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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: MGK7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00950

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245497**
2.STATE VENDOR OR MEDICAID NO.
(L2) **064742000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAVEN HOMES OF MAPLE PLAIN**
(L4) **1520 WYMAN AVENUE, PO BOX 369**
(L5) **MAPLE PLAIN, MN** (L6) **55359**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **10/01/2004**

6. DATE OF SURVEY 09/25/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **67** (L18)

13.Total Certified Beds **67** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective September 17, 2013, the facility is certified for 67 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 9/30/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1987 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
10/25/2013 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5497 December 20, 2013

Mr. Robert Mueller, Administrator
Haven Homes of Maple Plain
1520 Wyman Avenue, Po Box 369
Maple Plain, Minnesota 55359

Dear Mr. Mueller:

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 September 17, 2013, the above facility is certified for:

67 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 67 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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 30, 2013

Mr. Robert Mueller, Administrator
Haven Homes Of Maple Plain
1520 Wyman Avenue
PO Box 369
Maple Plain, Minnesota 55359

RE: Project Number S5497023

Dear Mr. Mueller:

On August 21, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 8, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 25, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 17, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 8, 2013, effective September 17, 2013 and therefore remedies outlined in our letter to you dated August 21, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (612) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245497	A. Building B. Wing	9/25/2013

Name of Facility	Street Address, City, State, Zip Code
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/17/2013**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **09/17/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/17/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/17/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/17/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/17/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/17/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** SG/AK	**Date:** 09/30/2013	**Signature of Surveyor:** 28589	**Date:** 09/25//2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/8/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MGK7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00950

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245497**
2.STATE VENDOR OR MEDICAID NO.
(L2) **064742000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAVEN HOMES OF MAPLE PLAIN**
(L4) **1520 WYMAN AVENUE, PO BOX 369**
(L5) **MAPLE PLAIN, MN** (L6) **55359**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **10/01/2004**

6. DATE OF SURVEY **08/08/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **67** (L18)

13.Total Certified Beds **67** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	67			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Marilyn Kaelke, HFE NEII 09/24/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 10/24/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/25/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5497

At the time of the August 8, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5612

August 21, 2013

Mr. Robert Mueller, Administrator
Haven Homes of Maple Plain
1520 Wyman Avenue, Po Box 369
Maple Plain, Minnesota 55359

RE: Project Number S5497023

Dear Mr. Mueller:

On August 8, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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;

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7365
Fax: (320)223-7348

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 September 17, 2013, 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 September 17, 2013 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 November 8, 2013 (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 February 8, 2014 (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:

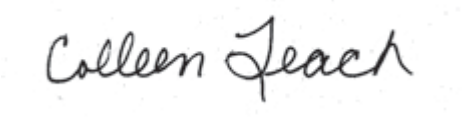
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**NOTE:** This POC will serve as Haven Homes of Maple Plain's credible allegation of compliance. Submission of this POC is not to be considered a legal admission that any deficiency exists, or that the areas cited on the Statement of Deficiencies are cited correctly. This POC does not constitute an admission of any kind as to the accuracy or truth of any facts or conclusions set forth in the Statement of Deficiencies by the Survey Agency. We are submitting this POC solely because its' submission is required by law as a condition of participation in the Medicare and Medicaid programs.	
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to include components of their abuse prevention policies to complete reference checks on all new employees in addition to background studies. The facility did not complete reference checks for 5 of 5 new employees records that were reviewed. This had the potential to affect 51 of 51 residents who reside in the facility. Findings include: The Criminal Backgroud Studies policy (dated 4/15/11) directed the facility to conduct background studies on all new employees. The	F 226	OK 9/24/13 SC See addendum	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Mueller	Administrator	9/4/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 1 policy did not identify or direct the facility to complete reference checks for previous employment. The Abuse Prevention Training and Orientation policy (dated 4/15/11) identified upon hire employees would attend a general orientation. Upon orientation, new employees would review facility policies related to Vulnerable Adult abuse and prevention. The orientation policies would include policies related to screening of new employees, training requirements, prevention, identification of possible abuse, investigation, protection of the resident, and individual//facility reporting and response. When interviewed on 8/6/13, at 2:00 p.m. the administrator identified there is a form that is sent out or a phone call placed for reference checks. He indicated the facility typically only gets the dates of service, if they are able to contact any past employers. He also indicated that it is very rare a form is ever returned with the requested information. When interviewed on 8/6/13, at 4:25 p.m. the administrator presented the applications for the five new employee records reviewed along with the letter to be sent out for reference checks. The administrator verified this form was not sent out for any of the five employee charts reviewed, and it had gotten dropped. He indicated they rely on the background checks for new hires rather than the reference checks. The staff development director indicated on 8/19/13, at 3:50 p.m. per phone conversation the reference checks are completed as a protocol with the application packet and are not part of the policies. On 9/18/12, dietary aide (DA)-A was hired by the	F 226	Our employment verification process has been reviewed, revised and implemented. Going forward on all applicants for employment, Haven Homes will attempt to verify previous employment either by mail or over the telephone. Upon application, all applicants will complete an Employment Verification authorization. After an initial interview, if it is determined an applicant is a prospective employee, the individual that conducted the interview will begin the process of employment verification. Employment verifications will be either done via mail or over the telephone. If done by mail the Employment Verification form will be forwarded to the Staff Development Director for mailing. If done over the telephone, the individual verifying the employment will forward the completed form to the Staff Development Director for inclusion in their personnel file. During the orientation process, the Staff Development will verify that an employment verification has been mailed or completed via the telephone. If not completed, the Staff Development Director will follow up to ensure that an attempt to verify employment has been made. The Staff Development Director will monitor this process on an ongoing basis.	9/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 2 facility. Reference check form signed by DA-A on 9/13/12, remained in the personnel file without being sent out. On 12/3/12, housekeeper (H)-C was hired by the facility. Reference check form signed by H-C on 11/29/12, remained in the personnel file without being sent out. On 5/13/13, activities (A)-A was hired by the facility. Reference check form signed by A-A on 5/26/13, remained in the personnel file without being sent out. On 6/6/13, registered nurse (RN)-C was hired by the facility. Reference check form signed by RN-C on 5/8/13, remained in the personnel file without being sent out. On 6/6/13, nursing assistant (NA)-C was hired by the facility. Reference check form signed by NA-C on 6/4/13, remained in the personnel file without being sent out	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 3 facility failed to ensure 1 of 3 residents (R55) was given a choice for bathing frequency. Findings include: R55 was interviewed on 8/5/13, at 2:23 p.m., and reported he received one bath per week and would like to bath more frequently. He reported that he had told several staff about this request without an increase in frequency. He indicated he preferred to be bathed every three days. The quarterly Minimum Data Set (MDS) completed on 5/22/13, indicated R55 was considered to be cognitively intact but needed extensive assistance of facility staff with bed mobility, transfers, dressing, toilet use and personal hygiene. R55 needed physical assistance with a portion of his bath. The Care Area Assessment (CAA) completed on 2/20/13, noted R55's long term memory was intact and had no communication barriers, other than a very soft voice related to Parkinson's but was able to make his needs known verbally. The plan of care, dated 3/15/12, noted R55 was dependent for activities of daily living and needed one staff to assist with his bath. The plan of care directed staff to allow the resident to wash his face and hands but were to bathe his upper and lower body and his hair. Interviews were done on 8/7/13, at 7:25 a.m. with nursing assistant (NA)-D, NA-A, NA-E and NA-F. They reported if a resident requested an increase in bathing frequency, they would tell the charge nurse, who would tell the director of nursing, who would then tell the quality assurance nursing	F 242	The resident in question has been interviewed and has been given a choice for bathing frequency. All residents will be given a choice of bathing frequency at their next quarterly care conference. Residents will also be given a choice initially upon admission, and on a quarterly basis. It will also be addressed on an annual basis or when there is a significant change of condition when the resident and/or their family or legal representative are interviewed for Section F, Preferences for Customary Routine and Activities," which is part of the MDS assessment process. These interviews will be conducted by the Therapeutic Recreation Director, who is also responsible for completion of Section F, and will be documented in the Activities progress notes. The Director of Nursing or designee will monitor residents requests and work with the bath aide and nursing assistant to ensure that their choice for bathing frequency is accommodated and documented on the care plan and on the residents closet list.	9/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 4 assistant (NA-QA) and then this request would attempted to be worked into the bathing schedule. They reported they did not remember that R55 had asked for additional bathes. An interview with licensed practical nurse (LPN) -C was completed on 8/7/13, at 11:45 a.m. She reported residents are bathed once per week and if they wanted more, they or their family just needed to ask. She reported that she was unsure if residents or families were asked about bathing frequency on admission but knew they were asked about day of the week preference and morning or evening bathing preference. She also indicated she thought bathing frequency was part of the MDS assessment process but did not know for sure. An interview with the director of nurses (DON) was completed on 8/7/13, at 12:34 p.m. The DON reported the activity department met with residents and asks of their personal preference regarding bathing, specifically tub vs. shower but was unsure if the activity staff asked about bathing frequency. An interview with the activity director (AD) was done on 8/7/13, at 1:43 p.m. She reported upon resident's admission, she will ask residents about preference between a tub bath or a shower but did not ask how often they want to be bathed. She reported that she thought the NA QA addressed this. An interview with NA-G, who was identified as the NA QA for the day shift, was completed on 8/7/13, at 2:15 p.m. She reported she did not think any staff member asked residents or their families upon admission or intermittently	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 5 throughout their stay, how often they would like to be bathed. She indicated residents are given one bath per week unless they have a physician order to increase the frequency of bathes or they request additional bathes (and if this request can be worked into the schedule, they will accommodate this request). The undated facility's policy Cleaning Bath, directed staff to ensure resident receive necessary assistance for bathes weekly or more frequently if indicated. The policy did not address the definition of "more frequently if indicated" and did not address resident preference for bathing frequency.	F 242		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 6 drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately identify parameters for use, or assess and identify the clinical indicators for the continued use of psychopharmacological medications for 1 of 5 residents (R46) reviewed who received psychopharmacological medications. Findings include: R46's diagnoses included Alzheimer's disease, aphasia (difficult or no speech), and anxiety. The quarterly Minimum Data Set (MDS) dated 6/19/13, indicated R46 had severe cognitive impairment, showed signs of inattention, disorganized thinking, altered level of consciousness, and psychomotor retardations-sluggishness, staring into space, staying in one position, or moving very slowly. The MDS also indicated R46 showed physical behaviors towards others, and rejected cares, and received antipsychotic medication daily. R46 required total staff assistance for all activities of daily living [ADL's]. R46's care area assessment (CAA) dated 12/19/12, included, "resident rarely speaks, but can be more responsive to family." R46's risks were listed as, "Increased [sic] in behaviors; Increased cognitive impairment; Missed communication; Social Isolating; Injury;	F 329	The drug regimen for the resident listed in the SOD has been reviewed by the Consultant Pharmacist for any potential unnecessary medications on 8/12/2013 and 9/3/2013 and recommendations have been forwarded to the attending physician for review and approval. On 8/12 a recommendation was made to reevaluate the continued need for Aricept 10 mg qhs due to a a BIMS score of 0. The attending physician decrease the Aricept to 5 mg qhs and will evaluate again at the next visit. On 9/3/2013 the CP made a recommendation to reevaluate the continued need for Amantadine100 mg q day due to it off label use as well as a pharmacodymanic interaction with quetiapine. This will again be reviewed by the attending physician on 9/6/2013. The resident listed in the SOD is administered Lorazepam for what the nurse on duty said was "twitching". However the diagnosis on the MAR was correctly listed as "agitation." In an effort to identify other resident potentially affected under this tag, the Consultant Pharmacist will continue to review each resident's medication regimen on a monthly basis and will assess each medication for its continued need and make recommendations where appropriate. Additionally the indicators for the use of each PRN medication will be reviewed on a monthly basis by the Consultant Pharmacist to ensure each medication is being administered for the proper indicators and diagnosis and that the charting reflects the appropriate use. The CP will also forward his recommendations to the facility Quality Improvement committee on a quarterly basis for discussion, review and follow-up.	9/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 7 Withdrawal." The psychotropic drug use CAA dated 12/19/12 included, "benefits of medication out weigh the risks at this time." However, the CAA failed to identify why the benefits out weigh the risks, which were listed as, "fall related injuries; side effects related to medications." R46's care plan dated 12/21/11, unknown when last updated, included; "Potential for drug related side-effects related to psychotropic medication use." The goal listed as, "Benefits of medication will outweigh side effects of medication." Staff were to administer medications, monitor for effectiveness and side effects, and notify physician with any changes in effectiveness and side effects. R46 was observed on 8/5/13, at 5:20 p.m. through 6:00 p.m., during the evening meal, R46 did not respond when spoken to, she stared straight ahead even with physical stimuli of touching her hand. R46 did however, eat when staff placed food/fluids up to mouth. R46 did not make any attempt to move any body part during the observation. R46 was again observed during the breakfast on lunch meals on 8/6/13 and 8/7/13, again R46 ate as food/fluid was brought to her lips by staff, but did not respond in any other way to staff interaction. R46 was administered lorazepam for a reason other than ordered by the physician. R46's physician order sheets for August 2013 included: Lorazepam intensol [liquid antianxiety medication] 0.5-1 ml [milliliter] (1-2 mg [milligrams]) by mouth/sublingually [under the tongue] every 2 hours as needed for agitation (0.5 ml for mild to moderate agitation and 1 ml for	F 329	On an ongoing basis, the Consultant Pharmacist will continue to make recommendations as clinically appropriate to ensure each resident's medication regimen is free or unnecessary medications. This process will be monitored and followed up by the Director of Nursing to ensure that recommendations are addressed by the attending physicians in a timely manner. She will review this information with the Quality Improvement Committee on a Quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 8 moderate to severe pagination) - not to exceed 8 mg in 24 hours. The start date was listed as 2/11/13. R46's Medication Administration Records showed R46 had been administered lorazepam intensol solution 1 ml [2 mg] on 2/4/13 for "shaking," and on 6/19/13 0.5 ml [1 mg] for "jerking movements." During interview on 8/7/13, at 12:50 p.m. registered nurse (RN)-A stated the lorazepam had originally been ordered for R46 in September 2012 when she was sent to the emergency room for "twitching." When the order required renewal, the nurse practitioner changed the order as it currently is, for agitation. RN-A stated, the facility should have questioned the nurse practitioner as to the ordered use of the medication. During interview on 8/8/13, at 9:40 a.m. licensed practical nurse (LPN)-A stated the lorazepam was for when R46 gets "twitchy, that's when the nurse practitioner told us to use it." LPN-A did not know why the order was for "agitation," stating R46 doesn't get agitated. During interview on 8/8/13, at 3:20 p.m. the facilities consultant pharmacist (CP) stated he had not recognized R46 had received the lorazepam for other than the physician ordered use, or he would have clarified it with the facility and physician. R46 received a medication without a clear indication for it's use. R46's August 2013's physician order sheets included: Amantadine HCL [an antiparkinson's	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 9 agent, sometimes used for movement disorders or behavioral disturbances] 100 mg 1 cap by mouth daily for dementia. The start date was listed as 7/20/12. During interview on 8/7/13, at 10:30 a.m. RN-B stated she did not know why the Amantadine was being used for R46. R46 had been hospitalized at a geriatric psychiatric facility in July 2012 and returned with the order, and the diagnosis was listed as only dementia. During interview on 8/7/13, at 12:50 p.m. RN-A stated she did not know what R46 was being administered Amantadine for, the diagnosis of dementia does not fit the known uses for this medication. During interview on 8/8/13, at 3:20 p.m. the facilities consultant pharmacist (CP) stated Amantadine is occasionally used as last resort, for severe, uncontrolled behavior problems. CP agreed, R46, with her late stage dementia, did not have uncontrolled behaviors. The medication can also be used for Parkinson's disease, or movement disorders associated with psychotropic drug use. CP agreed, it was unclear why R46 was receiving this medication. R46 continued to receive cognitive enhancer medication without reevaluation if the medications should be continued. R46's physician order sheets dated August 2013 included: Donepezil HCL [a cognitive enhancer used to treat mild to moderate Alzheimer's disease] 10 mg by mouth every bedtime, with a diagnosis of	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 10 dementia. The start date was listed as 7/20/12. Namenda [used to treat mild to moderate Alzheimer's disease] 10 mg twice daily, with a diagnosis of dementia. The start date was listed as 7/20/12. Cognitive enhancer's, such as Donepezil and Namenda are typically used for mild to moderate dementia, as the underlying disorder progresses into advanced stages, the continued use of the medication should be reevaluated. R46's medical record failed to identify how R46 would benefit from the continued use of these medication in the late stages of Alzheimer's dementia. The physician progress notes dated from July 2012 through present were reviewed and failed to address the continued use of these medication, even though R46 had progressed to a later stage of dementia. During interview on 8/7/13, at 10:30 a.m. RN-B stated R46 was in the late stages of Alzheimer's dementia, but had not questioned the physician about continued use of these medications as the consulting pharmacist had not questioned it. During interview on 8/7/13, at 12:50 p.m. RN-A stated most physicians are taking residents off of these cognitive enhancer's as decreased cognition occurs. R46 has severe cognitive impairment. RN-A did not know why the physician had continued the medication, and had not questioned the physician. During interview on 8/8/13, at 3:20 p.m. the PC stated he usually questions the physicians about continued use of these medications, but this physician may prefer to keep residents on it, and	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 11 had not done so. R46 received two anticonvulsant medications, identified as being used for "mood disorder," and "as a psychotropic." Neither of these medications had an attempted gradual dose reductions despite being used for "mood" or "as a psychotropic." R46's August 2013 physician order sheets included: Divalproex sodium [an anticonvulsant medication, off label uses include behavior disorders] 250 mg by mouth daily, with a diagnosis of mood disorder. The start date was listed as 7/20/12. Gabapentin solution [an anticonvulsant, off label uses include behavioral disorder and nerve pain] 100 mg three TID [three times a day], and 200 mg at bedtime, with a diagnosis of mood disorder. The start date was listed as 7/20/12. R46's medical record revealed no attempt at reducing the Divalproex sodium or the Gabapentin. R46's physician progress notes dated 4/11/13, included; "On 2/5/13, valproic acid [Divalproex] level of 19, low; however, the valproic acid is being used as a psychotropic medication for behavior, not for any seizure control...Due to the patient's severe dementia, review of systems is not possible." R46's physician progress notes from July 2013 though August 2013 failed to address if the Gabapentin was being used to control behaviors, mood, or pain. During interview on 8/7/13, at 10:30 a.m. RN-B stated R46 received the Divalproex for behavior	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 problems and the Gabapentin for pain. RN-B had not questioned the diagnosis for each of these medications and had not inquired about potentially decreasing either one, because the consultant pharmacist had not done so. RN-B was not aware that if an anticonvulsant medication was being used as an antipsychotic medication, attempts at gradual dose reduction were required to be addressed. During interview on 8/7/13, at 12:50 p.m. RN-A stated she did not know why a gradual dose reduction had not been attempted for R46's Divalproex, and thought the Gabapentin was being used for pain, even though the physician order clearly indicated it was for a mood disorder. During interview on 8/8/13, at 3:20 p.m. the PC stated he would treat the Gabapentin and the Divalproex as antipsychotic medications, and make recommendations to the physician routinely every 6 months, but had not done so. An undated facility policy entitled, Psychotropic Drug Therapy/House Policy, included under number 5: "Within three months from the time a resident is started on drug therapy for behavior/mood control or such a drug's dosage is increased, attempts will be made to have the attending physician document in the progress notes of the medical record why the medication is needed. At lest every four months thereafter, the attending physician will be encouraged to document in the progress notes, the continued need or benefit for every drug given for behavior/mood control." Number 6: "Unless clinically contraindicated, gradual dose reductions should be attempted according to OBRA-87	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 [Omnibus Reconciliation Act of 1987] guidelines."	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review the facility failed to minimize the risk of food borne illness with undated opened protein supplements in a refrigerator which had the potential to affect 25 of 50 residents. Findings include: A tour of the kitchen was completed on 8/5/13, at 12:50 p.m. The refrigerator in the medication room contained one opened and undated 16 ounce (oz.) chocolate protein energy supplement less than half full, one opened and undated 16 oz. vanilla protein energy supplement almost full, and one opened and undated 6 oz. white grape nutritional drink half full. The dietician/food service director identified the drinks are good for seven days once they are thawed. The dietician/food service director did not know when the supplements and nutritional drinks were put in the medication refrigerator or when they were opened.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 14 On 8/7/13, at 11:50 a.m. the medication room refrigerator contained one open and dated when taken out of the freezer to thaw but no date opened for use 16 oz. chocolate protein energy supplement and one open and dated when taken out of the freezer to thaw but no date opened for use 16 oz. maple nut protein energy supplement. The dietician/food service director stated the supplements where to be used in seven days after opened per policy. The dietician/food service director did not know when the supplements were opened. An interview on 8/8/13, at 11:01 a.m., with licensed practical nurse (LPN)-B revealed that staff should date the supplements when they were opened. The facility's policy Date Marking Ready-to-Eat, Potentially Hazardous Food (undated) indicated staff should label and date any processed, ready-to-eat potentially hazardous foods when opened. The product name and the date the product is prepared or opened must be written clearly on the label. Staff should indicate with a separate label the date prepared, the date frozen, and the date thawed of any refrigerated, ready-to-eat, potentially hazardous foods.	F 371	The policy covering the Medication Room Refrigerator has been reviewed and revised. The policy includes guidelines for cleaning, monitoring of temperatures and food storage. All food products not stored in their original containers will be placed in appropriate seamless, tightly sealed containers, that can be sanitized, labeled and dated for storage. All foods will be labeled and dated. The Dietary Manager will label all supplements with the date it was pulled from the freezer. The Dietary department will label all thickened liquids and juices with the date it was received. The Nursing department will label all supplements, thickened liquids and juices with the date it was opened. All item will be discarded seven (7) days after opening, or if they pass the manufacturers expiration date. All foods will be labeled and dated. This along with the refrigerator temps will be documented on a daily basis by the charge nurse or the Health Unit Coordinator. The Infection Control Nurse will also monitor this on a daily basis for 30 days, then weekly for 30 days, and monthly thereafter.	9/17/2013
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 15	F 428		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility's pharmacy consultant failed to report medication irregularities to the facility, or the physician for 1 of 5 residents (R46) reviewed for unnecessary medications.

Findings include:

R46's diagnoses included Alzheimer's disease, aphasia (difficult or no speech), and anxiety. The quarterly Minimum Data Set (MDS) dated 6/19/13, indicated R46 had severe cognitive impairment, showed signs of inattention, disorganized thinking, altered level of consciousness, and psychomotor retardations-sluggishness, staring into space, staying in one position, or moving very slowly. The MDS also indicated R46 showed physical behaviors towards others, rejected cares, and received antipsychotic medication daily.

R46 was administered lorazepam for a reason other than ordered by the physician. The facilities consultant pharmacist failed to identify and report this irregularity to the facility or the physician.

R46's physician order sheets for August 2013, included: Lorazepam [Ativan] intensol [liquid antianxiety medication] 0.5-1 ml [milliliter] (1-2 mg [milligrams]) by mouth/sublingually [under the tongue] every 2 hours as needed for agitation (0.5 ml for mild to moderate agitation and 1 ml for moderate to severe pagination) - not to exceed 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 16 mg in 24 hours. The start date was listed as 2/11/13. R46's Medication Administration Records showed R46 had been administered lorazepam intensol solution 1 ml [2 mg] on 2/4/13 for "shaking," and on 6/19/13 0.5 ml [1 mg] for "jerking movements." During interview on 8/7/13, at 12:50 p.m. registered nurse (RN)-A stated the lorazepam had originally been ordered for R46 in September 2012 when she was sent to the emergency room for "twitching." When the order required renewal, the nurse practitioner changed the order as it currently is, changing the rationale for use as agitation. RN-A stated, the facility should have questioned the nurse practioner as to the use of the medication. During interview on 8/8/13, at 9:40 a.m. licensed practical nurse (LPN)-A stated the lorazepam was for when R46 gets "twitchy, that's when the nurse practitioner told us to use it." LPN-A did not know why the order was for "agitation," stating R46 does not get agitated. R46's Medication Regimen Review dated 6/10/13 noted; "Ativan APR/x 1 June," noting R46 received the Ativan, but made no recommendations to the facility or the physician. The Medication Regimen Review forms from July 2012 through July 2013 made no other mention of this medication. During interview on 8/8/13, at 3:20 p.m. the facilities consultant pharmacist (CP) stated he had not recognized R46 had received the lorazepam for other than the physician ordered use, or he would have clarified this irregularity	F 428	The medication regimen for the resident listed in the SOD was reviewed by the Consultant Pharmacist on 8/12/2013 and again on 9/3/2013. Recommendation were made to decrease the resident Aricept to 5 mg qd due to a BIMS score of 0, with a recommendation that the resident be monitored for an cognitive changes with a goal of discontinuing the medication if no cognitive alterations are noted. Also a recommendation was made to decrease the Amantadine to 50 mg qd and continue to monitor for any behavior changes with a goal of eventually discontinue this medication as well. As of 9/3/2013, all residents drug regimens have been reviewed by the Consultant Pharmacist to ensure that each resident is free of potential unnecessary medications. Recommendations have been forwarded to attending physicians for action. The Consultant will review the results of his actions on a monthly basis to ensure that each recommendation is addressed by the attending physician. The CP will review his recommendations as well as the attending physicians responses on a quarterly basis with the Quality Improvement committee for discussion, review and follow-up. On an ongoing basis, the Consultant Pharmacist will continue to make recommendations as clinically appropriate to ensure that each resident's drug regimen is free of unnecessary drugs. This process will be monitored by the DON to ensure that recommendations are addressed by the attending physicians in a timely manner. She will review this information with the Quality Improvement Committee on a quarterly basis.	9/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 17 with the facility and physician. R46 received a medication without a clear indication for it's use. The facilities consultant pharmacist failed to identify this irregularity and notify the facility or the physician. R46's August 2013's physician order sheets included: Amantadine HCL [an antiparkinson's agent sometimes used for movement disorders or behavioral disturbances] 100 mg 1 cap by mouth daily for dementia. The start date was listed as 7/20/12. During interview on 8/7/13, at 10:30 a.m. RN-B stated she did not know why the Amantadine was being used for R46. R46 had been hospitalized at a geriatric psychiatric facility in July 2012 and returned with the order, which was listed only as dementia. During interview on 8/7/13, at 12:50 p.m. RN-A stated she did not know what R46 was being administered Amantadine for, the diagnosis of dementia does not fit the known uses for this medication. R46's Medication Regimen Review forms from July 2012 through July 2013 failed to note this medication and no recommendations had been made to the physician or the facility. During interview on 8/8/13, at 3:20 p.m. the facilities consultant pharmacist (CP) stated Amantadine is occasionally used for severe, last resort, for uncontrolled behavior problems. CP agreed, R46 did not have uncontrolled behaviors. The medication can also be used for Parkinson's	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 18 disease, or movement disorders associated with psychotropic drug use. CP agreed it was unclear why R46 was receiving this medication. R46 continued to receive cognitive enhancer medications without reevaluation if the medications should be continued. R46's physician order sheets dated August 2013 included: Donepezil HCL [a cognitive enhancer used to treat mild to moderate Alzheimer's disease] 10 mg by mouth every bedtime, with a diagnosis of dementia. The start date was listed as 7/20/12. Namenda [used to treat mild to moderate Alzheimer's disease] 10 mg twice daily, with a diagnosis of dementia. The start date was listed as 7/20/12. Cognitive enhancer's such as donepezil and Namenda are typically used for mild to moderate dementia, as the underlying disorder progresses into advanced stages, the continued use of the medication should be reevaluated. R46's medical record failed to identify how R46 would benefit from the continued use of these medication in the late stages of Alzheimer's dementia. The physician progress notes dated from July 2012 through present were reviewed and failed to address the continued use of these medication, even though R46 had progressed to a later stage of dementia. During interview on 8/7/13, at 10:30 a.m. RN-B stated R46 was in the late stages of Alzheimer's dementia, but had not questioned the physician	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 19 about continued use of these medications as the consulting pharmacist had not questioned it. During interview on 8/7/13, at 12:50 p.m. RN-A stated most physicians are taking residents off of these cognitive enhancer's decreased cognition occurs. R46 is has severe cognitive impairment. She did not know why the physician had continued the medication, and had not questioned the physician. R46's Medication Regimen Review forms from July 2012 through July 2013 failed to note these medications, and no recommendations had been made to the physician or the facility. During interview on 8/8/13, at 3:20 p.m. the PC stated he usually questions the physicians about continued use of these medications, but this physician may prefer to keep residents on it, and had not done so. R46 received two anticonvulsant medications, identified as being used for "mood disorder," and "as a psychotropic." Neither of these medications had an attempted gradual dose reductions despite being used for "mood" or "as a psychotropic." R46's August 2013 physician order sheets included: Divalproex sodium [an anticonvulsant medication, off label uses include behavior disorders] 250 mg by mouth daily, with a diagnosis of mood disorder. The start date was listed as 7/20/12. Gabapentin solution [an anticonvulsant, off label uses include behavioral disorder and nerve pain] 100 mg three TID [three times a day], and 200	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 20 mg at bedtime, with a diagnosis of mood disorder. The start date was listed as 7/20/12. R46's medical record revealed there had been no attempt at reducing the Divalproex sodium or the Gabapentin. R46's physician progress notes dated 4/11/13, included; "On 2/5/13, valproic acid [Divalproex] level of 19, low; however, the valproic acid is being used as a psychotropic medication for behavior, not for any seizure control...Due to the patient's severe dementia, review of systems is not possible." R46's physician progress notes from July 2013 though August 2013 failed to address if the Gabapentin was being used to control behaviors, mood, or pain. During interview on 8/7/13, at 10:30 a.m. RN-B stated R46 received the Divalproex for behavior problems and the Gabapentin for pain. RN-B had not questioned the diagnosis for each of these medications and had not inquired about potentially decreasing either one, because the consultant pharmacist had not done so. RN-B was not aware that if an anticonvulsant medication was being used as an antipsychotic medication, attempts at gradual dose reduction were required to be addressed. During interview on 8/7/13, at 12:50 p.m. RN-A stated she did not know why a gradual dose reduction had not been attempted for R46's Divalproex, and thought the Gabapentin was being used for pain, even though the physician order clearly indicated it was for a mood disorder. R46's Medication Regimen Review forms from	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 21 July 2012 through July 2013 failed to note this medication, and no recommendations had been made to the physician or the facility. During interview on 8/8/13, at 3:20 p.m. the PC stated he would treat the Gabapentin and the Divalproex as antipsychotic medications and make recommendations to the physician routinely every 6 months, but had not done so. An undated facility policy entitled, Psychotropic Drug Therapy/House Policy, included under number 5: "Within three months from the time a resident is started on drug therapy for behavior/mood control or such a drug's dosage is increased, attempts will be made to have the attending physician document in the progress notes of the medical record why the medication is needed. At lest every four months thereafter, the attending physician will be encouraged to document in the progress notes, the continued need or benefit for every drug given for behavior/mood control." Number 6: "Unless clinically contraindicated, gradual dose reductions should be attempted according to OBRA-87 [Omnibus Reconciliation Act of 1987] guidelines."	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 22 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an accurate reconciliation of 3 of 5 liquid narcotic medications affecting two residents (R55 and R6). Findings include: During the tour of medication storage of the north medication cart on 8/8/13, at 9:30 a.m. a count of the liquid narcotics did not match the documented narcotic record..	F 431	For all residents and medications identified in SOD an accurate reconciliation has been completed. The facility policy covering the inventory and control of controlled substances has been reviewed and will be reviewed with all licensed staff. Licensed staff will reconcile the number of doses remaining to the number remaining on the controlled substance sheet on a daily basis at shift change and will document on the Controlled Substance Verification/Shift Count Sheet. For Liquid controlled substances, specifically Methadone, Roxane Laboratories is the the only FDA approved supplier of these medications. During 2011 they began provided Methadone in a bottle containing 30 ml with a calibration method for helping to maintain an accurate inventory of product. Unfortunately the calibration does not cover the full amount in the bottle and does not begin to start until 22 ml. In this case until the calibration on the bottle can be used, with 2 nurses present the medication will be poured into a measuring med cup for accurate measurement until the level reaches the calibration on the bottle. Additionally we will maintain a record of purported amounts of the product remaining on hand until the calibration on the bottle allows for a clearer assessment of quantity on hand. We will also monitor and report any suspected diversion in accordance with current policies.	9/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 23 R55 had a physician order for a liquid narcotic medication, Morphine (oral solution) O/S C2 immediate release (IR) (also known as Roxanol, which has a high potential for abuse/diversion.) The medication was to be used for the treatment of severe pain and the physician order specified R55 was to be given 0.25 milliliters (ml), 5 milligram (mg) at 8 a.m. and bedtime. This medication could also be given to R55 every two hours as needed for pain. The Narcotic Record indicated 4 ml (80 mg) were left in the medication bottle. An inspection of the bottle revealed a small amount remained inside. Licensed practical nurse (LPN)-C removed the liquid that remained with a syringe, which revealed 0.5 ml (10 mg) remained. The narcotic count was missing 3.5 ml (70 mg) R6 had a physician order for Morphine O/S (Roxanol) 0.75 ml (15 mg) by mouth every two hours as needed for mild to moderate pain, and 1 ml (20 mg) by mouth every 2 hours as needed for moderate to severe pain. The Narcotic Record indicated 20 ml (400 mg) remained in the medication bottle. An inspection of the bottle showed 24 ml (440 mg) remained in the bottle. This was 40 mgs more than the narcotic record noted. This was verified by LPN-C. R6 had a physician order for a liquid concentrate of Methadone (a synthetic opiate medication with a high potential for abuse/diversion). The medication was to be given three times per day and to receive 1 ml (10 mg) per dose for pain management. The Narcotic Record indicated 13.75 ml (130.75 mg) remained in the bottle. An inspection of the bottle revealed the amount to be 18.75 ml (180.75 mg) in the bottle. This was 4 ml	F 431	The Don or designee will Audit this process 2 times per week for 4 weeks, then weekly for 4 weeks. This will be reviewed by the Quality Improvement Committee at the next quarterly committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 24 (40 mg) more than the narcotic record noted. This was verified by LPN-C. When interviewed on 8/8/13, at 9:30 a.m. LPN-A stated the narcotic count is done at the end of each shift by the nurse who has completed the shift and the charge nurse for the oncoming shift. When interviewed on 8/8/13 at 9:35 a.m., LPN-C indicated most of the bottles of the liquid narcotics are incorrect and if more is in the bottle than on the count sheet "they do not worry about it". LPN-C also confirmed it would be expected for the count to be right (accurate) and the signature on the book indicated the count was correct even when it did not match the amount in the medication container. LPN-C also indicated an assumption was made that the correct amount is received from the pharmacy; however no count was done when the pharmacy delivered the narcotic medications to ensure they had received the correct amount of medication. When interviewed on 8/8/13, at 9:35 a.m. director of nursing (DON) stated it would be her expectation the count to be accurate. When interviewed on 8/8/13, at 1:27 p.m. DON stated an investigation would be completed to determine why the liquid narcotic counts are not accurate. The DON stated it is her expectation to be notified by nursing staff when the narcotic count is off. She also stated the policy directs the nursing staff to count narcotic and other controlled medications at each change of shift, and if a discrepancy is found, they were to notify her. The DON indicated she had observed the narcotic counts completed between staff, but had not done an audit of the amount of narcotic	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 25 medication. She stated she has only looked at the medications when they are brought in for destruction. She indicated when narcotic medications are brought to the facility, a nurse meets the driver to see what is delivered and both sign off on it. The expectation is the bottle is looked at when a new one is started to verify the amount. When interviewed on 8/8/13, at 2:23 p.m. Omnicare nursing consultant stated her process was to review how the medications are logged in and the destruction process. Random audits are done quarterly, but not every medication bottle is looked at. She reported she had no concerns regarding the controls of narcotic medications. Omnicare nursing consultant indicated the DON would be notified immediately if the count was noted to be off during the random audit and a discrepancy report would be filled out. She reported the last medication audit was done on 7/30/13 with no discrepancy. Review of the Omnicare policy Inventory Control of Controlled Substances, revised 1/1/13, indicated the facility should reconcile the number of doses remaining in the package to the number of remaining doses recorded on the Controlled Substance Verification/Shift Count Sheet. It also indicated the facility should ensure that staff immediately report suspected theft or loss of controlled substances to their supervisor/manager for appropriate documentation, investigation, and timely follow-up in accordance with facility policy and applicable law.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 26 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	We have reviewed our infection control policy and have revised it to include having a system for monitoring illnesses of those staff that have direct contact with residents, or who handle food, to ensure that they are free of communicable diseases and open lesions. All employees calling in to be absent from work will be expected to give a reason for not being able to work their shift. The employee taking the call will be expected to complete a "call-in" form which will ask for basic information related to the employee illness. The forms will be forwarded to the Infection Control Nurse for review and completeness. If more information is needed the Infection Control Nurse will follow up with the employee. The Infection Control Nurse will review all forms on a weekly basis for trends or correlation with resident conditions or infections. On a monthly basis, the Infection Control Nurse will complete the Employee Call In log. She will determine if there is any correlation with any resident illnesses or infections. She will forward her report to the Quality Assurance/Improvement Committee on a ongoing quarterly basis for review and any possible follow-up.	9/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING _____ B. WING _____	08/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE, PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their infection control program included tracking and trending of employee infections in order to compare these with resident infections. This had the potential to affect all 51 residents who resided in the facility. Findings include: The facilities infection control logs and program was reviewed with registered nurse (RN)-B on 8/6/13, at 2:40 p.m. The Monthly Infection Log(s) and data analysis failed to include any information on employee illnesses. RN-B stated she does not track employee illnesses. She had never considered potential links between resident and employee illnesses. The January 2013 Monthly Infection Log showed 9 out of 52 residents had a respiratory illness. RN-B stated, they had an outbreak and took precautions. RN-B had not kept track if any employees had been ill and contributing to this outbreak. An undated facility policy entitled Infection Prevention and Control Program Overview included, Page 1: "Haven Homes has established an Infection Control Program under which it: 1 Investigates, controls, and prevents infections in the facility. 3 Maintains a record of incidents and corrective actions related to infections."	F 441		

CARE...BY THOSE WHO CARE

HAVEN
HOMES
INCORPORATED

1520 WYMAN AVENUE
MAPLE PLAIN, MINNESOTA 55359
(763) 479-1993
FAX (763) 479-3656

Provider's Plan of Correction Addendum

F226

On a monthly basis, the personnel files of all new employees will be reviewed/audited by the Administrator to ensure that an attempt has been made to obtain information from previous employers and/or current employers. The Administrator will review this with the facility Quality Assurance Committee at the quarterly meeting.

F242

On a monthly basis the Director of Nursing or Designee will audit resident care plans and care conference summaries to ensure that residents are being given choices in bathing frequency and that those choices are being carried out. The Director of Nursing will review the results of her monitoring with the Quality Improvement Committee.

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

F549702

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/08/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE. PO BOX 369 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Haven Homes of Maple Plain was found 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. Haven Homes of Maple Plain is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(000) construction. In 1999, an addition was constructed to the southeast and was determined to be of Type II(000) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 67 and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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