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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N2G2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00037

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245362**
2.STATE VENDOR OR MEDICAID NO.
(L2) **106540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLETON COMMUNITY HOME**
(L4) **301 TROENDLE STREET**
(L5) **MAPLETON, MN** (L6) **56065**

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)

6. DATE OF SURVEY **09/08/2017** (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 **60** (L18)
13.Total Certified Beds **60** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 10/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/02/2017 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245362

November 2, 2017

Ms. Roxanne Gosson, Administrator
Mapleton Community Home
301 Troendle Street
Mapleton, MN 56065

Dear Ms. Gosson:

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 29, 2017 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
November 2, 2017

Ms. Roxanne Gosson, Administrator
Mapleton Community Home
301 Troendle Street
Mapleton, MN 56065

RE: Project Number S5362025

Dear Ms. Gosson:

On October 6, 2017, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 3, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of October 6, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 3, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on August 3, 2017, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our October 6, 2017 notice. The most serious deficiencies at the time of the standard survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 8, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 24, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 3, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 29, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, as of September 29, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 29, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 6, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 3, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 3, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 3, 2017, is to be rescinded.

In our letter of October 6, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 3, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 29, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
October 6, 2017

Ms. Roxanne Gosson, Administrator
Mapleton Community Home
301 Troendle Street
Mapleton, MN 56065

RE: Project Number S5362025

Dear Ms. Gosson:

On August 17, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 3, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 8, 2017, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 3, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 8, 2017. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on August 3, 2017.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the August 3, 2017 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 3, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 3, 2017. They will also notify the State Medicaid Agency that they

must also deny payment for new Medicaid admissions effective November 3, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Mapleton Community Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 3, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 3, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N2G2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00037

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245362**
2.STATE VENDOR OR MEDICAID NO.
(L2) **106540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLETON COMMUNITY HOME**
(L4) **301 TROENDLE STREET**
(L5) **MAPLETON, MN** (L6) **56065**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/03/2017** (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 **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susan Kalis HFE NE II 08/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/12/2017 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 17, 2017

Ms. Roxanne Gosson, Administrator
Mapleton Community Home
301 Troendle Street
Mapleton, MN 56065

RE: Project Number S5362025

Dear Ms. Gosson:

On August 3, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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:

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

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

Remedies - 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:

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

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 12, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 3, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 3, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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
	245362	A. BUILDING _____ B. WING _____	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278		8/24/17

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

Electronically Signed | 08/28/2017

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F 278	Continued From page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents (R13) reviewed for oral and dental services and for 1 of 1 residents (R32) reviewed for urinary continence/Foley catheter. Findings include: R13 had been observed on 8/1/17, at 1:39 p.m. R13 was observed to have upper dentures in place. Interview with the resident at this time, indicated she had lower dentures as well, but that they were too loose to wear all the time. Review of the current quarterly Minimum Data Set (MDS) assessment dated 7/5/17, identified R13 as not having any loose or poor fitting dentures or partials and no concerns with her oral cavity. Review of the Oral/Dental Status assessment dated 1/3/17, identified R13 as having loosely fitting dentures with no natural teeth.	F 278	Modifications have been completed for R13 and R32 MDS errors. For all future MDS's, upon completion of the MDS, the MDS Coordinator will recheck for accuracy prior to locking and submission as the error to R32's MDS could be considered a "typo" item coding error. Now to be included during the interview on the ARD of the quarterly or non-full MDS will be MDS L section questions A. broken or loose fitting full or partial denture and F. mouth or facial pain, discomfort or difficulty chewing. Full L. Section oral assessments will be completed by the charge nurse with all full assessments. Will review care plan at time of MDS completion for coordination and accuracy. This plan will be reviewed and followed up as a team at the 11/16/17 Quality Assurance meeting.	

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F 278	Continued From page 2	F 278		

Review of the plan of care identifies R13 as having nutritional concerns related to poor fitting dentures and requires staff to assist with oral cares.

Interview with the MDS coordinator on 8/1/17, at 12:14 p.m. verified R13 had loose fitting dentures and confirmed she had made a coding error on the quarterly MDS dated 7/5/17.
R32 had been observed on 8/1/17, at 11:41 a.m. to be in bed with an indwelling Foley catheter bag attached to the bed frame.

R32's face sheet dated 8/3/17, identified an admission date of 3/30/17 and included diagnoses of obstructive and reflux uropathy (a structural or functional interruption of normal urine flow) and benign prostatic hyperplasia (enlarged prostate gland) with lower urinary tract symptoms.

The quarterly Minimum Data Set (MDS) assessment dated 7/7/17, did not identify R32 as having an indwelling catheter.

During interview on 8/2/17, at 12:14 p.m. registered nurse (RN)-A stated R32 had an indwelling Foley catheter due to an obstruction, and it had been in place since admission.

Interview with the MDS coordinator on 8/3/17, at 8:35 a.m. confirmed R32 had an indwelling catheter and verified R32's 7/7/17 MDS had not been completed accurately and reflective of urinary status. MDS coordinator further indicated a modification of the MDS would need to be completed because of the inaccuracy.

During interview on 8/3/17, at 8:45 a.m. director

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F 278	Continued From page 3 of nursing (DON) stated her expectation is for the MDS to be accurate and reflective of the resident status including use of an indwelling catheter for R32.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 279		9/4/17

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F 279	Continued From page 4 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive plan of care to monitor side effects for 2 of 4 residents (R31, R50) who was receiving an anticoagulant. Findings include: R31 had been observed on 8/2/17, at 12:55 p.m. R31 was observed to have several bruises on both hands and lower arms ranging in size from 10 cent to 50 cents. The top of the lower left leg	F 279	A person centered care plan will be developed with the resident and/or the resident representative during the admission process and continually until discharge of resident. After review care plans were not kept fully up to date by staff. In order to ensure this will be done a care plan sheet has been made for staff to write changes on. Each day at report ADON will collect the changes and make them in the official care plan(which began	

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F 279	Continued From page 5 has a 50 cent size bruised area and also a 50 cent size bruise was observed on the top of the right knee. Interview with R31 at this time, indicated she bruises easily when she bumps her arms and crosses her legs. Review of R31's physicians orders included an order for aspirin 81 milligrams (MG) daily and Warfarin (anticoagulajt) 6 mg one time weekly and 4 mg all other days of the week. Review of the progress notes dated 6/22/17, included a dark purplish bruise behind the left knee that measures 1.7 centimeter (CM) by 2.0 cm. No documentation was found that the bruise had been monitored. Review of the progress note dated 7/9/17, included a dark purplish bruise on the right shin that measures 7.3 cm by 1.9 cm by 0.1. No documentation was found that the bruise had been monitored. Review of the progress notes dated 7/18/17, included a dark purple raised hematoma on the left shin that measured 1.2 cm by 1.0 cm. No documentation was found that the hematoma had been monitored There was no documentation found in the record nor the treatment sheet related to the current bruising on R31's hands, arms or legs. Review of the current plan of care identifies R31 as requiring assistance with activity of daily living (ADL's). The care plan did not include the use of Coumadin or to monitor for side effects (that included bruising of the skin) due to increased risk of bleeding. Interview with the assistant director of nursing	F 279	on 8/28/17). A resident on Coumadin will have addressed in the care plan specifically information for the nursing assistant to monitor such as increased risk of bleeding including issues of bruising, bleeding from the gums and tarry stools and will notify the charge the nurse if these issues are found. Care plans will also be reviewed with all MDS reviews by the completion time for accuracy and coordination of the residents current condition. A weekly skin audit will be done by the nursing assistant during each residents weekly bath. The nursing assistant will mark all areas on body: bruises, discolorations, wounds, nail care that they are not able to perform. The nursing assistant will deliver the completed skin audit to the nurse who will measure all locations that were assessed during the skin audit and document in the progress notes until healed. If the skin issues are new for the resident they will also make a nursing order in the ETAR to measure Wed/Sun eve until healed and fill out a skin/bruise sheet for report. Auditing of this process will be completed weekly by DON choosing 2 residents to review CPS on. Weekly auditing will be done by NOC nurse with random residents assigned for body audit. R31 careplan updated on 8/2/17 for Coumadin side effects. R31 aspirin discontinued 8/24/17 and Warfarin monitored by anticoagulation team of Mankato Clinic. R31 bruising monitored 8/31/17 in ETAR and careplan. R50 careplan updated with Coumadin side effects 8/2/17. Will review plan and follow	

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F 279	Continued From page 6 (ADON) on 8/2/17, at 12:02 p.m. confirmed the plan of care did not include R31's use of Coumadin or to monitor for side effects (that included bruising) due to risk of increased bleeding. The ADON indicated monitoring for potential bleeding/bruising should have been included in R31's plan of care. Interview with registered nurse (RN)-B on 8/2/17 at 12:58 p.m. indicated she was not aware of R31's bruises. RN-B further included the nursing assistance (NA) monitor the resident's skin weekly on bath days and will report identified bruising to the charge nurse The bruise is then documented, investigated and monitored at that time. Interview with NA-B and NA-C on 8/2/17, at 1:03 p.m. both indicated the discolored areas on R31's hands, arms and legs were not identified as bruises and were not reported to the charge nurse but they both were aware of them. NA-B and NA-C indicated R31 often has these discolorations that look like bruises but were unsure if they were or not. Both NA's further revealed R31 always has bluish/purplish discolorations somewhere on her body most of the time. R50's physicians orders included an order for warfarin 3 milligrams (mg) one time weekly and 2 mg all other days of the week for diagnoses of Atrial Fibrillation (A. Fib) and blood clot prevention. Review of the current plan of care identifies R50 as requiring warfarin for diagnosis of Atrial Fibrillation and directs staff to give Coumadin as ordered and international ratio (INR) as ordered. The care plan did not include to monitor for side	F 279	up at 11/16/17 Quality Assurance meeting.	

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F 279	Continued From page 7 effects that included increased risk of bleeding and bruising of the skin. Review of the current treatment record did not reveal monitoring for side effects of warfain use. Interview with the assistant director of nursing (ADON) on 8/2/17, at 12:02 p.m. confirmed the plan of care did not include R50's use of Coumadin or to monitor for side effects due to risk of increased bleeding. The ADON indicated monitoring for potential bleeding/bruising should have been included in R50's plan of care. Interview with registered nurse (RN)-A on 8/02/17, 12:42 p.m. indicated the aids are good at reporting things and they can go to the care plan that is located behind the desk and read it for additional information they may need. RN-A further verified the care plan did not include the risk for and signs of increased bleeding.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any	F 280		8/28/17

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F 280	Continued From page 8 other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 280		

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F 280	Continued From page 9 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 3 residents (R57) reviewed for activity of daily living (ADL's). Findings include: R57 had been observed on 8/1/17, at 2:36 p.m. when nursing assistant (NA)-G and licensed practical nurse (LPN)-A attempted to transfer R57 from edge of bed into a wheelchair using a gait belt. R57 was unable to stand and pivot with two staff assisting as R57's knees were flexing and was assisted to sit back down on bed. After	F 280	Comprehensive care plans will be developed by the interdisciplinary team and reviewed with the resident and/or the family members when changes are made and at quarterly care conferences. Care plans will be reviewed quarterly by the IDT to ensure accuracy in correlation with the MDS. R57 careplan reviewed and updated 8/8/17. Care plans will be reviewed and updated appropriately within 48 hours of a hospital return. Updates in condition from direct staff, charge nurses and therapy departments will be brought to morning	

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F 280	Continued From page 10 allowing R57 to rest a couple minutes on side of bed, a second attempt at the transfer with NA-G and LPN-A assisting was successful. R57 required assist of both NA-G and LPN-A along with guidance, prompts and cues to stand and pivot into wheelchair. During interview at this time, LPN-A stated R57 was more dependent in cares and transfers than he used to be. LPN-A further indicated R57's ability depends on the day. During interview on 8/2/17, at 9:22 a.m. NA-A stated R57 is assist of two for all transfers and indicated R57 can be very difficult to transfer from bed to wheelchair. NA-A indicated R57 returned from an inpatient hospital stay approximately one month prior and had been requiring two assist since that time. A medicare 14 day Minimum Data Set (MDS) assessment dated 7/13/17, identified R57 with Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment. It further identified R57 as needing extensive assistance of two for transfers. R57's current care plan last reviewed 6/16/17, indicated R57 transferred with assist of one. During interview on 8/3/17, at 8:30 a.m. registered nurse (RN)-A stated R57's care plan was not reflective of current status and needed to be revised. Further indicated when R57 returned from the inpatient facility on 6/29/17, the whole care plan should've been reviewed. During interview on 8/3/17, at 8:48 a.m. the director of nursing (DON) indicated a better flow system with care plan revisions was needed to keep the care plans updated. DON stated her	F 280	report to be shared and updated as appropriate with the IDT. Pertinent departments will note any changes that need to be updated in their respective sections and update the care plan. Audits will be performed within 7 days of admission. A care plan update form(attached) may be used by any team member for the purpose of organizing needed information for multiple care plan updates. Will review plan and follow up at the 11/16/17 Quality Assurance meeting. Example: Care Plan Updates Date: _____ Resident: _____ _____ Task: _____ _____ _____ Teaching will be done with staff on 8/28/2017 and also at the monthly meetings and will continue on a PRN basis for staff.	

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F 280	Continued From page 11 expectation was for care plans to be revised to reflect current ADL needs A facility policy on care plan revision was requested but not provided.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such	F 309		9/4/17

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F 309	Continued From page 12 services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor bruising for 1 of 4 residents (R31) reviewed for non-pressure related skin conditions. Findings include: R31 had been observed on 8/2/17, at 12:55 p.m. R31 was observed to have several bruises on both hands and lower arms ranging in size from 10 cent to 50 cent piece. The top of the lower left leg has a 50 cent size bruised area and also a 50 cent size bruise was observed on the top of the right knee. Interview with R31 at this time, indicated she bruises easily when she bumps her arms and crosses her legs. Review of the annual Minimum Data Set (MDS) assessment dated 4/18/17, R31 was identified as requiring extensive assistance with all activities of daily living (ADL's). R31's Brief Interview for Mental Status (BIMS) score was "15" indicating no cognitive impairment. Review of the current plan of care identifies R31 as requiring assistance with ADL's. The care plan did not include the use of Coumadin or to monitor for side effects (that included bruising of the skin) due to increased risk of bleeding. Review of the progress notes dated 6/22/17, included a dark purplish bruise behind the left knee that measures 1.7 centimeter (CM) by 2.0	F 309	Nursing assistants will report to the charge nurse any skin integrity issues observed during the care of the resident. The charge nurse will review the observation noted by the nursing assistant by looking in the eTAR or progress notes to determine if this skin issue has been addressed. If this is new the nurse will complete a skin/bruise incident report and bring to report to discuss. Physician notification will be done on weekly rounds unless otherwise indicated. R31 careplan updated on 8/2/17 for Coumadin side effects and on 8/31/17 for monitoring of bruises. R31 aspirin discontinued 8/24/17. A weekly skin audit will be done by the nursing assistant performing the bath. The nursing assistant will mark all areas on body: bruises, discolorations, wounds, nail care that they are not able to perform. The nursing assistant will call the nurse for measuring of the skin issues. If the nurse is not available the nursing assistant will deliver the completed skin audit signed to the nurse who will measure all locations that were assessed during the skin audit and document in the progress notes until healed. If the skin issues are new for the resident they will also make a nursing order in the ETAR to measure Wed/Sun eve until healed and fill out a skin/bruise sheet for report. The	

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F 309	Continued From page 13 cm. No documentation was found that the bruise had been monitored. Review of the progress note dated 7/9/17, included a dark purplish bruise on the right shin that measures 7.3 cm by 1.9 cm by 0.1. No documentation was found that the bruise had been monitored. Review of the progress notes dated 7/18/17, included a dark purple raised hematoma on the left shin that measured 1.2 cm by 1.0 cm. No documentation was found that the hematoma had been monitored There was no documentation found in the record nor the treatment sheet related to the current bruising on R31's hands, arms or legs. Review of R31's physicians orders included an order for aspirin 81 milligrams (MG) daily and Warfarin (anticoagulation) 6 mg one time weekly and 4 mg all other days of the week. Interview with the assistant director of nursing (ADON) on 8/2/17, at 12:02 p.m. confirmed the plan of care did not include R31's use of Coumadin or to monitor for side effects (that included bruising) due to risk of increased bleeding. Review of the facility policy for Bruises and Warfarin dated 7/12/17, included; observe the resident for bruises when providing cares, report to the charge nurse, complete an incident report, determine cause, monitor/document, if the resident is on Warfarin include in the plan of care, along with interventions to ensure staff are aware of what signs to observe for and notify the physician and family of changes.	F 309	nurse will then sign the back of the skin audit and place under the MDS tab in the hard chart of the resident. Beginning 9/4/17 weekly auditing will be done by the NOC nurse. Will review at the 11/16/17 Quality Assurance meeting.	

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F 329	Continued From page 14	F 329		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral	F 329		9/1/17

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F 329	Continued From page 15 interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to evaluate the continued use of an antianxiety medication for 1 of 5 residents (R31). The facility further failed to identify the parameters for use of an as needed (PRN) antipsychotic medication (risperidone) and an antidepressant medication (trazodone), and failed to consistently document non-pharmacological interventions attempted prior administration of the PRN's for 1 of 5 residents (R57) reviewed for unnecessary medications. Findings include: R31's Diagnosis report obtained in the medical record included: major depressive disorder and anxiety. R31 was prescribed Buspar 10 milligrams (mg) twice daily (for anxiety). Observation on 8/2/17 at 7:47 a.m. R31 was sitting in her room waiting for breakfast. The resident was very calm mannered and pleasant. No anxiety noted during this time. Interview with R31 at this time denied feeling anxious. The resident indicated she used to worry about everyone when she first moved into the facility in 2012, but has accepted placement. R31 further included she could not recall receiving a medication for anxiety and that the only time she could remember getting anxious is when she had a bowel obstruction last fall.	F 329	PRN antipsychotic medications will be discontinued after 14 days. During the 14 days through the comprehensive care plan, the staff will be able to identify parameters for use for the medication, non-pharmacological interventions that are specific to each resident and the specific antipsychotic medication attempted prior to giving a PRN dose. R31 Buspar dose reviewed on 8/24/17 with PA-C. PA-C declined to reduce Buspar dose at this time. Will review at next month's physician visit. R57 careplan revised on 8/8/17 and PRN Trazadone discontinued on 8/4/17 and PRN Risperdone discontinued on 8/4/17. Residents who receive antipsychotic medications, antianxiety medication, antidepressant and hypnotics will be reviewed with the prescriber on the residents scheduled rounds. A review of the behavior monitoring sheets, BIMS, pharmacy recommendations and personal statements from the resident will be considered in the medication review. ADON will audit any new orders, new admissions beginning 9/1/17. Will review plan at 11/16/17 Quality Assurance Meeting.	

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Review of the annual Minimum Data Set (MDS) dated 4/18/17, identified R31 as having no concerns with behavior/mood other than feeling tired or having little energy. This occurred 12-14 days during the assessment period. No anxiety was noted. The resident had a BIMS score of "15" with no impairment in cognition.

Review of the residents daily mood and behavior monitoring log for the past 9 months, identified R31 as having no signs of anxiety.

Review of R31's physicians dictated note dated 11/10/16, included an order for Buspar 7.5 mg twice daily for an anxious stomach and previous bowel obstruction on 10/24/16.

Review of R31's physicians dictated note dated 5/25/17, included an order to increase Buspar to 10 mg twice daily. The progress note indicated the residents mood was normal and that she denied feeling anxious and had no concerns. There was no justification as to why the Buspar had been increased at this time.

Review of the pharmacy recommendations since the start of the Buspar on 11/10/16, did not include a review of the residents Buspar for continued need and why a titration was not attempted or a physician justification as to why a titration was contraindicated.

Interview with the facility Pharmacist on 8/3/17, at 11:25 a.m. confirmed R31's Buspar order had not been evaluated for continued use and verified there was no justification for the increase in the Buspar on 5/25/17, that could be identified.

Interview on 8/2/17, at 7:30 a.m. NA-B indicated

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R31 was cooperative and pleasant and did not exhibit signs of anxiety that she was aware of.

Interview on 8/2/17, at 7:32 a.m. RN-B indicated R31 was cooperative and pleasant and did not exhibit any signs of anxiety that she was aware of.

Interview on 8/2/17, at 7:33 a.m. NA-C indicated R31 was cooperative and pleasant and did not exhibit any signs of anxiety that she was aware of.
R57's Diagnosis report obtained in the medical record included: major depressive disorder and vascular dementia with behavioral disturbance.

R57's current physician orders dated 7/6/17, included the following as needed (PRN) medication orders: risperidone (antipsychotic medication) 0.25 milligrams (mg) every 4 hours PRN agitation with max of 3 doses in 24 hours and trazodone (antidepressant medication sometimes used for insomnia) 50 mg may give once if awake before 3 a.m. PRN for insomnia. In addition, scheduled doses included: risperidone 0.25 mg twice daily for agitation and trazodone 50 mg every bedtime for insomnia.

The medicare 14 day Minimum Data Set (MDS) assessment dated 7/13/17, identified that R57 had severe cognitive impairment. The MDS further indicated R57 did not have any behaviors, difficulty with falling asleep or staying asleep.

R57's care plan last reviewed 6/16/17, identified R57 received antipsychotic and antidepressant medications but did not clearly define when PRN medications were to be utilized nor were there non-pharmacological interventions identified.

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Review of the electronic administration record (eMAR) revealed R57 was administered PRN trazodone 4 times from 6/29/17 to 8/3/17 and PRN risperidone 1 time from 6/29/17 to 8/3/17. Further review of R57's eMAR and progress notes indicated on 7/27/17, R57 received PRN trazodone at 1:20 a.m. for agitation. On 7/28/17, PRN trazodone was administered at 1:10 a.m., however no administration rationalization or documented non-pharmacological interventions were documented.

When interviewed on 8/2/17, at 12:16 p.m. registered nurse (RN)-A stated if staff were unable to redirect R57 and if he was distraught she would consider administering a PRN risperidal for agitation. RN-A further stated she would give the PRN trazodone if R57 wasn't sleeping or agitated at night and it was before 3:00 a.m. RN-A confirmed there were no clear parameters on when to give the PRN risperidone or trazodone. RN-A further confirmed resident behaviors and non-pharmacological interventions attempted prior to administration of a PRN psychotropic medication were supposed to be charted in the electronic record.

During interview on 8/2/17, at 10:35 a.m. RN-C stated there should be documentation of behavior and interventions attempted prior to administration of a psychotropic PRN medication. RN-C further stated parameters related to use of R57's risperidone and trazodone and non-pharmacological interventions were not clear and this should be included in the care plan.

When interviewed on 8/3/17, at 8:51 a.m. the director of nursing (DON) confirmed the lack of

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F 329	Continued From page 19 nonpharmacological interventions and parameters for the PRN psychotropic medications. DON stated she would expect documentation to reflect behavior exhibited and interventions attempted prior to the administration of the PRN.	F 329		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 356		8/24/17

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F 356	Continued From page 20 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post nursing hours at the beginning of the shift as required. This had the potential to affect all 55 residents residing in the facility, including families and visitors. Findings include: During the initial tour of the facility on 7/31/17, at 12:51 p.m. observation of the facility nursing hour posting was dated 7/29/17 (two days prior). In addition, the nursing hour posting did not include the number of licensed and unlicensed nursing staff for the night and evening shift nor did it include the hours worked for those shifts. At this time, registered nurse (RN)-B confirmed the posting was not up to date, and had not been completed each shift. RN-B further indicated night staff usually filled out the staffing hours that are posted.	F 356	Nursing staff have been informed and shown how to fill out the nursing staff hours sheet. Review will be made daily by DON/ADON to ensure that the sheet is being filled out. DON or ADON will audit staff hours sheet weekly to ensure it is being completed. Will review plan at the 11/16/17 Quality Assurance meeting.	

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F 356	Continued From page 21 Again on 8/2/17 the nursing hour posting did not include the total number of licensed and unlicensed staff for the day or evening shifts nor did it include the hours worked for those shifts. During interview on 8/3/17, at 10:37 a.m. the director of health indicated the charge nurse was responsible for updating the nursing hour posting each shift. The director of health further verified the nursing hour posting had not been completed every shift and was lacking the required information for those shifts.	F 356		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 428		9/5/17

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F 428	Continued From page 22 drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility consulting pharmacist failed to identify irregularities related to ongoing monitoring for effectiveness of an antianxiety medication for 1 of 5 resident (R31) and failed to monitor the effectiveness of an antidepressant used for insomnia for 1 of 5 resident (R57) reviewed for unnecessary medication. Findings include:	F 428	Reviewed current policy and expectations with pharmacist and it is as follows: 1. Mapleton Community Home will (employ or contract) services of a pharmacist for the services of a pharmacist to provide consultation on all aspects of pharmaceutical services. 2. Mapleton Community Home will provide pharmacy consultant with a job description/outline of consultation services describing collaboration expectations for	

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F 428	Continued From page 23 R31's Diagnosis report obtained in the medical record included: major depressive disorder and anxiety. R31 was prescribed Buspar 10 milligrams (mg) twice daily (for anxiety). Observation on 8/2/17 at 7:47 a.m. R31 was sitting in her room waiting for breakfast. The resident was very calm mannered and pleasant. No anxiety noted during this time. Interview with R31 at this time denied feeling anxious. The resident indicated she used to worry about everyone when she first moved into the facility in 2012, but has accepted placement. R31 further included she could not recall receiving a medication for anxiety and that the only time she could remember getting anxious is when she had a bowel obstruction last fall. Review of the annual Minimum Data Set (MDS) dated 4/18/17, identified R31 as having no concerns with behavior/mood other than feeling tired or having little energy. This occurred 12-14 days during the assessment period. No anxiety was noted. The resident had a BIMS score of "15" with no impairment in cognition. Review of the residents daily mood and behavior monitoring log for the past 9 months, identified R31 as having no signs of anxiety. Review of R31's physicians dictated note dated 11/10/16, included an order for Buspar 7.5 mg twice daily for an anxious stomach and previous bowel obstruction on 10/24/16. Review of R31's physicians dictated note dated 5/25/17, included an order to increase Buspar to	F 428	effective consultation for pharmaceutical services. 3. The pharmacy consultant will assist Mapleton Community Home with obtaining and maintaining timely and appropriate pharmaceutical services to meet the residents healthcare needs consistent with current standards of practice and regulatory requirements. 4. The pharmacy consultant will provide Mapleton Community Home with a Pharmaceutical Policy and Procedure Manual. a. The pharmacy consultant will assist Mapleton Community Home to update as necessary with regulatory and changes in best practices regarding all aspects of pharmaceutical service. 5. The pharmacy consultant will coordinate pharmaceutical services with multiple providers delivering services to residents in Mapleton Community Home. 6. The pharmacy consultant will determine, in collaboration with the DON and Medical Director, consistent with State law, the contents of the emergency medication supply and monitor the use of the contents in Mapleton Community Home. 7. The pharmacy consultant will develop and monitor a system for communication and resolution of issues related to pharmaceutical services. 8. The pharmacy consultant will strive to assure that medications/biologicals are requested, received, and administered in a timely manner as ordered by the authorized prescriber (in accordance with state requirements), including physicians,	

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F 428	Continued From page 24 10 mg twice daily. The progress note indicated the residents mood was normal and that she denied feeling anxious and had no concerns. There was no reason to why the Buspar had been increased at this time. Review of the pharmacy recommendations since the start of the Buspar on 11/10/16, did not include a review of the residents Buspar for continued need and current dose/reduction. Interview with the facility Pharmacist on 8/3/17, at 11:25 a.m. confirmed R31's Buspar order had not been evaluated for continued use and verified there was no logical reason for the increase in the Buspar on 5/25/17, that could be identified. Interview on 8/2/17, at 7:30 a.m. NA-B indicated R31 was cooperative and pleasant and did not exhibit signs of anxiety that she was aware of. Interview on 8/2/17, at 7:32 a.m. RN-B indicated R31 was cooperative and pleasant and did not exhibit any signs of anxiety that she was aware of. Interview on 8/2/17, at 7:33 a.m. NA-C indicated R31 was cooperative and pleasant and did not exhibit any signs of anxiety that she was aware of. R57's Diagnosis report obtained in the medical record included: major depressive disorder and vascular dementia with behavioral disturbance. R57's physician orders dated 7/6/17, included an order for trazodone (antidepressant medication sometimes used to treat insomnia) 50 milligrams (mg) at bedtime for insomnia plus may give 1 tablet once by mouth if awake before 3:00 a.m.	F 428	advanced practice nurses, pharmacists, and physician assistants. 9. The pharmacy consultant will provide reports to the Director of Nursing as requested (i.e. psychotropic medications, antibiotic use, etc.). 10. The pharmacy consultant will discuss with the attending physician any problem of an immediate nature regarding a resident□s health status. 11. The consultant pharmacist or designee will, together with the Director of Nursing or designated RN, destroy all controlled substances, utilizing the appropriate forms and methods of destruction. a. Forms are submitted by the pharmacist or facility in accordance with State requirements. 12. The pharmacy consultant will provide feedback and assist the Administrator and Director of Nursing regarding performance and practices related to medication administration. a. The pharmacy consultant or designee will complete quarterly medication room and medication pass audits and provide report of findings and recommendations to the Director of Nursing. b. The pharmacy consultant will provide training to the facility staff regarding findings and recommendations from audits. c. The pharmacy consultant will provide assistance with the determination of OTCs. 13. The pharmacy consultant will provide feedback and assist the Administrator and Director of Nursing regarding	

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F 428	Continued From page 25 as needed (PRN). The trazodone had an order start date of 6/29/17. The medicare 14 day Minimum Data Set (MDS) assessment dated 7/13/17, identified that R57 had severe cognitive impairment. The MDS further indicated R57 exhibited no difficulty with sleep. Review of R57's 6/17 and 7/17 medication administration records (MAR) indicated R57 received the trazodone on a nightly basis since 6/29/17 with four doses of the PRN trazodone given in 7/17. During interview on 8/2/17, at 10:35 a.m. registered nurse (RN)-C indicated the trazodone was used for sleep and verified no sleep assessment had been completed for R57. Review of the pharmacy recommendations from 7/2017 did not include a recommendation for sleep monitoring related to the use of trazodone for insomnia. During interview on 8/3/17, at 11:04 a.m. the facility's consultant pharmacist (CP) indicated R57 should have had a documented sleep assessment completed to see what other factors could affect R57's sleep cycle. CP further stated that is a monitoring piece that should have been identified, and hadn't been.	F 428	performance and practices related to medication errors. a. The pharmacy consultant will provide training to the facility staff regarding medication/biologicals errors, best practices and recommendations. 14. The pharmacy consultant will be a part of the Interdisciplinary Team Quality Assurance and Performance Improvement program at Mapleton Community Home to address and resolve medication-related needs or problems. a. The pharmacy consultant will attend the quarterly quality assurance and assessment committee meeting at Mapleton Community Home. b. The pharmacy consultant will review the Quality Measures with the DON and collaborate on the development of an action plan. c. The pharmacy consultant will review antibiotic and psychotropic medication utilization and collaborate on the development of an action plan consistent with best practices and regulatory requirements. 15. The pharmacy consultant will: a. Conduct the monthly medication regimen review (MRR) for each resident in the facility: i. Addressing the expected time frames for conducting the review and reporting the findings, ii. Addressing the irregularities, iii. Documenting and reporting the results of the review and b. Provide medication regimen reviews for residents who are anticipated to stay less than 30 days or when the resident	

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F 428	Continued From page 26	F 428	experiences an acute change of condition as identified by facility staff. i. Charge nurse will notify pharmacy consultant of new resident admissions with anticipated/expected length of stay of less than 30 days and residents with acute changes of condition to ensure timely review for quality of care. A customized sleep journal will be designed for each resident prior to beginning, changing or adding a PRN sleep medication to the current regimen. R57 PRN Trazadone and Risperdone have been discontinued. R31 discontinued aspirin dose and decreased buspar. ADON will audit each resident at doctor rounds beginning 9/5/17 to notify the primary care provider regarding concerns of appropriate medications. Will review plan at 11/6/17 Quality Assurance meeting.	
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 431		8/17/17

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F 431	Continued From page 27 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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	F 431	DON conducted a meeting with nurses	

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F 431	Continued From page 28 review, the provider failed to: 1.) Identify, report, and follow their policy for the potential diversion of 2 of 2 residents' (R6 and R32) schedule II controlled narcotic medication that had tamper-resistant seals broken in a timely manner and 1 of 1 resident (R-71) whose medication reconciliation was found inaccurate by minus 6.25 milliliters (ml) of medication missing or unaccounted for from her medication bottle. 2.) Ensure 2 of 2 residents' (R63 and R71) controlled narcotic medications were not taped back into the blister medication packs and ensure the integrity of 1 of 1 resident (R8) controlled narcotic medication in a blister pack was secured. 3.) Ensure 1 of 1 resident (R35) cytotoxic medication was destroyed after it was discontinued and not co-mingled with in-use medication and separate medications awaiting destruction from medications in-use in 2 of 2 medication rooms. Findings include: 1.) Observation and interview on 8/1/17, at 12:05 p.m. with the assistant director of nursing (ADON) in the new wing medication room, indicated there were three bottles of hydromorphone (controlled narcotic pain medication) for R6 in the locked medication cupboard in the medication room. Of those three bottles, only one was reported to have been administered to R6. The 120 ml bottle dated having been dispensed from pharmacy on 7/6/17 and had its tamper-resistant tape seal broken. The ADON indicated she could not verify when that had occurred as staff had not reported the incident to her or the ADON. Although the bottle had a full amount of liquid inside, the ADON could not verify the contents of the bottle could not state it had not been diverted.	F 431	and TMAs 8/16/17 reviewing the drug diversion policy, what drug diversion was and reviewed practices that the staff were doing that were not to be done and were considered drug diversion. Our narcotic counting sheet was a 3-ring binder which each nurse signed off on after they completed the count. It did not go onto each person□s individual narcotic page stating that it was counted. We have since implemented a new narcotic counting system which includes both nurses counting off and recording on each individual narcotic record page every time a nurse change is made. Reiterated with nursing staff that a discrepancy in the measurement of the liquid needs to be reported to the DON immediately. If a safety seal is broken prior to use it also needs to be reported immediately to the DON. A lock box was purchased and is kept in the DONs office. This lock box will hold narcotics that are no longer in use for the residents and are awaiting pharmacy destruction. This will eliminate medications in use and medications not in use from being comingled in the narcotic cupboard and further eliminate the possibility of drug diversion. The DON and ADON are the only people who have access to the keys to this lock box and the box is kept in a separate area away from any other staff having access to it. We have also purchased a product called drug buster which is charcoal and will destroy the medication when it is placed into the container when the nurses destroy the non-narcotic medications.	

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F 431	Continued From page 29 Continued observation and interview on 8/1/17, at 12:05 p.m. with the ADON in the new wing medication room revealed another controlled narcotic medication bottle tamper seal was also broken. That bottle belonged to R32 was to have contained 233 ml of hydrocodone. It was dispensed from pharmacy on 7/7/17. The ADON indicated she could not verify when that tamper-resistant tape seal had been broken, as staff had not reported the incident to her or the ADON. Although the bottles had what appeared a full amount of liquid inside, the ADON could not verify the contents of the bottle and could not be sure it had not been diverted. The ADON was unsure of the facilities diversion policy but stated an investigation needed to begin as there was suspicion for suspect diversion. Observation and interview on 8/01/17 at 2:05 p.m. in the old wing medication room with the director of nursing (DON) indicated R71 had a bottle of hydrocodone medication in the locked narcotic cupboard in the medication room. There was an inconsistency noted between the individual narcotic record count sheet and what was actually in the medication bottle. The individual narcotic record narcotic count sheet indicated there was to have been 11.25 ml left in the medication bottle. Upon observation, only 5 ml remained. There was no accounting for where the missing medication had gone or that it had been recognized by staff. No one had reported the above findings to the DON. It was her expectation any discrepancies in a tamper- seal having been found broken or medication count discrepancies were to be reported right away. The DON stated she could not be sure the contents inside the bottle of hydrocodone was the	F 431	Medications were destroyed that had been taped back into individuals blister packs after verification through Omnicare verifying that the medication was in fact the correct medication by description of the numbers/letters on the medication. New processes began 8/9/17 and are reviewed weekly by DON/ADON with random audits of medication rooms and medication carts. Tamper seals were not properly placed on narcotic medications sent from Omnicare on two liquid narcotics. Those medications were returned to Omnicare along with another bottle that a nurse had broken the tamper seal on prior to the medication needing to be administered. These three medications were reported to MDH for possible drug diversion. R35 cytotoxic medication is no longer co-mingled with in-use medication and is in the process of being destroyed. The medication destruction policy was updated to include the following: If a medication is removed from a blister pack it is never to be returned into the blister pack. This medication will need to be destroyed by the LPN or RN and recorded in the individuals medication destruction sheet. R44 and R7□s medications were removed from the co-mingled medications and destroyed with the pharmacist on 8/17/17. Will review at 11/16/17 Quality Assurance meeting.	

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medication and that it had not been tampered with.

Interview on 8/2/17, at 9:00 a.m. with the ADON indicated she was unaware what steps the facility had taken to date, as discussed since the previous days discovery of the potential diversion, and needed to refer to the facility policy. She was not sure what the policy indicated facility management should do with suspect diversion.

Review of the Internal investigation Report for Loss of Controlled Substances on 8/2/17, provided by the DON at 11:15 revealed it was blank. There were no details of any investigation that had been filled out by management staff.

Interview on 8/2/17, at 11:15 a.m. with the administrator and the DON revealed they investigated the potential diversion of the above-mentioned medications. They indicated, the nurse wrote "wrong page" on R6's individual narcotic record, scratched it out, and possibly opened the other bottle of medication. They indicated their investigation into the other tamper seal was only that they felt the seals were defective. The administrator stated she had called the contracted pharmacy, and "They disagreed and said there was no issue with the tamper-resistant seals...they should have been affixed." The contracted pharmacy reported to the administrator they had used that tamper-resistant seals for years and they have had no known issues with broken seals before.

Review of the individual narcotic record count sheets for R6 and R32's controlled narcotic medications listed above indicated they were blank. They were not verified or signed and dated

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with the amount remaining for each bottle.

Interview on 8/2/17, at 12:40 p.m. with the consultant pharmacist indicated if anyone in the the facility was to have suspected diversion, they should have called the administrator, the DON, the ADON, the pharmacist, possible law enforcement, etc.. He was aware of one medication bottle tamper-seal being broken, but not two. "I can see one, but two medication bottles....you have to suspect diversion..." He was also unaware nursing staff were not documenting on the individual narcotic record for schedule II medications as to how much there was to have remained of each medication to be easily reconcilable to monitor for the potential diversion.

Interview on 8/2/17, at 1:15 p.m. with the administrator and the DON regarding the above medication tamper-seals and wrong count. The administrator indicated she agreed staff failed to notify the don, ADON or herself of the tamper-seal being broken. The administrator is not considering any diversion as she doesn't believe any had occurred.

Interview on 8/3/17, at 9:30 a.m. with the ADON regarding the above-mentioned potential diversion, the ADON indicated the facility had not had reported the potential diversion to the Minnesota Department of Health (MN DOH)-Office of Health Facility Complaints (OHFC) or any other regulatory agency while they were conducting their investigation. She acknowledged they had no current policy in place and were unsure what to do for diversion. their old policy had been from 1998. they created a new policy on 8/2/17 after the potential findings of diversion were noticed during observations from 8/1/17.

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Interview and review of the facility's 8/2/17 Authorization for Pickup of Controlled Substances log with the ADON and the DON at 9:30 a.m., revealed 3 medication bottles were listed, one belonging to R34 and two belonging to R6 with the reason for pickup as "tamper evident tape failure." The DON indicated it was the nurse who filled out the reason for pickup, not the pharmacy. The pharmacy had agreed to let the facility return the medication.

Review of reports to MN DOH-OHFC indicated they were dated 8/3/17 and timed 10:30 a.m., two days after the initial onset of findings, and related only to the two tamper-resistant seals broken from the two bottles. There was no indication that any other potential diversion activity had been reported as being actively investigated by the facility at that time.

Review of the provider's undated Drug Diversion policy revealed the facility must report the theft or significant loss of any controlled substance or loss to the MN board of nursing and to the Drug Enforcement Agency immediately. The report was to have included how the loss occurred, if known, the date, the steps taken to prevent future losses, and an inventory of missing the drugs. If a discrepancy was to have occurred, the nurse was to have notified the pharmacy, and the DON. The DON was to begin and investigation immediately. The DON was to have immediately notified the pharmacist and the administrator. All applicable parties were to be notified during the investigation process.

Review of the facility's 2017 Narcotic medication policy indicated narcotics were to have been

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counted by two nurses every time a new nurse came on shift, and recorded in a 3-ring binder that each nurse signed. by signing the 3 ringed binder, the nurses were stating "all information is correct" in the narcotic book.

2.) Observation and interview on 8/1/17, at 11:59 a.m. in the new wing medication with medication aide (TMA)-A. TMA-A indicated that was the usual practice if a medication was popped out of the blister pack by accident, if the resident refused their dose, or they had fallen out. The ADON unaware of the practice, it had not been reported, and agreed that was not an acceptable standard of practice and was a concern for diversion. There were also 6 tablets of Phenobarbital (anti-convulsant) in a blister pack that were punctured, at risk for falling out of the seal, and potential cross-contamination.

Observation and interview on 8/1/17 at 2:05 p.m. with the DON in the old wing medication room, indicated there was one tablet of tramadol belonging to R63 that was had been taped back into the blister pack. The DON was unaware of the practice, it had not been reported as potential diversion, and agreed that was a concern for diversion.

Review of the facility's undated policy and procedure for medication destruction indicated there was no mention or instruction for staff on how to handle or dispose of punctured blister packs. there was no mention medication should not be taped back into the packaging as was indicated to be an unacceptable facility practice from the DON and ADON.

Review of the provider's undated Drug Diversion

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policy revealed the facility must report the theft or significant loss of any controlled substance or loss... The report was to have included how the loss occurred...the steps taken to prevent future losses, and an inventory of missing the drugs. If a discrepancy had occurred, the nurse was to have notified the pharmacy, and the DON. The DON was to begin and investigation immediately. The DON was to have immediately notified the pharmacist and the administrator. All applicable parties were to be notified during the investigation process.

3.) Observation and interview on 8/1/17, at 12:05 p.m. with the assistant director of nursing (ADON) and TMA-A in the new wing medication room, indicated R35's cytotoxic medication was sitting on the shelf next in the narcotic medication cupboard. That medication, Revlimid, a cytotoxic medication (cancer treating medication that is harmful if touched with bare hands, ingested accidentally and causes birth defects to unborn children) was left in the cupboard. TMA-A was unsure why it was still there as the medication had been "discontinued a long time ago." It was co-mingled with in-use resident medications.

Review of R35's medical record revealed the medication had been discontinued 1/18/17 and had never been destroyed by staff or the contracted pharmacist.

Observation and interview on 8/1/17 at 2:05 p.m. in the old wing medication room with the director of nursing (DON) indicated R44 had 24 Tylenol with codeine (narcotic pain medication) dated 6/29/17 as discontinued, that was co-mingled with medication in use. It had not been given to the pharmacist during his visit in July for destruction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING _____ B. WING _____	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

(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 35 The DON agreed that was an area of concern. R71's hydrocodone was also co-mingled in with in-use medication. She had passed away on 7/19/17. Those medications were no longer counted as they were not in active inventory. Interview on 8/2/17, at 12:40 p.m. with the consultant pharmacist indicated he was unaware of the medications that had not been available for destruction or had been co-mingled with in-use medication. He advised the facility they needed a separate container for medication awaiting destruction several times, but they had not complied with his instruction. He was also very concerned about the facility's system having lacked individual counts of schedule II narcotic medications as he agreed the current system of a one time sign off was not easily reconcilable for each medication and could lead to potential diversion.	F 431		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 465	Rooms #201, 203, 305, 207, 209 and 211	9/8/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 36 failed to have a preventative maintenance program to maintain windows for a resident (R15) who complained of air leakage that also affected 6 of 6 rooms (201, 203, 305, 207, 209, and 211) located in the west hallway. Findings include: Observation and interview on 8/1/17, at 8:49 a.m. with R15 in her room indicated she had concerns about the cold air leaking through her windows during winter and cold months. "Some residents have to put blankets over the windows to keep the breeze out." There is one room that R15 reported that had blankets on their windows. She was told the facility had made mention they were thinking eventually they would replace the windows, but had no definite plans to do so. Observation and interview on 8/2/17 at 12:10 p.m. with the maintenance supervisor regarding R15's concerns indicated he was aware of the residents concerns regarding drafty windows. They were the crank-out style windows and that side of the building had in fact got drafty in the winter. In room 203, there had been blankets draped over the windows. In room 207, there had been a blanket placed in the bottom of the window well. There was no preventative maintenance program in place to ensure caulking was in place or windows had been maintained to prevent airflow leaks. There was no preventative maintenance program policy related to the maintence of windows provided to this surveyor prior to exit of the survey.	F 465	windows will be resealed. All other windows will be inspected and sealed as necessary. This work will be completed by 9/8/17. An inspection log will be created and an inspections will be done semi-annually there after. The log will be kept in the building Maintenance book. This plan will be reported and reviewed at the 11/16/17 Quality Assurance meeting.	

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	245362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	**301 TROENDLE STREET** **MAPLETON, MN 56065**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Mapleton Community Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

By email to:

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/28/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2017**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Mapleton Community Home was constructed as follows: The original building was constructed in 1965, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1977, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1983, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 4th Addition was constructed in 1997, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The 5th Addition was constructed in 201, is a one-story , has no basement, is fully fire sprinkler protected and was determined to be of Type II	K 000		

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	245362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2017**

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K 000	Continued From page 2 (111) construction. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 59 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 354 SS=D	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy. This	K 354	The "Out of Service Policy" has been changed to reflect the current Out of Service Policy adoped in the 2012 Life	8/4/17

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K 354	Continued From page 3 deficient practice could effect 1 of 59 residents. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings include: On facility tour between 9:00 AM and 1:00 PM on 08/03/2017, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current Staff/ Fire Marshal contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354	Safety Code. This correction was made on 8/4/17.	
K 521 SS=E	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		9/29/17

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K 521	Continued From page 4 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to ensure that the fire/smoke dampers were maintained according to 9.2 and in accordance with the manufacturer's specifications. The deficient practice could affect 57 out of 57 residents. HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 FINDINGS INCLUDE: On facility tour between 9:00 AM and 1:00 PM on 08/03/2017, documentation could not be provided that indicated the fire/smoke damper test had occurred within the past 4 years. This deficient practice was verified by the Facility Maintenance Director.	K 521	Documentation has been received and added to the Life Safety Book showing that the inspection and necessary repairs were done. The inspection was done on 8/24/15 and the necessary repairs were done on 9/29/15. This is in compliance with the required 4 year inspection time frame.	
K 920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity	K 920		8/11/17

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K 920	Continued From page 5 may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 37 of the 57 residents. Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general	K 920	An inspection was done during the week of 8/7/17 to find extension cords, or power strips that were being misused. Corrections were made where necessary. Housekeeping have been instructed to watch for extension cords and power strips and to report any found to the Maintenance Department immediately.	

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K 920	Continued From page 6 precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INCLUDE: On facility tour between 9:00 AM and 1:00 PM on 08/03/2017, an extension cord was observed being used in Resident Room #27. This deficient practice was verified by the Facility Maintenance Director.	K 920		

Electronically delivered
August 17, 2017

Ms. Roxanne Gosson, Administrator
Mapleton Community Home
301 Troendle Street
Mapleton, MN 56065

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5362025

Dear Ms. Gosson:

The above facility was surveyed on July 31, 2017 through August 3, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233 or at kathryn.serie@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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
	00037	A. BUILDING: _____ B. WING _____	08/03/2017

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 7/31/17-8/3/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 3 residents (R13) reviewed for oral and dental services and for 1 of 1 residents (R32) reviewed for urinary continence/Foley catheter. Findings include: R13 had been observed on 8/1/17, at 1:39 p.m. R13 was observed to have upper dentures in place. Interview with the resident at this time, indicated she had lower dentures as well, but that they were too loose to wear all the time. Review of the current quarterly Minimum Data Set (MDS) assessment dated 7/5/17, identified R13 as not having any loose or poor fitting	2 560	Corrected.	9/4/17

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	00037	A. BUILDING: _____ B. WING _____	08/03/2017

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2 560	Continued From page 3 dentures or partials and no concerns with her oral cavity. Review of the Oral/Dental Status assessment dated 1/3/17, identified R13 as having loosely fitting dentures with no natural teeth. Review of the plan of care identifies R13 as having nutritional concerns related to poor fitting dentures and requires staff to assist with oral cares. Interview with the MDS coordinator on 8/1/17, at 12:14 p.m. verified R13 had loose fitting dentures and confirmed she had made a coding error on the quarterly MDS dated 7/5/17 R32 had been observed on 8/1/17, at 11:41 a.m. to be in bed with an indwelling Foley catheter bag attached to the bed frame. R32's face sheet dated 8/3/17, identified an admission date of 3/30/17 and included diagnoses of obstructive and reflux uropathy (a structural or functional interruption of normal urine flow) and benign prostatic hyperplasia (enlarged prostate gland) with lower urinary tract symptoms. The quarterly Minimum Data Set (MDS) assessment dated 7/7/17, did not identify R32 as having an indwelling catheter. During interview on 8/2/17, at 12:14 p.m. registered nurse (RN)-A stated R32 had an indwelling Foley catheter due to an obstruction, and it had been in place since admission. Interview with the MDS coordinator on 8/3/17, at 8:35 a.m. confirmed R32 had an indwelling catheter and verified R32's 7/7/17 MDS had not	2 560		

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2 560	Continued From page 4 been completed accurately and reflective of urinary status. MDS coordinator further indicated a modification of the MDS would need to be completed because of the inaccuracy. During interview on 8/3/17, at 8:45 a.m. director of nursing (DON) stated her expectation is for the MDS to be accurate and reflective of the resident status including use of an indwelling catheter for R32. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure care plans are developed to accurately reflect any necessary interdisciplinary or medication concerns. The facility could update policies and procedures, educate staff on these changes and audit periodically to ensure care plans adequately reflect the needs of residents. The facility could report findings to the quality assurance committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of	2 570		8/28/17

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2 570	Continued From page 5 the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 3 residents (R57) reviewed for activity of daily living (ADL's). Findings include: R57 had been observed on 8/1/17, at 2:36 p.m. when nursing assistant (NA)-G and licensed practical nurse (LPN)-A attempted to transfer R57 from edge of bed into a wheelchair using a gait belt. R57 was unable to stand and pivot with two staff assisting as R57's knees were flexing and was assisted to sit back down on bed. After allowing R57 to rest a couple minutes on side of bed, a second attempt at the transfer with NA-G and LPN-A assisting was successful. R57 required assist of both NA-G and LPN-A along with guidance, prompts and cues to stand and pivot into wheelchair. During interview at this time, LPN-A stated R57 was more dependent in cares and transfers than he used to be. LPN-A further indicated R57's ability depends on the day. During interview on 8/2/17, at 9:22 a.m. NA-A stated R57 is assist of two for all transfers and indicated R57 can be very difficult to transfer from bed to wheelchair. NA-A indicated R57 returned from an inpatient hospital stay approximately one month prior and had been requiring two assist since that time. A medicare 14 day Minimum Data Set (MDS) assessment dated 7/13/17, identified R57 with	2 570	Corrected.	

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2 570	Continued From page 6 Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment. It further identified R57 as needing extensive assistance of two for transfers. R57's current care plan last reviewed 6/16/17, indicated R57 transferred with assist of one. During interview on 8/3/17, at 8:30 a.m. registered nurse (RN)-A stated R57's care plan was not reflective of current status and needed to be revised. Further indicated when R57 returned from the inpatient facility on 6/29/17, the whole care plan should've been reviewed. During interview on 8/3/17, at 8:48 a.m. the director of nursing (DON) indicated a better flow system with care plan revisions was needed to keep the care plans updated. DON stated her expectation was for care plans to be revised to reflect current ADL needs A facility policy on care plan revision was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		9/4/17

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2 830	Continued From page 7 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor bruising for 1 of 4 residents (R31) reviewed for non-pressure related skin conditions. Findings include: R31 had been observed on 8/2/17, at 12:55 p.m. R31 was observed to have several bruises on both hands and lower arms ranging in size from 10 cent to 50 cent piece. The top of the lower left leg has a 50 cent size bruised area and also a 50 cent size bruise was observed on the top of the right knee. Interview with R31 at this time, indicated she bruises easily when she bumps her arms and crosses her legs. Review of the annual Minimum Data Set (MDS) assessment dated 4/18/17, R31 was identified as requiring extensive assistance with all activities of daily living (ADL's). R31's Brief Interview for Mental Status (BIMS) score was "15" indicating	2 830	Corrected.	

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2 830	Continued From page 8 no cognitive impairment. Review of the current plan of care identifies R31 as requiring assistance with ADL's. The care plan did not include the use of Coumadin or to monitor for side effects (that included bruising of the skin) due to increased risk of bleeding. Review of the progress notes dated 6/22/17, included a dark purplish bruise behind the left knee that measures 1.7 centimeter (CM) by 2.0 cm. No documentation was found that the bruise had been monitored. Review of the progress note dated 7/9/17, included a dark purplish bruise on the right shin that measures 7.3 cm by 1.9 cm by 0.1. No documentation was found that the bruise had been monitored. Review of the progress notes dated 7/18/17, included a dark purple raised hematoma on the left shin that measured 1.2 cm by 1.0 cm. No documentation was found that the hematoma had been monitored There was no documentation found in the record nor the treatment sheet related to the current bruising on R31's hands, arms or legs. Review of R31's physicians orders included an order for aspirin 81 milligrams (MG) daily and Warfarin (anticoagulation) 6 mg one time weekly and 4 mg all other days of the week. Interview with the assistant director of nursing (ADON) on 8/2/17, at 12:02 p.m. confirmed the plan of care did not include R31's use of Coumadin or to monitor for side effects (that included bruising) due to risk of increased bleeding.	2 830		

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2 830	Continued From page 9 Review of the facility policy for Bruises and Warfarin dated 7/12/17, included; observe the resident for bruises when providing cares, report to the charge nurse, complete an incident report, determine cause, monitor/document, if the resident is on Warfarin include in the plan of care, along with interventions to ensure staff are aware of what signs to observe for and notify the physician and family of changes. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could audit resident records to ensure bruises and skin issues are being monitored, assessed and preventive measures are at place for residents at risk for skin injuries. The director of nursing or designee could revise policies and procedures related to skin care and monitoring, and educate staff on these changes. Findings of audit activity could be reported to the quality assurance committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan	21530		9/1/17

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21530	Continued From page 10 system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility consulting pharmacist failed to identify irregularities related to ongoing monitoring for effectiveness of an antianxiety medication for 1 of 5 resident (R31) and failed to monitor the effectiveness of an antidepressant used for insomnia for 1 of 5 resident (R57) reviewed for unnecessary medication.	21530	Corrected.	

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21530	Continued From page 11 Findings include: R31's Diagnosis report obtained in the medical record included: major depressive disorder and anxiety. R31 was prescribed Buspar 10 milligrams (mg) twice daily (for anxiety). Observation on 8/2/17 at 7:47 a.m. R31 was sitting in her room waiting for breakfast. The resident was very calm mannered and pleasant. No anxiety noted during this time. Interview with R31 at this time denied feeling anxious. The resident indicated she used to worry about everyone when she first moved into the facility in 2012, but has accepted placement. R31 further included she could not recall receiving a medication for anxiety and that the only time she could remember getting anxious is when she had a bowel obstruction last fall. Review of the annual Minimum Data Set (MDS) dated 4/18/17, identified R31 as having no concerns with behavior/mood other than feeling tired or having little energy. This occurred 12-14 days during the assessment period. No anxiety was noted. The resident had a BIMS score of "15" with no impairment in cognition. Review of the residents daily mood and behavior monitoring log for the past 9 months, identified R31 as having no signs of anxiety. Review of R31's physicians dictated note dated 11/10/16, included an order for Buspar 7.5 mg twice daily for an anxious stomach and previous bowel obstruction on 10/24/16. Review of R31's physicians dictated note dated	21530		

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5/25/17, included an order to increase Buspar to 10 mg twice daily. The progress note indicated the residents mood was normal and that she denied feeling anxious and had no concerns. There was no reason to why the Buspar had been increased at this time.

Review of the pharmacy recommendations since the start of the Buspar on 11/10/16, did not include a review of the residents Buspar for continued need and current dose/reduction.

Interview with the facility Pharmacist on 8/3/17, at 11:25 a.m. confirmed R31's Buspar order had not been evaluated for continued use and verified there was no logical reason for the increase in the Buspar on 5/25/17, that could be identified.

Interview on 8/2/17, at 7:30 a.m. NA-B indicated R31 was cooperative and pleasant and did not exhibit signs of anxiety that she was aware of.

Interview on 8/2/17, at 7:32 a.m. RN-B indicated R31 was cooperative and pleasant and did not exhibit any signs of anxiety that she was aware of.

Interview on 8/2/17, at 7:33 a.m. NA-C indicated R31 was cooperative and pleasant and did not exhibit any signs of anxiety that she was aware of.
R57's Diagnosis report obtained in the medical record included: major depressive disorder and vascular dementia with behavioral disturbance.

R57's physician orders dated 7/6/17, included an order for trazodone (antidepressant medication sometimes used to treat insomnia) 50 milligrams (mg) at bedtime for insomnia plus may give 1 tablet once by mouth if awake before 3:00 a.m.

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as needed (PRN). The trazodone had an order start date of 6/29/17.

The medicare 14 day Minimum Data Set (MDS) assessment dated 7/13/17, identified that R57 had severe cognitive impairment. The MDS further indicated R57 exhibited no difficulty with sleep.

Review of R57's 6/17 and 7/17 medication administration records (MAR) indicated R57 received the trazodone on a nightly basis since 6/29/17 with four doses of the PRN trazodone given in 7/17.

During interview on 8/2/17, at 10:35 a.m. registered nurse (RN)-C indicated the trazodone was used for sleep and verified no sleep assessment had been completed for R57.

Review of the pharmacy recommendations from 7/2017 did not include a recommendation for sleep monitoring related to the use of trazodone for insomnia.

During interview on 8/3/17, at 11:04 a.m. the facility's consultant pharmacist (CP) indicated R57 should have had a documented sleep assessment completed to see what other factors could affect R57's sleep cycle. CP further stated that is a monitoring piece that should have been identified, and hadn't been.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along

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21530	Continued From page 14 with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to evaluate the continued use of an antianxiety medication for 1 of 5 residents (R31). The facility further failed to	21540	Corrected.	9/1/17

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identify the parameters for use of an as needed (PRN) antipsychotic medication (risperidone) and an antidepressant medication (trazodone), and failed to consistently document non-pharmacological interventions attempted prior administration of the PRN's for 1 of 5 residents (R57) reviewed for unnecessary medications.

Findings include:

R31's Diagnosis report obtained in the medical record included: major depressive disorder and anxiety.

R31 was prescribed Buspar 10 milligrams (mg) twice daily (for anxiety).

Observation on 8/2/17 at 7:47 a.m. R31 was sitting in her room waiting for breakfast. The resident was very calm mannered and pleasant. No anxiety noted during this time. Interview with R31 at this time denied feeling anxious. The resident indicated she used to worry about everyone when she first moved into the facility in 2012, but has accepted placement. R31 further included she could not recall receiving a medication for anxiety and that the only time she could remember getting anxious is when she had a bowel obstruction last fall.

Review of the annual Minimum Data Set (MDS) dated 4/18/17, identified R31 as having no concerns with behavior/mood other than feeling tired or having little energy. This occurred 12-14 days during the assessment period. No anxiety was noted. The resident had a BIMS score of "15" with no impairment in cognition.

Review of the residents daily mood and behavior

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monitoring log for the past 9 months, identified R31 as having no signs of anxiety.

Review of R31's physicians dictated note dated 11/10/16, included an order for Buspar 7.5 mg twice daily for an anxious stomach and previous bowel obstruction on 10/24/16.

Review of R31's physicians dictated note dated 5/25/17, included an order to increase Buspar to 10 mg twice daily. The progress note indicated the residents mood was normal and that she denied feeling anxious and had no concerns. There was no justification as to why the Buspar had been increased at this time.

Review of the pharmacy recommendations since the start of the Buspar on 11/10/16, did not include a review of the residents Buspar for continued need and why a titration was not attempted or a physician justification as to why a titration was contraindicated.

Interview with the facility Pharmacist on 8/3/17, at 11:25 a.m. confirmed R31's Buspar order had not been evaluated for continued use and verified there was no justification for the increase in the Buspar on 5/25/17, that could be identified.

Interview on 8/2/17, at 7:30 a.m. NA-B indicated R31 was cooperative and pleasant and did not exhibit signs of anxiety that she was aware of.

Interview on 8/2/17, at 7:32 a.m. RN-B indicated R31 was cooperative and pleasant and did not exhibit any signs of anxiety that she was aware of.

Interview on 8/2/17, at 7:33 a.m. NA-C indicated R31 was cooperative and pleasant and did not

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exhibit any signs of anxiety that she was aware of.
R57's Diagnosis report obtained in the medical record included: major depressive disorder and vascular dementia with behavioral disturbance.

R57's current physician orders dated 7/6/17, included the following as needed (PRN) medication orders: risperidone (antipsychotic medication) 0.25 milligrams (mg) every 4 hours PRN agitation with max of 3 doses in 24 hours and trazodone (antidepressant medication sometimes used for insomnia) 50 mg may give once if awake before 3 a.m. PRN for insomnia. In addition, scheduled doses included: risperidone 0.25 mg twice daily for agitation and trazodone 50 mg every bedtime for insomnia.

The medicare 14 day Minimum Data Set (MDS) assessment dated 7/13/17, identified that R57 had severe cognitive impairment. The MDS further indicated R57 did not have any behaviors, difficulty with falling asleep or staying asleep.

R57's care plan last reviewed 6/16/17, identified R57 received antipsychotic and antidepressant medications but did not clearly define when PRN medications were to be utilized nor were there non-pharmacological interventions identified.

Review of the electronic administration record (eMAR) revealed R57 was administered PRN trazodone 4 times from 6/29/17 to 8/3/17 and PRN risperidone 1 time from 6/29/17 to 8/3/17. Further review of R57's eMAR and progress notes indicated on 7/27/17, R57 received PRN trazodone at 1:20 a.m. for agitation. On 7/28/17, PRN trazodone was administered at 1:10 a.m., however no administration rationalization or documented non-pharmacological interventions

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21540	Continued From page 18 were documented. When interviewed on 8/2/17, at 12:16 p.m. registered nurse (RN)-A stated if staff were unable to redirect R57 and if he was distraught she would consider administering a PRN risperidal for agitation. RN-A further stated she would give the PRN trazodone if R57 wasn't sleeping or agitated at night and it was before 3:00 a.m. RN-A confirmed there were no clear parameters on when to give the PRN risperidone or trazodone. RN-A further confirmed resident behaviors and non-pharmacological interventions attempted prior to administration of a PRN psychotropic medication were supposed to be charted in the electronic record. During interview on 8/2/17, at 10:35 a.m. RN-C stated there should be documentation of behavior and interventions attempted prior to administration of a psychotropic PRN medication. RN-C further stated parameters related to use of R57's risperidone and trazodone and non-pharmacological interventions were not clear and this should be included in the care plan. When interviewed on 8/3/17, at 8:51 a.m. the director of nursing (DON) confirmed the lack of nonpharmacological interventions and parameters for the PRN psychotropic medications. DON stated she would expect documentation to reflect behavior exhibited and interventions attempted prior to the administration of the PRN. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of mediation usage. The DON or designee, along	21540		

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21540	Continued From page 19 with the pharmacist, could audit medication review on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to have a preventative maintenance program to maintain windows for a resident (R15) who complained of air leakage that also affected 6 of 6 rooms (201, 203, 305, 207, 209, and 211) located in the west hallway. Findings include: Observation and interview on 8/1/17, at 8:49 a.m.	21705	Corrected.	9/8/17

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with R15 in her room indicated she had concerns about the cold air leaking through her windows during winter and cold months. "Some residents have to put blankets over the windows to keep the breeze out." There is one room that R15 reported that had blankets on their windows. She was told the facility had made mention they were thinking eventually they would replace the windows, but had no definite plans to do so.

Observation and interview on 8/2/17 at 12:10 p.m. with the maintenance supervisor regarding R15's concerns indicated he was aware of the residents concerns regarding drafty windows. They were the crank-out style windows and that side of the building had in fact got drafty in the winter. In room 203, there had been blankets draped over the windows. In room 207, there had been a blanket placed in the bottom of the window well. There was no preventative maintenance program in place to ensure caulking was in place or windows had been maintained to prevent airflow leaks.

There was no preventative maintenance program policy related to the maintence of windows provided to this surveyor prior to exit of the survey.

SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop and implement policies and procedures to ensure resident rooms are maintained at a comfortable temperature and educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the quality assurance committee for review.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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