnel or RN RN (Rural SN	7. Med	e of Services ical Director ent Room Size	
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY ME	ETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 18	861 (j) (1):	(L15	5)	
67 (L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM.	16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	EY AGENCY	APPROVAL	Γ	Date:
Holly Kranz, HFE NE II		1	1/7/2014	(L19)	Anne Kleppe	, Enforcen	nent Specialis	st	11/13/2014 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR	SINGLE ST	TATE AGEN	CY	
DETERMINATION OF ELIGIBIL 1. Facility is Eligible to P 2. Facility is not Eligible			IPLIANCE WITI HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 				
	(221)								
22. ORIGINAL DATE OF PARTICIPATION 10/01/1987	23. LTC AGREEI BEGINNING		4. LTC AGREEN ENDING DA		26. TERMINATION VOLUNTARY 01-Merger, Closure	_00		(L30) VOLUNTARY Fail to Meet H	_
(L24)	(L41)		(L25)		02-Dissatisfaction			Fail to Meet A	greement
25. LTC EXTENSION DATE:		VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involunt 04-Other Reason fo	-	<u>01</u> 07-	<u>HER</u> Provider Statu Active	us Change
(L27)	B. Rescind St	uspension Date:							
			(L45)						
28. TERMINATION DATE:	29). INTERMEDIARY	CARRIER NO.		30. REMARKS				
	03001								
31. RO RECEIPT OF CMS-1539	(L28)	2. DETERMINATION	I OE APPROVAT	(L31)					
on Real of CMS-1337	(L32)	DETERMINATION	. OI III KO VAL	(L33)	DETERMINA	ΓΙΟΝ APPR	ROVAL		
	•								



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 5008

October 1, 2014

Ms. Diane Lynch, Administrator Haven Homes Of Maple Plain 1520 Wyman Avenue, P.O. Box 369 Maple Plain, Minnesota 55359

RE: Project Number S5497024

Dear Ms. Lynch:

On September 12, 2014, 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.

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>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:

Jessica Sellner, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7365

Fax: (320)223-7365

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 October 22, 2014, 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 October 22, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If

the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 12, 2014 (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 March 12, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 10/01/2014 FORM APPROVED OMB NO. 0938-0391

	DROWDER OF ALL		A. BUILDING		COMPLETED	
	DDOWNED OF CUIT	245497		B. WING		
HAVEN	PROVIDER OR SUPPLIER			TREET ADDRESS CITY OF THE	09/12/201	
	HOMES OF MAPLE P	LAIN	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLI PRIATE DAT	
F 156 SS=D	surveyors of this De above provider and orders are issued. completed, please sthese orders and re Minnesota Departm Compliance Monito Certification Progra Suite 212, St Cloud 483.10(b)(5) - (10), RIGHTS, RULES, St.	2, 10, 11 and 12th, 2014 epartment's staff, visited the the following correction When corrections are sign and date, make a copy of eturn the original to the tent of Health, Division of ring, Licensing and m, 3333 West Division St, MN 56301. 483.10(b)(1) NOTICE OF SERVICES, CHARGES	F 000	Facility timely submits this response plan of correction pursuant to fede state law requirements. This respondence plan of correction are not admission agreement that a deficiency exists of the statement of a deficiency was concited or factually based and it's also be construed as an admission again interest of the facility, the administrative any employees, agents or other ind who participated in the drafting or the discussed or otherwise identified same.	ral and the standard of Health of Health of Health on the standard of Health on the standard of Health of Health on the standard of Health of Heal	
it	and in writing in a la understands of his oregulations governing responsibilities during facility must also promotice (if any) of the §1919(e)(6) of the Amade prior to or uporesident's stay. Recany amendments to writing. The facility must informatitled to Medicaid by a demission to the nesident becomes elicems and services the	orm the resident both orally nguage that the resident or her rights and all rules and ag resident conduct and ag the stay in the facility. The ovide the resident with the State developed under ct. Such notification must be n admission and during the eipt of such information, and it, must be acknowledged in orm each resident who is benefits, in writing, at the time ursing facility or, when the gible for Medicaid of the nat are included in nursing r the State plan and for		acertal pro		
o a th in	which the resident mather items and serving and for which the response amount of charge aftern each resident	ay not be charged; those ces that the facility offers ident may be charged, and is for those services; and when changes are made to				

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 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 program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/01/2014 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245497 B. WING 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 1. R11 and the resident's F 156 Continued From page 1 F 156 financial Power of Attorney the items and services specified in paragraphs (5) were contacted on 10/8/14 and (i)(A) and (B) of this section. an explanation was given The facility must inform each resident before, or regarding the facility's inability at the time of admission, and periodically during to find documentation that the resident's stay, of services available in the would prove that they were facility and of charges for those services, including any charges for services not covered provided notice of Medicare's under Medicare or by the facility's per diem rate. denial of coverage with the CMS 10123, or Notice of The facility must furnish a written description of Medicare Non-Coverage legal rights which includes: A description of the manner of protecting personal (NOMNC), on April 20th, 2014. funds, under paragraph (c) of this section; A late notice was also provided at that time, along with the A description of the requirements and procedures for establishing eligibility for Medicaid, including reassurance that, in the future, the right to request an assessment under section the facility would be sure to 1924(c) which determines the extent of a couple's supply them with all the non-exempt resources at the time of required notices in a timelier institutionalization and attributes to the community spouse an equitable share of resources which manner. cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicald fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance

		E CONSTRUCTION ((X3) DATE SURVEY COMPLETED		
		245497	B. WING		09	/12/2014
	ROVIDER OR SUPPLIER OMES OF MAPLE PLAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359		
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F 156	name, specialty, and a physician responsible The facility must promitten information, ar applicants for admissi information about how Medicare and Medicareceive refunds for presuch benefits. This REQUIREMENT by: Based on interview at facility failed to ensure R57) reviewed for liber required Notice of Medicare (CMS) Form 10123, in to an appeal and experiment of skill Findings include: R11 was admitted to the medicare coverage, 4 discontinuation of skill findings include: R11 was admitted to the medicare coverage or facility determined R1 coverage criteria and in non-coverage on continuation continuation continuation of skill provides the coverage or continuation of coverage or continuation coverage coverage or continuation coverage coverage or continuation coverage coverage or continuation coverage co	m each resident of the way of contacting the for his or her care. Ininently display in the facility and provide to residents and on oral and written to apply for and use in denefits, and how to avious payments covered by Is not met as evidenced and document review, the each of a residents (R11, illity notices, received the dicare Non-Coverage and Medicaid Services and Medicaid Services and Medicaid Services and Medicaid Services and Medicaid Services and Medicaid Services and Medicaid Services and Medicaid Services and Medicaid Services and Medicaid Services and Medicaid Services and Medicaid Services and Medicaid Services and services. The facility with skilled a 2/13/14. On 4/22/14, the ano longer met medicare and stay, with the first as 4/25/14. The facility are received the CMS	F 156		vas on ere fits nial h ered	
	expedited appeal.	a ner ngats for an				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245497	B. WING _	And all	09/12/2014			
HAVEN	PROVIDER OR SUPPLIER HOMES OF MAPLE PL	LAIN TEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359					
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F 156	the items and service (i)(A) and (B) of this The facility must infat the time of admist the resident's stay, facility and of charge including any charge under Medicare or the facility must fur legal rights which in A description of the funds, under parager A description of the for establishing eligithe right to request 1924(c) which deternon-exempt resource institutionalization as spouse an equitable cannot be considered toward the cost of the medical care in his down to Medicaid elements of all pertingroups such as the agency, the State licombudsman programadvocacy network, a unit; and a statemer complaint with the Sagency concerning misappropriation of	ces specified in paragraphs (5) is section. orm each resident before, or usion, and periodically during of services available in the es for those services, es for services not covered by the facility's per diem rate. nish a written description of cludes: manner of protecting personal raph (c) of this section; requirements and procedures ibility for Medicaid, including an assessment under section raines the extent of a couple's ces at the time of a dattributes to the community eshare of resources which ed available for payment the institutionalized spouse's or her process of spending	F 15	Attorney were contacted on 10/8/14 a explanation was given regarding the fainability to find documentation that we prove that they were provided notice of Medicare's denial of coverage with the 10123, or Notice of Medicare Non-Cov (NOMNC), on April 20 th , 2014. A late now was also provided at that time, along we the reassurance that, in the future, the facility would be sure to supply them we the required notices in a timelier manner. R57 & the resident's financial POA were contacted on 10/8/14 and an explanation was given regarding the facility's inabilication of Medicare Benefits — Skilled Nursing Facility (NEMB-SNF), following issuance of the Notice of Denial of Medicare general on 3/19/14. A late notice was issued at that time, along with the reassurance that, in the future, the fact would be sure to supply them with all required notices in a timelier manner. 2. All residents that would have qualified receive either one or both of the NOM and/or the NEMB-SNF within the last 1 months will be reviewed by 10/21/14 the ensure that all of the Medicare denials issued were in compliance according to guidelines.	and an cility's puld of e CMS verage otice with all mer. The also ion ity to that dicare s cility when the dicare s cility ed to NC4	5. October 22 nd , 2014		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	_AIN		15	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE, PO BOX 369 IAPLE PLAIN, MN 55359		
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F 156	directives requirem The facility must inf name, specialty, an physician responsib The facility must provitten information, applicants for adminformation about headicare and Medicare		F 1	56	3. DON/Designee will conduct an in-secon 10/16/14 for employees who have designated as the responsible parties issuing the NOMNC and/or NEMB-SN the residents and/or their POAs, regathe CMS forms that are required, as with the proper way to issue these denials receiving party. The policy for issuing Medicare denials will also be reviewed that time, and directions intended to	for F to rding vell as to the	
	by: Based on interview facility failed to ens R57) reviewed for I required Notice of I Centers for Medica (CMS) Form 10123						
	medicare coverage facility determined coverage criteria and non-coverage on conon-covered day list did not have record	to the facility with skilled on 2/13/14. On 4/22/14, the R11 no longer met medicare and issued a notice of medicare ontinued stay, with the first sted as 4/25/14. The facility I R11 received the CMS er of her rights for an					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF (DENTIFICATION NUMBER: A. BUILDING			001101110011011	(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/12	2/2014
	VIDER OR SUPPLIER	LAIN		152	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE, PO BOX 369 APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
Ramelet Ramered Co. Discontinuo del Ramered Co. Discontinu	edicare coverage ters contained of 7's last covered cords did not coredicare coverage mained in the factorial process of the cords did not coredicare coverage was discouring interview of 0:00 a.m. directorial did not have sue medicare described on provided copedicare Assessing ese did not addrate inform residents or required denial eccive. 33.15(a) DIGNIT IDIVIDUALITY The facility must propose and in an an an an an an an an an an an an an	to the facility with skilled e on 1/17/14. R57's denial nly the CMS 10123, indicating day was 3/19/14. R57 ntain the required notice of e on continued stay. R57 cility after her medicare	F	241	F-241 1. R12, R66 & R7 are currently provassistance with dining in a more digmanner. R52 expired on 9/23/14. Nocounseled on 10/8/14 regarding the procedures for maintaining resident during mealtimes. 2. The facility has determined that residents requiring feeding assistant meals have the potential to be affective.	A-P was e proper t dignity	5. October 22 nd , 2014

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
245497 B. WING	09	/12/2014	
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN STREET ADDRESS, CITY, STATE, ZIP 1520 WYMAN AVENUE, PO BOX 30 MAPLE PLAIN, MN 55359	CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COPERING (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
R12's quarterly minimum data set (MDS) dated 6/18/14, indicated R12 had severe cognitive impairment and required extensive staff assistance with dining. R52's quarterly MDS dated 8/20/14, identified R52 had severe cognitive impairment and required extensive staff assistance with dining. R66's quarterly MDS dated 8/8/14, identified R56 had severe cognitive impairment and required extensive staff assistance with dining. R7's quarterly MDS dated 8/8/14, identified R66 had severe cognitive impairment and required extensive staff assistance with dining. R7's quarterly MDS dated 8/27/14, identified R7 had severe cognitive impairment and required extensive staff assistance with dining. During dining observation on 9/8/14, at approximately 5:40 p.m. nursing assistant (NA)-P was observed sitting on a rolling stool in the dining room at a table with R12, R52, R66 and R7. After the residents received their food, NA-P rolled around the table on the stool going from resident to resident to give to the next resident, and continued rolling around the table on the stool the entire meal. During interview on 9/8/14, at 6:01 p.m. NA-P stated she was required to feed multiple residents at a time, and needed to use the rolling stool so she was able to go from resident to resident to ensure they all received their meal. NA-P stated there was not enough staff to ensure all the residents were being fed timely, so the NA's do	per procedures heals to ensure d during ecklist" was all whose duties determine if procedure ewed with each inseling was at weekly of staff during conths to ensure healing in accordance esident dignity dation a QA for further in x2 months, or ompliance has		

PRINTED: 10/01/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245497	B. WING			09	/12/2014
	PROVIDER OR SUPPLIER	_AIN		15	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE, PO BOX 369 APLE PLAIN, MN 55359		
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F 241	what they have to s meals. A policy on feeding	ge 5 o the residents receive their residents was requested but	F 2	241			
F 253 SS=D	not provided. 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.		F 2	253	1. R46's bathroom sink was repaired on 10/1/14. The water pressure for her room was restored on 9/11/14 by Environmental Services Director. The water pressure in R24's room was also		5. October 22 nd , 2014
	by: Based on observation review, the facility for residents (R46) bat equipment in good failed to ensure 2 o	NT is not met as evidenced tion, interview, and document ailed to ensure 1 of 48 hrooms had bathroom repair. In addition, the facility f 48 residents (R46, R24) quate water pressure to their			restored on the date listed above visame method. 2. On 10/8/14, the water pressure integrity of bathroom equipment with checked and deemed to be function in good repair for all 19 resident barrooms.	and vas ning and	.014
	8/6/14, identified th impairment. During interview on stated her bathroor had very little water sink. She stated she staff about both iss and no one did any low water pressure	num data set (MDS) dated e resident had no cognitive 9/8/14, at 4:30 p.m. R46 in sink was cracked and she is pressure in her bathroom he had talked to several of the ues with her bathroom sink, thing about it. R46 stated the and cracked sink had been dmission to the facility which oc.			3. On 10/8/14, Housekeeping staff educated regarding the following properties for identifying and maintaining equivalent: Housekeeping will be instructed sinks/toilets for damage/crawater pressure/leaks each day who cleaning these areas. Any damage malfunction will be forwarded to the maintenance dept. Via the work of system. Maintenance will investigate requests and make the necessary	procedure sipment cted to cks/low le noticed o he der ste all	

Facility ID: 00950

PRINTED: 10/01/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245497	B. WING _		09/	12/2014
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATI 1520 WYMAN AVENUE, PO E MAPLE PLAIN, MN 55359	E, ZIP CODE BOX 369	
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F 253	During a tour of the p.m. maintenance R46's sink had twe from the faucet known to the drain, and a constant of the sink. MS-F in R46's bathroom water trickled out had not been inform the stated had the resident, and he was pressure in R46's rounds of the facility equipment, however inspection. He stated had the resident rooms or inspection.	e facility on 9/12/14, at 1:00 supervisor (MS)-F verified to large cracks, one extending to be down the entire sink almost a second crack on the left edge also verified the water pressure is sink was very low and the of the faucet. MS-F stated he med of the cracked sink, which potential to, "Scratch" the was not aware of the low water room. MS-F stated he did daily ity looking for damaged ver, he did not go into any of the bathrooms during the ated it was the expectation in him of broken items so	F 2	4. Environmental Servi conduct an audit regar the equipment in each monthly x3 months. He work orders received a necessary maintenance fulfilled on a timely base results will be brought further review and/or	rding the integrity of a resident bathroom le will also review all each week to ensure e/requests are sis x6 weeks. Audit to QA each month for	
	R24's quarterly MDS dated 6/24/14, identified the resident had severe cognitive impairment and required extensive assistance of two staff for personal cares. During observations on 9/8/14, at 7:14 p.m. and 9/11/14, at 11:00 a.m. R24's water flowed out of the bathroom sink faucet slowly and took a long time for the temperature of the water to heat up to get warm.					
	p.m. MS-F verified pressure was very aware of the R24 and it was an east the problem for his	the facility on 9/12/14, at 1:00 d R24's bathroom sink water y low. MS-F stated he was not s low water pressure until now, y fix if he had been informed of s department to address the ed nursing staff are to notify him				

Facility ID: 00950

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245497	B. WING			09/12/2014		
	PROVIDER OR SUPPLIER	_AIN		152	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE, PO BOX 369 APLE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	provided. 483.20(g) - (j) ASS ACCURACY/COOF The assessment management in the status. A registered nurse each assessment in the status.	e problems. policy was requested but not ESSMENT RDINATION/CERTIFIED sust accurately reflect the must conduct or coordinate with the appropriate	F 2		F-278 1. Corrections according to CMS have been made for the previous inaccurate sections of the MDS for R56, R20, R59, R7 and R55. modified records will be submit as "Modified Assessments" by 2	isly- assessmei These ted to CM	nts nts	
	assessment is com Each individual who assessment must a that portion of the a Under Medicare ar willfully and knowin false statement in a subject to a civil me \$1,000 for each as willfully and knowin to certify a materia resident assessment penalty of not more assessment. Clinical disagreement and false in the complete of the comple	must sign and certify that the apleted. completes a portion of the sign and certify the accuracy of assessment. In Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a ant is subject to a civil money e than \$5,000 for each ent does not constitute a statement.			recent MDS assessment for all the building for accuracy, with on pressure ulcers, contracture significant changes in transfer declines in functional abilities, modifications if data-entry errors. 3. On 10/16/14, DON provided to both MDS Coordinators regards.	for accuracy, with an emphasis ulcers, contractures, and/or hanges in transfer status and/or functional abilities, and submit ins if data-entry errors are found. 6/14, DON provided re-education S Coordinators regarding all data collect information for obtaining ensive interdisciplinary review. Inators have completed (by a AANAC MDS 3.0 Knowledge to in order to identify any areas of the MDS that require elopment, and additional		
	This REQUIREME by:	NT is not met as evidenced			those results.	,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER	LAIN	1	TREET ADDRESS, CITY, STAT 520 WYMAN AVENUE, PO E IAPLE PLAIN, MN 55359	BOX 369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPE	BE	(X5) COMPLETION DATE
F 278	Based on interview facility failed to ens data set (MDS) ass (R56) reviewed for multiple unhealed president discharged resident rehabilitation servicts was not accurately (R7, R55) reviewed contractures which remains include: R56's quarterly Min 6/11/14, identified Fulcer development (unstageable) present on admissi Review of R56's Skinitial documentation date of 6/20/14, identified forms indicated been present since During interview on registered nurse (R R56's MDS dated 6 aware of one of R5 ulcers. RN-C verified documentation on RMDS was not code current pressure ulcers discharge MI R20's discharge MI R20's discharge MI	and document review, the ure accuracy of the minimum ressment for 1 of 2 residents pressure ulcers who had pressure sores, for 2 of 2 ts (R20, R59) reviewed for the est and transfer status which coded, and for 2 of 5 residents for range of motion and were not accurately coded. Imum data set (MDS) dated R56 was at risk for pressure and currently had one stage IV sure ulcer which had been on and was unhealed. In Injury Report sheets with no dates of 5/22/14, and ending ntified R56 had two ure ulcers, one on each heel. If both pressure ulcers had R56's admission on 12/10/13. 19/12/14, at 11:48 a.m. N)-C stated she completed of the completed states and the completed of the complete of the completed of the complete of the co	F 278	Nursing Assistants will a education on 10/9 & 10 the importance of cons documentation and acc ADLs, emphasizing the clack of coding and/or in have on a Skilled Nursin 4. DON/Designee will a documentation for all A functional maintenance week x6 weeks. Continu for a few months will be reported to Administrate DON/Designee will also MDS assessments each audits on section G, section accuracy. Audits will a month x6 months. Rebe brought to QA Communitaries.	o/10/14 related distent point-of-curate coding or detrimental efformaccurate coding or detrimental efformaccurate coding Facility. onduct audits of ADLs, restorative programs eacued, random audit on/QA team. or randomly selement of month to conducted sults of all audit mittee for reviewed.	care f fect ng can on CNA re and ch udits vill be cct 5 duct ction O once its will	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER	_AIN		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 278	indicated she was well demonstrating slow contact guard assist for pivot transfer and R20 was discharge on 8/21/14. R20 arwith a 4 wheeled was only for safety and twerbal cues were not R20 was discharge 8/21/14, and was all transfers with verbal cues after occupation stated as of 8/7/14, extensive assistance required verbal cues aftery. COTA-D stated as of 8/7/14, extensive assistance required verbal cues after COTA-D stated as of 8/7/14, extensive assistance as sisted living faindependent with all the discharge MDS coded. During interview on registered nurse (Rincorrectly coded R facility does not have changes in resident is only able to obtain assistant document medical record on rewhich is not always R59 discharge MDS	apy note dated 8/1/14, veight bearing, was reprogress, and required tance to stand by assist only dicues for proper techniques. If the form occupational therapy inbulated to all destinations alker with stand by assistance to ensure her balance and	F 2	78				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V4) PROVIDER/SUPPLIER/CLIA

1	(X3) DATE SURVEY COMPLETED	
245497 B. WING 09/12	2/2014	
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278 from surface to surface. R59's nursing assistant flowsheet dated 5/23/14, instructed R20 required supervision only for transfers from surface to surface. R59's occupational therapy discharge note dated 5/23/14, indicated R59 was independent with all transfers. R59's last physical therapy note, dated 5/26/14 identified R59 was independent with all transfers. During interview on 9/12/14, at 10:10 a.m. COTA-D stated R59 was independent with all transfers at the time of her discharge to her own home and the residents discharge MDS was incorrectly coded related to R59's transfer ability. During interview on 9/12/14, at 10:07 a.m. RN-C stated R59's discharge MDS completed on 5/27/14, was not coded accurately related to the residents transfer ability. R7 annual MDS dated 8/27/14, identified R7 had impairment to one side of the upper extremity only, and had no impairment to the lower extremities. R7's Physical Therapist Progress & Discharge Summary dated 3/4/14, indicated R7 demonstrated 28 degrees of left knee extension and 22 degrees of right knee extension, indicating R7 had contractures of the lower extremities. During interview on 9/9/14, at 9:46 a.m. RN-A stated R7 had contractures to her right hand since admission, and had surgery to release part		

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 278	Continued From pa	ge 11	F 2	78				
		p.m. R7 was evaluated by D and both verified R7 had n knees.						
	registered nurse (R aware of R7's right not aware of the bil RN-D verified R7's	9/11/14, at 1:57 p.m. N)-D stated she was only hand contractures, and was ateral knee contractures. MDS was coded incorrectly as identify R7's lower extremity						
	R55 quarterly MDS had no functional lir (contracture's).	dated 9/3/14, identified R55 mitations in ROM						
	stated R55 had con	9/8/14, at 5:55 p.m. RN-A atractures (fixed high we stretch of a muscle) in both						
:	therapy assistant (F contractures preser	9/10/14, at 2:05 p.m. physical PTA)-E stated R55 had knee nt when she was last treated m PT on 9/6/11, about 2 years						
F 282	stated she was one completing the MDS when completing ar information from int families, staff, and t code the MDS's. R any contractures ar was not coded to re	9/10/14, at 12:45 p.m. RN-C of two nurses responsible for S assessments. RN-C stated in MDS, she gathered derviews with residents, the residents medical record to N-C was not aware R55 had and was unsure why the MDS effect the residents limitations.	F 28	82				

PRINTED: 10/01/2014 FORM APPROVED OMB NO. 0938-0391

	ENT OF DEFICIENCIES NOF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245497	B. WING			09/12/2014		
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETION DATE	
F 282 SS=E	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F2	282	F-282 1. R-56 was re-evaluated by nursing sobeing turned and repositioned according to the frequency specified of care, and occasionally in addition the request. R31 & R1 have all been eby Physical and Occupational Therapic establish a "baseline" of their current functional abilities, and a restorative functional maintenance program, that updated ambulation programs, has be in order to more effectively address a functional limitations the resident may well as to prevent any further decline updated programs will be communicated CNAs and restorative nursing staff to out consistently, and according to the care plan. 2. Care plans were reviewed for all of residents who were previously set up restorative program and require assist complete ROM activities, currently had pressure ulcers, have a Braden score of less, and/or have co-morbidities that increased risk of pressure ulcer formatompliance with care plans was verifithe review of care plans and the review documentation completed by register assistants every shift and via informal one staff interviews.	ding to the ly in her place of this, per exeluated est to the leen set unity and have, as the carried eresident these with a trance to the leen to the leen to the leen to the leen to the leen to the leen to the leen to lee	October 22 nd , 2014 Sp. sp. sp. sp. sp. sp. sp. sp. sp. sp. s	

Facility ID: 00950

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE PO BOX 369	2/2014			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE PO BOX 369				
HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	BE COMPLETION			
During interview on 9/10/14, at 7:20 a.m. R56 stated he had pain in his buttocks and had been up in his chair since approximately 6:00 a.m. that morning. During interview on 9/10/14, at 9:54 a.m. licensed practical nurse (LPN)-B stated R56 should be repositioned at least every two hours, at least every two hours, and should lie down after breakfast. LPN-B requested assistance to lay R56 down in bed. NA-B and LPN-B transfered R56 to his bed to lay down on 9/10/14, at 10:05 a.m. Although R56's care plan instructed staff to reposition R56 every two hours, the resident had been in his chair for a total of 2 hours and 47 minutes without being repositioned. R31's quarterly MDS dated 6/11/14, indicated R31 had no current functional losses of range of motion (contractures) in the upper or lower extremities. R31s care plan dated 8/20/14, identified R31 was to receive passive range of motion daily to hips, knees, and ankles, 10-15 repetitions, as well as to bilateral shoulders, elbows, wrists and digits daily. Review of R31s ROM documentation for 7/2014, was not documented as being completed for 28 out of 31 days. During interview on 9/11/14, at 9:45 a.m. nursing	to ss, on o nt d			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	245497		B. WING			09/12/2014	
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359				
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F 282	any range of motion dressing activities. During interview on stated he had a strowalk anymore, but we complete leg exercions and persoprovide partial phys. The care plan dated needed the assist operferred to have a was directed to to hand provide care in During interview on stated recently she weeks without a bath have any bath aids. R11's point of care received a tub bath was a partial bath olater. During interview on stated it was possib a bath because their residents with bathin R1's quarterly MDS had functional limitate one side of the upper stated in the side of the upper	9/11/14, at 3:18 p.m. R31 p.m.	F2	282	4. To ensure on-going compliance of componitioning schedules are completed according to care plan by auditing comfor 3 randomly-selected residents who have a pressure ulcer and/or are at ris developing pressure ulcers weekly x6 then monthly x 4 months. To ensure the nursing assistants are carrying resident assignment sheets, Change Nurse will select 2 nursing assistants each shift that they have their resident assignment with them. These audits will be compliant ashifts daily x 7 days, then weekly on an ongoing basis. DON/Designee were compliance with bathing schedules are associated documentation for every stays, then daily x7 days, then weekly All audit results will be brought to QA month for review and further recommuntil consistent substantial compliance attained.	g and d npliance o current k of weeks, hat random o verify ent shee leted for thereaft vill audit nd the hift x3 x6 week each nendatio	ily t er s.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/12/2014		
		245497	B. WING	- 17-3-1			
	PROVIDER OR SUPPLIER	LAIN	,	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	1 00.		
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F 282	10-15 reps to bilate and digits. R1's PROM restorareviewed from April There was no docu was recieving PRO plan. During interview on 1:25 p.m. NA-B starestorative aid, and complete R1's PRO plan. During interview on non-verbally indicate forth motion with he when asked if staff on a daily basis. We the PROM being do on her communicate 483.25(a)(1) ADLS UNAVOIDABLE Based on the compresident, the facility abilities in activities unless circumstance condition demonstrational condition demonstration de	ge of motion (PROM) daily, ral shoulders, elbows, wrists, ative nursing sheets were 2014 - September 2014. mentation to determine if R1 M as directed by the care 9/10/14, at approximately ted the facility no longer had a the NAs are not able to DM as directed by the care 9/11/14, at 9:25 a.m. R1 ed by motioning in a back and ar hand to indicate 'so-so,' were assisting her with PROM then asked for a frequency of one, R1 spelled out, "monthly,"	F 282	F-310 1. R7 & R47 were both evaluated by and Occupational Therapies to estable "baseline" of their current level of function abilities, and a restorative OR function maintenance program, including upon ambulation programs has been set un order to more effectively address and functional limitations the resident mas well as to prevent any further decommunicated to the CNAs and restonursing staff to carry out consistently according to the resident care plan. For CAAs were reviewed and modified to address the resident's walking, transfability and current contractures. Resident care plans were undated.	olish a unctional conal dated up in y ay have, line. corative and R7's	5. October 22 nd , 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245497	B. WING			09/	12/2014
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HAVENI	HOMES OF MAPLE P	LAIN		1:	520 WYMAN AVENUE, PO BOX 369		
HAVEN	TOWIES OF WIAFEE P	LAIN	;	IV	MAPLE PLAIN, MN 55359		
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F 310	by: Based on observareview, the facility of services to prevent residents (R47 and assistance with am reassessed upon a decline in ability to harm for R47 and of Findings include: R47's quarterly Min 7/2/14, indicated Rimpairment, needestaff for transfers a wheelchair or a war R47's balance was and walking and shower function rang R47's Care Area As 10/9/13, identified of had clear speech, a able to understand gait, was able to be wheelchair behind of the restorative walk buring interview on stated she was conher ability to walk be assisting her to am supposed to be walnot enough staff to was, "Very rarely be Another interview was continuous to the supposed to be walnot enough staff to was, "Very rarely be Another interview was continuous to the supposed to be walnot enough staff to was, "Very rarely be Another interview was continuous to the supposed to be walnot enough staff to was, "Very rarely be Another interview was continuous to the supposed to be walnot enough staff to was, "Very rarely be another interview was continuous to the supposed to the s	tion, interview, and document failed to provide ambulation loss of function for 2 of 4 R7) who required physical bulation, and were not decline in ambulation. The ambulate resulted in actual R7. The ambulate resulted in actual R7. The ambulate resulted in actual R7. The ambulation and used a ker to aid her ambulation, not steady during transfers the had no loss of upper and the of motion (contractures). The ambulation are used a ker to aid her ambulation. The ambulation and used a ker to aid her ambulation. The ambulation	F	310	2. All residents in the building will, habeen and/or are currently in the probeing evaluated by physical and occupational therapies in order to es a current "baseline" level of function well as to determine the need for the appropriate restorative/functional maintenance/ambulation program. A effective restorative program is in th process of being established for all R who are assigned a restorative/funct maintenance/ambulation program. A newly-established restorative nursing programs will include measurable, attainable, individualized goals that we reviewed on a monthly basis. 3. Both MDS Coordinators were sent in-service on Restorative Nursing Program ADL coding on 9/24/14. A design Restorative RN and several restoration nursing assistants have been selected are training for their roles in the new formulated Restorative Committee. Will soon play an active role in the development and effectiveness of the restorative nursing programs. An educational in-service was held on 1 and 10/10/14 for all nursing departm staff, regarding the importance of compliance with ambulation and oth physical maintenance programs in our promote resident dignity, independent on maintain functional abilities, as well as a program of the maintain functional abilities, as well as a program in our promote resident dignity, independent on maintain functional abilities, as well as a program in our promote resident dignity, independent on maintain functional abilities, as well as a program in our promote resident dignity, independent on maintain functional abilities, as well as a program in our promote resident dignity, independent on maintain functional abilities, as well as a program in our promote resident dignity, independent on maintain functional abilities, as well as a program in our program in our promote resident dignity, independent on maintain functional abilities, as well as a program in our program in our program in our program in our program in our program in our program in our program in our program in our program in our prog	tablish ing as e an e e esidents ional all g will be to an organish atted and ally-They e new 10/9/14 hent er er der to ence and	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245497 B. WING		09/12/2014	
15	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369		
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F 310 Continued From page 17 not being walked twice a day due to staff shortage. She stated, "They just don't have time to walk me." R47 stated she had been involved in therapy and the therapist recommended she be walked. Because staff had not been assisting her to walk, R47 stated her joints are getting stiff and was not able to move as easily as she had in the recent past. She stated the last time she could remember she was walked was about 7-10 days ago. R47's care plan dated 7/9/14, indicated R47 was to be ambulated per the "Restorative program." The restorative program was not specified in the plan of care. R47's nursing assistant care sheet, dated 9/9/14, directed nursing assistants to ambulate the resident 57 feet to 115 feet, twice per day with assistance of one staff, a transfer belt, rolling walker, and wheelchair behind. R47's physical therapy note dated 8/7/14, indicated the resident was able to ambulate up to 80 feet with a rolling walker and contact guard assistance. R47 was seen in the occupational therapy (OT) department from 7/14/14 to 8/14/14. R47 was considered to be alert and able to follow directions. R47's discharge from OT on 8/14/14, indicated she transferred with contact guard assistance (CGA- the therapist would hold a transfer belt for stabilization), tolerated standing for greater than three minutes while she maintained a safe balance while using a 4 wheeled walker, had an increase in her endurance while performing her activities of daily living, and reported no increase in fatigue while	the equally important necessity of poir care documentation every time the programs are completed. Restorative Committee members will meet on a monthly basis and review the effective and compliance of each resident's program will as to review the compliance associated with documentation of restorative program minutes. A structure process has been created for monitori CNAs to ensure resident care is being completed each day as it reflects in the resident care plan, and consistent assignment lists have been implement ensure accountability of staff. Education been provided to all nursing departments aff about the new processes and assignments that have been put in planchelp ensure care delivery, in addition to clear expectations for completion that department staff will be held accountated for during each shift that they work. Further, education has been provided train staff of the expected and appropactions (asking for assistance from peet their nurse, the Charge nurse or DON) take if they feel they are unable to conall of the assigned interventions as list the care plans, prior to falling behind callowing resident care to be neglected. 4. DON will attend all monthly Restoral Meetings and DON/Designee will concrandom audits on residents with restoral months. In addition to the monthly restorative committee meeting minuter results of all audits will be brought to the south of all or the monthly restorative committee meeting minuters and the programs of all audits will be brought to the south of all audits will be brought to the south of all audits will be brought to the south of all audits will be brought to the south of all audits will be brought to the south of all audits will be brought to the south of all audits will be brought to the south of the south of all audits will be brought to the south of the south of all audits will be brought to the south of the south of the south of the south of the south of the south of the south of the south of the south of the south of the south of the south of the south of the	eness gram, ured ng e ed to on has ent ce to co very all able to riate ers, to mplete ed in or tive duct rrative rion enthly es, Page 18 of 79	

review and further recommendation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED			
		245497	B. WING		09	/12/2014		
	PROVIDER OR SUPPLIER	_AIN	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359					
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F 310	performing her exer R47's physician ord staff to ambulate the daily with a wheelch walker and transfer R47's restorative nufacility identified as programs are docur Routine Medications nursing book, were September 11, 2012—April 1 to June 30, twice a day, walking—July, 2014, R47 washift, and twice on the documentation of R7/23/14, when she values a 2014, to Seno documentation reduced by the ambulated twice assisted R47 to ambulated twice assisted R47 to ambulated twice assisted practical nuto be ambulated twice there was no way to	ers dated 9/5/14, directed e resident 57-115 feet twice nair behind, using a rolling belt. Ursing sheets (which the where resident restorative mented and tracked), titled is, located in the restorative reviewed from April 2014, to it identified the following: 2014, R47 was ambulating is 57 to 115 feet consistently. It is walked 15 times on the day the evening shift. The last it is walked 115 feet. In the properties of the was aware R47 was to a day, however, he had never bulate. NA-J stated staff does in the properties of the staff. 9/11/14, at 11:15 a.m. urse (LPN)-C stated R47 was to a day, however, she stated determine if R47 was being	F 31					
	During interview on therapy assistant (P	there was no documentation. 9/11/14, at 2:39 p.m. physical TA)-E stated she had worked 14, until her discharge from						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED			
		245497	B. WING			- 09/12/2014			
	PROVIDER OR SUPPLIER	_AIN		STREET ADDRESS, CITY, S 1520 WYMAN AVENUE, F MAPLE PLAIN, MN 55	STATE, ZIP CODE PO BOX 369				
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F 310	physical therapy on recommended R47 57-111 feet. PTA-E walked," and was a feet when discharg. During interview on registered nurse (R the person in charg Services), stated the efforts to walk R47 ambulate R47 twice sure if this was beir R47 had declined ir stated there was no completed of R47's ensure it was approas ordered. RN-A sher that they were unambulation related however, NA-A veri were not reassessed made with the progicompleted. During observation PTA-E assisted R4 to walk 45-60 feet be breath and needed R47's current ambufrom when the residence of the physical therapy on Although the facility being ambulated as did not reassess and to ensure the residence to ambulate. R47's	8/12/14. PTA-E had be ambulated twice a day, stated R47, "loved to be ble to consistently walk 80 ed from PT on 8/12/14. 9/11/14, at 3:24 p.m. N)-A (who was identified as e of Rehab/Restorative ere was no record of staff RN-A stated staff was to a day, however, she was not end done, and was unsure if the her ability to ambulate. RN-A formal nursing assessment ambulation program to opriate and being implemented stated NA's had complained to unable to assist residents with to being short staffed, fied the ambulation programs and and no changes had been ram to ensure it was being on 9/11/14, at 3:55 p.m. To to ambulate. R47 was able before becoming short of to sit down. PTA-E stated allation ability was a decline lent was discharged from	F3	10					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09/12/2014		
NAME OF PROVIDE		LAIN		15	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE, PO BOX 369 APLE PLAIN, MN 55359	, 00.	13,3017	
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R7's a had s (contr requir transf able tra	I harm for R4 annual MDS devere cognitive acture) to one ed extensive ers and walking stabilize where and off the uniprior look backletion date of CAAs dated 8 and, transfer about and raise and prior look backletion date of CAAs dated 8 and, transfer about and raise and prior look backletion date of CAAs dated 8 and prior look backletion date of comparison and raise and prior look backletion and raise and prior look backletion and raise and prior look backletion and raise and prior look backletion and raise and look backletion and 22 desurrent signed and look backletion and 22 desurrent signed and look backletion and l	n as assessed resulted in 7. lated 8/27/14, identified R7 re impairment, had impairment e side of the upper extremity, two person assistance with ng in the corridor, was only en standing with staff lking in the resident room, thad not occurred during the ext period of the MDS	F3	310				

1	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	Medications, locat book, from April 20 instructed two sta feet, two times dai documentation ide R7 from 4/2014- 9 R7's care plan dat pushed R7 to all dand transferred wibelt and walker. R the resident was a instruct staff on R7 program. When interviewed stated the restoratishambles right now revamp the prograr receiving their program decline in transfer RN-A stated NA's I were not able to coprograms becasue During interview or stated R7 had a detransfers, and staff her, however, R7 not have time to sp walking prior. NA-lorder foot pedals folonger raise her feetwhen staff were pu	ed in the restorative nursing 014 - September 2014, iff to walk the resident 29-57 ly. There was no entifying if staff was ambulating /2014. ed 9/3/14, indicated staff estinations in the wheelchair th assist of two with a transfer 17's care plan did not address if ble to ambulate, nor did it it assessed ambulation on 9/9/14, at 9:46 a.m. RN-A ive/ ambulating program was in w, and she was trying to m to ensure residents were grams as assessed. RN-A was not been ambulating or had a ability or ambulation, however, and complained to her they emplete residents ambulation	F3	310			
		nonths ago, and R7 "got to					

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 310	the point," of being walker, so staff was using a hand in har had done no formal ambulation program as assessed and R her ability to transfer. On 9/11/14, at 1:20 PTA-E and COTA-E and had some contibilateral knees. PT. R7 from the wheeled transfer, R7 did not weight on her feet, weight on her feet, weight on multiple staff was attempting knees. PTA-E and Councy," on multiple staff was attempting knees. PTA-E and Councy would benefit from the resident was declinity ambulating. COTA expressed concerns.	unable to bear weight on the stransferring the resident at method. RN-D stated she assessment of R7's when it was noted R7's a was not being implemented 7 was noted to be declining in	F 3-	10			
	and the resident wa had a decline in trar reassess and refer to This resulted in actu 483.25(a)(3) ADL C. DEPENDENT RESI A resident who is un	s no longer ambulating and asfers, the facility failed to the resident back to therapy. It is also that the resident back to therapy. It is also that the resident back to the rapy. It is also that the resident back to the rapy. It is also that the resident back to back	F 31	2			
		the necessary services to ion, grooming, and personal					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 312	and oral hygiene. This REQUIREMEN by: Based on interview the facility failed to p 1 of 3 residents (R1 dependent on staff of Findings include:	IT is not met as evidenced and documentation review, provide bathing assistance for 1) reviewed who was for bathing.	F 31	1. R11 receives baths routinel the frequency specified in her and occasionally in addition to request. 2. Compliance with bathing so residents in the facility was re residents are currently receivibaths/showers at the frequen	plan of care, o this, per her chedules for all viewed and all ing their cy that is		
	8/27/14, identified R assistance from star hygiene, and was all help for bathing. R11 care plan dated needed assist of one preferred to have a the goal was to resp	um data set (MDS) dated 11 required extensive ff for dressing and personal ple to provide partial physical 9/4/14, indicated R11 e staff for bathing and bath versus a shower, and ect the resident's wishes and and provide care in a timely		indicated in each individualize Further, the daily assignment resident bathing that the nurs to follow each week was revisevenly distributed across the sweekdays, and more evenly diamongst day and evening shift have become more manageable to complete each day.	schedules for sing assistants ed to be more span of the istributed ts, and thereby		
	manner. During interview on stated she had rece weeks without a bath have any bath aids to R11's Point of Care nursing assistants (Notes that received a tub be record of R11 received was a partial bath collater.	9/8/14, at 4:23 p.m. R11 ntly gone for a couple of n because the facility didn't o provide bathing assistance. Bathing Record (where the NA) document when a path/shower), identified R11 ath on 7/31/14. The next ing assistance with bathing empleted on 8/28/14, 28 days		3. A structured process has be monitoring CNAs to ensure ba completed each day as it has be and consistent assignment lists implemented to ensure accounstaff. Education has been provoursing department staff about processes and assignments that put in place to help ensure car addition to very clear expectat completion that all departmentheld accountable for during eathey work. Further, education	thing is being been assigned, is have been intability of wided to all with the new at have been be delivery, in the constitutions for the staff will be also shift that		

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245497	B. WING		09/	12/2014		
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
HAVEN	HOMES OF MAPLE PI	_AIN		1520 WYMAN AVENUE, PO BOX 369				
				MAPLE PLAIN, MN 55359				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ACTION SHOULD BE COMP TO THE APPROPRIATE D			
F 312	stated there were n residents with baths completed regularly R11 could have gor bath due to the lack with bathing. During interview on stated the facility us provide resident barago the bath aid left were not being com was possible R11 h a month because or During interview on registered nurse (R up concerns regard residents baths due RN-A stated the face	ge 24 ot enough staff to assist and they were not being and they were not being a NA-H stated it was possible to almost a month without a cof staff available to assist 9/12/14, at 9:34 a.m., NA-B sed to have a bath aid to this, however, a few months at the facility, so resident baths upleted timely. NA-B stated it ad not been bathed in almost af the lack of staffing. 9/11/14, at 10:30 a.m. N)-A stated NA's had brought ing not being able to complete to lack of staff, however, illity was still working on a insure resident cares are being	F3	provided to train staff of the expecta appropriate actions to take if they for are unable to complete the bath/she that they are assigned each day, price ever falling behind and/or having a miss a bath/shower, in order to main provision of quality resident care. 4. DON/Designee will audit compliant bathing schedules and the associate documentation for every shift x7day weekly x6 weeks. Continued, randor	eel they owers or to esident ntain the nce with d s, then			
F 314 SS=G	not provided. 483.25(c) TREATM PREVENT/HEAL PI Based on the comp resident, the facility who enters the facili does not develop pr individual's clinical of they were unavoidal pressure sores rece	rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having sives necessary treatment and healing, prevent infection and	F 3	14 1. R-56 was re-evaluated by nursing and is now on a 1.5 hour turning an repositioning schedule, and being to and repositioned according to the one of the facilities pressure ulcer prevent policy, and the importance of comprelated to the turning and repositions schedule in Robbs care plan, as well residents' care-planned turning and repositioning schedules. Due to resident refusals to be turned and repositioned, a low air loss alternated.	d urned are plan. about ion liance ning I as for all sident's	5. Completion Date: October 22 nd , 2014		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245497	B. WING		09/	09/12/2014	
	PROVIDER OR SUPPLIER HOMES OF MAPLE PI	_AIN	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 314	by: Based on observate review, the facility for (R56) who was admit was provided interview-evaluated to previous from developing. The R56 related to the compressure ulcers after Findings include: R56's quarterly Minit 6/11/14, identified Rimpairment, require staff for bed mobility staff for repositioning developing pressure one stage IV (unstawas present on admit R56's most recent 0 dated 6/23/14, reveal and repositioning producer care with drespressure reducing of the R56's most recent 0 dated 6/23/14, reveal and repositioning producer care with drespressure reducing of the R56's most recent 0 dated 6/23/14, reveal and repositioning producer care with drespressure reducing 0 dated 6/23/14, reveal and repositioning producer care with drespressure reducing 0 dated 6/23/14, reveal and repositioning producer care with drespressure reducing 0 dated 6/23/14.	ion, interview, and document ailed to ensure 1 of 1 resident nitted with a pressure ulcer entions as assessed, and was vent further pressure ulcers his resulted in actual harm for levelopment of multiple er admission to the facility.	F 31	pressure mattress has been implied to help ensure turning and reposition as frequently as it is needed. Turepositioning schedules were reall residents who currently have ulcers, and/or were identified the for pressure ulcers, to verify the plans reflect schedules that are the pressure ulcer healing and/prevention. NA-A has received regarding the importance of folicare plan as well. 2. Other residents having the particular residents who currently pressure ulcers, have a Braden or less, and/or have co-morbidic result in increased risk of pressure ulcers, and turning a repositioning compliance was well these residents and turning a repositioning compliance was well through observation and the returning and repositioning documents.	ioning occurs rning and eviewed for e pressure to be at risk at all care effective in for counseling dowing the otential to be practice have score of 18 ties that are ulcer ewed for all and erified view of daily mentation		
	a 1.3 x 0.3 unstages coccyx, should be re	ed 8/16/14, identified R56 had able pressure ulcer on the epositioned at no greater than d a pressure redistribution, and a pressure		3. The following systemic chang been implemented to further as facility to prevent pressure ulce residents identified to be at risk formation of pressure ulcers, no assistants will complete daily sk every morning during routine conductions and document their checks. In addi	ssist the rs: For all of the ursing in checks ares and		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		SDENTIEICATION NUMBER		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245497	B. WING_		09/	12/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 1520 WYMAN AVENUE, PO BOX MAPLE PLAIN, MN 55359	IP CODE		
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F 314	R56's Skin Observe through 6/5/14, ind intact and had no proceed to the pressure ulcer risky resident had a mild ulcers. The Brader R56 had recently goushion related to the ulcers. R56's Tissue Tolers to determine skins dated 6/17/14, identified to char the three hour moves unable to char the evaluation inditing the one, two or three position and was unindependently. The independently of the lying position independently. The was blanchable recombined the sitting and the independently. The R56's Tissue Tolers identified blanchable mark in the wheeld unable to reposition further assessment evaluation.	ation Reports dated 1/2/14, icated the resident's skin was pressure ulcers. e (a tool used to assess) dated 6/8/14, indicated the firsk of developing pressure in scale assessment indicated totten a new wheelchair the risk of developing pressure ance Evaluation (assessment ability to withstand pressure) intified non-blanchable redness thank in the lying position, and inge position independently. Icated R56 had no redness at the end of the redness at the redness at the end of the redness at the rednes		must report any changes findings immediately to a assessment and review. At licensed nurses will completed assessments for these residocument assessment find progress notes. An in-serv staff was held on 10/9/14 educate staff on the implenew procedures regarding prevention and monitoring received education on the for assessment/staging, in evaluation & types of drest the wound type on 10/15, 4. To ensure on-going complanned turning and repositioning completed according to cauditing compliance for 3 residents who currently hulcer and/or are at risk of pressure ulcers weekly x6 monthly x4 months. Audit reported in monthly QA m for review and further received and further rece	licensed nurse for dditionally, lete weekly skin idents as well, and dings in resident vice for all nursing & 10/10/14 to ementation of the g pressure ulcer leg. All nurses e correct method attervention, ssings according to leg. All ensure that schedules are are plan by randomly-selected lave a pressure developing is weeks, then the results will be neetings x6 months commendations.		

Event ID: JMZ111

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245497	B. WING)		09/	12/2014
	PROVIDER OR SUPPLIER HOMES OF MAPLE P	LAIN		STREET ADDRESS, CITY, STATE, ZIP 1520 WYMAN AVENUE, PO BOX 3 MAPLE PLAIN, MN 55359		001	1 And An U T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD : E APPROPR	BE	(X5) COMPLETION DATE
F 314	indicated R56 deveright gluteal fold med 0.8 cm with a pink work pressure ulcer (parpresenting as a shapink wound bed, with cleansed and a prophysician was faxed Measurements of the documented weekly Report. Review of 6/17/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, through 9/10/14, idea of the facility identified stage 2. The documulcer on 9/10/14, idea worsened to an unsincreased in size with pressure ulcer as 2. yellow slough wound unstageable.	loped a pressure ulcer in the easuring 0.5 centimeter (cm) x wound bed, and was a stage 2 tial thickness loss of dermis allow open ulcer with a red thout slough). The area was tective cream applied, and the	F 3	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i e	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
			245497	B. WING		0.	9/12/2014	
		PROVIDER OR SUPPLIER	.AIN		STREET ADDRESS, CITY, STATE, ZIF 1520 WYMAN AVENUE, PO BOX : MAPLE PLAIN, MN 55359	CODE		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
		instructed staff to ap dressing to reddene every shift, and chaneeded (PRN). Teg was to be applied to and gluteal fold every (PRN). The physicisthat R56 was not ap intervals ordered for to skin issues, there repositioned at no g R56's Nurses notes resident was admitted ulcers on the right a seen at the wound of they had been debringast. During continuous of from 7:18 a.m. through this weight indep hour and 28 minute approached by staff. During interview on Stated he had pain in up sitting in his wheeleficity of assistant (NA)-A stat staffed and NAs did to reposition as assed aware of R56's press and, "They were prefered."	pply Tegaderm with foam and area on the sacrum, checkinge every three days and as laderm with a foam dressing the right buttock, sacrum, by 3 days and as needed an orders also instructed staff apropriate to have three hour repositioning programs due	F 3	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245497	B. WING			09	/12/2014	
	PROVIDER OR SUPPLIER	_AIN		STREET ADDRESS, C 1520 WYMAN AVEN MAPLE PLAIN, M		,		
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F 314	Continued From pa	ge 29	F3	14				
	practical nurse (LPI repositioned after 2	9/10/14, at 9:54 a.m. licensed N)-B stated R56 should be hours and should lie down N-B requested assistance 6 down.						
	NA-B entered R56's which was 2 hours constant observation minutes since R56 chair. NA-B lifted R standing lift and ren	on 9/10/14, at 10:05 a.m. s room to reposition him, and 47 minutes after the initial in began, and 4 hours and 5 stated he had been up in his 156 out of his chair using a noved his brief. R56's red in color and had a foam it buttock.						
	registered nurse (R the wound nurse, he re-assignment of we delegating them out	9/10/14, at 11:23 a.m. N)-A stated LPN-B had been owever, there was a recent ound duties and she was to the staff. RN-A was not condition of R56's ulcers.						
	stated R56 had gott when the buttock pr around 6/21/14, an currently had three LPN-B was not clea the pressure ulcers. decided to get R56 because the resider he was sitting in a h evaluate the resider cushion was approp							
		of R56's current pressure t 1:58 p.m. the director of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
		245497	B. WING		0!	9/12/2014	
HAVEN HOMES OF MAPLE P (X4) ID SUMMARY ST. (EACH DEFICIENCE REGULATORY OR IT) F 314 Continued From particular open areas on his gluteal cleft which and was an unstage slough wound bedom x 2 cm. The set the right buttock ar whitish in color at to 2.5 cm x 2 cm, and LPN-B stated both in size and stage set them, however, LP last time she had of During interview or occupational theral she had not been in adequate wheelchas		LAIN		STREET ADDRESS, CITY, STATE, 1520 WYMAN AVENUE, PO BO MAPLE PLAIN, MN 55359	ZIP CODE	7722014	
PRÉFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	nursing (DON) and open areas on his beginter grown and was an unstage slough wound bed or x 2 cm. The set the right buttock an whitish in color at the 2.5 cm x 2 cm, and LPN-B stated both in size and stage sithem, however, LPI last time she had of During interview on occupational therapshe had not been in adequate wheelchair cushion. During interview on of nursing (DON) st R56's worsening promote healing of During interview on stated she was indivipromote healing of During interview on stated she was not pressure ulcers so sinterventions with Othe current interventions with Othe current interventions with Othe current further pressure United Services on 9/11/14, at 1:39	LPN-B verified R56 had two puttocks, one on the upper was whitish at the wound base eable pressure ulcer with 90% which currently measured 1.5 cond pressure ulcer was on d had 60-70% slough that was ne wound base and measured was also unstageable. pressure ulcers had increased nce the last time she had seen N-B was unable to verify the bserved R56 pressure ulcers. 9/10/14, at 2:17 p.m. certified by assistant (COTA)-D stated exolved in assessing R56 for ir positioning or the cated she was not aware of essure ulcers. DON stated chedule of every two hours evaluated after the pressure end worsened to ensure the dualized and adequate to the pressure ulcers. 9/11/14, at 1:10 p.m. RN-B aware of R56's worsening she had not discussed T, nor had she reassessed tions in place to ensure they ented and were adequate to	F 3	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245497	B. WING		09/12/2014		
	PROVIDER OR SUPPLIER HOMES OF MAPLE PL	AIN	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPL	ETION.	
F 314 F 317 SS=G	be reached to discular The facility policy, ti indicated it was the place a system to ic for each resident ar hours or more frequesident's condition load may be implemed repositioning (i.e. of warranted for individual development. The facility department weight distribution, pressure redistribution, pressure redistribution, and the facility policy tit last revised 12/01/9 who sits too long on prone to get ischial 483.25(e)(1) NO REUNAVOIDABLE Based on the compersident, the facility who enters the facility motion does not expendion unless the resident.	tled Repositioning, undated, policy of the facility to have in dentify repositioning programs and repositioning every two lently depending upon the and tolerance of the tissue mented, and more frequent of loading hourly) may be duals at high risk for pressure. The policy indicated the assessed postural alignment, sitting balance, stability, and ion along with the commendations in the nursing department. Ited Wound/Skin Care Policy, 7, indicated an at-risk resident a static surface may be more	F 314	F-317 1. R7 & R55 were both evaluated by Pl and Occupational Therapies to establis "baseline" of their current level of fun abilities, and a restorative OR function maintenance program, including upda ambulation programs has been set up order to more effectively address any functional limitations the resident ma as well as to prevent any further declinations the second and these updated programs will be	ctional al ted in 5. October 22 y have, ne.		
	This REQUIREMEN by: Based on observati	IT is not met as evidenced on, interview, and record tion (ROM) services were not		communicated to the CNAs and resto nursing staff to carry out consistently according to the resident care plan. R CAAs were reviewed and modified to address the resident's walking, transf ability and current contractures. All c plans were updated.	and 2014 7's 4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245497	B. WING _	the state of the s	09/	12/2014	
	PROVIDER OR SUPPLIER HOMES OF MAPLE PL		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359				
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F 317	provided for 2 of 4 reviewed for ROM. harm with a reductive Findings include: R55's quarterly Min 6/4/14, identified R5 functional limitations was totally dependent toileting, dressing, at the contractures (fixed stretch of a muscle) utilize any splint devany formal ROM procession of the completed by staff. R55's care plan, last identify the presence instruct staff on the completed by staff. R55's restorative nufacility identified as programs are docur Routine Medications restorative nursing 16/30/14, and instruct daily restorative nur included the following staff.	residents (R55 and R7) R55 and R7 sustained actual on in functional ROM. imum Data Set (MDS) dated 55 did not walk, had no in ROM (contractures), and ent on staff for transferring, and all activities of daily living. 9/8/14, at 5:55 p.m. N)-A stated R55 had high resistance to passive in both knees only, did not vices, and was not receiving ogram. It updated 6/9/14, did not e of any contractures nor did it type of ROM exercises to be arrived and tracked), titled in the cook dated 1/1/14, through the staff R55 was to receive sing treatments which ing: ange of motion (PROM) 10-15 on/extension reps bilateral is reps bilateral	F 31	2. All residents in the building wibeen and/or are currently in the being evaluated by physical and occupational therapies in order to a current "baseline" level of function well as to determine the need for appropriate restorative/function maintenance/ambulation prograte effective restorative program is in process of being established for who are assigned a restorative from a maintenance/ambulation prograte newly-established restorative nutrograms will include measurable attainable, individualized goals the reviewed on a monthly basis. All recommended restorative prograpart of the care plan and communall nursing staff through both the and the nursing communication of the care plan and communal nursing staff through both the and the nursing communication of the care plan and communal nursing staff through both the and the nursing communication of the care plan and communication of the care plan and communication of the care plan and communication of the care plan and communication of the care plan and communication of the care plan and communication of the care plan and several restorative RN and several restorative RN and several restorative RN and several restorative RN and several restorative RN and several restorative development and effectiveness of restorative nursing programs. Are educational in-service was held of and 10/10/14 for all nursing depastaff, regarding the importance of the care plan and the importance of the care plan and the importance of the care plan and the importance of the care plan and the programs. Are educational in-service was held of and 10/10/14 for all nursing depastaff, regarding the importance of the care plan and the importance of the care plan and the importance of the care plan and the program and the program and the program and the program and the program and the program and the program and the program and the program and the program and the program and the program and the program and the program and the program and the program and the program and the program and the progr	process of o establish tioning as r the al m. An n the all Residents unctional m. All rsing e, nat will be ams will be ricated to care plan book. sent to an Programs signated rative ected and newly- ee. They e of the new on 10/9/14 artment		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245497	B. WING	3. WING			12/2014
	PROVIDER OR SUPPLIER HOMES OF MAPLE PI	_AIN		18	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE, PO BOX 369 IAPLE PLAIN, MN 55359	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		BE	(X5) COMPLETION DATE
F 317	flexion/extension -Elbow PROM 10-1 flexion/extension -Knee PROM 10-18 flexion/extension The 7/2014 restora restorative treatme opportunities. The facility was una nursing sheets for for 9/2014. The fac ROM was done for was unable to verify was started, and if time to determine if Review of R55's El- from 7/1/14, to 9/12 received any ROM assessment to ens appropriate for R55 During observation was observed being legs would not fully and the residents k assistant (NA)-B wa above her head to needed to slide the stretch it over her h up her arms or stra elbow. NA-B verifie stiff. During interview on stated R55's ROM	5 reps bilateral 5 reps bilateral tive nursing sheet identified 3 nts were provided out of the 31 able to provide any restorative R55 for the months of 8/2014, ility had no documentation any R55 for 2 months. The facility y when R55's ROM program it had been reassessed at any it was appropriate for R55. ectronic Point Of Care Record 2/14, did not identify R55 services, nor was there any ure the ROM program was	F 3	.17	compliance with ambulation and other physical maintenance programs in ore promote-resident dignity, independent to maintain functional abilities, as we the equally important necessity of pocare documentation every time the programs are completed. Restorative Committee members will meet on a monthly basis and review the effective and compliance of each resident's proas well as to review the compliance associated with documentation of restorative program minutes. A structure process has been created for monito CNAs to ensure resident care is being completed each day as it reflects in the resident care plan, and consistent assignment lists have been implement assignment lists have been implement accountability of staff. Educated been provided to all nursing departments staff about the new processes and assignments that have been put in phelp ensure care delivery, in additional clear expectations for completion the department staff will be held accounted to during each shift that they work. Further, education has been provided train staff of the expected and approactions to take if they feel they are accomplete all of the assigned interversible in the care plans, prior to falling behind or allowing resident care to be neglected.	der to nce and ll as int-of- veness ogram, tured ring she nted to tion has nent lace to n to very at all ntable ed to opriate unable to ntions as ng	

Facility ID: 00950

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/IDENTIFICA	SUPPLIER/CLIA TION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
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	PROVIDER OR SUPPLIER			į	STREET ADDRESS, CITY, STATE, ZIP 1520 WYMAN AVENUE, PO BOX 3 MAPLE PLAIN, MN 55359			
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F 317	to spend time comstated R55 only revexercises which the as needing. During interview or stated when restor provided to the restor document in Point completed. RN-C further documentation in Freceiving any ROV. During interview or practical nurse (LP responsible for confor the residents as completed in the responsible for confor the residents as completed in the responsible for confor the residents as completed in the responsible for confor the residents as completed in the responsible for confor the residents as completed in the responsible for confor the residents as completed in the responsible for conforthing completed. R55's Physical The dated 9/6/11, indicapassive stretching and 25 degrees of to be pain free and continue bilateral lowith staff. R55's Occupational dated 7/17/12, indicapitation in the summary did nupper extremity conformal transfer in the summary did nupper	pleting the execeived about 1 e resident had a 9/10/14, at 12 ative services idents, the NAs of Care when it was unable to tion that R55 which was unable to tion that R55 which was unable to tion of Care R1 services. In 9/11/14, at 9:3 N)-B stated the pleting the R0 well as charting the R0 well as charting the R0 well as charting and aware R5 would be disclosed R55 demonstrated R55 exhipment while in the left knee. For would be disclosed R55 exhipment while in the left knee in	o% of the ROM been assessed 2:45 p.m., RN-C or ROM was should t was provide any was no 55 was 38 a.m. licensed e NAs were of the NAs were of the NAS were of the Sis ROM was no 5's ROM was no 5's ROM was no 6's ROM program harge Summary instrated to 22 degrees RS5 was noted harged to ROM program harge Summary bited proper the wheelchair. Is sence of any	F 317	4. DON will attend all month Meetings and DON/Designee random audits on residents wand/or functional maintenan ambulation programs for doc compliance weekly x6 weeks x3 months. In addition to the restorative committee meeting results of all audits will be browned and further recommentation.	e will cond with restor ce and/or cumentation, then more monthly ng minute	uct rative on nthly	
	During interview on occupational therap	y assistant (Co	OTA)-D					
JKM CMS-256	37(02-99) Previous Versions	Obsolete	Event ID: JMZ111	Fac	cility ID: 00950	continuation	sheet F	age 35 of 7

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245497	B. WING		09	/12/2014	
	PROVIDER OR SUPPLIER HOMES OF MAPLE PL	AIN		STREET ADDRESS, CITY, STATE, ZIP COD 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359			
(X4) ID PREFIX TAG			ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 317	examined R55's up R55 was somewhar evaluate total ROM completely assess wrist, and finger conindicated R55 appe extremity contracture of prior. COTA-D st benefit from a spling which was identified joint during the exame PTA-E was also in completed an exame PTA-E stated when physical therapy dis 9/6/11, R55's kneed PTA-E stated the rig worsened to 55 deg before, and the left compared to 25 deg PTA-E both verified ROM as had been a been referred back R55's knees were beand noted a decline move the upper ext with dressing. During interview on (FM)-A stated recerpurchase larger parso it would be easied R55 was becoming her arms and straig struggle to get her costated staff asked for the stated e 35 per extremities and indicated tresistant when attempting to so she was unable to the degree of the shoulder, ntractures. However, COTA-D ared to have bilateral upper res, which she was not aware ated R55 would definitely to device for the right thumb of the bethe most contracted m. Physical therapy assistant atterviewed at this time and for R55's lower extremities. compared to the most recent scharge summary dated contractures had worsened. The should be receiving assessed, and should have to OT/PT when staff noted becoming more contracted, in the resident's ability to remities when being assisted. 19/11/14, at 9:09 a.m. family atly staff had asked him to the sand different types of shirts or to dress R55. FM-A stated so stiff she was not able to lift then her knees so it was a tressed every day. FM-A or shirts that opened in the ger pants, to make it slide on	F3	17				

Facility ID: 00950

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245497	B. WING_			09/12/2014	
_	PROVIDER OR SUPPLIER HOMES OF MAPLE PI	_AIN		STREET ADDRESS, CITY, STATE, ZIP COE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECONDS - REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 317	During interview on stated range of mot completed and R55 result. NA-H stated her arms and legs I the resident dresse the resident's family clothing. During another interested the resident's family clothing. During another interested the assessment in place current restorative program is adequated in ROM. RN-A state concerns about not complete resident in ROM. RN-A state concerns about not complete resident in ROM. The facility has resorative nursing program was reassed program was reassed program was being adequate to prevent Although the facility further difficulty with in ROM, the facility further difficulty with in ROM, the facility interventions and reactual harm to R55. R7's annual MDS day had severe cognitive impairment (contract extremity.	9/11/14, at 10:13 a.m. NA-H ion services were not being was becoming stiff as a R55 wasn't able to stretch out like before which made getting d more difficult, so staff asked member to bring in different review on 9/11/14, at 11:10 a.m. are was no formal ROM e for R55 to ensure the brogram was being sessed, nor to ensure the e to prevent further decrease ed the NA's had brought up having enough staff to ROM programs, however, she ad not reviewed the current brograms to ensure they could ensure R55's restorative essed to ensure the ROM implemented and was a further decline in ROM. was aware R55 was having dressing related to decrease failed to provide further assessment which resulted in	F 3	17			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245497	B. WING		09/	09/12/2014	
	PROVIDER OR SUPPLIER	_AIN		STREET ADDRESS, CITY, STATE, ZIP COD 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE	
F 317	which was released and was regaining right hand. During observation was lying in bed on was in a fist. During observation was sitting in her will and her left hand will buring observation was sitting in the acclosed in a fist. During observation was sitting in the direct with buring observation was sitting in the direct with buring observation was sitting in the direct was not observe hand, nor did she at R7's PT Progress at 3/4/14, indicated the onto the walker with receive ROM. R7's current Physic September 2014, in to receive the follow program: Ankle PROM Odorsiflexion Digits PROM 10 flexion/extension 1x flexion/extension	I with surgery, had no pain, muscular function back in the on 9/9/14, at 2:50 p.m. R7 her back and her left hand on 9/10/14, at 6:53 a.m. R7 heelchair in the activities room as closed in a fist. on 9/11/14, at 9:40 a.m. R7 heir back and her left hand on 9/12/14, at 8:40 a.m. R7 hing room with her left hand her fingers bent inward. of R7 from 9/9/14- 9/12/14, at tempt to use her left hand. and Discharge Summary dated a resident was able to hang hout hand support, and was to ian Orders sheets for istructed staff the resident was ving restorative nursing	F3	317			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245497	B. WING			09/12/2014	
	PROVIDER OR SUPPLIER	LAIN		15	TREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE, PO BOX 369 IAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	REFIX (EACH CORRECTIVE ACTION SHOU		BE	(X5) COMPLETION DATE
F 317	flexion/extension 12 Hip PROM 10- flexion/extension, a Knee PROM 10 flexion/extension 12 Shoulder PROI flexion/extension 12 Walk 29-57 fee wheelchair behind s roller walker transfe Wrist PROM 10 flexion/extension 12 R7's restorative nur identified as where are documented ar Medications, locate book, indicated the contracture. The re reviewed from April noted the following R7 on the day shift: Ankle PROM 0 dorsiflexion/extension 12 Elbow PROM 1 flexion/extension 13 Hip PROM 10- flexion/extension, a Knee PROM 10 flexion/extension 13 Shoulder PROI flexion/extension 13 Shoulder PROI flexion/extension 13 Walk 29-57 fee	15 reps bilateral abduction/adduction 1x 0-15 reps bilateral x W 10-15 reps bilateral x to two times daily with stand by assistance of two er belt x2 0-15 reps bilateral x rsing sheets (which the facility resident restorative programs and tracked), titled Routine and in the restorative nursing resident had a right hand storative nursing sheets 12014, - September 2014, program to be completed for 15 reps bilateral 1x 0-15 reps bilateral 1x 15 reps bilateral 1x 15 reps bilateral 1x 15 reps bilateral 1x 15 reps bilateral 1x 16 -15 reps bilateral 1x 17 reps bilateral 1x 18 to -15 reps bilateral 1x 19 to -15 reps bilateral 1x 10 to -15 reps bilateral 1x 10 to -15 reps bilateral 1x 1x 1x 1x 1x 1x 1x 1x 1x 1x 1x 1x 1x	F3	3317			
	wheelchair behind : roller walker transfe	stand by assistance of two er belt x2					

Facility ID: 00950

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER HOMES OF MAPLE PL	.AIN		15	FREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE, PO BOX 369 APLE PLAIN, MN 55359	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 317	R7's restorative nur September 2014, nur program to be complowed and service and however, there was receiving any ROM. R7's care plan date right hand contract. On 9/11/14, at 1:20 PTA-E and COTA-E resistive and had so hand and bilateral k R7 grimaced and stoccasions when PT attempting ROM. C R7 would benefit frosplint or cone for the hand. During interview on stated R7 had a conhad surgery to release RN-A stated the respense was trying to restated R7 should be as had been assess aware of R7's left had contractures.	sing sheets for April 2014 - oted the restorative nursing bleted for R7 on the day shift, no documentation R7 was d 6/11/14, identified R7 had a ure. p.m. R7 was evaluated by o, who both verified R7 was ome contracture(s) in her left nees. During the evaluation rated, "Ouch" on multiple A-E and COTA-D were OTA-D and PTA-E both stated om therapy and possibly a re new contracture in her left 9/9/14, at 9:46 a.m. RN-A ntracture to her right hand and rise part of the contracture. residents as assessed, and residents as assessed, and receiving the ROM services red by PT. RN-A was not and or bilateral knee	F 3	317			
	completed with NA- able to complete RC feel sorry for the res	0/14, at 1:00 p.m. was A who stated staff was not DM for residents and stated, "I idents because they need the A-A stated staff just does not					

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED
		245497	B. WING			09/12/2014
	PROVIDER OR SUPPLIER HOMES OF MAPLE PL	.AIN		STREET ADDRESS, CITY, STATE, ZIP (1520 WYMAN AVENUE, PO BOX 36 MAPLE PLAIN, MN 55359	CODE	00/12/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 317	have any extra time ambulation. During interview on stated R7 had a corwhich was repaired contracture identifier RN-D stated several point of being unable her hands, so staff hand in hand. RN-I time to have a declirelated to being unable however, R7's restoreassessed, and the back to PT to preveability. The facility failed to program was reasses program was reasses program was reasses program was being adequate to prevent Although the facility able to hang onto the facility failed to proveassessment which R7. The facility policy titl undated, identified the individual admitted the become involved in the services available highest possible, propsychosocial level. Follanned, systematic builds on strengths a criteria:	ge 40 to provide any ROM or 9/11/14, at 1:57 p.m. RN-D ntracture to the right hand, via surgery, and was the d on the resident's MDS. I months ago R7 got to the e to hang onto the walker with was ambulating the resident D stated R7 was noted at that ne in ROM in her left hand ble to hang onto the walker, rative program was not e resident was not referred nt further decline in ROM ensure R7's restorative essed to ensure the ROM implemented and was further decline in ROM. was aware R7 was no longer e walker to ambulate, the ide further interventions and n resulted in actual harm to ed Restorative Nursing, ne philosophy was each to the facility had the right to his/her own care and to have the to him/her to reach their acticable physical and Restorative nursing is a gorganized program that and must meet the following ectives and interventions	F3	317		

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 317	must be documented clinical record 2. Evidence of per nurse must be pres 3. Nursing assistate the techniques that in the activity 4. Restorative active active active active active active active and a minimum of 6 day 6. Each Restorative a minimum of 15 minimum of	riodic evaluation by licensed ent in the clinical record nts/aides must be trained in promote resident involvement vities must be carried out or bers of the nursing staff e programs must be provided s/week re program must be provided nutes in a 24 hour period entified nurses in an axion of the restorative oring the delivery of restorative sis to assure the programs onsistently and as planned. It policy documented the ve nursing was mandated by dget Reconciliation Act] in the keep residents at their cticable physical, mental and	F 31	7		

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE COMF	SURVEY PLETED
	-	245497	B. WING_		09/1	2/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HAVENI	HOMES OF MAPLE PL	ΔΙΝ		1520 WYMAN AVENUE, PO BOX 369		
TIPATE ETT	TOMES OF MALEET E			MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 317	Continued From pa	ge 42	F 31	17		
F 318 SS=D	individual needs inc and enhances well 483.25(e)(2) INCRE	ASE/PREVENT DECREASE	F 31	F-318 1. R31, R64 & R1 were all evaluated by Physical and Occupational Therapies to establish a "baseline" of their current	o	5. Octol
	resident, the facility with a limited range appropriate treatme	nt and services to increase l/or to prevent further		of functional abilities. A restorative OR functional maintenance program, incluupdated ambulation programs has been up in order to more effectively address functional limitations the resident may as well as to prevent any further declinates updated programs will be communicated to the CNAs and restor nursing staff to carry out consistently as	en set sany have, he.	5. October 22 nd , 2014
	by:	IT is not met as evidenced		according to the resident care plan.		
	review the facility fa and/ or ambulation s maintain current lev	ion, interview, and document iled to ensure range of motion services were provided to el of functioning for 3 of 5 , and R1) reviewed for range nbulation services.		2. All residents in the building will, hav been and/or are currently in the proce being evaluated by physical and occupational therapies in order to esta a current "baseline" level of functionin well as to determine the need for the	ess of ablish	
	Findings include:			appropriate restorative/functional maintenance/ambulation program. Ar		
	6/11/14, indicated R	mum data set (MDS) dated 31 had no current functional notion in the upper or lower		effective restorative program is in the process of being established for all Res who are assigned a restorative/function maintenance/ambulation program. All newly-established restorative nursing	nal	
	to receive 10-15 rep of motion (PROM) to	ed 8/20/14, indicated R31 was etitions daily, passive range o hips, knees, bilateral writs, fingers, and ankles.		programs will include measurable, attainable, individualized goals that wi reviewed on a monthly basis All recommended restorative programs w	vill be	
		rsing PROM documentation /14, indicated R31 received		part of the care plan and communicate all nursing staff through both the care and the nursing communication book.	plan	

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		E CONSTRUCTION		E SURVEY IPLETED
		245497	B. WING_			09/	12/2014
NAME OF I	PROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAVENI	HOMES OF MAPLE PL	AIN		18	520 WYMAN AVENUE, PO BOX 369		
HAVENT	TOWES OF WAPLE PE	_AIN		М	IAPLE PLAIN, MN 55359		:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	Continued From pa	ge 43	F 31	18	3. Both MDS Coordinators were sent t	o an	
	· ·	vices 3 out of 31 days for the			in-service on Restorative Nursing Prog		
		nd 12 days in the last month			and ADL coding on 9/24/14. A designa		
	(8/12/14, through 9/				Restorative RN and several restorative		
					nursing assistants have been selected	and	
		on 9/10/14, at 9:39 a.m. R31		·	are training for their roles in the newl		
		neelchair. R31 was not		ĺ	formulated Restorative Committee. The		
		4, 9/11/14, and 9/12/14,		İ	will soon play an active role in the		
	receiving any ROM	services.			development and effectiveness of the	new	
	During interview on	9/10/14, at 2:00 p.m. physical		!	restorative nursing programs. An		
		PTA)-E stated R31 had no		i	educational in-service was held on 10		Į.
		ess of range of motion in his		'	and 10/10/14 for all nursing department	ent	
		owever, would be at high risk			staff, regarding the importance of		
		contractures if he continued to			compliance with ambulation and other		
		essed range of motion			physical maintenance programs in ord		
	services.				promote resident dignity, independer to maintain functional abilities, as well		
	During interview on	09/11/14, at 9:45 a.m. nursing			to maintain functional admities, as we	1 03	
		ated R31 did not receive any			the equally important necessity of po	nt-of-	
		vices other than routine			care documentation every time the		
		or the last several months			programs are completed. Restorative		
	related to lack of sta	affing.			Committee members will meet on a		
					monthly basis and review the effectiv		
		9/11/14, at 3:18 p.m., R31			and compliance of each resident's pro	ogram,	
		oke a while back and did not would like to use his legs if he			as well as to review the compliance		
		ce. R31 stated he would be		ı	associated with documentation of	urad	
		eting leg exercises, however,		-	restorative program minutes. A struct process has been created for monitor		
		mpleting them at the facility in		- 1	CNAs to ensure resident care is being	ıı ığ	
	the last few months				completed each day as it reflects in the	ie.	
					resident care plan, and consistent		
		S dated 8/13/14, indicated			assignment lists have been implemen	ted to	
		gnitive impairment, required			ensure accountability of staff. Educati		
		e for all ADL's including bed g, and walking. R64 was not			been provided to all nursing department		
		y able to stabilize with staff			staff about the new processes and	,	·
		d no impairment to his upper			assignments that have been put in pla	ice to	
	or lower extremity ra				help ensure care delivery, in addition		
	· · · · · · · · · · · · · · · · · · ·	Ĭ			clear expectations for completion tha		1

Facility ID: 00950

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DESICIENCIES (VAL) BROWIDER(SUBPLIER(CLAS

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		STRUCTION		TE SURVEY MPLETED
		245497	B. WING			na	/12/2014
	PROVIDER OR SUPPLIER HOMES OF MAPLE PL	_AIN		1520 WY	ADDRESS, CITY, STATE, ZIP CODE (MAN AVENUE, PO BOX 369 PLAIN, MN 55359	1 09.	712/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	R64's Physical thera 5/16/14, indicated R improvement in bed could ambulate up to discharged on a resprogram. R64's occupational dated 5/16/14, instructontinue on the rest program. During a review of R64 was to have cemoves their own join physical therapy (P7 (OT) recommendating directed staff R64 wrestorative nursing. A Nursing Assistant to know a residents 9/12/14, directed staff eet twice a day on the staff using a transfel R64's nursing rehab medical record, (while received any PROM) evidence any nursing PROM) was comple 8/14, or 9/14. During interview on 9 assistant (NA)-A staff ambulate or do reside because they are shipped to the staff using a transfel R64's nursing rehab medical record, (while received any PROM) was comple 8/14, or 9/14.	apy discharge summary dated R64 had significant if mobility and pivot transfers, to 230 feet, and was storative nursing ambulation. R64's care plan dated 8/15/14, rvical (neck) active (subject not) range of motion per (and occupational therapy ons. The care plan also has to ambulate with (and a walker). Care Sheet (which staff used individual care needs) dated aff to ambulate R64, 115-230 he day shift, with assist of 1 or belt and a walker. time log in the electronic och identified if the resident or ambulation), lacked grehab (ambulation or ted for the months of 7/14, 19/10/14, at 1:00 p.m. nursing ted staff did not have time to lent ROM program for R64	F 3	for du Furthe train s action compl listed behind negled 4. DOI Meeti rando and/o ambul compl x3 mo restor results	rtment staff will be held accountring each shift that they work. er, education has been provided staff of the expected and approns to take if they feel they are unlete all of the assigned interven in the care plans, prior to falling d or allowing resident care to be cted. N will attend all monthly Restorings and DON/Designee will command and the command of the command of the command with the command the committee meeting minutes of all audits will be brought to and further recommendation.	d to priate nable to tions as g e rative iduct orative or tion onthly y tes, QA for	

AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		ATE SURVEY OMPLETED
		245497	B. WING			0.5	9/12/2014
ĺ	PROVIDER OR SUPPLIER HOMES OF MAPLE PI	_AIN		1520	EET ADDRESS, CITY, STATE, ZIP COD WYMAN AVENUE, PO BOX 369 PLE PLAIN, MN 55359	DE , O.	011212014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 318	physical therapy as had contractures of walked and receive contractures don't go During observation was assisted by PT, in the hallway. R64 time to get up from with his walker to the COTA-D stated R64 "About the same," a from services on 5/d decline in ROM or a During an interview registered nurse (R1 assistants should be of passive range of residents electronic RN-C verified R64's blank for 7/14, 8/14, was no way for the freceiving PROM or stated there currenti responsible for assenursing program to ecompleted or was approximately approximately many completed or was approximately model of the up R1's care plan dated receive daily passive	sistant (PTA)-E stated R64 his knees and needed to be the PROM to ensure the net worse. on 9/11/14, at 1:50 p.m. R64 A-E and COTA-D to ambulate needed encouragement and his recliner, but did ambulate e nurse's station. PTA-E and l's ability to ambulate was, s when he was discharged 16/14, and there was no mbulation. on 9/12/14, at 11:00 a.m. N)-C stated the nursing e documenting the completion motion and ambulation in the medical record program. nursing rehab time log was and 9/14, therefore, there acility to identify if R64 was being ambulated. RN-C y was not a nurse who was ssing residents restorative	F3	18			

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED
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PROVIDER OR SUPPLIER	LAIN		1520	WYMAN AVENUE, PO BOX 369	1 00	TIELEVIT
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		x	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
R1's restorative nur resident was to reco Ankle PROM 1 dorsiflexion/flexion Digits PROM 15 flexion/extension 15 Elbow PROM 1 flexion/extension 15 Hip PROM 0-15 flexion/extension 15 Knee PROM 10 flexion/extension 15 Shoulder PROM flexion/extension 15 Wrist PROM 10	rsing program identified the eive the following daily: 0-15 reps bilateral 1x 0-15 reps bilateral 30-15 reps bilateral 40-15 reps bilateral 40-15 reps bilateral 60-15 reps bilateral 60-15 reps bilateral 60-15 reps bilateral 60-15 reps bilateral 60-15 reps bilateral	F3	118			
nursing program fro September 2014, w ROM program had months. When interviewed o licensed practical nuncled practical nuncled facility, so the NA's supposed to be provambulation for the rehave enough staff to completed. LPN-As complained of not wand feel they have lower than the stated ROM and am	om April 2014, through ere all blank, indicating the not been completed for 5 on 9/10/14, at 7:10 a.m. urse (LPN)-A stated there was live NA employed by the staffed on the floor are viding the ROM and esidents, however, they don't be ensure this is being stated residents have ralking or receiving their ROM lost strength.					
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa R1's restorative nur resident was to reco Ankle PROM 1 dorsiflexion/flexion Digits PROM 15 flexion/extension 1> Elbow PROM 1 flexion/extension 1> Knee PROM 10 flexion/extension 1> Shoulder PROM flexion/extension 1> Wrist PROM 10 flexion/extension 1> Wrist PROM 10 flexion/extension 1> Wrist PROM 10 flexion/extension 1> Wrist PROM 10 flexion/extension 1> Complexion/extension	PROVIDER OR SUPPLIER ### SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 46 R1's restorative nursing program identified the resident was to receive the following daily: Ankle PROM 10-15 reps bilateral dorsiflexion/flexion 1x Digits PROM 10-15 reps bilateral flexion/extension 1x Elbow PROM 10-15 reps bilateral flexion/extension 1x Hip PROM 0-15 reps bilateral flexion/extension abduction/adduction 1x Knee PROM 10-15 reps bilateral flexion/extension 1x Shoulder PROM 10-15 reps bilateral flexion/extension 1x Wrist PROM 10-15 reps bilateral flexion/extension 1x Wrist PROM 10-15 reps bilateral flexion/extension 1x Review of R1's documentation of the restorative nursing program from April 2014, through September 2014, were all blank, indicating the ROM program had not been completed for 5	PROVIDER OR SUPPLIER ### A BUILD 245497	PROVIDER OR SUPPLIER 245497 245497 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 46 R1's restorative nursing program identified the resident was to receive the following daily: Ankle PROM 10-15 reps bilateral dorsiflexion/extension 1x Elbow PROM 10-15 reps bilateral flexion/extension 1x Hip PROM 0-15 reps bilateral flexion/extension abduction/adduction 1x Knee PROM 10-15 reps bilateral flexion/extension 1x Wist PROM 10-15 reps bilateral flexion/extension 1x Shoulder PROM 10-15 reps bilateral flexion/extension 1x Wrist PROM 10-15 reps bilateral flexion/extension 1x Wrist PROM 10-15 reps bilateral flexion/extension 1x Wrist PROM 10-15 reps bilateral flexion/extension 1x Wrist PROM 10-15 reps bilateral flexion/extension 1x Wrist PROM 10-15 reps bilateral flexion/extension 1x When interviewed on 9/10/14, at 7:10 a.m. licensed practical nurse (LPN)-A stated there was no longer a restorative NA employed by the facility, so the NA's staffed on the floor are supposed to be providing the ROM and ambulation for the residents, however, they don't have enough staff to ensure this is being completed. LPN-A stated residents have complained of not walking or receiving their ROM and feel they have lost strength. When interviewed on 9/10/14, at 9:18 a.m. NA-E stated ROM and ambulation of residents was not	TROVIDER OR SUPPLIER 1245497 1245497 1245497 1245497 1245497 1250	A BUILDING 245497 B. WINS STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 389 MAPLE PLAIN, MN 55359 SUMMARY STATEVENT OF DETICIENCIES (EACH DETICIENCY WIST SE PRECEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 46 R1's restorative nursing program identified the resident was to receive the following daily; Ankile PROM 10-15 reps bilateral flexion/extension 1x Elbow PROM 10-15 reps bilateral flexion/extension 1x Hip PROM 0-15 reps bilateral flexion/extension 1x Shoulder PROM 10-15 reps bilateral flexion/extension abduction/adduction 1x Noncider PROM 10-15 reps bilateral flexion/extension 1x Wister PROM 10-15 reps bilateral flexion/extension 1x Wister PROM 10-15 reps bilateral flexion/extension 1x Review of R1's documentation of the restorative nursing program from April 2014, through September 2014, were all blank, indicating the ROM program had not been completed for 5 months. When interviewed on 9/10/14, at 7:10 a.m. licensed practical nurse (LPN)-A stated there was no longer a restorative Na Manployed by the facility, so the NA's staffed on the floor are supposed to be providing the ROM and ambulation for the residents have complained of not walking or receiving their ROM and feel they have lost strength. When interviewed on 9/10/14, at 9:18 a.m. NA-E stated ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulation of residents was not the state of ROM and ambulati

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	verified R1's restoral completed. During interview on non-verbally responsand forth motion wit "so-so," when asked ROM and ambulation was asked how often spelled out, "monthal board. When interviewed on COTA-D stated R1 contractures if PRO being done, however R1 having any declination of the services available highest possible, proposed possible, prop	ge 47 ative nursing was not being 9/11/14, at 9:25 a.m. R1 ded by motioning in a back h her hand to indicate, d if staff was assisting her with on on a daily basis. When R1 n staff was assisting, R1 y" on her communication n 9/12/14, at 9:49 a.m. would be at risk for increased M and ambulation was not or, COTA-D was not aware of nes in ROM or ambulation. policy titled Restorative e philosophy was each to the facility had the right to his/her own care and to have le to him/her to reach their acticable physical, and Restorative nursing is a to organized program that and must meet the following sectives and interventions d in the care plan and in the codic evaluation by licensed ent in the clinical record ints/aides must be trained in comote resident involvement wities must be carried out or there of the nursing staff programs must be provided	F3	18				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 318	a minimum of 6 day 6. Each Restorativa minimum of 15 m. The policy identified positions were responganization of the monitoring the delivity routine basis to assign followed consistention 483.25(h) FREE OF HAZARDS/SUPER' The facility must enenvironment remainas is possible; and adequate supervision prevent accidents. This REQUIREMENT by: Based on observator review, the facility favore thoroughly assign propriate/pertiner implemented or review, with multiple farmings include: R64 admission face indicated the reside weakness, dementing quarterly Minimum 18/13/14, indicated R	rs/week ve program must be provided inutes in a 24 hour period I nurses in management onsible for maintaining the restorative program and very of restorative care on a ure the programs are being y and as planned. FACCIDENT VISION/DEVICES sure that the resident has as free of accident hazards each resident receives on and assistance devices to IT is not met as evidenced ion, interview, and document eiled to ensure resident falls bessed to ensure of interventions could be ised, for 2 of 2 residents (R64, ills. Is sheet, dated 2/24/12, int had diagnoses including a, and incontinence. R64's Data Set (MDS) dated ion interver cognitive			d for eview g to ends d/or s cation as well several emented ions wil) 	
•	impairment, require	d extensive assistance for all					

NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 156 Continued From page 3 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG O9/12/2014 STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359 PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG TOMBUTE ON/12/2014 STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359 F 156 ON/12/2014 STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359 COMPLETION DATE	STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(XX	3) DATE SURVEY COMPLETED
HAVEN HOMES OF MAPLE PLAIN STREET ADDRESS, CITY, STATE, ZIP CODE		NOTOBERS COMMUNICATION OF THE PROPERTY OF THE	245497	B. WING			09/12/2014
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 156 Continued From page 3 PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE COMPLETION DATE COMPLETION DATE	f				1520 WYMAN AVENUE, PO BOX 369		00/14/50/14
	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LDBE	(X5) COMPLETION DATE
R57 was admitted to the facility with skilled medicare coverage on 1/17/14. R57's denial lettex contained only the CMS 10123, indicating R57's last covered day was 3/19/14. R57 records dR) not contain the required notice of medicare coverage on continued stay. R67 remained in the facility after her medicare coverage was discontinued. During interview on 9/11/14, at approximately 10:00 a.m. director of nursing (DON) stated the facility did not have a policy specific to how to issue medicare censilas, end verified there were no other denial letters on file for R1 nor R67. DON provided copies of a Haven Horing Medicare Assessment Tool and a blank halce of medicare coverage on continued stay, however, these did not address the facility process on how to inform residents of medicare appeal rights or for required denial letters the residents must receive. F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for redidents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 4 of 4 residents observed during dining who required staff assistance, (8/2, R52, R68 and R7), were provided assistance in a dignified manner.	F 241 SS=E	R57 was admitted to the medicare coverage or letter contained only R57's last covered day records did not contain medicare coverage on remained in the facility coverage was disconting of the medicare coverage was disconting of the medicare denial letters of the medicare denial letters of the medicare coverage on the med	he facility with skilled 1/17/14. R57's denial the CMS 10123, indicating was 3/19/14. R57 1 the required notice of continued stay. R57 1 after her medicare nued. 1/1/14, at approximately nursing (DON) stated the policy specific to how to s, and verified there were on file for R1N or R57. In a Haven Homes Tool and a blank notice of continued stay, however, the facility process on how nedicare appeal rights or rs the residents must D RESPECT OF te care for residents in a comment that maintains or t's dignity and respect in ther individuality. In not met as evidenced interview, and document to ensure 4 of 4 residents who required staff R66 and R7), were		an in-service on 10/16/14 for employees who have been designated as the responsibly parties for issuing the NOM and/or NEMB-SNF to the residents and/or their POAs, regarding the CMS forms the are required, as well as the proper way to issue these denials to the receiving party. The policy for issuing Medical denials will also be reviewed that time, and directions intended to guide them with process will be provided to the for them to use as a reference the future. 4. DON/Designee will condumonthly audits of all Medical Denials issued throughout earnouth for timeliness and use the appropriate forms per CM guidelines. This will be done each month x6 months. Resulting will be brought to the QA Committee for further review and/or recommendation.	e NC at this he in of 4S lts	

	IT OF DÉFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE
	activities of dally live mobility, transfer, we was not steady, and staff assistance. R64's care plan dain at high risk for falls admission to the thanticipate R64's to mat on the floor wheafety alarm system socks while in bed, R64's wheelchair/of anti-rollback device wheelchair. R64's Fall Risk/Residated 5/20/14, indicated 5/20/14, indicated 5/20/14, indicated falls risk; [six] 6 falls attempts self transfedelusional reverting pastor Gripper soc [wheelchair] alarm; system remain approaction 7/27/14. Acc R64's progress note fall on 7/27/14. Acc R64's alarm sounded observed sitting on the had no injuries. R64 wanted to go to school staff he needed staff assisted the resurinated. Staff was assessment or invested to go to represent the propriate, new interpropriate, new interpropriate, new interpropriate in the staff assisted the resurinated.	ing (ADL), including bed valking, and toilet use. R64 d only able to stabilize with ded 8/19/14, indicated R64 was and had falls prior to and after e facility. Staff were directed to leting needs, place the floor en in bed, have the call light non while in bed, wear gripper ensure safety alarm was on hair, and ensure an was on the residents traint Evaluation Review ated, "Resident remains high in [three] 3 months. Resident ers frequently. Confused and to his days of being a cks when in bed; W/C motion sensor; Bed alarm opriate. Floor mat added." It is indicated the resident had a ording to the progress notes, d, and the resident was he floor at his bedside and was alert, and reported he bol and rolled out of bed. R64 to go to the bathroom and he unable to provide any further stigation of the fall to interventions were erventions were needed, and was being implemented and	F	323	2. All residents with 3 or more falls in the past 2 months, OR one fall with major injury in the past 6 months, will be subject the same review/investigation described in #1. Additional interventions were implemented for these residents as well. 3. On 10/9/14 or 10/10/14, DC held an in-service during which a thorough review of the Have Homes Fall Prevention Policy was reviewed. During this time training was also provided for effective fall prevention techniques and interventions in the long term care environment and what their role is in preventing resident falls. This policy operates under the notion that all nursing department employees are members of the Fall Reduction Committee, and all members are involved in the mandatory fall scene investigation report that is required to involve all staff on the floor at the time of the fall every time a fall occurs.	d N	

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
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F 323	Continued From pa	ge 50	F 320	3		
First d	another fall on 8/24/ progress notes, R64 was observed on the injuries were noted. clip his nails. Staff w further assessment determine if current appropriate, if there residents falls, or if r needed to prevent fu During interview on 9 registered nurse (RN of conducting post fa there was no further regarding these falls, were not completed to caused the fail, if the the current interventions nee stated, "We are work know he [R64] had a Although R64's fall as ndicated the resident prior three months wh he facility was unable ncident reports, or an he falls they had iden R3's diagnoses listed ncluded visual loss, s nvoluntary movement ementia, and frequer	were any trends with the new interventions were arther falls. 2/12/14, at 10:00 a.m., 1)-B stated she was in charge and post fall assessments to determine what may have be were any trends noted, if cons were appropriate, or if ded to be modified. RN-B and injury and injury and fall ast week." Seessment dated 5/20/14, had fallen six times in the facility are to provide progress notes, by documentation regarding tiffed in the fall assessment. On the undated facesheet pasm of muscle, abnormal s, lack of coordination,		Staff are required to meet soon as possible after the factors to conduct an investigation to identify all contributing factors and cora root cause analysis for the ultimate cause of the fall. Finally, staff must come up a new intervention related to identified root cause, with thopes of preventing additionals of this type in the future educational in-service was provided on 10/9/14 or 10/1 for all members of the nursiteam, where the fall preventional individuals additional education regardifall prevention interventions were reviewed.	all nduct e o with to the the onal re. A 10/14 ing tion	

DEPAI CENTI	RTMENT OF HEALTH ERS FOR MEDICARE	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 10/01/2 FORM APPROV	
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F F F T T T T T T T T T T T T T T T T T	was severely cognitive textensive assistance asteady when standing steady when standing an interview of stated R3 had three 8/22/14, and 9/4/14. Impulsive and leaned often rolled out of he not injured during the not injured during the not injured during the not injured during the not injured during the not injured during the new seated in her wheeld the nurses station. R back of her blouse, a anti-rollback device of attempted to stand members attempted in her to sit down. R3 wheelchair and would wheelchair which would was attached to her. Of member offered R3 a and read calmly in heminutes paging through about each picture. R3's care plan dated files alls. Staff were directed polleting needs. The capposite of the capposite of	lively impaired, required e with all ADL's, and was not ag or transferring. In 9/8/14, at 4:20 p.m., RN-A recent falls, on 8/20/14, RN-A stated R3 was at forward in her chair and rechair. RN-A stated R3 was ese falls. In the area in front of 3 had a alarm clipped to the nd had a Safe-T-Mate on her wheelchair. R3 any times and multiple staff to redirect R3 and assisted as able to self propel her of the near forward in her ald sound the alarm which on one occasion, a staff magazine, which R3 sat rewheelchair for several ghithe magazine and talking and to observe for unsafe pate R3's needs, especially are plan also directed staff esp her busy, to offer towels pe surfaces she could	F 32	- Company Comman	5	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		l 245497	B. WING			09.	/12/2014
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F 323	outside of her room were no injuries not going to get to her a increased confusion toileted and laid down provide any further determine the caus interventions were a interventions were a interventions were a interventions were a interventions were a interventions were a interventions were a interventions were a interventions were a interventions were a interventions were a interventions were a interventions were a intervention on 08/22/2014, R3's observed slowly fall room. No injuries we attempting to get up room when she fell. her wheelchair and restroom to be toiled provide any further appropriate, or if ne On 9/5/14, R3's aland witnessed her stand desk in the main pastanding to reach for front of her at the definition her wheelchair closer to her. Staff of further assessment current interventions were resistered nurse (RI charge of conduction RN-B stated there wavailable regarding assessments were what may have cause interventions were rewhat may have cause of the standard	and fell to her knees. There ted. R3 indicated she was appointment. Staff noted in after lunchtime and R3 was with for nap. Staff was unable to assessment of the fall to e of the fall, if current appropriate, or if new needed. Is alarm sounded and she was ing to the floor in the activity ere noted. R3 stated she was and walk out of the activity R3 was assisted back into promptly assisted to the ted. Staff was unable to assessment of the fall to interventions were witherventions were with watermelon that was in esk. R3 was assisted back and the food was placed was unable to provide any of the fall to determine if swere appropriate, or if new needed. On 9/12/14, at 10:00 a.m., N)-B indicated she was in g post fall investigations. Was no further information	F3	323			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
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SS=F	followed. The facility undated and Risk/Restraint Fall Evaluation will [director of nursing] hours after a reside 483.30(a) SUFFICIL PER CARE PLANS The facility must ha provide nursing and maintain the highes and psychosocial will determined by residindividual plans of compersonnel on a 24-hours of each of personnel on a 24-hours care to all residents care plans: Except when waived section, licensed nurse to serve as a duty. This REQUIREMEN by: Based on observation	I policy titled Fall Prevention Evaluation included, "The Post be completed by the DON or her/his designee within 72 nt fall." ENT 24-HR NURSING STAFF ve sufficient nursing staff to I related services to attain or it practicable physical, mental, ell-being of each resident, as ent assessments and are. byide services by sufficient the following types of your basis to provide nursing in accordance with resident d under paragraph (c) of this rses and other nursing d under paragraph (c) of this hust designate a licensed charge nurse on each tour of T is not met as evidenced on, interview, and document	F3		F 353 1. R11 receives baths routinely accorthe frequency specified in her plan of and occasionally in addition to this, prequest. R1, R7, R47, R31 & R55 were evaluated by Physical and Occupation Therapies to establish a "baseline" of current level of functional abilities, ar restorative OR functional maintenance program, including updated ambulating programs has been set up in order to effectively address any functional limit the resident may have, as well as to pany further decline. These updated programs will be communicated to the and restorative nursing staff to carry consistently and according to the rescare plan. R7's CAAs were reviewed a modified to address the resident's was transfer ability and current contractusts and series and the series of the seri	ding to care, er her all hal their nd a se on more itations or event ident alking, res. R	5. October 22 nd 2014
	review, the facility fa	iled to ensure sufficient ailable to provide services in			been re-educated about the facilities pressure ulcer prevention policy, and importance of compliance related to	the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245497	B. WING		09/12/2014		
	PROVIDER OR SUPPLIER	_AIN		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 353	accordance with ea 48 residents (R7, R R12, R52, R66, and members (FM-B) we cares were not being this practice had the residents who residents who residents who residents who residents who residents who residents who residents who residents who residents who residents who residents who residents who residents who residents who residents who residents where the first and the second of the weak a result, she felt ambulation and posterior and was unable to reported R7 had different and was unable to reported R7 had different wheelchair. R7's annual Minimus (R7's annual Minimus (R7's annual Minimus (R7's current signed (R7's current signed (R7's current signed (R7's restorative nur (R7's restorativ	ch resident's needs for 11 of 47, R1, R31, R55, R56, R11, R7) and 1 of 4 family ho had concerns resident g met related to lack of staff. The potential to affect all 48 and in the facility. Talked according to the enursing orders. During the analysis and R7, and R7 had a decline in the enough staff to walk R7, and R7 had a decline in the enough staff to walk R7, and R7 had a decline in the enough staff to walk R7, and R7 had a decline in the enough staff to walk R7, and R7 had a decline in the enough staff to walk transferring now, raise her feet up while in the entremity, and required on assistance with the balance was impaired and do with staff assistance. The physician orders dated aff to walk the resident 29-57 of two staff, twice daily using sing documentation from April 1014, lacked documentation alked/ambulated by staff from the program was in shambles	F 353	turning and repositioning schedule in care plan, as well as for all residents' planned turning and repositioning schedules. R12, R66 & R7 are current provided assistance with dining in an dignified manner. DON contacted FM 10/10/14 to inquire about the conce brought forth on 9/10/14, as there we previous record or formal complaint FM-B was satisfied with explanation a cares and additional training. In the DON will work with FM-B to resolve concerns according to the grievances. 2. The facility has determined that all residents in the building are potential risk to be affected by this practice. 3. DON worked on the floor with the on several occasions & on all shifts in to evaluate the workload and/or determined there is enough staff present. DON Administrator also investigated reason and/or explanations for times when different employees successfully and completed all cares for all residents we one occasion, even 2 less CNAs as contowhat is normally staffed. CNA staffithours have also been compared to his performing neighboring facilities with census and case mix, all of which show significantly less staff than Haven Hora result, consistent assignments have developed and will go into effect duri week of 10/13/14. Daily assignment	tly more 1-B on rns vas no on file. about future s policy. I other lly at CNAs order ermine and ons timely rith, on mpared ing gh similar w nes. As been		
	right now, and she v	vas trying to revamp the		week of 10/15/14. Daily assignment	i		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DAT	. <u>0938-0391</u> E SURVEY IPLETED
NAME OF BROKEN	245497	B. WINC			09/	12/2014
NAME OF PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE		
HAVEN HOMES OF MAPLE P	LAIN		,	520 WYMAN AVENUE, PO BOX 369		
(X4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES	T	Į įv	MAPLE PLAIN, MN 55359		T
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 252 6				schedules for resident bathing that	the	
F 353 Continued From pa	-	F:	353	nursing assistants to follow each w	eek was	
program. She verif	ied there was no evidence that			revised to be more evenly distribut	ed across	
R7 was being walk	ea.			the span of the weekdays, and mo	e evenly	
An interview on 9/1	0/14, at 1:00 p.m. was			distributed amongst day and eveni	ng shifts,	
completed with NA-	-A who stated staff tries to			and thereby have become more		
ambulate residents	, but it does not always			manageable for the staff to comple	ete each	
	the lack of staffing. NA-A able to complete ROM for			day. No additional shfits were adde		
residents either, an	d stated, "I feel sorry for the			A structured process has been crea	atad for	
	they need the range of			monitoring CNAs to ensure cares a		
motion." NA-A stated staff just does not have any extra time to provide any ROM or ambulation.				completed as it has been assigned,	•	
extra time to provide	e any ROIM of ambulation.			· · · · · · · · · · · · · · · · · · ·		
R47 stated during in	nterview on 9/8/14, at 3:57			consistent assignment lists have be		
p.m., there was not	sufficient staff at the present			implemented to ensure accountable	'	
	ne waited for over 20 minutes			staff. Education has been provided		
	o an hour for staff to respond			nursing department staff on 10/9 8		
	did not feel that was so reported that due to staffing			10/10/14 about the new processes		
shortage, she had to	o wait a long time to be			assignments to help ensure care de		
served her food and	by the time she gets her food			addition to very clear expectations		
it is cold.				completion that all department stat		
Desir				held accountable for during each sh	ift that	
During a second into	erview on 9/8/14, at 7:02 p.m. Id transfer herself to the			they work. Further, education has a		
I .	pes not respond to her call			provided to train staff of the expect	ed and	[
light. She stated she				appropriate actions to take if they f	eel they	
incontinent of urine	or stool because of having to			are unable to complete the bath/sh	owers	
	a result will transfer herself.			that they are assigned each day, pri	or to	
She stated she was				ever falling behind and/or having a	resident	
because of previous	r herself to the bathroom falls, however, she can not			miss a bath/shower, in order to mai	ntain the	
wait for staff over 20	minutes for assistance. She			provision of quality resident care. A		
reported the nursing	assistants are aware she			training for Supervision for nurses in		
does this due to staf	f shortage. R47 stated she is			building will be conducted on 10/13		
supposed to be assi	sted with walking twice a day,			the nurses be better able to hold CN	•	
nowever, staff is not	able to do this as they just			accountable. DON will also provide s		
been walked for abo	she didn't think she had ut 10 days.			education on 10/9 or 10/10/14 rega		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY PLETED	
		245497	B. WING _		09/	12/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE
F 353	on 9/10/14, at 1:15 to staff a "couple of being walked and lose strength. FM-twice each day, bustated R47 had fall was not willing to be assistance from stanswered for long stated there were call light was on for would have to go staff to assist her. R47's quarterly Millians was cognitively into f delirium. She in two staff with bed of one staff for trapersonal hygiene, assistance of one R47's nursing assistance of one walker and wheeld Physician orders, complete passive ankles, digits, kneed ally. In addition, be walked 57-115 wheelchair behind transfer belt.	FM)-B of R47 was interviewed in p.m. and stated he had talked of times" that R47 was not he was concerned she would B stated R47 was to be walked at it seldom happened. FM-B len a couple of times as she be incontinent while waiting for aff when her call light was not periods of time. FM-B also times when he visited and the prover 15 minutes and he but to the hall and try to find another to the hall and try to find another call times when he visited and the pout to the hall and try to find another to the hall and try to find another to the hall and try to find another to the hall and try to find another to the hall and try to find another to the hall and try to find another the staff with ambulation.	F 35	the importance and necessity care documentation and the interest that it can have on staffing lever. 4. DON will ensure that staffing remain adequate and at a lever residents receive the care the of call light audits, documents of ambulation and/or restorated Audits (completed by Charge conducted daily x7 days, then weeks with results brought to review and recommendation.	ndirect effect vels. In glevels el where all y need via use etion reviews tive programs. Nurse) will be weekly x6 QA for further	

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245497	B. WING	3		00/42/2044	
	PROVIDER OR SUPPLIER HOMES OF MAPLE PL	AIN		STREET ADDRESS, CITY, STATE, ZIP C 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	ODE	09/12/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
	to September, 2014 no documentation the range of motion to each of the completation of	were reviewed and there was nat R47 received any passive extremities or ambulation. ensed practical nurse eted on 9/11/14, at 11:15 a.m. was aware R47 was to be with staff assistance. LPN-C documentation on the sheets to identify if R47 had ambulation or any PROM in 14, at 1:10 p.m. she did not client staff and she has been the call light was not being gh. R1 also was concerned ceiving ROM, and when had been receiving ROM ut, "monthly," using her d. completed 6/25/14, indicated gnitive ability, had no signs ium/ psychosis, had no not had limitations to one side er extremity (contractures). 7/2/14, and restorative 4/2014- 9/2014, directed we range of motion daily to ws, wrists, and fingers. Ing sheets for April 2014, to lacked any documentation motion was being done for	F3	353			
į.	Duffing an interview o	n 9/10/14, at 7:10 a.m.				l l	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '			(X3) DATE SURVEY COMPLETED	
	245497	B. WING_		09/	/12/2014	
PROVIDER OR SUPPLIER	_AIN		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	1 00.	12/2014	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL)) BE	(X5) COMPLETION DATE	
licensed practical not have time to do residents due to being an interview on 9/10 assistant (NA)-E wa ROM and ambulation done due to being a During an interview stated the restorative several months ago not have time to proresidents. When interviewed on stated there was not this time, and NA's ware residents with ambulating enough staff and assist residents program. R31 reported on 9/1 stroke a while back He stated he would not get the chance be staff to help him. R31's quarterly MDS R31 was cognitively on two staff for all track extensive assistance locomotion.	urse (LPN)-A stated NAs did restorative nursing for ing short staffed. D/14, at 9:18 a.m. with nursing is completed and she stated on of residents were not being short staffed. On 9/10/14, at 1:25 p.m. NA-B re aide position had been cut, and nursing assistants did wide ROM and ambulation to on 9/11/14 at 10:30 a.m., RN-F formal restorative program at were directed to assist station and ROM. RN-F stated to concerns to her about not to complete resident cares with the restorative nursing 1/14, at 3:18 p.m. he had a and did not walk anymore. like to use his legs, but does because there are not enough as dated 6/11/14, indicated impaired, totally dependent ansfers, and needed of one staff for all	F 35	53			
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa licensed practical not have time to do residents due to being stated the restorativ several months ago not have time to pro residents. When interviewed or stated there was not this time, and NA's v residents with ambut NA's had brought up having enough staff and assist residents program. R31 reported on 9/1 stroke a while back He stated he would not get the chance be staff to help him. R31's quarterly MDS R31 was cognitively on two staff for all tra extensive assistance locomotion. R31's care plan date to receive PROM me	PROVIDER OR SUPPLIER **GOMES OF MAPLE PLAIN** **SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)* Continued From page 58 licensed practical nurse (LPN)-A stated NAs did not have time to do restorative nursing for residents due to being short staffed. An interview on 9/10/14, at 9:18 a.m. with nursing assistant (NA)-E was completed and she stated ROM and ambulation of residents were not being done due to being short staffed. During an interview on 9/10/14, at 1:25 p.m. NA-B stated the restorative aide position had been cut several months ago, and nursing assistants did not have time to provide ROM and ambulation to residents. When interviewed on 9/11/14 at 10:30 a.m., RN-F stated there was no formal restorative program at this time, and NA's were directed to assist residents with ambulation and ROM. RN-F stated NA's had brought up concerns to her about not having enough staff to complete resident cares and assist residents with the restorative nursing program. R31 reported on 9/11/14, at 3:18 p.m. he had a stroke a while back and did not walk anymore. He stated he would like to use his legs, but does not get the chance because there are not enough staff to help him. R31's quarterly MDS dated 6/11/14, indicated R31 was cognitively impaired, totally dependent on two staff for all transfers, and needed extensive assistance of one staff for all	PROVIDER OR SUPPLIER ### ADMINISTRATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 58 licensed practical nurse (LPN)-A stated NAs did not have time to do restorative nursing for residents due to being short staffed. An interview on 9/10/14, at 9:18 a.m. with nursing assistant (NA)-E was completed and she stated ROM and ambulation of residents were not being done due to being short staffed. During an interview on 9/10/14, at 1:25 p.m. NA-B stated the restorative aide position had been cut several months ago, and nursing assistants did not have time to provide ROM and ambulation to residents. When interviewed on 9/11/14 at 10:30 a.m., RN-F stated there was no formal restorative program at this time, and NA's were directed to assist residents with ambulation and ROM. RN-F stated NA's had brought up concerns to her about not having enough staff to complete resident cares and assist residents with the restorative nursing program. R31 reported on 9/11/14, at 3:18 p.m. he had a stroke a while back and did not walk anymore. He stated he would like to use his legs, but does not get the chance because there are not enough staff to help him. R31's quarterly MDS dated 6/11/14, indicated R31 was cognitively impaired, totally dependent on two staff for all locomotion. R31's care plan dated 8/20/14, indicated R31 was to receive PROM motion to hips, knees, and	PROVIDER OR SUPPLIER 10MES OF MAPLE PLAIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 58 Icicensed practical nurse (LPN)-A stated NAs did not have time to do restorative nursing for residents due to being short staffed. An interview on 9/10/14, at 9:18 a.m. with nursing assistant (NA)-E was completed and she stated ROM and ambulation of residents were not being done due to being short staffed. During an interview on 9/10/14 at 1:25 p.m. NA-B stated the restorative aide position had been cut several months ago, and nursing assistants did not have time to provide ROM and ambulation to residents. When interviewed on 9/11/14 at 1:30 a.m., RN-F stated there was no formal restorative program at this time, and NA's were directed to assist residents with ambulation and ROM. RN-F stated NA's had brought up concerns to her about not having enough staff to complete resident cares and assist residents with the restorative nursing program. R31 reported on 9/11/14, at 3:18 p.m. he had a stroke a while back and did not walk anymore. He stated he would like to use his legs, but does not get the chance because there are not enough staff to help him. R31's quarterly MDS dated 6/11/14, indicated R31 was cognitively impaired, totally dependent on two staff for all transfers, and needed extensive assistance of one staff for all locomotion.	245497 245497 245497 245497 245497 245497 245497 245497 245497 245497 245497 25TREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 58 Ilicensed practical nurse (LPN)-A stated NAs did not have time to do restorative nursing for residents due to being short staffed. An interview on 9/10/14, at 9:18 a.m. with nursing assistant (NA)-E was completed and she stated ROM and ambulation of residents were not being done due to being short staffed. During an interview on 9/10/14, at 1:25 p.m. NA-B stated ther estorative alde position had been cut several months ago, and nursing assistants did not have time to provide ROM and ambulation to residents. When interviewed on 9/11/14 at 10:30 a.m., RN-F stated there was no formal restorative program at this time, and NA's were directed to assist residents with ambulation and ROM. RN-F stated A's had brought up concerns to her about not having enough staff to complete resident cares and assist residents with the restorative nursing program. R31 reported on 9/11/14, at 3:18 p.m. he had a stroke a while back and did not walk anymore. He stated he would like to use his legs, but does not get the chance because there are not enough staff to complete residents with anymore. He stated he would like to use his legs, but does not get the chance because there are not enough staff to rell transfers, and needed extensive assistance of one staff for all locomotion.	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245497	B. WING		·	09/	12/2014
	PROVIDER OR SUPPLIER	LAIN		1:	STREET ADDRESS, CITY, STATE, ZIP CODE 520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	·	
(X4) ID PREF!X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	bilateral shoulders, A review of R31's re 8/12/14, through 9/ PROM only 12 time RN-A stated the factormalized restoratitime due to lack of During interview on assistant (NA)-E stany range of motion R55 was not received staff shortage. R55's quarterly MD did not walk, had not walk, had not walk, had not walk, had not walk, had not walk, had not walk, had not walk was total transferring, toiletin daily living. R55 sheets from the dated 1/1/14-6/30/1 R55 received daily included the following shoulder, wrist, ank The 7/2014 MAR id were provided out of facility was unable to had received passive to 9/11/14. During interview on stated R55's ROM is because they didn't time completing the	elbows, wrists and fingers. estorative nursing sheets from 14/14, indicated R31 received es. cility did not currently offer ve programs at the present staffing. 09/11/14, at 9:45 a.m. nursing ated R31 did not ever receive	F	353			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LTIPLE CONSTRUCTION DING	(XS	(X3) DATE SURVEY COMPLETED	
		245497	B. WING			09/12/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 1520 WYMAN AVENUE, PO B MAPLE PLAIN, MN 55359	OX 369	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	ACTION SHOULD BE O THE APPROPRIAT	
F 353	which the resident needing. During interview or stated range of more completed and R5 result. NA-H stated her arms and legs the resident dresse asked the resident different clothing. R56 stated on 9/8/ the facility had eno to wait a long time. During interview or stated he had pain up sitting in his who 6:00 a.m. that more than the facility had eno to wait a long time. The quarterly MDS was cognitively into assistance of two sassistance of one schair, and was at riulcers. He currently (Unstageable) preson admission over. R56's admission cadated 12/17/13, idea repositioned at no good puring continuous from 7:18 a.m. throwing his wheelchair arweight independent.	had been assessed as 1 9/11/14, at 10:13 a.m., NA-H otion services were not being 5 was becoming stiffer as a 1 R55 wasn't able to stretch out like before which made getting and more difficult so facility staff is family member to bring in 14, at 3:50 p.m. he did not feel ugh staff. He reported having to have his call light answered. 1 9/10/14, at 7:20 a.m. R56 in his buttocks and had been belchair since approximately ning without repositioning. 1 dated 6/11/14, identified R56 act and he required extensive staff for bed mobility, extensive staff for repositioning in the sk for developing pressure y had one stage IV source ulcer, that was present a year ago, and was unhealed. 1 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 2 are area assessment (CAA) 3 are area assessment (CAA) 3 are area assessment (CAA) 4 are area assessment (CAA) 5 are area assessment (CAA) 6 are area assessment (CAA) 6 are area assessment (CAA) 6 are area assessment (CAA) 6 are area assessment (CAA)	F3	353		

NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN SITERET ADDRESS, CITY, STATE, ZIP CODE 1520 WMAN AVENUE, PO BOX 369 MAPLE PLAIN, WN 55359 D PROVIDER'S PLAIN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 61 assessed. During interview on 9/10/14, at 9.46 a.m. nursing assistant (NA)—A stated the facility was short staffed and NA's did their best to assist residents to reposition as assessed but at times were unable to do so. NA-A verified RSh and not been repositioned every two hours as assessed because of the facility of having sufficient staffing to provide resident cares. R11 stated during an interview on 9/8/14, at 4:23 p.m. she had gone for a couple of weeks without a bath because the facility in thaving sufficient staffing to provide bathing assistance. In addition, R11 stated she had to wait 40 minutes to an hour for staff to respond to her call light when she had to go to go to the bathroom. In staff to respond to her call light on for over 40 minutes to go to the bathroom so she had to, "Poop in my diaper." R11's quarterly MDS dated 8/27/14, identified R11 had moderate cognitive impairment and required extensive assistance from staff for tolleting. R11's Point of Care Bathing Record (where the nursing assistants document when a resident receives cares), identified R11 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath on 8/28/14, 28 days later. Divide interview on 9/8/14 at 3/3/3 p.m. NA K.		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
HAVEN HOMES OF MAPLE PLAIN (X4) ID (X			245497	B. WING		0,	9/12/2014	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 61 assessed. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short staffed and NA's did their best to assist residents to reposition as assessed but at times were unable to do so. NA-A verified R66 had not been repositioned every two hours as assessed because of the facility not having sufficient staffing to provide resident cares. R11 stated during an interview on 9/8/14, at 4:23 p.m. she had gone for a couple of weeks without a bath because the facility didn't have any bath aids to provide bathing assistance. In addition, R11 stated she had to wait 40 minutes to an hour for staff to respond to her call light when she had to go to go to the bathroom. She stated this happened a lot, and a few nights ago she had her call light on for over 40 minutes to go to the bathroom so she had to, "Poop in my diaper." R11's quarterly MDS dated 8/27/14, identified R11 had moderate cognitive impairment and required extensive assistance from staff for toileting. R11's Point of Care Bathing Record (where the nursing assistants document when a resident receives cares), identified R11 had received a tub bath on 7/3/14.1 The next record of R11 receiving assistance with bathing was a partial bath on 8/28/14, 28 days later.			LAIN		1520 WYMAN AVENUE, PO BOX	ZIP CODE		
assessed. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short staffed and NA's did their best to assist residents to reposition as assessed but at times were unable to do so. NA-A verified R56 had not been repositioned every two hours as assessed because of the facility not having sufficient staffing to provide resident cares. R11 stated during an interview on 9/8/14, at 4:23 p.m. she had gone for a couple of weeks without a bath because the facility didn't have any bath aids to provide bathing assistance. In addition, R11 stated she had to wait 40 minutes to an hour for staff to respond to her call light when she had to go to go to the bathroom. She stated this happened a lot, and a few nights ago she had her call light on for over 40 minutes to go to the bathroom, no staff came to help her to the bathroom, no staff came to help her to the bathroom so she had to, "Poop in my diaper." R11's quarterly MDS dated 8/27/14, identified R11 had moderate cognitive impairment and required extensive assistance from staff for toileting. R11'S Point of Care Bathing Record (where the nursing assistants document when a resident receives cares), identified R11 had received a tub bath no 7/83/14. The next record of R11 receiving assistance with bathing was a partial bath on 8/28/14, 28 days later.	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE ACTOR CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION	
During interview on 9/9/14, at 3:03 p.m. NA-K stated there are not enough staff to provide residents a bath. NA-K stated she often is not able to complete all the resident cares because of		assessed. During interview on assistant (NA)-A stastaffed and NA's did to reposition as assunable to do so. Na repositioned every the because of the facilistaffing to provide residents abath because the aids to provide bath R11 stated she had for staff to respond to go to go to the bashappened a lot, and call light on for overbathroom, no staff to bathroom so she had R11's quarterly MDS had moderate cogniextensive assistance R11's Point of Care nursing assistants direceives cares), identification of the point of the po	9/10/14, at 9:46 a.m. nursing ated the facility was short of their best to assist residents essed but at times were A-A verified R56 had not been two hours as assessed ity not having sufficient esident cares. In interview on 9/8/14, at 4:23 for a couple of weeks without facility didn't have any bath ing assistance. In addition, to wait 40 minutes to an hour to her call light when she had athroom. She stated this a few nights ago she had her 40 minutes to go to the same to help her to the ad to, "Poop in my diaper." So dated 8/27/14, identified R11 five impairment and required the from staff for toileting. Bathing Record (where the ocument when a resident intified R11 had received a tub to next record of R11 receiving ing was a partial bath on the enext at 3:03 p.m. NA-K enough staff to provide A-K stated she often is not	F 3	353			

F 353 Continued From page 62 the facility being short staffed. NA-K stated residents complain of the long wait times when they put on their call light, and some residents had transferred independently when staff is not able to respond timely to their call light due to being short staffed. During interview on 9/10/14, at 2:23 p.m., NA-F stated it was possible that some residents had gone for weeks without getting a bath because the facility does not have enough staff to complete all the resident cares. NA-F stated if another staff calls in sick, the facility does not replace them. NA-F stated she had complained to the administration about this because she knew resident cares were being neglected. During interview on 9/11/14, at 10:13 a.m., NA-H stated there was not enough staff to accommodate baths for the residents, and resident baths are not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist residents. During interview on 9/12/14, at 9:34 a.m., NA-B stated resident baths are not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m., registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staffin, however, the facility is still working on the staffing concerns.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED			
HAVEN HOMES OF MAPLE PLAIN SIMMARY STATEMENT OF DEFIDIENCIES 1250 WYMAN AVENUE, P. DOX 389 MAPLE PLAIN, MN 55359 1250 WYMAN AVENUE, P. DOX 389 MAPLE			245497	B. WING		00	09/12/2014		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 62 the facility being short staffed. NA-K stated residents complain of the long wait times when they put on their call light, and some residents had transferred independently when staff is not able to respond timely to their call light due to being short staffed. During interview on 9/10/14, at 2:23 p.m., NA-F stated if another staff calls in sick, the facility does not replace them. NA-F stated she had complained to the administration about this because she knew resident cares were being neglected. During interview on 9/11/14, at 10:13 a.m., NA-H stated there was not being completed regularly, NA-H stated twas possible R11 oud have gone almost a month without a bath due to the lack of staff available to assist residents. During interview on 9/12/14, at 9:34 a.m., NA-B stated resident baths are not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA-s had brought up concerns regarding not being able to complete residents baths due to lack of staffin, neweyer, the facility is still working on the staffing concerns.			_AIN		1520 WYMAN AVENUE, PO BOX	IP CODE	112/2014		
the facility being short staffed. NA-K stated residents complain of the long wait times when they put on their call light, and some residents had transferred independently when staff is not able to respond timely to their call light due to being short staffed. During interview on 9/10/14, at 2:23 p.m., NA-F stated it was possible that some residents had gone for weeks without getting a bath because the facility does not have enough staff to complete all the resident cares. NA-F stated if another staff calls in sick, the facility does not replace them. NA-F stated she had complained to the administration about this because she knew resident cares were being neglected. During interview on 9/11/14, at 10:13 a.m., NA-H stated there was not enough staff to accommodate baths for the residents, and resident baths are not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist residents. During interview on 9/12/14, at 9:34 a.m., NA-B stated resident baths are not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staff, however, the facility is still working on the staffing concerns.	PREFIX	(EACH DEFICIENCY	' MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
During dining observation on 9/8/14, at approximately 5:40 p.m. NA-P was observed		the facility being shore residents complain they put on their call had transferred indeable to respond time being short staffed. During interview on stated it was possib gone for weeks with the facility does not complete all the resianother staff calls in replace them. NA-F to the administration knew resident cares During interview on stated there was not accommodate baths resident baths are not not accommodate baths resident baths are not accommodate baths are not accommodate baths are not accommodate baths are not accommodate. The stated it was palmost a month with staff available to assume the stated resident baths timely. NA-B stated been bathed in almodack of staffing. During interview on stated been bathed in almodack of staffing. During interview on stated been bathed in almodack of staffing. During interview on stated been bathed in almodack of staffing.	of the long wait times when I light, and some residents ependently when staff is not ely to their call light due to 9/10/14, at 2:23 p.m., NA-F le that some residents had out getting a bath because have enough staff to ident cares. NA-F stated if sick, the facility does not stated she had complained about this because she were being neglected. 9/11/14, at 10:13 a.m., NA-H enough staff to for the residents, and ot being completed regularly. I could have gone out a bath due to the lack of ist residents. 9/12/14, at 9:34 a.m., NA-B are not being completed it was possible R11 had not st a month because of the could have gone out a bath due to the lack of ist residents. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m. 9/11/14, at 10:30 a.m.	F 3	53				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245497	B. WING _		09	/12/2014
	PROVIDER OR SUPPLIER	_AIN		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 353	sitting on a rolling stable with R12, R52 residents received the table on the storesident giving then rolling on the stool or resident. NA-P woo food, set the fork or immediately roll over continued rolling are entire meal. R12's quarterly MD R12 had severe concequired extensives. R52's quarterly MD R52 had severe concequired extensives. R66's quarterly MD R52 had severe conceptive extensive staff assistance. R7's quarterly MDS had severe cognitive extensive staff assistance. During interview on stated she was requarted extensive on stated she was requarted extensive. The was not enough the residents were being what they have to smeals.	tool in the dining room at a part of the dining room at a part of the dining room at a part of the dining food, NA-P rolled around on a bite of food, and then using her feet to the next all give a resident a bite of a spoon down, and the room of the dining of the dini	F 35	53		

NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN STREET ADDRESS, CITY, STATE, 2IF CODE 1520 WYMAN AVENUE, PO BOX 359 MAPLE PLAIN, MN 55358 FROVIDER'S PLAN OF CORRECTION FROM DEFFICIENCY OR LIST BE PRECEDED BY FILL FROM DEFFICE OR SHOULD BE PRECEDED BY FILL FROM DEFFICE OR SHOULD BE PRECEDED BY FILL FROM DEFFICE OR SHOULD BE PRECEDED BY FILL FROM DEFFICE OR SHOULD BE PRECEDED BY FILL FROM DEFFICE OR SHOULD BE PRECEDED BY FILL FROM DEFFICIENCY FROM DEFFICIEN			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
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PREFIX TAG REGULATORY OR USC IDENTIFYING INFORMATION) F 353 Continued From page 64 LPN-A stated sometimes the residents needed to wait for help because the facility is short staffed. LPN-A stated the managers are not typically assisting residents with dining, however, the week during the survey, they have been helping out. LPN-A stated residents have voiced concerns of the call lights not being answered and not having cares provided. LPN-A stated restorative nursing/ ambulation for the residents have complained of not walking and feel they are losing strength. LPN-A stated on the weekends, the staff brings residents with behavioral issues to the lobby and this falls on the nurse to provide additional supervision, which makes it difficult to complete all the resident cares which need to be completed. When interviewed on 9/10/14, at 6:50 a.m. NA-L stated there were not enough staff on the night shift and staff was struggling to provide the necessary care for over 2 months. NA-L stated residents have been complaining of waiting 45 - 60 minutes for help. NA-L stated when there is a sick call, the staff is not replaced and they work short, and there have been nights the facility had only one nurse working to take care of all the residents have voiced concerns about not having enough staff to complete the cares and she had reported this to the charge nurse on duty multiple times. NA-M stated nothing had changed with staffing, even after reporting residents are not receiving the cares they require. When interviewed on 9/10/14, at 7:01 a.m. NA-N stated the night shift, sick calls are not replaced,			_AIN		1520 WYMAN AVENUE, PO	BOX 369	1 00/	12/2014	_
LPN-A stated sometimes the residents needed to wait for help because the facility is short staffed. LPN-A stated the managers are not typically assisting residents with dining, however, the week during the survey, they have been helping out. LPN-A stated residents have voiced concerns of the call lights not being answered and not having cares provided. LPN-A stated restorative nursing/ ambulation for the residents is not being completed, and residents have complained of not walking and feel they are losing strength. LPN-A stated on the weekends, the staff brings residents with behavioral issues to the lobby and this falls on the nurse to provide additional supervision, which makes it difficult to complete all the resident cares which need to be completed. When interviewed on 9/10/14, at 6:50 a.m. NA-L stated there were not enough staff on the night shift and staff was struggling to provide the necessary care for over 2 months. NA-L stated residents have been complaining of waiting 45 - 60 minutes for help. NA-L stated when there is a sick call, the staff is not replaced and they work short, and there have been nights the facility had only one nurse working to take care of all the residents in the facility. When interviewed on 9/10/14, at 6:57 a.m. NA-M stated residents have voiced concerns about not having enough staff to complete the cares and she had reported this to the charge nurse on duty multiple times. NA-M stated nothing had changed with staffing, even after reporting residents are not receiving the cares they require. When interviewed on 9/10/14, at 7:01 a.m. NA-N stated the night shift, sick calls are not replaced,	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI)	((EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD TO THE APPROP) BE	COMPLETION	
and they often work short staffed.		LPN-A stated some wait for help becaus LPN-A stated the massisting residents during the survey, the LPN-A stated reside the call lights not be cares provided. LP ambulation for the recompleted, and resiwalking and feel the stated on the weeke with behavioral issu on the nurse to provisupervision, which make the resident cares with the resident cares with the resident cares with the resident cares with the resident cares with the resident cares with the resident cares with the resident cares with the resident cares with the resident cares with the resident cares with the resident cares with the resident cares with the resident cares with the resident care with the residents have been 60 minutes for help. Sick call, the staff is short, and there have only one nurse work residents in the facil. When interviewed on stated residents have had reported this multiple times. NA-P changed with staffing residents are not recommended.	stimes the residents needed to se the facility is short staffed. It is an agers are not typically with dining, however, the week they have been helping out. It is have voiced concerns of sing answered and not having N-A stated restorative nursing/ esidents is not being dents have complained of not be yare losing strength. LPN-A ands, the staff brings residents es to the lobby and this falls wide additional makes it difficult to complete all which need to be completed. In 9/10/14, at 6:50 a.m. NA-L but enough staff on the night truggling to provide the over 2 months. NA-L stated in complaining of waiting 45 - NA-L stated when there is a not replaced and they work to be been nights the facility had ing to take care of all the ity. In 9/10/14, at 6:57 a.m. NA-M e voiced concerns about not to complete the cares and so to the charge nurse on duty of stated nothing had go, even after reporting seiving the cares they require.	F 3	53				

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D.	O. 0938-039 ATE SURVEY OMPLETED
NAME OF	DD ON ID TO	245497	B. WING	;			0/40/0044
HAVEN	PROVIDER OR SUPPLIER	LAIN		152	REET ADDRESS, CITY, STATE, ZIP CO 20 WYMAN AVENUE, PO BOX 369 APLE PLAIN, MN 55359		9/12/2014
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I Saaa aa aa aa aa aa aa aa aa aa aa aa a	When interviewed of stated residents are they need and deserostrative services aid and bath aid posmonths ago, and stated fing. She stated the dining room to emanagement had be room, which never had have time to do stated some resident are not receiving the not have time to do stated some residents are not gerestless and then try. When interviewed or stated she did not fer and nursing assistant all cares, including be ambulation. NA-E stated the cand R11 complained to ROM not being do NA-F stated the NA's are simbulation, and baths re not able to complet taffing.	on 9/10/14 at 7:46 a.m. NA-H enot getting the quality care enve, and there had been no for 3 months. The restorative sitions were eliminated several aff had quit due to short residents not being helped in at, and during survey een helping in the dining happens on a regular week. It is have voiced concerns they eir baths because staff does this extra task. NA-H also ts are only assisted twice per from due to staffing, and etting walked so they get to walk alone. In 9/10/14, at 9:18 a.m. NA-E el there were enough staff ts were not able to provide aths, shaving, ROM, and ated residents have all lights not being answered, of having less strength due ne. In 9/10/14, at 1:15 p.m., constantly feel rushed. She upposed to do ROM, is for residents, and the NA's ete this because of short	F3	353	DEFICIENCY)		
SL	ufficient staff to comp ad tears in her eyes	9/10/14, at approximately difference that the facility did not have plete resident cares. NA-B as she stated they are					

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
		245497	B. WING	3	0	0/42/2044
	PROVIDER OR SUPPLIER HOMES OF MAPLE PL	_AIN		STREET ADDRESS, CITY, STATE, ZIP C 1520 WYMAN AVENUE, PO BOX 36 MAPLE PLAIN, MN 55359	CODE	9/12/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	N SHOULD BE	(X5) COMPLETION DATE
·	unable to complete bathing, ROM, dining. When interviewed of stated it is difficult to being short staffe. On 9/11/14, at 9:08 light times was requisitated they did not hout the report. She the facility was using response times. When interviewed of verified there is no for this time. RN-A concomplaints from NA's staff to complete resumbulation. RN-A staff to complete resumbulation. RN-A staff to complete resumbulation. RN-A staff to according interview on stated the facility was resident cares were stated ROM was not residents, specifically stiffer as a result. NA enough staff to according interview on stated the NA's had concept the staffing, however, and they we stated the NA's had continued in the staffing is short staffing, however, and they staffing is staffing in the staffing is staffing in the staffing is staffing.	resident cares, especially 19, and ambulation. In 9/10/14, at 2:07 p.m. NA-O or provide resident cares due d. a.m. a print out of the call ested from the DON, who have the capability of printing did not identify the process of to monitor call light In 9/11/14 at 10:30 a.m. RN-A firmed there have been a about not having enough hident cares or ROM and atted the NA's were asked to swhile assisting to dress is was not a formal program intention of a restorative B/11/14, at 10:13 a.m., NA-H as short staffed and the not being completed. NA-H being completed for y R55 who was becoming and the stated there were not modate baths for the ere often skipped. NA-H complained to the the nurse meetings about er, nothing had been done to	F3	353		

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 245497 B. WING 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLÉTION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 353 | Continued From page 67 F 353 staffing coordinator (MR)-J stated when there was a sick call, replacement depended on the number of staff scheduled. She reported if a sick call resulted in staff working a shift with less than established minimums, she would consult with the director of nursing (DON). She indicated there is no policy on staffing. When interviewed on 9/12/14, at 11:04 a.m. the DON and administrator stated staffing was based on census, not necessarily on resident care levels. The goal was to have six nursing assistants on both the day and evening shift, and three nursing assistants on the night shift. If there is a call in, they have not been replacing the staff if it would require overtime. They stated they had not reduced the hours of staff, and there had not been layoffs, however, they would not replace staff if someone left or retired, until they met the right staff. They stated they felt the facility was significantly overstaffed, and did not believe their was an issue with lack of staffing. They stated they had been trying to educate staff on being more efficient in providing residents cares. They NA's should have been able to complete all of the duties necessary with less staff and they felt the NA's were making a choice to not complete things such as baths or restorative nursing services. DON stated they F-431 5. October 22nd, 2014 used to have nine NA's working at a time and now they have six, because having nine, "Just 1. All expired medications have been didn't make good business sense." removed from the medication carts and all F 431 483.60(b), (d), (e) DRUG RECORDS, F 431 undated multi-dose vials have been LABEL/STORE DRUGS & BIOLOGICALS SS=F removed from the medication storage The facility must employ or obtain the services of refrigerator. All newly-opened vials have a licensed pharmacist who establishes a system been clearly marked with the date of of records of receipt and disposition of all

DEPARTMENT OF HEALTH AND HUMAN SERVICES

opening.

PRINTED: 10/01/2014

•	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY IPLETED
		245497	B. WING			09/	12/2014
	PROVIDER OR SUPPLIER	LAIN		152	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE, PO BOX 369 APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 431	controlled drugs in accurate reconcilia records are in order controlled drugs is reconciled. Drugs and biologic labeled in accordance professional principal appropriate access instructions, and the applicable. In accordance with facility must store a locked compartme controls, and permit have access to the The facility must professional principal facility must store a locked compartme controls, and permit have access to the The facility must professional principal facility must professional permit permanently affixed controlled drugs list Comprehensive Drugs control Act of 1976 abuse, except whe package drug districts.	sufficient detail to enable an tion; and determines that drug or and that an account of all maintained and periodically als used in the facility must be nee with currently accepted bles, and include the sory and cautionary e expiration date when State and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to keys. Tovide separately locked, dompartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to in the facility uses single unit ibution systems in which the ininimal and a missing dose can	F 4	31	2. DON/Designee, partnering with consultant pharmacist conducted review and inspection of all medicall three medication to confirm the were no more expired medication cart or medication storage area. 3. The facility's consultant pharmagreed to conduct a more thorout of the facility's medication carts of month, which includes the remove expired medications from the medication. In addition, all nurses and be reminded during an education service on 10/9/14 or 10/10/14 to importance of checking the expired medication prior to admit addits of medication storage are expired medications monthly x6 with results brought to QA meet review and further recommendations.	a full cations in last there has in any acist has ligh review each wal of all edication for acid instration date hinistration onthly leas for months cings for	
	by: Based on observa review, the facility to ensure expired me medication storage in the storage area	NT is not met as evidenced tion, interview, and document failed to establish a system to dications were removed from a in 2 of 2 medication carts and in the east hallway. In a failed to date an open.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		TE SURVEY MPLETED
		245497	B. WING _		09	/12/2014
	PROVIDER OR SUPPLIER	_AIN		STREET ADDRESS, CITY, STATE, ZI 1520 WYMAN AVENUE, PO BOX MAPLE PLAIN, MN 55359	PCODE	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 431	multi-dose vial in 1 in the medication st potential to affect a residing in the facili admitted residents. Findings include: During observation room on 9/12/14, at nursing (DON)-A ar (LPN)-A, the refrige undated, vial of Tub testing for tuberculc verified the vial was was opened, and w long the vial had be DON-A stated on th Minimum Medicatio Omnicare, Inc. date should have, "Date portion after 30 days the tuberculin protei admitted residents a in the refrigerator, a the refrigerator in the also contained a bot (medication used fo (milligram/milliliter) f with an opened date sticker that directed LPN-A stated R2 ha order for the medication. DOI was expected that a were responsible for	of 1 medication refrigerators orage room. This had the II 48 residents currently by, as well as any newly ty, as well as any newly ty, as well as any newly ty, as well as any newly ty, as well as any newly ty, as well as any newly ty, as well as any newly ty, as well as any newly ty, as well as any newly ty, as well as any newly ty, as well as any newly ty, as well as any newly and lensed with the date it ere unable to determine how en opened in the refrigerator. The facility's, "Recommended in Storage Parameters," from the date of 2013, tuberculin protein when opened; discard unused in Storage Parameters," from the date of 3013, tuberculin protein when opened; discard unused in was used for newly and new employees and was vailable for use. In addition, the medication storage room the of liquid Lorazepam in seizures) 2mg/ml for R2. The bottle was labeled to 3/13/14, with a pharmacy staff to discard after 90 days, and a current PRN (as needed) that was the only se if R2 required a dose of N-A and LPN-A indicated it II staff giving medications of going through medications to going through medications to going through medications to the the type of the type of the type of the type of the type of type of the type of type o	F 43			

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		MPLETED
		245497	B, WING			/12/2014
	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359)	
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	LPN-A, the locked the end of the Eas unopened stock becated Aspirin 32 8/14. LPN-A state available for use thave been removed buring an observation with LPN-A, the New contained Aspir-loan expiration date been using chewastated the Aspir-loago, and should heart.	n on 9/12/14, at 8:50 a.m. with I medication storage cabinet at st hallway, contained four ottles of Geri Care Enteric 5 mg, with an expiration date of ed the bottles of Aspirin were out were expired and should ed. ation on 9/12/14, at 8:55 a.m. lorth/ East medication cart by 81 mg tablets for R38, with e of 9/13. LPN-A stated R38 had able aspirin since 2/14/14, but by tablets were expired a year nave been removed from the	F 43		•	
	LPN-B, the South stock bottle of Ge 325 mg, with an e stated the Aspirin and were expired from the medicat also contained Adunits per gram, for 8/14. R55's physincluded a currer used PRN. Anot Cream 100,000 the medication or current physician current order for In addition, Hydrofor R40 had an e 5/14 however, the	on on 9/12/14, at 9:20 a.m. with medication cart contained a eri Care Enteric Coated Aspirin expiration date of 8/14. LPN-B were available for resident use and should have been removed ion cart. The medication cart ctavis Nystatin Cream, 100,000 or R55, which had expired on sician orders, dated 9/14, at order for Nystatin cream to be her tube of Actavis Nystatin units per gram, for R17 was in art and expired 8/14. R17's orders, dated 9/14, included a Nystatin cream to be used PRN ocortisone Butyrate 0.1% cream expiration date on the tube of the pharmacy sticker indicated the filled on 5/31/13, and was to be	e			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		245497	B. WING	<u></u>	09/12/2014
	PROVIDER OR SUPPLIER	_AIN	-	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE COMPLETION
F 441 SS=D	of R40's current ph lacked evidence of LPN-B verified thes but remained availa all staff giving medicheck expiration da lacked a system to completed. Review of the facility Medications, Biology policy, dated 12/1/0 ensure that medicate Expiration Date on retained longer that manufacturer or su medication or biolo Facility should folloguidelines with responed medication the date opened or when the medication the date opened or when the medication deteriorated medicate once opened. Teturn all discontinuate once opened. Teturn all discontinuates for proper storegularly scheduled 483.65 INFECTION SPREAD, LINENS The facility must estinate in the safe, sanitary and control propers of the safe, sanitary and control propers.	s after being filled. A review ysician orders, dated 9/14, an order for this medication. See medications were expired able for use. LPN-B reported cations were responsible to ates, however, the facility assure this was being ty's Storage and Expiration of gicals, Syringes and Needles 17, included, "Facility should ations and biologicals: Have and the label; Have not been in recommended by pplier guidelines Once any gical package is opened, we manufacturer/supplier opect to expiration dates for s. Facility staff should record in the medication container on has a shortened expiration in Facility should destroy or used, outdated/expired, or ations or biologicals Facility inspect nursing station storage or age compliance on a dispass." N CONTROL, PREVENT		F-441 1. NA-B has been provided couns re-education related to the impo hand washing on 10/8/14. Learni verified via return demonstration verbalization of the most importatimes/scenarios for washing hand	rtance of ng was n and ant
FORM CMS-2	 567(02-99) Previous Versions	Obsolete Event ID: JMZ111	<u> </u>	Facility ID: 00950 If continue	ation sheet Page 72 of 79

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		E SURVEY MPLETED
		245497	B. WING		09/	12/2014
HAVEN I	PROVIDER OR SUPPLIER HOMES OF MAPLE PI	_AIN	,	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 441	(a) Infection Contro The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a re prevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr. (3) The facility must hands after each di hand washing is inc professional practic (c) Linens Personnel must han	I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective fections. ad of Infection ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which licated by accepted	F 441	 2. DON/Designee will conduct randor observation audits of staff at various throughout the day to ensure that ha washing occurs at the appropriate tine. 3. All staff has been provided re-eduction during an in-service held on 10/9/14 10/10/14 regarding the importance of washing in order to prevent the spreinfection, and the hand washing policing reviewed at that time. 4. DON/Designee will conduct rando audits with staff whenever situations appropriate, with results to QA for reand further recommendation. 	times nd nes. cation or of hand ad of cy was	5. October 22 nd , 2014
	by: Based on observat review, the facility fa performed hand hyg	ion, interview, and document ailed to ensure nursing staff giene following providing of 3 residents (R55) resonal cares.				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245497	B. WING		00	9/12/2014		
	PROVIDER OR SUPPLIER	_AIN		STREET ADDRESS, CITY, STATE, ZI 1520 WYMAN AVENUE, PO BOX MAPLE PLAIN, MN 55359	P CODE	5/12/2014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 441	Findings include: R55's quarterly Min 6/4/14, identified R5 impairment and was all activities of daily personal hygiene. During observation nursing assistant (Nincontinence care to brief was wet and hit. NA-B removed the with multiple disposingloves, NA-B placed started to pull up R5 same gloved hands stool. NA-B then repulling up R55's par R55 out of bed and R55 was in the whee bathroom and wash. An interview was concompletion of R55's gloves should have washing completed R55's incontinent stodone that. During interview on the director of nursing (I wash their hands aft contaminated with significant control, hand hygien Control, hand hygien	imum Data Set (MDS) dated 55 had severe cognitive is totally dependent on staff for living, bed mobility, and on 9/10/14, at 7:18 a.m. IA)-B was observed providing to R55 while still in bed. R55's ad a small amount of stool in the soiled pad and wiped R55 able wipes. Without changing dia clean pad under R55, and 65's pants. NA-B used the as she used to wipe R55's moved the gloves, finished at and proceeded to assist into the wheelchair. Once elchair, NA-B went into the ed her hands. Inducted with NA-B at the cares and NA-B stated the been removed and hand immediately after wiping up tool, however, she had not 19/12/14, at 10:12 a.m. DON) stated the staff should er removing gloves	F 4	41				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		STRUCTION	(X3) DATE COMP	SURVEY LETED
-		245497	B. WING_		and the second s	09/	12/2014
	ROVIDER OR SUPPLIER			1520 V	T ADDRESS, CITY, STATE, ZIP CODE YYMÄN AVENUE, PO BOX 369 LE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	O TO THE OWNER OF THE OWNER OF THE OWNER O	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	directed staff to comp	lete hand hygiene before	F 4	41	REVISION TO F-520:		
F 520 SS=F	and after gloving, and providing resident car 483,75(o)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANS	ERS/MEET	F 5	20	1. This plan will be implemented to correct all deficient practices that affect all residents identified in the 2014 CMS-2567 for Haven	ed	-
	assurance committee nursing services; a pl	in a quality assessment and consisting of the director of hysician designated by the other members of the		tillen met eine ein der Steret des dieses vom die der Jeros eine meteorischen	Homes of Maple Plain. 2. All residents in the facility have been identified as being affected by this deficiency.		
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies.		essalinensen konser ur i keit Broude däre, seken språge sogs om konse	3. The facility has created a Quality Assurance Committe (QAC) that is scheduled to monthly for the purposes of	ieet	
· ·		rds of such committee th disclosure is related to the committee with the		m di 1924 i . di di 1921 i mi 1927 i pristra didanal merendenen denemberan de	reviewing all deficiencies and ensure corrections are maintained with ongoing compliance, as well as to address all other quality-rela-		
- Transport of the second of t	Good faith attempts to and correct quality do a basis for sanctions.	by the committee to identify spliciencies will not be used as	er er ekkom p.n.) en ekkomikarian interprinten	di cinciamo (como de marter esta como del deste della 17,511 (#11)	concerns that are brought for throughout the previous mon The DON, Administrator, an	th th.	ę
The state of the s	by: Based on interview a facility failed to ensure and assurance (QAA)	is not met as evidenced and document review, the e the quality assessment committee met quarterly as the facility failed to develop	, o and the state of the state	errentere en en en en en en en en en en en en en	department leaders will be required to attend this meetin on a regular basis. Frontline staff from all departments who invited and encouraged to attend these meetings as well	ill)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN				
		245497	B. WING_			09	12/2014
	OVIDER OR SUPPLIER			152	REET ADDRESS, CITY, STATE, ZIP CODE 20 WYMAN AVENUE, PO BOX 369 APLE PLAIN, MN 55359		OVE)
(X4) ID PREFIX TAG	TABLE DESIGNATION	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	JBE	(X5) COMPLETION DATE
F 520	identified areas of care concerns in the potential to affect all resided in the facility. Findings include: Refer to F278 as the accuracy of the minassessment for 1 of for pressure ulcers pressure sores, fair mobility status was residents (R20, R5 services and failed contractures for 2 of reviewed for range. Refer to F310 as the ambulation services and reassessed up. The decline in ability actual harm for R4 Refer to F312 as the appropriate bathin 1 of 3 residents (R dependent on state (ADL's). Refer to F314 as resident (R56), while the service resident (R56), while the service resident to the service resident (R56), while the service resident to the service resident to the service resident to the service resident to the service resident to the service resident to the service resident resid	opriate action plans for oncern related to resident facility. This had the 48 residents who currently for the facility failed to ensure imum data set (MDS) for 2 residents (R56) reviewed who had multiple unhealed led to ensure transfer and accurately coded for 2 of 2 go reviewed for rehabilitation to accurately code of 5 residents (R7, R55) of motion. The facility failed to provide to the failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to the facility failed to provide to	F	520	A formal Quarterly QA & A (Quality Assessment & Assurance) meeting, consisting of the DON, Administrator, to consultant pharmacist, facility Medical Director, and all departmental team leaders walso be held routinely every months. This meeting will theld in accordance with the Elim Care Quality Assessment and Assurance Policy. Facil Administrator will be responsible for ensuring that Committee remains in compliance with the policy for all quality concerns be presented and addressed at meeting, and is ultimately responsible for the effective and maintenance of this quarterly meeting.	the ty ill 3 be ent iity and this	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<i>J.</i> 0938-0391
STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
245497		B. WING_	B. WING			/12/2014	
NAME OF P	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE		
			1	15	520 WYMAN AVENUE, PO BOX 369		
HAVEN HO	OMES OF MAPLE PLAIN	•		M	IAPLE PLAIN, MIN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	Refer to F317 as the range of motion (ROM for 2 of 4 residents (F ROM. R55 and R7 s reduction in functional Refer to F318 as the range of motion and/provided to maintain for 3 of 5 residents (F for range of motion and Refer to F353 as the sufficient nursing staff services in accordanceds, for 11 of 48 re R55, R56, R11, R12, 4 family members (F1 resident cares were rof staff. This practice all 48 residents who romain to the resident cares were rof staff. This practice all 48 residents who romain to the resident cares were rof staff. This practice all 48 residents who romain to the resident cares were rof staff. This practice all 48 residents who romain to the resident cares were rof staff. The practice all 48 residents who romain to the resident care was documented meeting on 6/6/14. We dates of all of the QA the administrator was documented meeting administrator acknow been holding the requirements. RN-B stated they were with staffing, however resident census. RN-concerns had not been	facility failed to ensure A) services were provided 55 and R7) reviewed for ustained actual harm with a I ROM. facility failed to ensure or ambulation services were current level of functioning 31, R64, and R1) reviewed ad/ or ambulation services. facility failed to ensure f was available to provide the with each resident's sidents (R7, R47, R1, R31, R52, R66, and R7) and 1 of A-B) who had concerns not being met related to lack thad the potential to affect the sided in the facility. a.m., the administrator and b-B who had recently served or of nursing, were inistrator stated she had the new administrator in 1/14, ther first QAA committee then asked to provide the A meetings for the last year, only able to find one other on 5/10/13. The tiedged that the facility hadn't uired quarterly meetings. The aware of the concerns on B stated the staffing and iscussed at the QA	F	520	4. An informational memo will be posted in the employee brea room regarding the purposes of monthly Quality Assurance Committee meetings, attached to the invitation for staff to attend these meetings and bring forth quality concerns and suggestions. Staff will also be reminded about the "Suggestions and Concerns" box located in the employee break room to serve as a means for all staff to offer suggestions and concerns, should they prefet to bring them forth anonymously.	k S	
	resident census. RN- concerns had not bee	B stated the staffing					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIS AND PLAN OF CORRECTION 245497 NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG COntinued From page 77 there was enough staff to provide the necessary care. The administrator stated she was aware residents were not being bathed because staff had brought this concern up to her. The administrator recalled QAA committee had discussed R56's pressure ulcers at the QAA meeting, but was unable to to recall anything specific that was put into place as a result of the discussion. The administrator stated specific staffing concerns were not discussed in QA. During interview on 9/12/14, at 12:05 p.m., housekeeping (H)-A was unaware of the facility on any quality improvement projects, and was unfamiliar with the purpose/ role of the committee. H-A staded it would be nice to have meetings and know what was going on in the facility, and she felt he housekeeping staff were missing out on informetion. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility and she felt he housekeeping staff were missing out on informetion. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility and she felt he housekeeping staff were missing out on informetion. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility, and she felt he housekeeping staff were missing out on informetion. When interviewed on 9/11/14, at 10:30 a.m. RN-A who also served as the assistant director of nursing, confirmed there had been complaints from NA's about not having enough staff to complete resident cares. RN-A was unaware of the purpose/role of the committee was. When interviewed on 9/11/14, at 10:30 a.m. RN-A who also served as the assistant director of nursing, confirmed there had been complaints from NA	CENTER	S FOR MEDICARE 8	MEDICAID SERVICES				OMBIN	O. 0938-0391
MAVEN HOMES OF MAPLE PLAIN CALID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS CITY, STATE, ZIP CODE 1530 WYMAN AVENUE, PO BOX 399 MAPLE PLAIN, MN 5539			(X1) PROVIDER/SUPPLIER/CLIA	MADED:		CONSTRUCTION		
HAVEN HOMES OF MAPLE PLAIN SUMMANY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MIST BE PRECEDED BY FULL TAG FEETX TAG CONTINUED From page 77 there was enough staff to provide the necessary care. The administrator stated she was aware residents were not being bathed because staff had brought this concern up to her. The administrator recalled QAA committee had discussed R56's pressure ulcers at the QAA meeting, but was unable to to recall anything specific that was put into place as a result of the discussion. The administrator stated specific staffing concerns were not desicused in QA. During interview on 9/12/14, at 12:05 p.m., housekeeping (H)-A was unaware of the facility's QAA committee. H-A stated it would be nice to have meetings and know what was going on in the facility, and she felt the housekeeping staff were missing out on information. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility had a QAA committee was. When interviewed on 9/11/14, at 10:30 a.m. RN-A who also served as the assistant director of nursing, confirmed there had been complaints from NA's about not having enough staff to complete resident carses. RN-A was unaware of the committee was.	245497		B. WING	· ·		09	9/12/2014	
MAPLE PLAIN, MN 53559 (CA) ID (CA) ID (EACH DEFICIENCIES) SUMMARY STATEMENT OF DEFICIENCIES TAG FRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 520 Continued From page 77 there was enough staff to provide the necessary care. The administrator stated she was aware residents were not being bathed because staff had brought this concern up to her. The administrator recalled QAA committee had discussed R56's pressure ulcers at the QAA meeting, but was unable to to recall anything specific that was put into place as a result of the discussion. The administrator stated specific staffing concerns were not discussed in QA. During interview on 9/12/14, at 12:05 p.m., housekeeping (H)-A was unaware of the facility and sunfamiliar with the purpose/ role of the committee. H-A stated it would be nice to have meetings and know what was going on in the facility, and she felf the housekeeping staff were missing out on information. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility had a QAA committee, whether the committee was currently working on any quality improvement projects, and was unfamiliar with the purpose/ role of the committee. H-A stated it would be nice to have meetings and know what was going on in the facility, and she felt the housekeeping staff were missing out on information. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility had a QAA committee, was. When interviewed on 9/11/14, at 10:30 a.m. RN-A who also served as the assistant director of nursing, confirmed there had been complaints from NA's about not having enough staff to complete resident cares. RN-A was unaware of the complete resident cares. RN-A was unaware of the complete resident cares. RN-A was unaware of the complete resident cares. RN-A was unaware of the complete resident cares. RN-A was unaware of the complete resident cares. RN-A was unaware of the	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CALID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY SPULL TAG) F 520 Continued From page 77 there was enough staff to provide the necessary care. The administrator stated she was aware residents were not being bathed because staff had brought this concern up to her. The administrator recalled QAA committee had discussed R56's pressure ulcers at the QAA meeting, but was unable to to recall anything specific that was put into place as a result of the discussion. The administrator stated specific staffing concerns were not discussed in QA. During interview on 9/12/14, at 12:05 p.m., housekeeping (H)-A was unaware of the facility, and she felt the housekeeping staff were missing out on information. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility had a QAA committee or what the purpose/role of the committee was. When interviewed on 9/11/14, at 10:30 a.m. RN-A who also served as the assistant director of nursing, confirmed there had been complaints from NA's about not having enough staff to complete resident carses. RN-A was unaware of the facility and ministrator is responsible for monitoring the effectiveness and success of the quarterly QA & A meetings, and will complete a QA & A Audit immediately following the completion of this meeting each month for the next 6 months. At that time Committee members will evaluate and determine if further monitoring of the effectiveness of the Committee remains necessary. 5. October 22, 2014					13	520 WYMAN AVENUE, PO BOX 369		
F520 Continued From page 77 there was enough staff to provide the necessary care. The administrator stated she was aware residents were not being bathed because staff had brought this concern up to her. The administrator recalled QAA committee had discussed R56's pressure ulcers at the QAA meeting, but was unable to to recall anything specific that was put into place as a result of the discussion. The administrator stated specific staffing concerns were not discussed in QA. During interview on 9/12/14, at 12:05 p.m., housekeeping (H)-A was unaware of the facility's QAA committee, whether the committee was currently working on any quality improvement projects, and was unfamiliar with the purpose/ role of the committee. H-A stated it would be nice to have meetings and know what was going on in the facility, and she felt the housekeeping staff were missing out on information. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility had a QAA committee or what the purpose/role of the committee was. When interviewed at the monthly QAC meetings and addressed as needed for ongoing quality improvement. The facility administrator is responsible for monitoring the effectiveness and success of the quarterly QA & A meetings, and will complete a QA & A Audit immediately following the completion of this meeting each month for the next 6 months. At that time Committee members will evaluate and determine if further monitoring of the effectiveness of the Committee remains necessary. 5. October 22, 2014	HAVEN H	OMES OF MAPLE PLAI	N		M	IAPLE PLAIN, MN 55359		·
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PRINTED: 10/01/2014 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN (M3) ID (M4)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER HAVEN HOMES OF MAPLE PLAIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG		245497 B. WING				09/	12/2014		
F 520 Continued From page 78 Assurance Committee dated 5/14, indicated the facility was to have an ongoing QAA committee that would meet at least quarterly, or more often as the facility deemed necessary, to fulfill committee functions and operate effectively. Further, the policy identified that the facility would implement action plans to address quality deficiencies which would include processes to revise plans that were not achieving or sustaining				STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369					
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	F 520	Assurance Commit facility was to have that would meet at as the facility deem committee function Further, the policy i implement action prodeficiencies which we revise plans that we	tee dated 5/14, indicated the an ongoing QAA committee least quarterly, or more often ed necessary, to fulfill s and operate effectively. dentified that the facility would lans to address quality would include processes to	F 5	20				

Event ID: JMZ111

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 245497 09/15/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION ID PRÉFIX (EACH_DEFICIENCY_MUST_BE_PRECEDED_BY_FULL PREFIX (EACH CORRECTIVE ACTION-SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 DIC 11-7.14 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 B 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on September 15, 2014. At the time of this survey, Haven Homes of Maple Plain was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Please return the plan of correction NOV - 6 2014 for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division MN DEPT. OF PUBLIC SAFETY 444 Cedar St., Suite 145 STATE FIRE MARSHAL DIVISION St Paul, MN 55101-5145, or By email to: TITLE (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 10/22 Adminis

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ig 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 day, 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.

Facility ID: 00950

If continuation sheet Page 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245497			0017072011				
15	PROVIDER OR SUPPLIER HOMES OF MAPLE P	A 10 6 1 A 11		STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	3		
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K 000	Continued From pa Marian.Whitney@s	_	K 00	0			
¥.	with no basement, at 2 different times, constructed in 1963	laple Plain is a 1-story building The building was constructed The original building was 7 and was determined to be of uction. In 1999, an addition		g s g s			
	was constructed to	the southeast and was Type II(000) construction.					
· · ·	Because the original meet the construction buildings, the facilition building.	al building and the 1 addition on type allowed for existing y was surveyed as one	į.				
K 029 SS=E	sprinkler system. To system that consist corridors and areas monitored for fire difacility has a capacida at the time of the The requirement at MET. NFPA 101 LIFE SAID One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 protothe approved automoption is used, the according to the approved automoption is used, the according to the accor	ne facility has a fire alarm s of smoke delection in the open to the corridors that is epartment notification. The ty of 67 and had a census of	K 029	As referenced in 19.3.2.1. we will apply approved fire resistive material to these spaces to preventhe passage of smoke into the other parts of this smoke compartment should there be an incident that would generate smoke. Work completed on 10/20/2014	ent		

AND PLAN	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245497 PROVIDER OR SUPPLIER HOMES OF MAPLE PLAIN	(X2) MULTIF A. BUILDING B. WING	TE SURVEY MPLETED 0/15/2014	
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K 029	Continued From page 2 doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient practice could affect 25 residents, staff and visitors as smoke from a fire in these rooms could enter the corridor making it untenable. Findings include:	K 029		
K 130 SS=F	On facility tour between 12:30 PM and 3:30 PM on 9/15/2014, it was observed that the nurse's storage room (which is over 50 sq.ft.) was not smoke resistant; where the wall and corrugated roof deck meet was installed with wool installation but was not sprayed with a fire rated material to prevent the passage of smoke not in accordance with 19.3.2.1. This deficient practice was verified by the Maintenance Supervisor at time of discovery. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	K130 As per requirement of section 2703.9.3 we will install posts to acras a protective barrier between possible vehicle and natural gas line impact. These posts were installed in accordance with section 312 as referenced here. Completion date 10/10/2014	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245497		1 ' '	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED 09/15/2014	
	PROVIDER OR SUPPLIER HOMES OF MAPLE P	7 9 37	8	STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
K 130	This STANDARD is Minnesota State Fi 312.1and 2703.9.3. protected with guard This deficient practi	ge 3 s not met as evidenced by: re Code (07) Edition Section Requires gas fuel piping be d posts from vehicle impact. ce could affect all patients, the event of a collision.	K1	SECTION 312 VEHICLE IMPACT PROTECT 312.1 General. Vehicle impa protection required by this code shall be provided by po- that comply with Section 312 or by other approved physica barriers that comply with Sec 312.3.	sts 2.2
- /4	on 9/15/2014, it was	een 12:30 PM and 3:30 PM s observed that a dumpster lft, of the generator's natural		312.2 Posts. Guard posts sha comply with all of the following requirements:	
	required by MN Stat and 2703.9.3.	uard post protection as e Fire Code section 312.1 be was verified by the facility's visor.		1. Constructed of steel not lest than 4 inches (102 mm) in diameter and concrete filled. 2. Spaced not more than 4 feet (1219 mm) between posts of	et .
				center. 3. Set not less than 3 feet (91 mm) deep in a concrete footi of not less than a 15-inch (38 mm) diameter.	ng
	(02-99) Previous Versions O			4. Set with the top of the posless than 3 feet (914 mm) above ground. 5. Located not less than 3 feemm) from the protected object. 312.3 Other barriers. Physical barriers shall be a minimum 36 inches (914 mm) in heigh shall resist a force of 12,000	ical of it and

pounds (53 375 N) applied 3 inches (914 mm) above the adjacent ground surface.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 5008

October 1, 2014

Ms. Diane Lynch, Administrator Haven Homes Of Maple Plain 1520 Wyman Avenue, P.O. Box 369 Maple Plain, Minnesota 55359

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5497024

Dear Ms. Lynch:

The above facility was surveyed on September 8, 2014 through September 12, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

Haven Homes Of Maple Plain October 1, 2014 Page 2 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 W Division, #212 St Cloud, MN 56301. 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 immediately contact Jessica Sellner at (320) 223-7343.

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,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00950	B. WING	09/1	/12/2014	
	PROVIDER OR SUPPLIER	AIN 1520 WYN		STATE, ZIP CODE E, PO BOX 369 5359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
	In accordance with 144A.10, this correct pursuant to a survey found that the deficing herein are not corrected shall be with a schedule of fithe Minnesota Departments of the Minnesota Departments of the number and MN Ru When a rule contain comply with any of telack of compliance. re-inspection with arresult in the assess that was violated ducorrected. You may request a het that may result from orders provided that the Department with notice of assessment in the facility's plan of as your allegation of Department's acceptottom of the first pate used as verification.	nether a violation has been compliance with all rule provided at the tag le number indicated below. It is several items, failure to the items will be considered. Lack of compliance upon any item of multi-part rule will ment of a fine even if the item ring the initial inspection was nearing on any assessments non-compliance with these a written request is made to in 15 days of receipt of a not for non-compliance. S: correction (POC) will serve compliance upon the tance. Your signature at the age of the CMS-2567 form will	2 000	and politically and the second		
	partment of Health		<u></u>			

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If continuation sheet 1 of 63

PRINTED: 10/01/2014 FORM APPROVED

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 2 000 Continued From page 1 revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 2 255 2 255 MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required. In addition, the facility failed to develop and implement appropriate action plans for identified areas of concern related to resident care concerns in the facility. This had the potential to affect all 48 residents who currently resided in the facility. Findings include: Refer to F278 as the facility failed to ensure

Minnesota Department of Health STATE FORM

JMZ111

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 255 | Continued From page 2 2 255 accuracy of the minimum data set (MDS) assessment for 1 of 2 residents (R56) reviewed for pressure ulcers who had multiple unhealed. pressure sores, failed to ensure transfer and mobility status was accurately coded for 2 of 2 residents (R20, R59) reviewed for rehabilitation services and failed to accurately code contractures for 2 of 5 residents (R7, R55) reviewed for range of motion. Refer to F310 as the facility failed to provide ambulation services to prevent loss of function for 2 of 4 residents (R47 and R7) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The decline in ability to ambulate resulted in actual harm for R47 and R7. Refer to F312 as the facility failed to provide appropriate bathing and grooming assistance for 1 of 3 residents (R11) reviewed, who were dependent on staff for activities of daily living (ADL's). Refer to F314 as the facility failed to ensure 1 of 1 resident (R56), who was admitted with a pressure ulcer was provided interventions as assessed, and was re-evaluated to prevent further pressure ulcers from developing, which resulted in actual harm for R56 related to the development of multiple pressure ulcers after admission to the facility. Refer to F317 as the facility failed to ensure range of motion (ROM) services were provided for 2 of 4 residents (R55 and R7) reviewed for ROM. R55 and R7 sustained actual harm with a

Minnesota Department of Health

reduction in functional ROM.

Refer to F318 as the facility failed to ensure range of motion and/ or ambulation services were provided to maintain current level of functioning for 3 of 5 residents (R31, R64, and R1) reviewed

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 2 5 5 2 255 Continued From page 3 for range of motion and/ or ambulation services. Refer to F353 as the facility failed to ensure sufficient nursing staff was available to provide services in accordance with each resident's needs, for 11 of 48 residents (R7, R47, R1, R31, R55, R56, R11, R12, R52, R66, and R7) and 1 of 4 family members (FM-B) who had concerns resident cares were not being met related to lack of staff. This practice had the potential to affect all 48 residents who resided in the facility. On 9/12/14, at 11:31 a.m., the administrator and registered nurse (RN)-B who had recently served as the interim director of nursing, were interviewed. The administrator stated she had been brought in as the new administrator in 1/14, and had conducted her first QAA committee meeting on 6/6/14. When asked to provide the dates of all of the QAA meetings for the last year, the administrator was only able to find one other documented meeting on 5/10/13. The administrator acknowledged that the facility hadn't been holding the required quarterly meetings. RN-B stated they were aware of the concerns with staffing, however, staffing was based on resident census. RN-B stated the staffing concerns had not been discussed at the QA meeting because the facility management felt there was enough staff to provide the necessary care. The administrator stated she was aware residents were not being bathed because staff had brought this concern up to her. The administrator recalled QAA committee had discussed R56's pressure ulcers at the QAA meeting, but was unable to to recall anything specific that was put into place as a result of the

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 255 Continued From page 4 2 255 discussion. The administrator stated specific staffing concerns were not discussed in QA. During interview on 9/12/14, at 12:05 p.m., housekeeping (H)-A was unaware of the facility's QAA committee, whether the committee was currently working on any quality improvement projects, and was unfamiliar with the purpose/ role of the committee. H-A stated it would be nice to have meetings and know what was going on in the facility, and she felt the housekeeping staff were missing out on information. During interview on 9/12/14, at 12:17 p.m., licensed practical nurse (LPN)-A was unaware the facility had a QAA committee or what the purpose/role of the committee was. When interviewed on 9/11/14, at 10:30 a.m. RN-A who also served as the assistant director of nursing, confirmed there had been complaints from NA's about not having enough staff to complete resident cares. RN-A was unaware of any current quality improvement projects/action plans put into place by the QAA committee, and stated she was not aware what was discussed at the facility QA meetings. The facility's policy Quality Assessment and Assurance Committee dated 5/14, indicated the facility was to have an ongoing QAA committee that would meet at least quarterly, or more often as the facility deemed necessary, to fulfill committee functions and operate effectively. Further, the policy identified that the facility would implement action plans to address quality deficiencies which would include processes to revise plans that were not achieving or sustaining desired outcomes.

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 5 2 255 SUGGESTED METHOD OF CORRECTION: The administrator could work with the DON or designee, medical director, and governing body to update polices and procedures, identify issues, develop improvement plans, and ensure the committee meets quarterly. The administrator and DON could audit cares to ensure resident needs are met, audit charts for completion of restorative and range of motion programs, and report results to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days, 2 565 2 565 MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced Based on observation, interview, and document review, the facility failed to ensure the care plan was implemented for repositioning for 1 of 2 residents (R56), reviewed for pressure ulcers, for 1 of 1 residents bathing needs (R11), reviewed who required assistance with bathing, and for or 2 of 5 residents ROM programs (R31, R11) reviewed for range of motion services. Findings include: R56's quarterly Minimum data set dated 6/11/14, identified R56 had no cognitive impairments,

Minnesota Department of Health STATE FORM

Minnesota Department of Health? (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 565 2 565 | Continued From page 6 required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for pressure ulcer development, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed. R56's care plan dated 8/16/14, identified R56 had a unstageable pressure ulcer measuring 1.3 x 0.3 the coccyx. The care plan instructed R56 to be repositioned at no greater than 2 hour intervals. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m. the resident was not repositioned and was unable to shift his weight independently in the wheelchair. During interview on 9/10/14, at 7:20 a.m. R56 stated he had pain in his buttocks and had been up in his chair since approximately 6:00 a.m. that morning. During interview on 9/10/14, at 9:54 a.m. licensed practical nurse (LPN)-B stated R56 should be repositioned at least every two hours, and should lie down after breakfast. LPN-B requested assistance to lay R56 down in bed. NA-B and LPN-B transfered R56 to his bed to lay down on 9/10/14, at 10:05 a.m. Although R56's care plan instructed staff to reposition R56 every two hours, the resident had been in his chair for a total of 2 hours and 47 minutes without being repositioned. R31's quarterly MDS dated 6/11/14, indicated R31 had no current functional losses of range of motion (contractures) in the upper or lower extremities.

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2 565	Continued From pa	ge 7	2 565		
,	to receive passive r knees, and ankles,	ed 8/20/14, identified R31 was ange of motion daily to hips, 10-15 repetitions, as well as s, elbows, wrists and digits			
	the resident recieve days in the last mor R31's restorative do	M documentation indicated d range of motion services 12 hth (8/12/14 through 9/14/14). Socumentation for 7/2014, was being completed for 28 out of			
	assistant (NA)-E sta	09/11/14, at 9:45 a.m. nursing ated R31 did not ever receive services other than routine			
	stated he had a stro	9/11/14, at 3:18 p.m. R31 like a while back and did not vould like to use his legs and ses.			
1000 mm	required extensive a dressing and person	dated 8/27/14, identified R11 assistance from staff for hal hygiene and was able to cal help with bathing.			
	needed the assist of preferred to have a	9/4/14, identified R11 f one staff for bathing and bath versus a shower. Staff onor resident's preferences a timely manner.			
	stated recently she l	9/8/14, at 4:23 p.m. R11 nad gone for a couple of h because the facility didn't			
	R11's point of care b	pathing record indicated R11			

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 565 2 565 Continued From page 8 received a tub bath on 7/31/14, and the next entry was a partial bath on 8/28/14, which was 28 days later. During interview on 9/12/14, at 9:34 a.m. NA-B stated it was possible R11 went for weeks without a bath because there is not enough staff to assist residents with bathing. R1's quarterly MDS dated 6/25/14, indicated R1 had functional limitation in range of motion (ROM) to one side of the upper and lower extremities. R1 care plan dated 7/2/14, identified R1 was to receive passive range of motion (PROM) daily, 10-15 reps to bilateral shoulders, elbows, wrists, and digits. R1's PROM restorative nursing sheets were reviewed from April 2014 - September 2014. There was no documentation to determine if R1 was recieving PROM as directed by the care plan. During interview on 9/10/14, at approximately 1:25 p.m. NA-B stated the facility no longer had a restorative aid, and the NAs are not able to complete R1's PROM as directed by the care plan. During interview on 9/11/14, at 9:25 a.m. R1 non-verbally indicated by motioning in a back and forth motion with her hand to indicate 'so-so,' when asked if staff were assisting her with PROM on a daily basis. When asked for a frequency of the PROM being done, R1 spelled out, "monthly," on her communication board.

SUGGESTED METHOD OF CORRECTION:

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 565 Continued From page 9 2 565 The facility could develop a system which ensures that resident care plans are current and that all staff are delivering care according to the care plan and educate all care givers and nurse managers. The facility could monitor resident care for accurate delivery of care plan interventions and develop and auditing system to track ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 2 800 2 800 MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced Based on observation, interview, and document review, the facility failed to ensure sufficient nursing staff was available to provide services in accordance with each resident's needs, for 11 of 48 residents (R7, R47, R1, R31, R55, R56, R11, R12, R52, R66, and R7) and 1 of 4 family members (FM-B) who had concerns resident cares were not being met related to lack of staff. This practice had the potential to affect all 48 residents who resided in the facility.

FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 00950 09/12/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC [DENTIFYING INFORMATION] TAG DEFICIENCY) 2 800 2 800 Continued From page 10 R7 was not being walked according to the assessed restorative nursing orders. During interview on 9/11/14, at 1:42 p.m. NA-F stated the facility did not have enough staff to walk R7, and as a result, she felt R7 had a decline in ambulation and possibly range of motion. NA-F reported R7 had difficulty with transferring now, and was unable to raise her feet up while in the wheelchair. R7's Annual minimum data set (MDS) dated 8/27/14, identified she had severe cognitive impairment, impairment (contractures) to one side of the upper extremity, and required extensive two person assistance with transfers/walking. Her balance was impaired and she could only stand with staff assistance. R7's current signed physician orders dated 9/5/14, instructed staff to walk the resident 29-57 feet with assistance of two staff, twice daily using a walker. R7's restorative nursing documentation from April 2014 - September 2014, lacked documentation that R7 had been walked/ambulated by staff from 4/2014 to 9/2014. When interviewed on 9/9/14, at 9:46 a.m. RN-A stated the restorative program was in shambles right now, and she is trying to revamp the program. She verified there was no evidence that R7 was being walked. An interview on 9/10/14 at 1:00 p.m. was

completed with NA-A who stated staff tries to ambulate residents, but it does not always happen because of the lack of staffing. NA-A stated staff is not able to complete ROM for resident either, and stated, "I feel sorry for the

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 800 Continued From page 11 2 800 residents because they need the range of motion." NA-A stated staff just does not have any extra time to provide any ROM or ambulation. R47 stated during interview on 9/8/14, at 3:57 p.m., there was not sufficient staff at the present time. She stated she waited for over 20 minutes and all the way up to an hour for staff to respond to her call light and did not feel that was acceptable. She also reported that due to staffing shortage, she had to wait a long time to be served her food and by the time she gets her food it is cold. During a second interview on 9/8/14, at 7:02 p.m. R47 stated would transfer herself to the bathroom as staff does not respond to her call light. She stated she. "Refuses," to be incontinent of urine or stool because of having to wait for staff, and as a result will transfer herself. She stated she is aware she is not supposed to transfer herself to the bathroom because of previous falls, however, she can not wait for staff over 20 minutes for assistance. She reported the nursing assistants are aware she does this due to staff shortage. R47 stated she is supposed to be assisted with walking twice a day, however, staff is not able to do this as they just don't have time, and she didn't think she had been walked for about 10 days. A family member (FM)-B of R47 was interviewed on 9/10/14, at 1:15 p.m. and stated he had talked to staff a, "couple of time" that R47 was not being walked and he was concerned she would lose strength, FM-B stated R47 was to be walked twice each day, but it seldom happened. FM-B stated R47 had fallen a couple of times as she was not willing to be incontinent while waiting for assistance from staff when her call light is not answered for long periods of time. FM-B also

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED. AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 800 2 800 | Continued From page 12 stated there were times when he visited and the call light was on for over 15 minutes and he would have to go out to the hall and try to find staff to assist her. R47's quarterly MDS dated 7/2/14, indicated R47 was cognitively intact with no signs or symptoms of delirium. She needed extensive assistance of two staff with bed mobility, extensive assistance of one staff for transfers, dressing, toilet use and personal hygiene. R47 needed extensive assistance of one staff with ambulation. R47's nursing assistant care sheet dated 9/9/14, directed nursing assistants to ambulate the resident 57 feet to 115 feet twice per day with assistance of one staff, a transfer belt, rolling walker and wheelchair behind. Physician orders, signed 9/5/14, directed staff to complete passive range of motion to wrists, ankles, digits, knees, elbows, shoulder and hips daily. In addition, the physician ordered that R47 be walked 57-115 feet twice a daily with a wheelchair behind, using a rolling walker and transfer belt. R47's restorative nursing sheets for August, 2014 to September, 2014 were reviewed and there was no documentation that R47 received any passive range of motion to extremities or ambulation. An interview with licensed practical nurse (LPN)-C was completed on 9/11/14 at 11:15 a.m. and she stated she was aware R47 was to be walked twice a day with staff assistance. LPN-C stated there was no documentation on the restorative nursing sheets to identify if R47 had been assisted with ambulation or any PROM in the prior months.

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2 800	Continued From pa	ge 13	2 800			
	feel there were suff incontinent because answered fast enoughe had not been reasked how often she	14 at 1:10 p.m., she did not icient staff and she has been the call light was not being ligh. R1 also was concerned eceiving ROM, and when the had been receiving ROM out,"monthly," using her red.				
	R1 had moderate or or symptoms of deli- behavioral issues, a of her upper and lov	, completed 6/25/14, indicated ognitive ability, had no signs rium/ psychosis, had no and had limitations to one side wer extremity (contractures).				
	nursing sheets from staff to provide pass	d 7/2/14, and restorative a 4/2014- 9/2014, directed sive range of motion daily to ows, wrists, and fingers.				
	September 12, 2014	sing sheets for April, 2014 to 4 lacked any documentation of motion was being done for		•		
	licensed practical nu	on 9/10/14, at 7:10 a.m. urse (LPN)-A stated a NA's do restorative nursing for ng short staffed.	-		•	
	assistant (NA)-E wa	0/14, at 9:18 a.m. with nursing is completed and she stated on of residents were not being hort staffed.		-		
	stated the restorativ several months ago	on 9/10/14, at 1:25 p.m. NA-B e aid position had been cut , and nursing assistants did vide ROM and ambulation to				

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Minnesota Department of Health

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2 800	Continued From pa	ge 14	2 800			
-	residents.					
·	stated there was no this time, and NA's residents with ambu	on 9/11/14 at 10:30 a.m., RN-F formal restorative program at were directed to assist lation and ROM. RN-F stated to concerns to her about not				
	having enough staff	to complete resident cares with the restorative nursing				
	stroke a while back He stated he would	1/14, at 3:18 p.m. he had a and did not walk anymore. like to use his legs, but does because there are not enough				
	R31 was cognitively	S dated 6/11/14, indicated impaired, totally dependent ansfers, and needed e of one staff for all			1	
	to receive PROM mankles 10-15 repetit	ed 8/20/14, indicated R31 was otion to hips, knees, and ions daily as well as to elbows, wrists and fingers.				
		storative nursing sheets from 4/14, indicated R31 received s.	,			
		lity did not currently offer re programs at the present taffing.				
		09/11/14, at 9:45 a.m. nursing ted R31 did not ever receive services.				

Minneso	ota Department of He	ealth				
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2 800	Continued From pa	ge 15	2 800			
		ing range of motion due to				
	staff shortage.				A 4	
		S dated 6/4/14, identified R55	,			
	did not walk, had no	o functional limitations in lly dependent on staff for				
	transferring, toileting	g, dressing and all activities of				
	daily living.					
		e restorative nursing book				
		4, instructed staff to ensure				
	included the following	restorative treatments which ng passive range of motion to				
	shoulder, wrist, ank	ie, finger, elbows and knees:				
	The 7/2014 MAR id	entified 3 restorative services of the 31 opportunities. The				
	facility was unable t	o provide evidence that R55				
-	had received passive to 9/11/14.	ve range of motion from 8/14,				
	During interview on	9/10/14, at 11:50 a.m., NA-B exercises were often not done				
	because they didn't	have enough staff to spend				
	time completing the	exercises. NA-B stated R55				
		10% of the ROM exercises and been assessed as				
}	needing.				Α,	
	During interview on	9/11/14, at 10:13 a.m., NA-H				~
	stated range of mot	ion services were not being				-
	completed and R55	was becoming stiffer as a R55 wasn't able to stretch out				
	her arms and legs li	ke before which made getting				
	the resident dressed	d more difficult so facility staff family member to bring in				
	different clothing.	ramily member to bring in				
	R56 stated on 0/9/1	4, at 3:50 p.m. he did not feel				
	the facility had enou	igh staff. He reported having				
İ	to wait a long time to	o have his call light answered.]

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B, WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE. 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 800 2 800 Continued From page 16 During interview on 9/10/14, at 7:20 a.m. R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning. The quarterly MDS dated 6/11/14, identified R56 was cognitively intact and he required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, and was at risk for developing pressure ulcers. He currently had one stage IV (Unstageable) pressure ulcer, that was present on admission over a year ago, and was unhealed. R56's admission care area assessment (CAA) dated 12/17/13, identified R56 was to be repositioned at no greater than two hour intervals. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m., R56 was sitting in his wheelchair and was unable to shift his weight independently, and was not approached by staff to assist the resident to reposition as assessed. During interview on 9/10/14, at 9:46 a.m. nursing assistant (NA)-A stated the facility was short staffed and NA's did their best to assist residents to reposition as assessed but at times were unable to do so. NA-A verified R56 had not been repositioned every two hours as assessed because of the facility not having sufficient staffing to provide resident cares. R11 stated during an interview on 9/8/14, at 4:23 p.m. she had gone for a couple of weeks without a bath because the facility didn't have any bath

aids to provide bathing assistance. In addition,

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 800 Continued From page 17 2 800 R11 stated she had to wait 40 minutes to an hour for staff to respond to her call light when she had to go to go to the bathroom. She stated this happened a lot, and a few nights ago she had her call light on for over 40 minutes to go to the bathroom, no staff came to help her to the bathroom so she had to, "Poop in my diaper." R11's quarterly MDS dated 8/27/14, identified R11 had moderate cognitive impairment and required extensive assistance from staff for toileting. R11's Point of Care Bathing Record (where the nursing assistants document when a resident receives cares), identified R11 had received a tub bath on 7/31/14. The next record of R11 receiving assistance with bathing was a partial bath on 8/28/14, 28 days later. During interview on 9/9/14, at 3:03 p.m. NA-K stated there are not enough staff to provide residents a bath. NA-K stated she often is not able to complete all the resident cares because of the facility being short staffed. NA-K stated residents complain of the long wait times when they put on their call light, and some residents had transferred independently when staff is not able to respond timely to their call light due to being short staffed. During interview on 9/10/14, at 2:23 p.m., NA-F stated it was possible that some residents had gone for weeks without getting a bath because the facility does not have enough staff to complete all the resident cares. NA-F stated if another staff calls in sick, the facility does not replace them. NA-F stated she had complained to the administration about this because she knew resident cares were being neglected.

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) Continued From page 18 2 800 2 800 During interview on 9/11/14, at 10:13 a.m., NA-H stated there was not enough staff to accommodate baths for the residents, and resident baths are not being completed regularly. NA-H stated it was possible R11 could have gone almost a month without a bath due to the lack of staff available to assist residents. During interview on 9/12/14, at 9:34 a.m., NA-B stated resident baths are not being completed timely. NA-B stated it was possible R11 had not been bathed in almost a month because of the lack of staffing. During interview on 9/11/14, at 10:30 a.m. registered nurse (RN)-A stated NA's had brought up concerns regarding not being able to complete residents baths due to lack of staff, however, the facility is still working on the staffing concerns. During dining observation on 9/8/14, at approximately 5:40 p.m. NA-P was observed sitting on a rolling stool in the dining room at a table with R12, R52, R66 and R7. After the residents received their food, NA-P rolled around the table on the stool going from resident to resident giving them a bite of food, and then rolling on the stool using her feet to the nextresident. NA-P would give a resident a bite of food, set the fork or spoon down, and immediately roll over to the next resident, and continued rolling around the table on the stool the entire meal. R12's quarterly MDS dated 6/18/14, indicated R12 had severe cognitive impairment and required extensive staff assistance with dining. R52's quarterly MDS dated 8/20/14, identified R52 had severe cognitive impairment and

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	required extensive	staff assistance with dining.		· ·	
		S dated 8/6/14, identified R66 e impairment and required stance with dining.			
	R7's quarterly MDS had severe cognitiv extensive staff assis	dated 8/27/14, identified R7 e impairment and required stance with dining.			
	stated she was requat a time, and need she was able to go ensure they all recethere was not enougheresidents were bein	9/8/14, at 6:01 p.m. NA-P lired to feed multiple residents ed to use the rolling stool so from resident to resident to ived their meal. NA-P stated gh staff to ensure all the g fed timely, so the NA's do the residents receive their		-	
	LPN-A stated some wait for help because LPN-A stated the massisting residents of during the survey, the LPN-A stated resident the call lights not be cares provided. LP ambulation for the recompleted, and resimples walking and feel the stated on the weeked with behavioral issue on the nurse to provide the stated on the provided the stated on the stated on the stated on the weeked with behavioral issue on the nurse to provide the stated on the stated the stated that the state	in 9/10/14, at 7:10 a.m. times the residents needed to se the facility is short staffed. anagers are not typically with dining, however, the week ney have been helping out. ents have voiced concerns of sing answered and not having N-A stated restorative nursing/esidents is not being dents have complained of not by are losing strength. LPN-A ends, the staff brings residents es to the lobby and this falls vide additional nakes it difficult to complete all			
	the resident cares w When interviewed of	which need to be completed. on 9/10/14, at 6:50 a.m. NA-L of enough staff on the night			

Minnesota Department of Health

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shift a neces reside 60 mi sick of short, only of reside When stated having she had multip changed reside When stated and the When stated they not restored and the staffing the direction manageroom, NA-H are not not had stated shift to	sary care for ints have been utes for help all, the staff is and there have not interviewed or residents have detimes. Nated with staffir nts are not reinterviewed of the night shift ey often work interviewed or residents are not reinterviewed or residents are not reinterviewed or residents are sed and deseative services distant and possible sago, and stag. She stated ing room to experient had be which never he stated resident to do some resider use the bathints are not get and the sage of the stated resider the stated resider use the bathints are not get and the sage of the stated resider use the bathints are not get and the sage of the stated resider use the bathints are not get and the sage of the stated resider use the bathints are not get and the sage of the stated resider use the bathints are not get and the sage of the stated resider use the bathints are not get and the sage of the stated resider use the bathints are not get and the sage of the stated resider use the bathints are not get and the sage of the stated resider use the bathints are not get and the sage of the sage	struggling to provide the over 2 months. NA-L stated in complaining of waiting 45 NA-L stated when there is a struggling to take deare of all the lity. In 9/10/14, at 6:57 a.m. NA-M we voiced concerns about not if to complete the cares and is to the charge nurse on duty in stated nothing had ing, even after reporting ceiving the cares they require. In 9/10/14, at 7:01 a.m. NA-N it, sick calls are not replaced, short staffed. In 9/10/14 at 7:46 a.m. NA-H in not getting the quality care rive, and there had been no for 3 months. The restorative sitions were eliminated several aff had quit due to short residents not being helped in at, and during survey een helping in the dining nappens on a regular week. In the have voiced concerns they sit baths because staff does this extra task. NA-H also into are only assisted twice per room due to staffing, and etting walked so they get	2 800			

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	and nursing assista all cares, including ambulation. NA-E complained of the o	eel there were enough staff ints were not able to provide baths, shaving, ROM, and stated residents have call lights not being answered, d of having less strength due lone.				
	NA-F stated the NA stated the NA's are ambulation, and ba	on 9/10/14, at 1:15 p.m., 's constantly feel rushed. She supposed to do ROM, ths for residents, and the NA's plete this because of short				
	1:25 p.m. NA-B sta sufficient staff to co had tears in her eye	on 9/10/14, at approximately atted the facility did not have implete resident cares. NA-B as as she stated they are resident cares, especially and ambulation.				
	When interviewed of stated it is difficult to being short staffer	on 9/10/14, at 2:07 p.m. NA-O o provide resident cares due ed.		·		
	light times was requestated they did not out the report. She	a.m. a print out of the call uested from the DON, who have the capability of printing did not identify the process g to monitor call light	-	-		
	verified there is no this time. RN-A cor complaints from NA staff to complete re ambulation. RN-A s	on 9/11/14 at 10:30 a.m. RN-A formal restorative program at affirmed there have been also about not having enough sident cares or ROM and tated the NA's were asked to ts while assisting to dress				

FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 800 Continued From page 22 2 800 them, and verified this was not a formal program and did not meet the intention of a restorative nursing program. During interview on 9/11/14, at 10:13 a.m., NA-H stated the facility was short staffed and the resident cares were not being completed. NA-H stated ROM was not being completed for residents, specifically R55 who was becoming stiffer as a result, NA-H stated there were not enough staff to accommodate baths for the residents and they were often skipped. NA-H stated the NA's had complained to the administration staff at the nurse meetings about short staffing, however, nothing had been done to correct the staffing issue. When interviewed on 9/12/14, at 10:34 a.m., the staffing coordinator (MR)-J stated when there was a sick call, replacement depended on the number of staff scheduled. She reported if a sick call resulted in staff working a shift with less than established minimums, she would consult with the director of nursing (DON). She indicated there is no policy on staffing. When interviewed on 9/12/14, at 11:04 a.m. the DON and administrator stated staffing was based on census, not necessarily on resident care levels. The goal was to have six nursing assistants on both the day and evening shift, and three nursing assistants on the night shift. If there is a call in, they have not been replacing the staff if it would require overtime. They stated they had not reduced the hours of staff, and there had not been layoffs, however, they would not replace staff if someone left or retired, until they

met the right staff. They stated they felt the facility was significantly overstaffed, and did not believe their was an issue with lack of staffing.

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 800 2 800 | Continued From page 23 They stated they had been trying to educate staff on being more efficient in providing residents cares. They NA's should have been able to complete all of the duties necessary with less staff and they felt the NA's were making a choice to not complete things such as baths or restorative nursing services. DON stated they used to have nine NA's working at a time and now they have six, because having nine, "Just didn't make good business sense." SUGGESTED METHOD OF CORRECTION: The facility could work with the Administrator to develop a system to ensure staffing levels are adequate to meet resident care needs. The facility could develop auditing tools to ensure the required resident care is being provided and report results to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 2 830 MN Rule 4658.0520 Subp. 1 Adequate and 2 830 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.

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 00950 09/12/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 Continued From page 24 This MN Requirement is not met as evidenced Based on observation, interview, and document review, the facility failed to ensure resident falls were thoroughly assessed to ensure appropriate/pertinent interventions could be implemented or revised, for 2 of 2 residents (R64, R3), with multiple falls. Findings include: R64 admission face sheet, dated 2/24/12, indicated the resident had diagnoses including weakness, dementia, and incontinence. R64's quarterly Minimum Data Set (MDS) dated 8/13/14, indicated R64 had severe cognitive impairment, required extensive assistance for all activities of daily living (ADL), including bed mobility, transfer, walking, and toilet use. R64 was not steady, and only able to stabilize with staff assistance. R64's care plan dated 8/19/14, indicated R64 was at high risk for falls and had falls prior to and after admission to the the facility. Staff were directed to anticipate R64's toileting needs, place the floor mat on the floor when in bed, have the call light safety alarm system on while in bed, wear gripper socks while in bed, ensure safety alarm was on R64's wheelchair/chair, and ensure an anti-rollback device was on the residents wheelchair. R64's Fall Risk/Restraint Evaluation Review dated 5/20/14, indicated, "Resident remains high falls risk; [six] 6 falls in [three] 3 months. Resident attempts self transfers frequently. Confused and delusional reverting to his days of being a pastor... Gripper socks when in bed; W/C

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2 830	system remain app. R64's progress note fall on 7/27/14. Acc R64's alarm sound observed sitting on had no injuries. R64 wanted to go to sch told staff he needed staff assisted the reurinated. Staff was assessment or inved determine if current appropriate, new in if R64's toileting pla was appropriate to R64's progress note another fall on 8/24 progress notes, R6-was observed on the injuries were noted. Clip his nails. Staff of further assessment determine if current appropriate, if there residents falls, or if needed to prevent for the progress note of conducting post of the conducting post	motion sensor; Bed alarm ropriate. Floor mat added." es indicated the resident had a cording to the progress notes, ed, and the resident was the floor at his bedside and was alert, and reported he cool and rolled out of bed. R64 to go to the bathroom and sident to the bathroom and he unable to provide any further stigation of the fall to interventions were needed, and n was being implemented and prevent further falls. es indicated the resident had with a larm sounded, and he e floor on his buttocks. No R64 indicated he needed to was unable to provide any or investigation of the fall to interventions were were any trends with the new interventions were	2 830			

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 830 Continued From page 26 2 8 3 0 know he [R64] had a fall last week." Although R64's fall assessment dated 5/20/14, indicated the resident had fallen six times in the prior three months while a resident in the facility, the facility was unable to provide progress notes, incident reports, or any documentation regarding the falls they had identified in the fall assessment. R3's diagnoses listed on the undated facesheet included visual loss, spasm of muscle, abnormal involuntary movements, lack of coordination, dementia, and frequency of urination. R3's quarterly MDS dated 7/2/14, indicated R3 was severely cognitively impaired, required extensive assistance with all ADL's, and was not steady when standing or transferring. During an interview on 9/8/14, at 4:20 p.m., RN-A stated R3 had three recent falls, on 8/20/14, 8/22/14, and 9/4/14. RN-A stated R3 was impulsive and leaned forward in her chair and often rolled out of her chair. RN-A stated R3 was not injured during these falls. During multiple observations on 9/10/14, R3 was seated in her wheelchair, in the area in front of the nurses station. R3 had a alarm clipped to the back of her blouse, and had a Safe-T-Mate anti-rollback device on her wheelchair. R3 attempted to stand many times and multiple staff members attempted to redirect R3 and assisted her to sit down. R3 was able to self propel her wheelchair and would often lean forward in her wheelchair which would sound the alarm which

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was attached to her. On one occasion, a staff member offered R3 a magazine, which R3 sat and read calmly in her wheelchair for several

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 830 Continued From page 27 minutes paging through the magazine and talking about each picture. R3's care plan dated 7/8/14, indicated R3 was at risk for additional falls due to a history of frequent falls. Staff were directed to observe for unsafe practices and to anticipate R3's needs, especially toileting needs. The care plan also directed staff to offer activities to keep her busy, to offer towels for folding, cloths to wipe surfaces she could reach, and dolls to dress and undress. R3's progress notes related to her recent falls, included the following: On 8/20/14, R3 stood up from her wheelchair outside of her room and fell to her knees. There were no injuries noted. R3 indicated she was going to get to her appointment. Staff noted increased confusion after lunchtime and R3 was toileted and laid down for nap. Staff was unable to provide any further assessment of the fall to determine the cause of the fall, if current interventions were appropriate, or if new interventions were needed. On 08/22/2014, R3's alarm sounded and she was observed slowly falling to the floor in the activity room. No injuries were noted, R3 stated she was attempting to get up and walk out of the activity room when she fell. R3 was assisted back into her wheelchair and promptly assisted to the restroom to be toileted. Staff was unable to provide any further assessment of the fall to determine if current interventions were appropriate, or if new interventions were needed. On 9/5/14, R3's alarm sounded and staff witnessed her standing and then falling by the desk in the main parlor. R3 stated she was standing to reach for the watermelon that was in front of her at the desk. R3 was assisted back into her wheelchair and the food was placed

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		further assessment	was unable to provide any of the fall to determine if swere appropriate, or if new needed.				
		registered nurse (RI charge of conductin RN-B stated there wavailable regarding assessments were what may have causany trends noted, if	on 9/12/14, at 10:00 a.m., N)-B indicated she was in g post fall investigations. was no further information R3's falls. Post fall not completed to determine sed R3's falls, if there were the current interventions were a plan of care was being				
		and Risk/Restraint E Fall Evaluation will b	policy titled Fall Prevention Evaluation included, "The Post se completed by the DON or her/his designee within 72 nt fall."				
		The DON or designed Committee to update assessing causative could also perform a documentation to en	HOD OF CORRECTION: e could work with the QA e policies and procedures for factors for falls. The facility audits of post-fall issure interventions were put tial contributing factors were				
		TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				
	2 890	MN Rule 4658.0525 Motion	Subp. 2 A Rehab - Range of	2 890			
		Subp 2 Range of n	notion A supportive program				

Minnesota Department of Health STATE FORM

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 890 2 890 Continued From page 29 that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide ambulation services to prevent loss of function for 2 of 4 residents (R47 and R7) who required physical assistance with ambulation, and were not reassessed upon a decline in ambulation. The decline in ability to ambulate resulted in actual harm for R47 and R7. Findings include: R47's quarterly Minimum Data Set (MDS) dated 7/2/14, indicated R47 had no cognitive impairment, needed extensive assistance of one staff for transfers and ambulation, and used a wheelchair or a walker to aid her ambulation. R47's balance was not steady during transfers and walking and she had no loss of upper and lower function range of motion (contractures). R47's Care Area Assessments (CAA) dated 10/9/13, identified R47 was alert and oriented.

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PRINTED: 10/01/2014 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 890 Continued From page 30 2 890 had clear speech, and she was understood and able to understand others. R47 had an unsteady gait, was able to bear weight, and required a wheelchair behind her when she was involved in the restorative walking program. During interview on 9/8/14, at 7:11 p.m. R47 stated she was concerned she was going to lose her ability to walk because staff had not been assisting her to ambulate. She stated she was supposed to be walked twice a day but there was not enough staff to do this. She indicated she was, "Very rarely being walked." Another interview was completed on 9/11/14, at 11:00 a.m. R47 stated she was, "upset," about not being walked twice a day due to staff shortage. She stated. "They just don't have time to walk me." R47 stated she had been involved in therapy and the therapist recommended she be walked. Because staff had not been assisting her to walk, R47 stated her joints are getting stiff and was not able to move as easily as she had in the recent past. She stated the last time she could remember she was walked was about 7-10 days ago, R47's care plan dated 7/9/14, indicated R47 was to be ambulated per the "Restorative program." The restorative program was not specified in the plan of care. R47's nursing assistant care sheet, dated 9/9/14, directed nursing assistants to ambulate the

resident 57 feet to 115 feet, twice per day with assistance of one staff, a transfer belt, rolling

R47's physical therapy note dated 8/7/14, indicated the resident was able to ambulate up to

walker, and wheelchair behind.

STATEME	ota Department of He INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	· '	00950	B. WING		09/1	2/2014
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2 890	80 feet with a rolling assistance. R47 was seen in the department from 7/considered to be all directions. R47's dindicated she transfer belt for state for greater than thremaintained a safe by wheeled walker, has endurance while peliving, and reported performing her exes R47's physician ordered staff to ambulate the daily with a wheeled walker and transfer R47's restorative in facility identified as programs are documentally as a programs are documentally with a wheeled walker and transfer R47's restorative in facility identified as programs are documentally as a program and could be a program and could be a program and could be a day, walking book, were september 11, 201.	g walker and contact guard e occupational therapy (OT) 14/14 to 8/14/14. R47 was ert and able to follow ischarge from OT on 8/14/14, ferred with contact guard he therapist would hold a bilization), tolerated standing ee minutes while she balance while using a 4 d an increase in her erforming her activities of dally no increase in fatigue while rcises. Hers dated 9/5/14, directed e resident 57-115 feet twice hair behind, using a rolling belt. Lursing sheets (which the where resident restorative mented and tracked), titled s, located in the restorative reviewed from April 2014, to 4 identified the following: 2014, R47 was ambulating g 57 to 115 feet consistently. as walked 15 times on the day				
	shift, and twice on a documentation of F 7/23/14, when she -August 2014, to Sono documentation	the evening shift. The last R47 being ambulated was walked 115 feet. eptember 11 2014, there was regarding R47 ambulating.				
	During interview on	9/11/14, at 9:44 a.m. nursing ated he was aware R47 was to		•		

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B, WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369. HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 890 2 8 9 0 Continued From page 32 be ambulated twice a day, however, he had never assisted R47 to ambulate. NA-J stated staff does not have time to complete R47 ambulation program because of short staff. During interview on 9/11/14, at 11:15 a.m. licensed practical nurse (LPN)-C stated R47 was to be ambulated twice a day, however, she stated there was no way to determine if R47 was being ambulated because there was no documentation. During interview on 9/11/14, at 2:39 p.m. physical therapy assistant (PTA)-E stated she had worked with R47 from 7/14/14, until her discharge from physical therapy on 8/12/14. PTA-E had recommended R47 be ambulated twice a day, 57-111 feet, PTA-E stated R47, "loved to be walked," and was able to consistently walk 80 feet when discharged from PT on 8/12/14. During interview on 9/11/14, at 3:24 p.m. registered nurse (RN)-A (who was identified as the person in charge of Rehab/Restorative Services), stated there was no record of staff efforts to walk R47. RN-A stated staff was to ambulate R47 twice a day, however, she was not sure if this was being done, and was unsure if R47 had declined in her ability to ambulate. RN-A stated there was no formal nursing assessment completed of R47's ambulation program to ensure it was appropriate and being implemented as ordered. During observation on 9/11/14, at 3:55 p.m. PTA-E assisted R47 to ambulate. R47 was able to walk 45-60 feet before becoming short of breath and needed to sit down. PTA-E stated R47's current ambulation ability was a decline from when the resident was discharged from physical therapy on 8/12/14.

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2 890	Continued From pa	ge 33	2 890			
	being ambulated as did not reassess an to ensure the reside to ambulate. R47's related to the lack of ambulation program actual harm for R47 R7's annual MDS did had severe cognitive (contracture) to one required extensive it transfers and walking able to stabilize who assistance, and wal unit, and off the unit	ated 8/27/14, identified R7 e impairment, had impairment e side of the upper extremity, two person assistance with ng in the corridor, was only en standing with staff lking in the resident room, t had not occurred during the lk period of the MDS				
	walking, transfer ab During observation	27/14, did not address R7's ility, or current contractures. on 9/9/14, at 2:50 p.m. R7 her back and both knees d off the bed.				
	Summary dated 3/4 ambulate 20-30 fee with assist of two st able to hang onto the and did not need the services. PT also in motion (ROM) was extension, and 22 december 20-30 feet.	apist Progress & Discharge /14, indicated R7 was to t, using a four wheeled walker aff, two times a day. R7 was be walker without hand support a platform walker on even halicated R7's knee range of 26 degrees of left knee egree of right knee extension.				
	R7's current signed 9/5/14 instructed st	physician orders dated aff to walk the resident 29-57				

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED. A. BUILDING: _ B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 890 2 890 Continued From page 34 feet with assistance of two staff, two times daily using a walker. R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, located in the restorative nursing book, from April 2014 - September 2014, instructed two staff to walk the resident 29-57 feet, two times daily. There was no documentation identifying if staff was ambulating R7 from 4/2014-9/2014. R7's care plan dated 9/3/14, indicated staff pushed R7 to all destinations in the wheelchair and transferred with assist of two with a transfer belt and walker. R7's care plan did not address if the resident was able to ambulate, nor did it instruct staff on R7's assessed ambulation program. When interviewed on 9/9/14, at 9:46 a.m. RN-A stated the restorative/ ambulating program was in shambles right now, and she was trying to revamp the program to ensure residents were receiving their programs as assessed. RN-A was not aware R7 had not been ambulating or had a decline in transfer ability or ambulation. During interview on 9/11/14, at 1:42 p.m. NA-F stated R7 had a decline in ambulating as well as transfers, and staff was supposed to be walking. her, however, R7 no longer walks, and staff did not have time to spend to try to assist her in walking prior. NA-F stated recently she had to order foot pedals for R7 because she could no longer raise her feet up when in the wheelchair when staff were pushing her to destinations. During interview on 9/11/14, at 1:57 p.m. RN-D

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	1520 WY		STATE, ZIP CODE E, PO BOX 369		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 890	transferring a few in the point," of being walker, so staff was using a hand in har had done no forma ambulation program as assessed and R her ability to transfer. On 9/11/14, at 1:20 PTA-E and COTA-E and had some contibilateral knees. PT R7 from the wheeled transfer, R7 did not weight on her feet, heavy assist. Durin "ouch," on multiple staff was attempting knees. PTA-E and would benefit from referred back to the resident was declin ambulating. COTA expressed concern. Although the facility program was not be and the resident was had a decline in transfer. This resulted in activities.	erved R7 ambulating and nonths ago, and R7, "got to unable to bear weight on the stransferring the resident and method. RN-D stated she lassessment of R7's when it was noted R7's was not being implemented was noted to be declining in and ambulate. p.m. R7 was evaluated by D, and stated R7 was resistive ractures in her left hand and A-E and COTA-D transferred thair to her bed. During the take any steps, bear any and was lifted into bed with the evaluation, R7 stated, occasions and grimaced when g to straighten the resident's COTA-D both verified R7 therapy and should have been erapy when staff noted the ing in transfers and no longer and should have been stated residents have so with not being ambulated. If was aware R7's ambulation eing completed as assessed, as no longer ambulating and insfers, the facility failed to the resident back to therapy, and harm for R7.				
	The facility could we and therapy departs	HOD OF CORRECTION: ork with the QA Committee ment to identify and develop sidents in need of range of				

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 890 2 890 Continued From page 36 motion services or those at risk for decline. The facility could develop systems to audit range of motion services for completion and report to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 2 895 MN Rule 4658,0525 Subp. 2.B Rehab - Range of 2 8 9 5 Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, range of motion (ROM) services were not provided for 2 of 4 residents (R55 and R7) reviewed for ROM. R55 and R7 sustained actual harm with a reduction in functional ROM. Findings include:

R55's quarterly Minimum Data Set (MDS) dated 6/4/14, identified R55 did not walk, had no functional limitations in ROM (contractures), and was totally dependent on staff for transferring,

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 00950 09/12/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) > TAG TAG DEFICIENCY) 2 895 Continued From page 37 2 895 toileting, dressing, and all activities of daily living. During interview on 9/8/14, at 5:55 p.m. registered nurse (RN)-A stated R55 had contractures (fixed high resistance to passive stretch of a muscle) in both knees only, did not utilize any splint devices, and was not receiving any formal ROM program. R55's care plan, last updated 6/9/14, did not identify the presence of any contractures nor did it instruct staff on the type of ROM exercises to be completed by staff. R55's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine Medications, was located in the restorative nursing book dated 1/1/14, through 6/30/14, and instructed staff R55 was to receive daily restorative nursing treatments which included the following: -Shoulder passive range of motion (PROM) 10-15 REPS-bilateral flexion/extension -Wrist PROM 10-15 reps bilateral flexion/extension -Ankle PROM 10-15 reps bilateral dorsiflexion/flexion -Digits PROM 10-15 reps bilateral flexion/extension -Elbow PROM 10-15 reps bilateral flexion/extension -Knee PROM 10-15 reps bilateral flexion/extension The 7/2014 restorative nursing sheet identified 3 restorative treatments were provided out of the 31 opportunities.

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 895 Continued From page 38 2 895 The facility was unable to provide any restorative nursing sheets for R55 for the months of 8/2014, or 9/2014. The facility had no documentation any ROM was done for R55 for 2 months. The facility was unable to verify when R55's ROM program was started, and if it had been reassessed at any time to determine if it was appropriate for R55. Review of R55's Electronic Point Of Care Record from 7/1/14, to 9/12/14, did not identify R55 received any ROM services, nor was there any assessment to ensure the ROM program was appropriate for R55. During observation on 9/10/14, at 7:18 a.m. R55 was observed being assisted with dressing. R55's leas would not fully extend and rest on the bed, and the residents knees stayed bent. Nursing assistant (NA)-B was unable to raise R55's arms above her head to put on her shirt, and instead needed to slide the shirt up R55's arms and then stretch it over her head. R55 was not able to lift up her arms or straighten her arms from the elbow. NA-B verified R55 was becoming more stiff. During interview on 9/10/14, at 11:50 a.m. NA-B stated R55's ROM exercises were not being completed because they didn't have enough staff to spend time completing the exercises. NA-B stated R55 only received about 10% of the ROM exercises which the resident had been assessed as needing. During interview on 9/10/14, at 12:45 p.m., RN-C stated when restorative services or ROM was provided to the residents, the NAs should document in Point of Care when it was completed. RN-C was unable to provide any

further documentation that R55 was receiving any

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVE COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, :	STATE, ZIP CODE		-
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2 895	Continued From pa	ge 39	2 895			
		verified there was no oint of Care R55 was services.		·		
	practical nurse (LPN responsible for comfor the residents as completed in the residents	9/11/14, at 9:38 a.m. licensed N)-B stated the NAs were pleting the ROM treatments well as charting when it was sidents electronic point of care not aware R55's ROM was d.				
	dated 9/6/11, indicarpassive stretching cand 25 degrees of to be pain free and	rapy Discharge Summary ted R55 demonstrated of the right knee to 22 degrees he left knee. R55 was noted would be discharged to wer extremity ROM program				
	dated 7/17/12, indic hip/knee/ankle align	Therapy Discharge Summary ated R55 exhibited proper iment while in the wheelchair ot note the presence of any tractures.				
	occupational therap examined R55's upp R55 was somewhat evaluate total ROM, completely assess t wrist, and finger conindicated R55 appearently contractur of prior. COTA-D stabenefit from a splint which was identified joint during the examples.	9/10/14, at 2:03 p.m. certified y assistant (COTA)-D per extremities and indicated resistant when attempting to so she was unable to the degree of the shoulder, attractures. However, COTA-D ared to have bilateral upper res, which she was not aware ated R55 would definitely device for the right thumb to be the most contracted m. Physical therapy assistant terviewed at this time and				

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 2 895 2 895 Continued From page 40 completed an exam of R55's lower extremities. PTA-E stated when compared to the most recent physical therapy discharge summary dated 9/6/11, R55's knee contractures had worsened. PTA-E stated the right knee contractures had worsened to 55 degrees compared to 22 degrees before, and the left knee was now at 35 degrees compared to 25 degrees prior. COTA-D and PTA-E both verified R55 should be receiving ROM as had been assessed, and should have been referred back to OT/PT when staff noted R55's knees were becoming more contracted. and noted a decline in the resident's ability to move the upper extremities when being assisted with dressing. During interview on 9/11/14, at 9:09 a.m. family (FM)-A stated recently staff had asked him to purchase larger pants and different types of shirts so it would be easier to dress R55. FM-A stated R55 was becoming so stiff she was not able to lift her arms and straighten her knees so it was a struggle to get her dressed every day. FM-A stated staff asked for shirts that opened in the back, as well as larger pants, to make it slide on better. During interview on 9/11/14, at 10:13 a.m. NA-H stated range of motion services were not being completed and R55 was becoming stiff as a result. NA-H stated R55 wasn't able to stretch out her arms and legs like before which made getting the resident dressed more difficult, so staff asked the resident's family member to bring in different clothing. During interview on 9/11/14, at 11:10 a.m. RN-A confirmed there was no formal ROM assessment in place for R55 to ensure the current restorative

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 MAPLE PLAIN, MN 55359		
	(X5) COMPLETE DATE	
nor to ensure the program is adequate to prevent further decrease in ROM. The facility failed to ensure R55's restorative program was reassessed to ensure the ROM program was being implemented and was adequate to prevent further decline in ROM. Although the facility was aware R55 was having further difficulty with cressing related to decrease in ROM, the facility failed to provide further interventions and reassessment which resulted in actual harm to R55. R7's annual MDS dated 8/27/14, indicated R7 had severe cognitive impairment and had ROM impairment (contracture) to one side of the upper extremity. R7's clinic note dated 3/21/14, indicated the resident had a chronic right hand contracture which was released with surgery, had no pain, and was regaining muscular function back in the right hand. During observation on 9/9/14, at 2:50 p.m. R7 was lying in bed on her back and her left hand was in a fist. During observation on 9/10/14, at 6:53 a.m. R7 was sitting in her wheelchair in the activities room and her left hand was closed in a fist. During observation on 9/11/14, at 9:40 a.m. R7 was sitting in the activity room with her left hand closed in a fist. During observation on 9/12/14, at 8:40 a.m. R7 was sitting in the activity room with her left hand up to her face with her fingers bent inward.		

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: ___ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 8 9 5 2 895 Continued From page 42 During observation of R7 from 9/9/14- 9/12/14, R7 was not observed to release the fist of her left hand, nor did she attempt to use her left hand. R7's PT Progress and Discharge Summary dated 3/4/14, indicated the resident was able to hang onto the walker without hand support, and was to receive ROM. R7's current Physician Orders sheets for September 2014, instructed staff the resident was to receive the following restorative nursing program: Ankle PROM 0-15 reps bilateral dorsiflexion/flexion 1x Digits PROM 10-15 reps bilateral flexion/extension 1x Elbow PROM 10-15 reps bilateral flexion/extension 1x Hip PROM 10-15 reps bilateral flexion/extension, abduction/adduction 1x Knee PROM 10-15 reps bilateral flexion/extension 1x Shoulder PROM 10-15 reps bilateral flexion/extension 1x Walk 29-57 feet two times daily with wheelchair behind stand by assistance of two roller walker transfer belt x2 Wrist PROM 10-15 reps bilateral flexion/extension 1x R7's restorative nursing sheets (which the facility identified as where resident restorative programs are documented and tracked), titled Routine

Medications, located in the restorative nursing book, indicated the resident had a right hand contracture. The restorative nursing sheets reviewed from April 2014, - September 2014,

Minnesota Department of Health							
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2 895	Continued From pa	ge 43	2 895				
	noted the following R7 on the day shift: Ankle PROM 0-dorsiflexion/flexion Digits PROM 10 flexion/extension 1x Elbow PROM 1 flexion/extension 1x Hip PROM 10-flexion/extension, a Knee PROM 10 flexion/extension 1x Shoulder PROM flexion/extension 1x Walk 29-57 fee wheelchair behind s roller walker transfer	program to be completed for 15 reps bilateral 1x 0-15 reps bilateral 6 0-15 reps bilateral 6 15 reps bilateral bduction/adduction 1x 0-15 reps bilateral 6 11 10-15 reps bilateral 6 12 two times daily with 6 tand by assistance of two 15 reps bilateral 16 17 18 18 19 19 19 19 19 19 19 19 19 19 19 19 19					
	R7's restorative nur September 2014, no program to be comp however, there was receiving any ROM. R7's care plan date right hand contract. On 9/11/14, at 1:20 PTA-E and COTA-E resistive and had so hand and bilateral k R7 grimaced and st occasions when PT attempting ROM. C R7 would benefit fro	sing sheets for April 2014 - oted the restorative nursing oleted for R7 on the day shift, no documentation R7 was d 6/11/14, identified R7 had a					

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 895 2 895 Continued From page 44 During interview on 9/9/14, at 9:46 a.m. RN-A stated R7 had a contracture to her right hand and had surgery to release part of the contracture. RN-A stated the restorative program was not being completed for residents as assessed, and she was trying to revamp the program. RN-A stated R7 should be receiving the ROM services as had been assessed by PT. RN-A was not aware of R7's left hand or bilateral knee contractures. An interview on 9/10/14, at 1:00 p.m. was completed with NA-A who stated staff was not able to complete ROM for residents and stated, "I feel sorry for the residents because they need the range of motion." NA-A stated staff just does not have any extra time to provide any ROM or ambulation. During interview on 9/11/14, at 1:57 p.m. RN-D stated R7 had a contracture to the right hand, which was repaired via surgery, and was the contracture identified on the resident's MDS. RN-D stated several months ago R7 got to the point of being unable to hang onto the walker with her hands, so staff was ambulating the resident hand in hand. RN-D stated R7 was noted at that time to have a decline in ROM in her left hand related to being unable to hang onto the walker, however, R7's restorative program was not reassessed, and the resident was not referred back to PT to prevent further decline in ROM ability. The facility failed to ensure R7's restorative program was reassessed to ensure the ROM program was being implemented and was adequate to prevent further decline in ROM. Although the facility was aware R7 was no longer

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	facility failed to prov	ne walker to ambulate, the ride further interventions and h resulted in actual harm to				
	undated, identified to individual admitted become involved in the services available highest possible, propsychosocial level. planned, systematic builds on strengths criteria: 1. Measurable objusts be documented clinical record 2. Evidence of pernurse must be presented as in the activity 4. Restorative activity 4. Restorative activity and individual record supervised by mem	led Restorative Nursing, the philosophy was each to the facility had the right to his/her own care and to have be to him/her to reach their acticable physical and Restorative nursing is a corganized program that and must meet the following ectives and interventions and in the care plan and in the ciodic evaluation by licensed ent in the clinical record ints/aides must be trained in promote resident involvement wities must be carried out or bers of the nursing staff				
	a minimum of 6 day 6. Each Restorativ a minimum of 15 mi The policy further id management position maintaining the orga program and monito care on a routine bat are being followed of	re program must be provided nutes in a 24 hour period entified nurses in ons were responsible for anization of the restorative oring the delivery of restorative is to assure the programs consistently and as planned.	-			
	following, "Restorati	policy documented the ve nursing was mandated by dget Reconciliation Act] in				

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 895 2 895 Continued From page 46 1987, as a means to keep residents at their highest possible practicable physical, mental and psychosocial level. Maintaining function enhances dignity and self-esteem. It is the primary reason for implementing effective restorative nursing programs. A comprehensive organized program guides staff to accurately identify restorative needs, implement restorative programs that assure residents receive the restorative services as planned and document to maintain a permanent record of the entire process. It does not feel good to lose function. Loss of function decreases a person's self-worth and one's ability to experience and enjoy quality of life. An organized restorative program that delivers systematic care based on the resident's individual needs increases self-esteem and worth and enhances well being." SUGGESTED METHOD OF CORRECTION: The facility could work with the QA Committee and therapy department to identify and develop programming for residents in need of range of motion services or those at risk for decline. The facility could develop systems to audit range of motion services for completion and report to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 2 900 MN Rule 4658.0525 Subp. 3 Rehab - Pressure 2 900 Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B, WING 00950 09/12/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 47 2 900 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R56) who was admitted with a pressure ulcer was provided interventions as assessed, and was re-evaluated to prevent further pressure ulcers from developing. This resulted in actual harm for R56 related to the development of multiple pressure ulcers after admission to the facility. Findings include: R56's quarterly Minimum Data Set (MDS) dated 6/11/14, identified R56 had no cognitive impairment, required extensive assistance of two staff for bed mobility, extensive assistance of one staff for repositioning in the chair, was at risk for developing pressure ulcers, and currently had one stage IV (unstageable) pressure ulcer that was present on admission and unhealed. R56's most recent Care Area Assessment (CAA) dated 6/23/14, revealed R56 was at risk for pressure ulcer development, was on a turning and repositioning program, receiving pressure ulcer care with dressing application, and had a

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 2 900 Continued From page 48 pressure reducing device for the chair and bed. R56 was identified as being admitted with pressure ulcers both heels. R56's care plan dated 8/16/14, identified R56 had a 1.3 x 0.3 unstageable pressure ulcer on the coccyx, should be repositioned at no greater than 2 hour intervals, had a pressure redistribution mattress on the bed, and a pressure redistribution wheelchair cushion. R56's Skin Observation Reports dated 1/2/14, through 6/5/14, indicated the resident's skin was intact and had no pressure ulcers. R56's Braden Scale (a tool used to assess pressure ulcer risk) dated 6/8/14, indicated the resident had a mild risk of developing pressure ulcers. The Braden scale assessment indicated R56 had recently gotten a new wheelchair cushion related to the risk of developing pressure ulcers. R56's Tissue Tolerance Evaluation (assessment to determine skins ability to withstand pressure) dated 6/17/14, identified non-blanchable redness at the three hour mark in the lying position, and was unable to change position independently. The evaluation indicated R56 had no redness at the one, two or three hour mark in the sitting position and was unable to change position independently. There was no further assessment. R56's Tissue Tolerance Evaluation dated 6/23/14, identified no redness at the one or two hour mark in the lying position, and able to reposition independently. The evaluation indicated there was blanchable redness at the two hour mark while sitting and that R56 could reposition

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 Continued From page 49 2 900 independently. There was no further assessment. R56's Tissue Tolerance Evaluation dated 8/25/14, identified blanchable redness at the two hour mark in the wheelchair and the resident was unable to reposition independently. There was no further assessment of the tissue tolerance evaluation. R56's Skin Injury/Wound Report(s) dated 6/17/14, indicated R56 developed a pressure ulcer in the right gluteal fold measuring 0.5 centimeter (cm) x 0.8 cm with a pink wound bed, and was a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough). The area was cleansed and a protective cream applied, and the physician was faxed for further orders. Measurements of the pressure ulcer were documented weekly on the Skin Injury/ Wound Report. Review of the weekly monitoring from 6/17/14, through 9/10/14, indicated the pressure ulcer had worsened increasing in size and developing into an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough, yellow, tan, gray, green or brown, and/or eschar, tan, brown or black tissue, in the wound bed). On 9/10/14, the pressure ulcer was 1.5 cm x 2 cm, with a 70% slough yellow wound base and was unstageable. Another pressure ulcer was identified on a Skin Injury/Wound Report(s) dated 7/27/14, on the right buttock measuring 0.5 cm x 0.4 cm was identified by staff as, "trauma from the adhesive dressing being used on the gluteal fold." However, the area was identified as a "pressure uicer," on the Skin Injury/Wound Report because it was located on a pressure area. On 8/29/14, the facility identified the pressure ulcer was a

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: B, WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2.900 2 900 Continued From page 50 stage 2. The documentation of the pressure ulcer on 9/10/14, identified the pressure ulcer had worsened to an unstageable pressure ulcer, and increased in size with a description of the pressure ulcer as 2.5 cm x 2 cm, with 50% white/ yellow slough wound bed, and was currently unstageable. R56's current physician orders dated 9/5/14, instructed staff to apply Tegaderm with foam dressing to reddened area on the sacrum, check every shift, and change every three days and as needed (PRN). Tegaderm with a foam dressing was to be applied to the right buttock, sacrum, and gluteal fold every 3 days and as needed (PRN). The physician orders also instructed staff that R56 was not appropriate to have three hour intervals ordered for repositioning programs due to skin issues, therefore, needed to be repositioned at no greater than every two hours. R56's Nurses notes dated 6/2/14. indicated the resident was admitted with two, stage 4 pressure ulcers on the right and left heel. R56 was being seen at the wound clinic for these wounds, and they had been debrided by the surgeon in the past. During continuous observation of R56 on 9/10/14, from 7:18 a.m. through 9:46 a.m., R56 was sitting in his wheelchair on a cushion, and was unable to shift his weight independently. Throughout the 2 hour and 28 minute observation, R56 was not approached by staff to reposition as assessed. During interview on 9/10/14, at 7:20 a.m., R56 stated he had pain in his buttocks and had been up sitting in his wheelchair since approximately 6:00 a.m. that morning without repositioning.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
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	assistant (NA)-A sta staffed and NAs did to reposition as ass aware of R56's pres and, "They were pre verified R56 was to hours.	9/10/14, at 9:46 a.m. nursing ated the facility was short I their best to assist residents essed. NA-A stated she was sure ulcers on his buttocks etty open," right now. NA-A be repositioned every 2 9/10/14, at 9:54 a.m. licensed					
	repositioned after 2 after breakfast. LP from staff to lay R56	N)-B stated R56 should be hours and should lie down N-B requested assistance 3 down. on 9/10/14, at 10:05 a.m.					
	NA-B entered R56's which was 2 hours constant observation minutes since R56 chair. NA-B lifted R standing lift and ren	s room to reposition him, and 47 minutes after the initial in began, and 4 hours and 5 stated he had been up in his (56 out of his chair using a noved his brief. R56's red in color and had a foam					
·	registered nurse (R the wound nurse, he re-assignment of we delegating them ou	9/10/14, at 11:23 a.m. N)-A stated LPN-B had been owever, there was a recent ound duties and she was to the staff. RN-A was not condition of R56's ulcers.					
	stated R56 had gott when the buttock pi around 6/21/14, an currently had three LPN-B was not clea the pressure ulcers	9/10/14, at 11:35 a.m. LPN-B en a new wheelchair cushion essure ulcers developed d she though the resident pressure ulcers, however, ar on the current condition of LPN-B stated nursing a new wheelchair cushion		·		-	

FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 09/12/2014 00950 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 ! Continued From page 52 2 900 because the resident had complained he felt like he was sitting in a hole. LPN-B stated OT did not evaluate the resident to ensure the wheelchair cushion was appropriate. During observation of R56's current pressure ulcers on 9/10/14, at 1:58 p.m. the director of nursing (DON) and LPN-B verified R56 had two open areas on his buttocks, one on the upper gluteal cleft which was whitish at the wound base and was an unstageable pressure ulcer with 90% slough wound bed which currently measured 1.5 cm x 2 cm. The second pressure ulcer was on the right buttock and had 60-70% slough that was whitish in color at the wound base and measured 2.5 cm x 2 cm, and was also unstageable. LPN-B stated both pressure ulcers had increased in size and stage since the last time she had seen them, however, LPN-B was unable to verify the last time she had observed R56 pressure ulcers. During interview on 9/10/14, at 2:17 p.m. certified occupational therapy assistant (COTA)-D stated she had not been involved in assessing R56 for adequate wheelchair positioning or the wheelchair cushion. During interview on 9/11/14, at 1:07 p.m. director of nursing (DON) stated she was not aware of R56's worsening pressure ulcers. DON stated R56 repositioning schedule of every two hours should have been re-evaluated after the pressure ulcers developed and worsened to ensure the schedule was individualized and adequate to promote healing of the pressure ulcers. During interview on 9/11/14, at 1:10 p.m. RN-B stated she was not aware of R56's worsening

pressure ulcers so she had not discussed interventions with OT, nor had she reassessed

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED. AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 09/12/2014 00950 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 900 Continued From page 53 the current interventions in place to ensure they were being implemented and were adequate to prevent further pressure ulcers. On 9/11/14, at 1:39 p.m., a call was placed to R56's medical doctor (MD)-C who was unable to be reached to discuss R56's pressure ulcers. The facility policy, titled Repositioning, undated, indicated it was the policy of the facility to have in place a system to identify repositioning programs for each resident and repositioning every two hours or more frequently depending upon the resident's condition and tolerance of the tissue load may be implemented, and more frequent repositioning (i.e. off loading hourly) may be warranted for individuals at high risk for pressure ulcer development. The policy indicated the therapy department assessed postural alignment, weight distribution, sitting balance, stability, and pressure redistribution along with cushion/mattress recommendations in coordination with the nursing department. The facility policy titled Wound/Skin Care Policy, last revised 12/01/97, indicated an at-risk resident who sits too long on a static surface may be more prone to get ischial ulcerations. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could assign the interdisciplinary team to review all residents with pressure sores to assure they are receiving the necessary treatment/services to prevent pressure sores from developing and to promote healing. The Director of Nursing could assign the Quality Assurance Committee to provide on-going monitoring of the delivery of care to residents to ensure that pressure sores do not develop unless the resident's clinical condition

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	demonstrates that t	hey were unavoidable.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			٠.	
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			
	comprehensive resi home must ensure B. a resident who activities of daily livi	is unable to carry out ing receives the necessary a good nutrition, grooming,				
	by: Based on interview the facility failed to	and documentation review, provide bathing assistance for 1) reviewed who was for bathing.				
	8/27/14, identified Rassistance from sta	num data set (MDS) dated R11 required extensive ff for dressing and personal ble to provide partial physical				
	needed assist of on preferred to have a the goal was to resp maintain autonomy, manner.	e staff for bathing and bath versus a shower, and bect the resident's wishes and and provide care in a timely				
	During interview on	9/8/14, at 4:23 p.m. R11				

Winnesc	ota Department of He	aith				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: *	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00950			B. WING		09/1	2/2014
NAME OF	PROVIDER OR SUPPLIER		•	STATE, ZIP CODE		
HAVEN F	HOMES OF MAPLE PL	AIN	IAN AVENUI	E, PO BOX 369 5359		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 55	2 920			:
	weeks without a ba	ently gone for a couple of th because the facility didn't to provide bathing assistance.				
	nursing assistants (resident received a had received a tub record of R11 receive	Bathing Record (where the NA) document when a bath/shower), identified R11 bath on 7/31/14. The next ving assistance with bathing ompleted on 8/28/14, 28 days				
·	stated there were n residents with baths completed regularly R11 could have gor	9/11/14, at 10:13 a.m. NA-H ot enough staff to assist s and they were not being NA-H stated it was possible he almost a month without a s of staff available to assist	,			
	stated the facility us provide resident bat ago the bath aid lef were not being com was possible R11 h	9/12/14, at 9:34 a.m., NA-B sed to have a bath aid to the showever, a few months the facility, so resident baths pleted timely. NA-B stated it ad not been bathed in almost fithe lack of staffing.				
	registered nurse (R up concerns regard residents baths due RN-A stated the fac	9/11/14, at 10:30 a.m. N)-A stated NA's had brought ing not being able to complete to lack of staff, however, illity was still working on a nsure resident cares are being				
	A policy on resident not provided.	bathing was requested but			ī	

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A, BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 920 Continued From page 56 2 920 SUGGESTED METHOD OF CORRECTION: The director of nursing could provide education on the performance of providing activities of daily living and follow up with audits/observation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21426 21426 MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R37), who was reviewed for tuberculosis screening,

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 21426 Continued From page 57 21426 received a two-step mantoux or a baseline tuberculosis symptom screen. Findings include: R37 was admitted to the facility on 5/22/14. R37's medical record lacked any documentation of a tuberculosis symptom screen or baseline mantoux testing. Copies of any further information were requested from the DON on 9/12/14, at 10:12 a.m., none were provided. DON verified there was no record of R37 receiving a tuberculosis symtpom screen or baseline mantoux testing. A facility policy on resident tuberculosis testing was requested but not provided. SUGGESTED METHOD OF CORRECTION: The facility could develop an auditing system to ensure all residents receive a baseline tuberculosis symptom screen and appropriate testing. The facility could report findings to the QA Committee to develop a system for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21695 MN Rule 4658.1415 Subp. 4 Plant 21695 Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21695 Continued From page 58 21695 This MN Requirement is not met as evidenced Based on observation, interview, and document review, the facility failed to ensure 1 of 48 residents (R46) bathrooms had bathroom equipment in good repair. In addition, the facility failed to ensure 2 of 48 residents (R46, R24) were provided adequate water pressure to their bathroom sink. Findings include: R46's annual minimum data set (MDS) dated 8/6/14, identified the resident had no cognitive impairment. During interview on 9/8/14, at 4:30 p.m. R46 stated her bathroom sink was cracked and she had very little water pressure in her bathroom sink. She stated she had talked to several of the staff about both issues with her bathroom sink, and no one did anything about it. R46 stated the low water pressure and cracked sink had been like this since her admission to the facility which was over a year ago. During a tour of the facility on 9/12/14, at 1:00 p.m. maintenance supervisor (MS)-F verified R46's sink had two large cracks, one extending from the faucet knob down the entire sink almost to the drain, and a second crack on the left edge of the sink. MS-F also verified the water pressure in R46's bathroom sink was very low and the water trickled out of the faucet. MS-F stated he had not been informed of the cracked sink, which he stated had the potential to, "Scratch" the resident, and he was not aware of the low water pressure in R46's room. MS-F stated he did daily

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 00950 09/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1520 WYMAN AVENUE, PO BOX 369 HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21695 21695 Continued From page 59 rounds of the facility looking for damaged equipment, however, he did not go into any of the resident rooms or bathrooms during the inspection. He stated it was the expectation nursing staff inform him of broken items so maintence could repair them. R24's quarterly MDS dated 6/24/14, identified the resident had severe cognitive impairment and required extensive assistance of two staff for personal cares. During observations on 9/8/14, at 7:14 p.m. and 9/11/14, at 11:00 a.m. R24's water flowed out of the bathroom sink faucet slowly and took a long time for the temperature of the water to heat up to get warm. During the tour of the facility on 9/12/14, at 1:00 p.m. MS-F verified R24's bathroom sink water pressure was very low. MS-F stated he was not aware of the R24's low water pressure until now, and it was an easy fix if he had been informed of the problem for his department to address the issue. MS-F stated nursing staff are to notify him of any maintenance problems. A facility maintence policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident rooms and bathrooms are in functional working order. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance.

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00950		B. WING		09/12/2014		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
HAVEN	HOMES OF MAPLE PL	_AIN	MAN AVENU LAIN, MN	JE, PO BOX 369		. •
(X4) lD 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		(X5) COMPLETE DATE
21695	Continued From page	ge 60	21695			
	TIME PERIOD FOR (21) days.	TIME PERIOD FOR CORRECTION: Twenty-one				
21800		651 Subd. 4 Patients & c.Bill of Rights	21800	·		
	Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.					
	This MN Requiremer	nt is not met as evidenced				

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