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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NMZ7
Facility ID: 00950

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245497**

2. STATE VENDOR OR MEDICAID NO.
(L2) **064742000**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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

6. DATE OF SURVEY **09/21/2015** (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 **52** (L18)

13. Total Certified Beds **52** (L17)

10. THE FACILITY IS CERTIFIED AS:

X 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
	52			
(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 :
Brenda Fischer, Unit Supervisor 09/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 09/14/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/21/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245497
September 30, 2015

Mr. Garrett Bothun, Administrator
Haven Homes of Maple Plain
1520 Wyman Avenue
Maple Plain, Minnesota 55359

Dear Mr. Bothun:

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 11, 2015 the above facility is certified for or recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 30, 2015

Mr. Garrett Bothun, Administrator
Haven Homes of Maple Plain
1520 Wyman Avenue
Maple Plain, Minnesota 55359

RE: Project Number S5497025

Dear Mr. Bothun:

On August 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 6, 2015. 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 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 11, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 6, 2015, effective September 11, 2015 and therefore remedies outlined in our letter to you dated August 20, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245497	A. Building B. Wing	9/21/2015

Name of Facility	Street Address, City, State, Zip Code
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	09/11/2015	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	09/11/2015	ID Prefix F0314 Reg. # 483.25(c) LSC	09/11/2015
ID Prefix F0332 Reg. # 483.25(m)(1) LSC	09/11/2015	ID Prefix F0425 Reg. # 483.60(a),(b) LSC	09/11/2015	ID Prefix F0465 Reg. # 483.70(h) LSC	09/11/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	BF/KJ	09/30/2015	20794	09/21/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 8/6/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NMZ7

Facility ID: 00950

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2. STATE VENDOR OR MEDICAID NO. (L2) **064742000**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

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

6. DATE OF SURVEY **08/06/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

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And/Or Approved Waivers Of The Following Requirements:
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___ 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
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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17. SURVEYOR SIGNATURE Date :
Timothy Rhonemus, HFE NE II 08/31/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 09/14/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

Posted 09/21/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 20, 2015

Mr. Garrett Bothun, Administrator
Haven Homes Of Maple Plain
1520 Wyman Avenue
Maple Plain, Minnesota 55359

RE: Project Number S5497025

Dear Mr. Bothun:

On August 6, 2015, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> <u>Opportunity to Correct</u> **- the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> <u>Electronic Plan of Correction</u> **- when a plan of correction will be due and the information to be contained in that document;**
>
> <u>Remedies</u> **- the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> <u>Potential Consequences</u> **- the consequences of not attaining substantial compliance 3 and 6**

months after the survey date; and

<u>**Informal Dispute Resolution**</u> **- your right to request an informal reconsideration to dispute the attached deficiencies.**

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 15, 2015, 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 6, 2015 (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 6, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a dignified dining experience for 4 of 4 residents (R32, R33, R42, R52) with cognitive impairment who were not served their meals in a timely manner, and for 1 of 1 residents (R18) with cognitive impairment who was assisted with eating by staff while they were standing. Findings include: LACK OF TIMELY MEAL SERVICE:	F 241	F241 Dignity with dining It is the policy of this facility to provide residents with the proper amount of feeding assistance, and to promote and maintain resident dignity during mealtimes. In this case the certified nursing assistants were reminded to ask coworkers for help if they are not available to assist the residents as the meals are being served. The certified nursing assistant was reminded of proper body positioning while assisting a resident to	9/11/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(X4) ID 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 241	Continued From page 1 R32's quarterly Minimum Data Set (MDS) dated 7/1/15, identified R32 had severe cognitive impairment, and required extensive assistance with eating. R33's quarterly MDS dated 6/3/15, identified R33 had severe cognitive impairment, and required limited assistance with eating. R42's significant change MDS dated 6/29/15, identified R42 had both long and short term memory impairments, and required extensive assistance with eating. R52's annual MDS dated 5/6/15, identified R52 had both long and short term memory impairments, and was totally dependent on staff for eating. During observation of the evening supper meal in the North Wing dining room on 8/3/15, at 6:03 p.m., R32, R33, R42, and R52 were seated at the same table in the middle of the dining room. At 6:05 p.m. dietary aide (DA)-A and DA-B wheeled a mobile cart into the dining room which contained pre-plated food and began to pass drinks to each resident in the dining room. At 6:16 p.m. DA-A and DA-B began serving the plated food to the three other tables with residents where R32, R33, R42, and R52 were not seated. At 6:19 p.m. no food had been served to the table with R32, R33, R42, and R52 but the rest of the dining room had been served with the residents eating their meals. Nursing assistant (NA)-A was seated at a different table helping other residents cut up their food and providing cues to help them eat. DA-A and DA-B stood by the mobile cart with the plated food and shouted aloud acros the dining room to NA-A they had "just that middle table left" to serve, and continued waiting by the mobile cart. The NA-A, DA-A, or DA-B did not offer or provide any assistance to R32, R33, R42, or R52, who continued to sit and wait for their meals. At 6:25	F 241	eat their meal. Because all residents who need assistance with mealtimes are potentially affected by the cited deficiency the interim director of nursing reviewed the facility¿s expectations for dining with dignity with the nurses and certified nursing assistants. Dining room audits were completed on August 14th, 18th and 20th. To enhance our currently compliant operations and under the direction of the interim director of nurses, on August 24th nursing staff received in-service training regarding state and federal requirements for the dignity and respect of individuality of our residents during their dining experience. Effective August 24th a quality assurance program was implemented under the supervision of the interim director of nurses to monitor the dining room experience. The director of nurses or designated representative, including certified nursing assistants, will perform three random dining room audits a week for a time period of four weeks. The audits will continue at two times per week for four weeks. Any deficiencies will be corrected on the spot, and the findings of the audits will be submitted at the monthly quality assurance committee meetings for further review or corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING ______ B. WING ______	08/06/2015

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F 241	Continued From page 2	F 241		

p.m. (9 minutes after serving began) R32, R33, R42, and R52 still had not been served their meals. During this time, several observations were made of R32 and R42 looking around the dining room and watching the other residents eat their food. R32 had a furrowed brow and puckered lower lip as she watched other residents eating their meal, at times looking down at the bare table in front of her. At 6:28 p.m. (12 minutes after serving began) NA-B entered the dining room, and DA-A served R32, R33, R42, and R52 their meals.

When interviewed on 8/3/15, at 6:45 p.m. DA-A stated dietary staff waited to serve R32, R33, R42, and R52 until additional NA's staff are present because they have a higher risk of choking on their food. Further, DA-A stated the meal service for R32, R33, R42, and R52 "makes me feel bad" because "everybody is getting served and they have to wait."

During interview on 8/4/15, at 2:03 p.m. NA-A stated R32, R33, R42, and R52 needed assistance with eating and were at risk of choking if someone isn't seated by them. On 8/3/15 (the supper meal observed by the surveyor) their was only one NA available when the food was ready and she couldn't be at two tables at once, so R32, R33, R42, and R52 had to wait for additional help before being served. Further, NA-A stated she "felt bad" they had to wait to have their meals served to them and watch other residents eat.

When interviewed on 8/6/15, at 12:52 p.m. the director of quality (DOQ)-B stated R32, R33, R2, and R52 were to be served "when we have caregivers down there" as they required assistance to eat. The staff are expected to

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F 241	Continued From page 3	F 241		

create a "homelike fashion" dining experience for all the residents so as to "eat at the same time", and the staff should have gotten more help so all residents could be served and assisted promptly.

STANDING WHILE FEEDING:

R18's quarterly Minimum Data Set (MDS) dated 6/17/15, indicated R18 had moderate cognitive impairment, had an upper extremity impairment on both sides, and required physical assist from staff to eat.

During an observation on 8/3/15, at 6:14 p.m. R18 was seated at a table in the dining room with two other residents and nursing assitant (NA)-D. NA-D was seated opposite the table from R18, and was assisting the two other residents with eating. At 6:22 p.m., NA-D stood up from helping the other two residents and walked over to R18 where she stood over him and assisted him to eat until 6:25 p.m., then sat back down across the table and continued assisting the other two residents. At 6:31 p.m., NA-D stood up again and walked over to R18 and assisted him to eat while standing over him before returning to the opposoite side of the table to assist the other two residents to finish their meal. At 6:35 p.m., NA-D stood up from the table and walked over to R18 to help him eat, standing over him while while helping him eat until 6:39 p.m..

During an interview on 8/6/15, at 12:52 p.m. the director of quality (DOQ)-A stated two staff members should have been helping the residents at R18's table to eat. Further, NA-D should not have been standing up while helping R18 to eat, "I would expect them to be sitting down."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING ______ B. WING ______	08/06/2015

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned interventions for dental care were followed for 1 of 3 residents (R32) reviewed for dental and who had missing teeth. Findings include: R32's quarterly Minimum Data Set (MDS) dated 7/1/15, identified R32 had severe cognitive impairment, was able to follow directions, but required physical assistance to complete personal hygiene. R32's dental care plan dated 7/22/15, identified R32 had missing teeth and directed staff to, "Encourage Resident [R32] to do own oral cares and participate with brushing after set-up. Staff complete brushing twice daily if [R32] is unable to complete process." During observation of morning cares on 8/5/15, at 6:57 a.m. nursing assistant (NA)-C assisted R32 to use the restroom by helping R32 transfer to her wheelchair. NA-C laid a clean towel on R32's chest/lap while she was seated in the wheelchair and instructed R32 to open her mouth while NA-C inserted a toothbrush with toothpaste into her mouth. NA-C brushed R32's teeth for approximately 15 seconds, provided her a small cup of water and instructed her to rinse her	F 282	F282 Services by Qualified Persons/Per Care Plan It is the policy of this facility to provide adequate cares as the care plan states. Some of the many ways that this has been achieved for resident #32 is by reviewing the current care plan and updating it. The care plan has been updated to instruct caregivers to complete oral care as the resident is unable to complete own oral cares and participate in brushing. After the surveyor reported the incident all caregivers were reminded to promote independence with activities of daily living and to follow the resident¿s care plan. Caregivers were in-serviced on approach. Because all residents receiving physical assistance with oral cares are potentially affected by the cited deficiency the RAI coordinator will audit the caregivers¿ assignment sheets against the care plans. Assignment sheets will be edited to provide specific instructions on oral care needs of all residents at the residents quarterly care conference. To enhance currently compliant operations and under the direction of the interim director of nurses, on August 17th,	9/11/15

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HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE** **MAPLE PLAIN, MN 55359**

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F 282	Continued From page 5 mouth and spit the water into a pink emesis basin. NA-C then continued to help R32 dress for the day with clean clothing. NA-C provided no encouragement for R32 to complete her own oral care, even though this was identified in R32's plan of care. When interviewed on 8/5/15, at 10:08 a.m. NA-C stated R32 had been missing teeth for "a long time", and R32's care plan just required staff to "help brush her teeth." Further, NA-C stated she felt R32 required "total care" for her oral cares. When interviewed on 8/5/15, at 10:30 a.m. registered nurse (RN)-B stated a care plan is used to "ensure the resident is getting the proper care", and staff were expected to encourage R32 to complete her own oral cares as directed by the care plan. During interview on 8/6/15, at 9:42 a.m. the director of quality (DOQ)-B stated the care plan helps to "determine someone's needs and how to provide them", and staff should "support as much independence" as possible with the resident (R32) by having her attempt to complete her own oral care as directed by her plan of care. A facility care planning policy was requested, but none was provided. A facility General Resident Rights Guidelines policy dated 11/2012, identified, "Encourage resident to participate in care as much as possible."	F 282	18thand the 20th nursing staff were reminded of the importance of care plans. Nursing staff continue to have conversation and report on all residents and their care planned needs. On August 24th nursing staff was in-serviced on care plans. Effective August 11th, a quality assurance program was implemented under the supervision of the interim director of nurses to monitor resident care plans. The RAI coordinator and designated quality assurance representative will perform the following systemic changes: weekly audits of assignment sheets and care plans for four weeks, bi-weekly for four weeks, then on-going at residents quarterly care conference. Random observations of certified nursing assistants providing activities of daily living care will be conducted to ensure the compliance with the care plan. Any deficiencies will be corrected on the spot, and the findings of the quality assurance checks will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		9/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 6 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and consistently implement pressure ulcer interventions for 1 of 3 residents (R50) who had a current pressure ulcer. Findings include: R50's quarterly minimum data set (MDS) dated 2/18/2015, indicated she had moderate cognitive impaired. The MDS further indicated R50 had an unstageable pressure ulcer (PU) (indicates extent of tissue involvement cannot be assessed because the edges cannot not clearly be seen) on her right heel. The MDS identified the PU was 4 centimeter (cm) x 2.5 cm with no depth indicated, the skin tissue denoted as eschar (which is a dry scab or slough tissue). R50's quarterly MDS, dated 05/20/2015, identified R50 had one stage 3 pressure ulcer, (full thickness skin loss), which measured 1.2 cm x 0.5 cm with a depth of 2.0 cm. The MDS indicated the most severe tissue type was granulation tissue (new connective tissue growth). The Care Area Assessment (CAA) for Pressure Ulcers, dated 12/05/2014, indicated R50 was at risk for loss of skin integrity, utilized a pressure redistribution cushion and mattress, and R50 had, "Popped Blister to RT [right] Heel 5 x	F 314	F314 Treatment/Services to prevent/heal pressure sores It is the policy of this facility to provide adequate cares as the care plan states. In this case, after the surveyor reported the incident with the boot it was corrected, and the certified nursing assistants were reminded of the importance of following their assignment sheets for care planned interventions. Some of the many ways that this has been achieved for resident #50 is by reviewing the current care plan and updating it. The care plan was updated to reflect the right foam boot to be on right lower extremity at all times, and foam boots on to both feet while in bed. A request was sent to the physician to change the current dressing orders for the wound on the right heel. The dressing orders were changed on August 12th, 2015. On August 17th the RAI coordinator provided training materials for nurses on the staging of pressure ulcers. The documentation was corrected immediately to reflect the appropriate wound stage. On August 17th and the 19th the RAI Coordinator provided training materials for nurses on staging of	

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F 314	Continued From page 7 4.2 cm Stage III noted by staff". R50's Careplan, last updated 07/17/2015, identified alteration in skin integrity related to diagnosis of peripheral neuropathy, incontinence, and immobility. The care plan directed staff to apply foam boot to left lower extremity at all times, with Derma Saver (foam protective device to alleviate pressure) to right ankle while in bed only. Review of the facility nursing assistant care sheet, part of the facility care plan, (undated), entitled: List 3 Work list, identified R50 had "Foam boots to Rt. [sic]when up". During observation on 08/04/2015 at 2:34 p.m., R50 was seated in her wheelchair in the activity room. R50 had a foam boot on her right foot, which was resting on the foot pedal. R50's left foot, was covered with sock was resting on the floor. During observation on 08/05/2015, at 6:57 a.m.,(NA)-E completed morning cares for R50 and the foam boot was on R50's left foot. NA-E placed R50's right foot onto the foot pedal, and R50 yelled out, "Ouch, that's my sore foot! Clear up to my knee!" Both of R50's feet were now resting on the foot pedals as R50 was wheeled out of the room for the morning meal. At 8:03 a.m., R50 was in the therapy room participating in rehabablitation exercises. The foam boot remained on R50's left foot. The certified occupation therapy assistant (COTA)-A removed R50's right foot off the foot pedals. R50 complained of pain in her right foot. The COTA-A and physical therapy assistant (PTA)-A discussed the placement of R50's foam boot. The COTA-A stated she spoke with the director of quality (DOQ)-B and R50's foam boot should be on the right foot, and not the left foot. R50's foam boot was changed from the left foot to the right foot by COTA-A.	F 314	pressure ulcers. On August 27th, 2015 all pressure wounds were reviewed by the Interim Director of Nursing for accuracy on staging. All pressure wounds were accurately documented with the proper stages. Each week the Director of Nursing will review each pressure wound, this will include a review of wound characteristics to ensure accurate staging. Any deficiencies will be corrected on the spot, and the findings of the quality assurance checks will be documented and submitted at the monthly quality assurance committee meeting for review or corrective action. Because all residents with pressure sores are potentially affected by the cited deficiency the interim director of nurses audited the care planned interventions of those residents. On August 13th and August 19th the RAI coordinator compared the assignment sheets to the care plan to ensure accuracy. All care planned interventions were updated. To enhance currently compliant operations and under the direction of the interim director of nurses, on August 17th, 18thand the 20th nursing staff were reminded of the importance of care planned interventions, and reviewed all residents who have pressure sores. Nursing staff continue to have conversation and report on all residents and their care planned needs. On August 24th nursing staff was in-serviced on care planned interventions and wound care. Effective August 11th a quality assurance	

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F 314	Continued From page 8 During interview on 08/05/2015, at 8:09 a.m., DOQ-B stated that R50's wound was on her right heel and the foam boot should be placed on her right foot. DOQ-B stated that she would educate the staff and check R50's assignment and care plan so they were correct. Review of the facility Nursing Progress Note dated 07/15/2015, indicated "Wound review, resident has a stage 2 pressure ulcer on her right heel... progressive healing and is currently 1 cm round with .4 cm depth.... Wears foam boot to right foot when up and Derma-saver circle cushion in bed to prevent pressure to the wound area.." During observation on 08/05/2015 at 2:13 p.m. licensed practical nurse (LPN)-A and registered nurse (RN)-C provided wound care for R50. LPN-A described R50's pressure ulcer as 1 cm x 1 cm, peri wound (area surrounding wound opening) 1 cm white and moist, the widest area measuring 1 cm in width on edges. During interview at 08/05/2015, at 2:25 p.m. at, DOQ-A, stated that R50's pressure ulcer "should have remained as unstageable", and not a stage II as identified in the 7/15/2015 progress notes. DOQ-A stated, they are not to backstage pressure ulcers (staging of a granulating healing pressure ulcers). Although R50 was identified as having an unstageable pressure ulcer on her right heel, the foam boot was not implemented according to the plan of care to prevent further skin breakdown and promote healing. Furthermore, the facility has not consistently assessed R50 pressure ulcer	F 314	program was implemented under the supervision of the director of nurses to monitor the implementation of the care planned interventions. The director of nurses or designated quality assurance representative will perform the following systematic changes: weekly review of all interventions of those residents with wounds. This will be ongoing. Nurses will be randomly checking that the interventions are physically in place when they perform the dressing changes. Any deficiencies will be corrected on the spot, and the findings of the quality assurance checks will be documented and submitted at the monthly quality assurance committee meeting for review or corrective action.	

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F 314	Continued From page 9 staging to ensure the current status of the unstaged pressure ulcer. A facility policy, entitled: Elim Care Pressure Ulcer Documentation reviewed June 2014 indicated: "The Care Plan for Skin Integrity is to be reviewed and revised based on treatment and needs of the resident." "Update Nurse Aide assignment sheet as needed."	F 314		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were provided in accordance with signed physician orders for 1 of 9 residents (R3) observed during the survey medication administration pass which resulted in 11% (percent) medication error rate. Findings include: R3's quarterly Minimum Data Set (MDS) dated 05/18/2015 and was moderately cognitively impaired. During observation of the medication pass on 08/03/2015 at 5:54 p.m. licensed practical nurse (LPN)- B prepared medications for R31, which included multivitamin one tablet, Colace 100 mg one capsule (stool softener), and one tablet of	F 332	F332 Free of Medication Error Rates of 5% or more It is the policy of this facility to provide medications to our residents with error rates of 5% or less. After the surveyor reported that there was a potential error that LPN was reminded to be cautious and to confirm identity of residents during med pass. There had not been previous concerns with this LPN¿s medication administration. Some of the many ways this has been achieved is with in-services and supportive trainings for all those who administer medications. Because all residents receiving medication administration are potentially affected by the cited deficiency, on August 18th, 19th and 24th random observations and audits were completed of the	9/11/15

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F 332	Continued From page 10 vitamin D3 1000 units (supplement) and placed in a clear plastic cup. LPN-B approached R3, (not R31, whose medications LPN-B prepared for administration) and placed medications in front of R3, along with a glass of water. R3 placed her hand on cup to take the medications. Before R3 took R31's medication, the surveyor intervened prior to ingestion of R31's medication. LPN-B identified these were not the correct medications for R3's and immediately disposed the medications. LPN-B prepared the correct medication which was then administered to R31. During interview on 08/03/2015 at 6:00 p.m. LPN-B stated he almost administered the wrong medications to R3. In an interview on 08/05/2015 at 01:35 p.m. the Director of Quality (DOQ)-A stated there has been no previous concerns about any medicaiton errors for LPN-B. As a facility, if there is a concern with an individual, "we have done written re-education." Review of the facility's policy, entitled: General Dose Preparation and Medication Administration policy, (last reviewed 01/01/2013), indicated that "Facility staff should: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident."	F 332	medication pass and documentation. To enhance already currently compliant operations and under the supervision of the interim director of nurses, on Aug 17, 18th, 19th and 20th the practical guide to ¿Prevention of Medication Errors¿ was reviewed with staff. On August 24th an in-service was held with trained medication assistants and the nurses on medication administration and medication errors. The training emphasizes proper technique to prevent medication errors. Effective August 11th a quality assurance program was implemented under the supervision of the director of nurses to monitor the rate of medication errors. The director of nurses or designated quality assurance representative will perform the following systematic changes: weekly medication pass audit for four weeks, ongoing support and training, implementation of every shift MAR audits starting on August 26th, 2015, weekly review of medication errors and will provide further training and support for the trained medication assistants. Any deficiencies will be corrected on the spot, and the findings of the quality assurance checks will be documented and submitted at the monthly quality assurance committee meeting for review or corrective action.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425		9/11/15

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 425	Continued From page 11 §483.75(h) 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 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure current physician's orders were accurately transcribed to the facility's medication administration record (MAR) for 1 of 1 resident (R21), who received Lidoderm patches for pain. Findings include: R21's quarterly minimum data set (MDS), dated 6/17/15, indicated she was cognitively intact and complained of pain rated ten out of ten almost constantly which affected her ability to sleep, and limited her day to day activities. R21's care plan dated, 7/21/15, indicated a risk for alteration in comfort related to diagnosis of degenerative joint disease, exhibited by verbal and non-verbal signs and symptoms of pain.	F 425	It is the policy of this facility to provide medications to our residents in an accurate fashion. After the surveyor reported that there was a transcription error the nurse corrected it immediately. Then on August 10th, the order was changed and was discontinued on August 23rd. Some of the many ways this has been achieved is with in-services and supportive trainings for those who administer medications. Because all residents receiving medication administration are potentially affected by the cited deficiency, on August 18th, 19th and 24th random observations and audits were completed of the medication pass, transcription and documentation.	

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	245497	A. BUILDING ______ B. WING ______	08/06/2015

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F 425	Continued From page 12 Review of R21's Physician Order Report: 7/1/15 - 7/31/15, directed staff to apply "Lidoderm adhesive patch, one to three patches; topical every morning to low back twice daily due to diagnosis of Spondylosis" (spinal degeneration accompanied by pain). Further review of R21's physicians orders identified an order was received via facsimile (fax) on 6/29/15 for, "Lidoderm patches seem to be very effective for her [R21's] pain." "Can we change order to wear 24 hrs a day?" "Apply 3 patches to low back and remove and replace every 24 hours?" The physician responded, "OK as above." The change order was noted by registered nurse (RN)-A on 6/30/15. Review of R21's medication administration record (MAR) for the month of July and August 2015 directed staff to apply Lidoderm adhesive patch; 1-3 patches topical once per day. The MAR further indicated R21 received only two Lidoderm patches 12 days during the month of July and four times During the month of August 2015. The resident did not receive three Lidoderm patches daily, as directed by the new physician order change on 6/29/15. During an interview on 8/4/15, at 2:53 p.m., trained medication aide (TMA)-A stated, R21 receives one to three Lidoderm patches based on her level of pain. During an interview on 8/4/15, at 3:06 p.m., registered nurse (RN)-A reviewed R21's record and stated, "R21 should be getting 3 patches of Lidoderm." She further stated, "It looks like it [the order] was transcribed wrong, and it was my	F 425	To enhance already currently compliant operations and under supervision of the interim director of nurses, on Aug 17, 18th, 19th and 20th the practical guide to ¿Prevention of Medication Errors¿ was reviewed with staff. On August 24th an in-service was held with trained medication assistants and the nurses on medication administration and medication errors. The training emphasizes proper technique to prevent medication errors. Effective August 11th a quality assurance program was implemented under the supervision of the director of nurses to monitor the rate of medication errors. The director of nurses or designated quality assurance representative will perform the following systematic changes: weekly medication order audit for four weeks, ongoing support and training, weekly review of medication errors and will provide further training and support for the trained medication assistants. Any deficiencies will be corrected on the spot, and the findings of the quality assurance checks will be documented and submitted at the monthly quality assurance committee meeting for review or corrective action.	

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F 425	Continued From page 13 transcription error." During interview on 8/6/15, at 8:35 a.m., director of quality (DOQ)- A stated, the process for transcribing an order is as follows: " the nurses get the order, then do the order." She further stated that faxed orders should come in and be noted and transcribed immediately. DOQ- A stated, there was no system in place to double check physician orders. Review of Elim Care, Inc. policy titled: Entry of Orders into Resident Medical Record, dated December 2009, directed staff when working from a signed order to complete the following steps: Enter the order into the resident's electronic medical record, sign off on the original order page that the order has been entered, verify the order in electronic medical record by visually comparing the order on the order page, print out the MAR, and, a second nurse is to verify that each order on the original page appears on the appropriate MAR sheet with second nurse to initial and date.	F 425		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident mechanical lifts were cleaned and maintained in	F 465	F 465 Safe/Environmental/Sanitary/Comfortable Environments	9/11/15

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F 465 Continued From page 14

proper working order on 2 of 4 wings (east and south) which had the potential to affect 5 residents (R23, R18, R57, R62 and R1) residing in the east and south wing who utilized the mechanical lifts.

Findings include:

During the initial tour on the east wing on 08/03/15 at 1:15 p.m., a mechanical lift, EZ Way Stander, (a device used for transferring residents) was in the hallway with a remote control hanging on the lift stand. The control case was separated, leaving an approximately 1/8 inch gap. The plastic remote casing was held together with white medical paper tape that had tan and gray stains.

During observation on the south wing on 08/04/15, at 4:00 p.m. an EZ Way Stander was in the hallway that had padded lift arms shaped like a U fork. The right arm, had a plastic cover on the end that was cracked with jagged edges. The plastic end was covered with black electrical tape that was coming off, exposing the jagged edges, which faced any resident who used the mechanical lift.

During observation on 8/03/15, at 3:25 p.m., nursing assistant (NA)-J was transferring R23 with the EZ Way stand lift that had the remote case taped together. During interview NA-J stated "the remote itself is falling apart, the buttons do still work." NA-J then stated the remote has been apart for at least two weeks.

Review of the nursing assistant South and East List Sheet (nursing assistant care sheet), undated, identified that R23, R18, R57,R62 and

F 465

It is the policy of this facility to provide a safe clean comfortable environment for our residents. After the surveyor pointed out the defect in the remote control the maintenance supervisor was notified and replaced the remote control and covered the jagged edge on the lift arm.
This deficiency would have the potential to affect any residents utilizing facility lift equipment. On August 18th, the representative from the lift manufacturer visited the facility to evaluate current equipment and facility needs. The facility will be purchasing 2 new standing lifts and 1 new mechanical lift to replace current inventory.
The environmental service director will complete audit of current equipment by August 27th and will conduct ongoing monthly audits to ensure continued compliance.
Effective August 11th a quality assurance program was implemented under the supervision of the environmental services director to monitor the mechanical lifts.
The environmental services director or designated representative will perform the following systematic changes: monthly mechanical lift audits and cleaning. Any deficiencies will be corrected on the spot, and the findings of the quality assurance checks will be documented and submitted at the monthly quality assurance committee meeting for review or corrective action.

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F 465	Continued From page 15	F 465		

R1 all used an EZ Way stand lift for transfers.

During interview on 8/4/15, at 4:15 p.m., the maintenance director (MD) stated he was aware of the issues with both lifts. "I fixed the lift with the broken remote on 8/3/15 and was aware of the end of the lift arm being broken." They need to replace these lifts for along time, and have replaced any part of the lifts and the facility was planning on replacing the lifts.

In review of the manufactures instruction, entitled: EZ Way stand Operators Instructions, revised 3/11/09, directions were given to "do a visual check for any damaged, missing or loose parts. Repair as necessary."

The facilities cleaning policy, entitled: Lift Cleaning policy dated 7/21/14, indicated all residents lifts will be cleaned weekly and as needed. The policy indicated to use house disinfectant and to spray entire lift using disinfectant, wipe down lift using a micro fiber cloth, check entire lift for repairs as needed and to report repairs to maintenance staff.

Minnesota Department of Health

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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	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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 08/31/15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ____ B. WING ____	08/06/2015

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2 000	Continued From page 1	2 000		

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 August 3-6, 2015, 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.

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

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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		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		9/11/15

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2 302	Continued From page 3 Based on interview and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training in a written or electronic form. This had the potential to affect all residents in the facility. Findings include: Review of the facility's Alzheimer's training program, indicated there was no information or documentation that identified consumers were provided a description of Alzheimer's training program, the categories of employees trained, the frequency of training and the basic topics covered. During an interview on 8/5/15, at 1:00 p.m., the director of quality (DOC)-A stated, the staff receive dementia training but the families do not receive the information. The DOC-A stated, besides notifying families we have a memory care wing, no family education was provided regarding Alzheimer's training. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet for consumer/family information. The DON or designee could educate staff and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	Corrected.	

Minnesota Department of Health

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2 565	Continued From page 4	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned interventions for dental care were followed for 1 of 3 residents (R32) reviewed for dental and who had missing teeth. Findings include: R32's quarterly Minimum Data Set (MDS) dated 7/1/15, identified R32 had severe cognitive impairment, was able to follow directions, but required physical assistance to complete personal hygiene. R32's dental care plan dated 7/22/15, identified R32 had missing teeth and directed staff to, "Encourage Resident [R32] to do own oral cares and participate with brushing after set-up. Staff complete brushing twice daily if [R32] is unable to complete process." During observation of morning cares on 8/5/15, at 6:57 a.m. nursing assistant (NA)-C assisted R32 to use the restroom by helping R32 transfer to her wheelchair. NA-C laid a clean towel on R32's chest/lap while she was seated in the wheelchair and instructed R32 to open her mouth while NA-C inserted a toothbrush with toothpaste into her mouth. NA-C brushed R32's teeth for approximately 15 seconds, provided her a small	2 565	Corrected.	9/11/15

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2 565	Continued From page 5	2 565		

cup of water and instructed her to rinse her mouth and spit the water into a pink emesis basin. NA-C then continued to help R32 dress for the day with clean clothing. NA-C provided no encouragement for R32 to complete her own oral care, even though this was identified in R32's plan of care.

When interviewed on 8/5/15, at 10:08 a.m. NA-C stated R32 had been missing teeth for "a long time", and R32's care plan just required staff to "help brush her teeth." Further, NA-C stated she felt R32 required "total care" for her oral cares.

When interviewed on 8/5/15, at 10:30 a.m. registered nurse (RN)-B stated a care plan is used to "ensure the resident is getting the proper care", and staff were expected to encourage R32 to complete her own oral cares as directed by the care plan.

During interview on 8/6/15, at 9:42 a.m. the director of quality (DOQ)-B stated the care plan helps to "determine someone's needs and how to provide them", and staff should "support as much independence" as possible with the resident (R32) by having her attempt to complete her own oral care as directed by her plan of care.

A facility care planning policy was requested, but none was provided. A facility General Resident Rights Guidelines policy dated 11/2012, identified, "Encourage resident to participate in care as much as possible."

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing and/or designee could could review with direct care staff the importance

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2 565	Continued From page 6 of following the individualize resident care plans. Audits could be performed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and consistently implement pressure ulcer interventions for 1 of 3 residents (R50) who had a current pressure ulcer. Findings include: R50's quarterly minimum data set (MDS) dated 2/18/2015, indicated she had moderate cognitive	2 900	Corrected.	9/11/15

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HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE MAPLE PLAIN, MN 55359**

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2 900	Continued From page 7 impaired. The MDS further indicated R50 had an unstageable pressure ulcer (PU) (indicates extent of tissue involvement cannot be assessed because the edges cannot not clearly be seen) on her right heel. The MDS identified the PU was 4 centimeter (cm) x 2.5 cm with no depth indicated, the skin tissue denoted as eschar (which is a dry scab or slough tissue). R50's quarterly MDS, dated 05/20/2015, identified R50 had one stage 3 pressure ulcer, (full thickness skin loss), which measured 1.2 cm x 0.5 cm with a depth of 2.0 cm. The MDS indicated the most severe tissue type was granulation tissue (new connective tissue growth). The Care Area Assessment (CAA) for Pressure Ulcers, dated 12/05/2014, indicated R50 was at risk for loss of skin integrity, utilized a pressure redistribution cushion and mattress, and R50 had, "Popped Blister to RT [right] Heel 5 x 4.2 cm Stage III noted by staff". R50's Careplan, last updated 07/17/2015, identified alteration in skin integrity related to diagnosis of peripheral neuropathy, incontinence, and immobility. The care plan directed staff to apply foam boot to left lower extremity at all times, with Derma Saver (foam protective device to alleviate pressure) to right ankle while in bed only. Review of the facility nursing assistant care sheet, part of the facility care plan, (undated), entitled: List 3 Work list, identified R50 had "Foam boots to Rt. [sic]when up". During observation on 08/04/2015 at 2:34 p.m., R50 was seated in her wheelchair in the activity room. R50 had a foam boot on her right foot, which was resting on the foot pedal. R50's left foot, was covered with sock was resting on the floor. During observation on 08/05/2015, at 6:57 a.m.,(NA)-E completed morning cares for R50 and the foam boot was on R50's left foot. NA-E	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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2 900	Continued From page 8	2 900		

placed R50's right foot onto the foot pedal, and R50 yelled out, "Ouch, that's my sore foot! Clear up to my knee!" Both of R50's feet were now resting on the foot pedals as R50 was wheeled out of the room for the morning meal.
At 8:03 a.m., R50 was in the therapy room participating in rehabilitation exercises. The foam boot remained on R50's left foot. The certified occupation therapy assistant (COTA)-A removed R50's right foot off the foot pedals. R50 complained of pain in her right foot. The COTA-A and physical therapy assistant (PTA)-A discussed the placement of R50's foam boot. The COTA-A stated she spoke with the director of quality (DOQ)-B and R50's foam boot should be on the right foot, and not the left foot. R50's foam boot was changed from the left foot to the right foot by COTA-A.

During interview on 08/05/2015, at 8:09 a.m., DOQ-B stated that R50's wound was on her right heel and the foam boot should be placed on her right foot. DOQ-B stated that she would educate the staff and check R50's assignment and care plan so they were correct.

Review of the facility Nursing Progress Note dated 07/15/2015, indicated "Wound review, resident has a stage 2 pressure ulcer on her right heel... progressive healing and is currently 1 cm round with .4 cm depth.... Wears foam boot to right foot when up and Derma-saver circle cushion in bed to prevent pressure to the wound area.."

During observation on 08/05/2015 at 2:13 p.m. licensed practical nurse (LPN)-A and registered nurse (RN)-C provided wound care for R50. LPN-A described R50's pressure ulcer as 1 cm x 1 cm, peri wound (area surrounding wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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2 900	Continued From page 9	2 900		

opening) 1 cm white and moist, the widest area measuring 1 cm in width on edges.

During interview at 08/05/2015, at 2:25 p.m. at, DOQ-A, stated that R50's pressure ulcer "should have remained as unstageable", and not a stage II as identified in the 7/15/2015 progress notes. DOQ-A stated, they are not to backstage pressure ulcers (staging of a granulating healing pressure ulcers).

Although R50 was identified as having an unstageable pressure ulcer on her right heel, the foam boot was not implemented according to the plan of care to prevent further skin breakdown and promote healing. Furthermore, the facility has not consistently assessed R50 pressure ulcer staging to ensure the current status of the unstaged pressure ulcer.

A facility policy, entitled: Elim Care Pressure Ulcer Documentation reviewed June 2014 indicated: "The Care Plan for Skin Integrity is to be reviewed and revised based on treatment and needs of the resident." "Update Nurse Aide assignment sheet as needed."

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing and/or Designee could review interventions for pressure ulcer prevention and healing, to assure that the interventions are appropriately being applied.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE MAPLE PLAIN, MN 55359**

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21426	Continued From page 10	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a required two step tuberculin skin test (TST) was completed for 3 of 5 residents (R49, R57, R12) and 2 of 5 employees (NA-G, NA-H) reviewed for tuberculosis (TB) prevention and management. Findings include: RESIDENTS: R49's Baseline TB Screening for Residents form	21426	Audit was completed on all employees and residents. Any employee who is missing components of their TB screening are completing a new 2-step process. Any resident who is missing components of their TB screening are completing a new 2-step process. Initiated a new protocol to ensure residents compliance which includes using electronic records for TB screening documentation. Weekly audits 4x to ensure compliance.	9/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21426	Continued From page 11	21426		

dated 6/15/15, identified R49 did not have any recorded results for the 2nd step TST administered on 6/15/15. The space identified to record the results was left blank.

R49's Medication Flowsheet dated June 2015, identified R49 received the 2nd step TST on 6/15/15, however the space identified on the flowsheet to record the results was filled in with numerous "X" markings and did not identify a positive or negative result, nor any millimeters of induration left by the test to determine a result.

R57's Baseline TB Screening for Residents form dated 7/19/15, identified R57 did not have any recorded results for the 2nd step TST administered on 7/19/15. The space identified to record the results was left blank.

R57's Medication Flowsheet dated July 2015, identified R57 received the 2nd step TST on 7/19/15, however the space identified on the flowsheet to record the results was filled in with numerous "X" markings and did not identify a positive or negative result, nor any millimeters of induration left by the test to determine a result.

R12's Baseline TB Screening for Residents form dated 7/6/15, identified R12 did not have any recorded results for the 2nd step TST administered on 7/6/15. The space identified to record the results was left blank.

R12's Medication Flowsheet dated July 2015, identified R12 received the 2nd step TST on 7/6/15, however the space identified on the flowsheet to record the results was filled in with numerous "X" markings and did not identify a positive or negative result, nor any millimeters of induration left by the test to determine a result.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 12 EMPLOYEES: Nursing assistant (NA)-G's Baseline TB Screening for Health Care Workers (HCWs) form dated 6/18/15, identified NA-G did not have a 2nd step TST completed. The space to record the administration and result of the test was blank. NA-H Baseline TB Screening for Health Care Workers (HCWs) form dated 7/10/15, identified NA-H did not have a 2nd step TST completed. The space to record the administration and result of the rest was blank. When interviewed on 8/6/15, at 1:03 p.m. director of quality (DOQ)-A stated the facility needed "a better tracking system" to ensure the 2nd step TST's were being completed. Residents and HCW's should have a two step TST completed, and the identified errors "got missed." A facility Standard Guidelines for Facility Tuberculosis (TB) Prevention and Control Program policy dated 2/20/09, identified, "All HCW's must receive a two-step tuberculin skin test." In addition, the policy identified, "All residents must receive baseline TB screening ... and a two step TST..."	21426		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is	21545		9/11/15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21545	Continued From page 13	21545		

incorporated by reference in part 4658.1315. For purposes of this part, a medication error means:

(1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or

(2) the administration of expired medications.

B. It is free of any significant medication error. A significant medication error is:

(1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or

(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.

C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.

This MN Requirement is not met as evidenced by:

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ____ B. WING ____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21545	Continued From page 14	21545		

Based on observation, interview, and document review, the facility failed to ensure medications were provided in accordance with signed physician orders for 1 of 9 residents (R3) observed during the survey medication administration pass which resulted in 11% (percent) medication error rate.

Corrected.

Findings include:

R3's quarterly Minimum Data Set (MDS) dated 05/18/2015 and was moderately cognitively impaired.

During observation of the medication pass on 08/03/2015 at 5:54 p.m. licensed practical nurse (LPN)- B prepared medications for R31, which included multivitamin one tablet, Colace 100 mg one capsule (stool softener), and one tablet of vitamin D3 1000 units (supplement) and placed in a clear plastic cup. LPN-B approached R3, (not R31, whose medications LPN-B prepared for administration) and placed medications in front of R3, along with a glass of water. R3 placed her hand on cup to take the medications. Before R3 took R31's medication, the surveyor intervened prior to ingestion of R31's medication. LPN-B identified these were not the correct medications for R3's and immediately disposed the medications. LPN-B prepared the correct medication which was then administered to R31.

During interview on 08/03/2015 at 6:00 p.m. LPN-B stated he almost administered the wrong medications to R3.

In an interview on 08/05/2015 at 01:35 p.m. the Director of Quality (DOQ)-A stated there has been no previous concerns about any medicaiton errors for LPN-B. As a facility, if there is a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21545	Continued From page 15 concern with an individual, "we have done written re-education." Review of the facility's policy, entitled: General Dose Preparation and Medication Administration policy, (last reviewed 01/01/2013), indicated that "Facility staff should: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident." SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or Designee could inservice staff assigned medication pass to remember to check the "3 Rights" when setting up and giving medications. Audits could be performed to ensure these were being consistently implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced	21685		9/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21685	Continued From page 16	21685		

by:
Based on observation, interview and document review, the facility failed to ensure resident mechanical lifts were cleaned and maintained in proper working order on 2 of 4 wings (east and south) which had the potential to affect 5 residents (R23, R18, R57, R62 and R1) residing in the east and south wing who utilized the mechanical lifts.

Corrected.

Findings include:

During the initial tour on the east wing on 08/03/15 at 1:15 p.m., a mechanical lift, EZ Way Stander, (a device used for transferring residents) was in the hallway with a remote control hanging on the lift stand. The control case was separated, leaving an approximately 1/8 inch gap. The plastic remote casing was held together with white medical paper tape that had tan and gray stains.

During observation on the south wing on 08/04/15, at 4:00 p.m. an EZ Way Stander was in the hallway that had padded lift arms shaped like a U fork. The right arm, had a plastic cover on the end that was cracked with jagged edges. The plastic end was covered with black electrical tape that was coming off, exposing the jagged edges, which faced any resident who used the mechanical lift.

During observation on 8/03/15, at 3:25 p.m., nursing assistant (NA)-J was transferring R23 with the EZ Way stand lift that had the remote case taped together. During interview NA-J stated "the remote itself is falling apart, the buttons do still work." NA-J then stated the remote has been apart for at least two weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ____ B. WING ____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21685	Continued From page 17	21685		

Review of the nursing assistant South and East List Sheet (nursing assistant care sheet), undated, identified that R23, R18, R57,R62 and R1 all used an EZ Way stand lift for transfers.

During interview on 8/4/15, at 4:15 p.m., the maintenance director (MD) stated he was aware of the issues with both lifts. "I fixed the lift with the broken remote on 8/3/15 and was aware of the end of the lift arm being broken." They need to replace these lifts for along time, and have replaced any part of the lifts and the facility was planning on replacing the lifts.

In review of the manufactures instruction, entitled: EZ Way stand Operators Instructions, revised 3/11/09, directions were given to "do a visual check for any damaged, missing or loose parts. Repair as necessary."

The facilities cleaning policy, entitled: Lift Cleaning policy dated 7/21/14, indicated all residents lifts will be cleaned weekly and as needed. The policy indicated to use house disinfectant and to spray entire lift using disinfectant, wipe down lift using a micro fiber cloth, check entire lift for repairs as needed and to report repairs to maintenance staff.

SUGGESTED METHOD OF CORRECTION:
The Administrator and/or designee could review the facility's processes for preventative maintenance and inservice responsible staff. They could develop a system to consistently monitor the maintenance/cleanliness of mechanical lifts in the facility.

TIME PERIOD FOR CORRECTION: Twenty-one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21685	Continued From page 18 (21) days.	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a dignified dining experience for 4 of 4 residents (R32, R33, R42, R52) with cognitive impairment who were not served their meals in a timely manner, and for 1 of 1 residents (R18) with cognitive impairment who was assisted with eating by staff while they were standing. Findings include: LACK OF TIMELY MEAL SERVICE: R32's quarterly Minimum Data Set (MDS) dated 7/1/15, identified R32 had severe cognitive impairment, and required extensive assistance with eating. R33's quarterly MDS dated 6/3/15, identified R33 had severe cognitive impairment, and required limited assistance with eating. R42's significant change MDS dated 6/29/15, identified R42 had both long and short term memory impairments, and required extensive assistance with eating. R52's annual MDS dated 5/6/15, identified R52 had both long and short term memory impairments, and was totally	21805	Corrected.	9/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ___ B. WING ___	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21805	Continued From page 19	21805		

dependent on staff for eating.

During observation of the evening supper meal in the North Wing dining room on 8/3/15, at 6:03 p.m., R32, R33, R42, and R52 were seated at the same table in the middle of the dining room. At 6:05 p.m. dietary aide (DA)-A and DA-B wheeled a mobile cart into the dining room which contained pre-plated food and began to pass drinks to each resident in the dining room. At 6:16 p.m. DA-A and DA-B began serving the plated food to the three other tables with residents where R32, R33, R42, and R52 were not seated. At 6:19 p.m. no food had been served to the table with R32, R33, R42, and R52 but the rest of the dining room had been served with the residents eating their meals. Nursing assistant (NA)-A was seated at a different table helping other residents cut up their food and providing cues to help them eat. DA-A and DA-B stood by the mobile cart with the plated food and shouted aloud acros the dining room to NA-A they had "just that middle table left" to serve, and continued waiting by the mobile cart. The NA-A, DA-A, or DA-B did not offer or provide any assistance to R32, R33, R42, or R52, who continued to sit and wait for their meals. At 6:25 p.m. (9 minutes after serving began) R32, R33, R42, and R52 still had not been served their meals. During this time, several observations were made of R32 and R42 looking around the dining room and watching the other residents eat their food. R32 had a furrowed brow and puckered lower lip as she watched other residents eating their meal, at times looking down at the bare table in front of her. At 6:28 p.m. (12 minutes after serving began) NA-B entered the dining room, and DA-A served R32, R33, R42, and R52 their meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 20	21805		

When interviewed on 8/3/15, at 6:45 p.m. DA-A stated dietary staff waited to serve R32, R33, R42, and R52 until additional NA's staff are present because they have a higher risk of choking on their food. Further, DA-A stated the meal service for R32, R33, R42, and R52 "makes me feel bad" because "everybody is getting served and they have to wait."

During interview on 8/4/15, at 2:03 p.m. NA-A stated R32, R33, R42, and R52 needed assistance with eating and were at risk of choking if someone isn't seated by them. On 8/3/15 (the supper meal observed by the surveyor) their was only one NA available when the food was ready and she couldn't be at two tables at once, so R32, R33, R42, and R52 had to wait for additional help before being served. Further, NA-A stated she "felt bad" they had to wait to have their meals served to them and watch other residents eat.

When interviewed on 8/6/15, at 12:52 p.m. the director of quality (DOQ)-B stated R32, R33, R2, and R52 were to be served "when we have caregivers down there" as they required assistance to eat. The staff are expected to create a "homelike fashion" dining experience for all the residents so as to "eat at the same time", and the staff should have gotten more help so all residents could be served and assisted promptly.

STANDING WHILE FEEDING:

R18's quarterly Minimum Data Set (MDS) dated 6/17/15, indicated R18 had moderate cognitive impairment, had an upper extremity impairment on both sides, and required physical assist from staff to eat.

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	00950	A. BUILDING: ____ B. WING ____	08/06/2015

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21805	Continued From page 21	21805		

During an observation on 8/3/15, at 6:14 p.m. R18 was seated at a table in the dining room with two other residents and nursing assitant (NA)-D. NA-D was seated opposite the table from R18, and was assisting the two other residents with eating. At 6:22 p.m., NA-D stood up from helping the other two residents and walked over to R18 where she stood over him and assisted him to eat until 6:25 p.m., then sat back down across the table and continued assisting the other two residents. At 6:31 p.m., NA-D stood up again and walked over to R18 and assisted him to eat while standing over him before returning to the opposoite side of the table to assist the other two residents to finish their meal. At 6:35 p.m., NA-D stood up from the table and walked over to R18 to help him eat, standing over him while while helping him eat until 6:39 p.m..

During an interview on 8/6/15, at 12:52 p.m. the director of quality (DOQ)-A stated two staff members should have been helping the residents at R18's table to eat. Further, NA-D should not have been standing up while helping R18 to eat, "I would expect them to be sitting down."

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing and/or designee could review dining room service and inservice the staff inregards to resident meal service and assistance

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES F549 7024
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245497	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/05/2015

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on August 05, 2015. At the time of this survey, Haven Homes of Maple Plain was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Haven Homes of Maple Plain is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(000) construction. In 1999, an addition was constructed to the southeast and was determined to be of Type II(000) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 52 and had a census of 43 at the time of the survey.	K 000		

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

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	245497	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	08/05/2015

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Electronically submitted
August 20, 2015

Mr. Garrett Bothun, Administrator
Haven Homes Of Maple Plain
1520 Wyman Avenue
Maple Plain, Minnesota 55359

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5497025

Dear Mr. Bothun:

The above facility was surveyed on August 3, 2015 through August 6, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule 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 immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	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.	

Minnesota Department of Health

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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 August 3-6, 2015, 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	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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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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		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		

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2 302	Continued From page 3	2 302		

Based on interview and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training in a written or electronic form. This had the potential to affect all residents in the facility.

Findings include:

Review of the facility's Alzheimer's training program, indicated there was no information or documentation that identified consumers were provided a description of Alzheimer's training program, the categories of employees trained, the frequency of training and the basic topics covered.

During an interview on 8/5/15, at 1:00 p.m., the director of quality (DOC)-A stated, the staff receive dementia training but the families do not receive the information. The DOC-A stated, besides notifying families we have a memory care wing, no family education was provided regarding Alzheimer's training.

SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet for consumer/family information. The DON or designee could educate staff and conduct audits to ensure compliance.

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

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2 565	Continued From page 4	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned interventions for dental care were followed for 1 of 3 residents (R32) reviewed for dental and who had missing teeth. Findings include: R32's quarterly Minimum Data Set (MDS) dated 7/1/15, identified R32 had severe cognitive impairment, was able to follow directions, but required physical assistance to complete personal hygiene. R32's dental care plan dated 7/22/15, identified R32 had missing teeth and directed staff to, "Encourage Resident [R32] to do own oral cares and participate with brushing after set-up. Staff complete brushing twice daily if [R32] is unable to complete process." During observation of morning cares on 8/5/15, at 6:57 a.m. nursing assistant (NA)-C assisted R32 to use the restroom by helping R32 transfer to her wheelchair. NA-C laid a clean towel on R32's chest/lap while she was seated in the wheelchair and instructed R32 to open her mouth while NA-C inserted a toothbrush with toothpaste into her mouth. NA-C brushed R32's teeth for approximately 15 seconds, provided her a small	2 565		

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2 565	Continued From page 5	2 565		

cup of water and instructed her to rinse her mouth and spit the water into a pink emesis basin. NA-C then continued to help R32 dress for the day with clean clothing. NA-C provided no encouragement for R32 to complete her own oral care, even though this was identified in R32's plan of care.

When interviewed on 8/5/15, at 10:08 a.m. NA-C stated R32 had been missing teeth for "a long time", and R32's care plan just required staff to "help brush her teeth." Further, NA-C stated she felt R32 required "total care" for her oral cares.

When interviewed on 8/5/15, at 10:30 a.m. registered nurse (RN)-B stated a care plan is used to "ensure the resident is getting the proper care", and staff were expected to encourage R32 to complete her own oral cares as directed by the care plan.

During interview on 8/6/15, at 9:42 a.m. the director of quality (DOQ)-B stated the care plan helps to "determine someone's needs and how to provide them", and staff should "support as much independence" as possible with the resident (R32) by having her attempt to complete her own oral care as directed by her plan of care.

A facility care planning policy was requested, but none was provided. A facility General Resident Rights Guidelines policy dated 11/2012, identified, "Encourage resident to participate in care as much as possible."

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing and/or designee could could review with direct care staff the importance

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2 565	Continued From page 6	2 565		

of following the individualize resident care plans. Audits could be performed to ensure compliance.

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

2 900 MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers 2 900

Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:

A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and

B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to comprehensively assess and consistently implement pressure ulcer interventions for 1 of 3 residents (R50) who had a current pressure ulcer.

Findings include:
R50's quarterly minimum data set (MDS) dated 2/18/2015, indicated she had moderate cognitive

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2 900	Continued From page 7	2 900		

impaired. The MDS further indicated R50 had an unstageable pressure ulcer (PU) (indicates extent of tissue involvement cannot be assessed because the edges cannot not clearly be seen) on her right heel. The MDS identified the PU was 4 centimeter (cm) x 2.5 cm with no depth indicated, the skin tissue denoted as eschar (which is a dry scab or slough tissue).
R50's quarterly MDS, dated 05/20/2015, identified R50 had one stage 3 pressure ulcer, (full thickness skin loss), which measured 1.2 cm x 0.5 cm with a depth of 2.0 cm. The MDS indicated the most severe tissue type was granulation tissue (new connective tissue growth). The Care Area Assessment (CAA) for Pressure Ulcers, dated 12/05/2014, indicated R50 was at risk for loss of skin integrity, utilized a pressure redistribution cushion and mattress, and R50 had, "Popped Blister to RT [right] Heel 5 x 4.2 cm Stage III noted by staff".
R50's Careplan, last updated 07/17/2015, identified alteration in skin integrity related to diagnosis of peripheral neuropathy, incontinence, and immobility. The care plan directed staff to apply foam boot to left lower extremity at all times, with Derma Saver (foam protective device to alleviate pressure) to right ankle while in bed only. Review of the facility nursing assistant care sheet, part of the facility care plan, (undated), entitled: List 3 Work list, identified R50 had "Foam boots to Rt. [sic]when up".
During observation on 08/04/2015 at 2:34 p.m., R50 was seated in her wheelchair in the activity room. R50 had a foam boot on her right foot, which was resting on the foot pedal. R50's left foot, was covered with sock was resting on the floor.
During observation on 08/05/2015, at 6:57 a.m.,(NA)-E completed morning cares for R50 and the foam boot was on R50's left foot. NA-E

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 8	2 900		

placed R50's right foot onto the foot pedal, and R50 yelled out, "Ouch, that's my sore foot! Clear up to my knee!" Both of R50's feet were now resting on the foot pedals as R50 was wheeled out of the room for the morning meal.
At 8:03 a.m., R50 was in the therapy room participating in rehabilitation exercises. The foam boot remained on R50's left foot. The certified occupation therapy assistant (COTA)-A removed R50's right foot off the foot pedals. R50 complained of pain in her right foot. The COTA-A and physical therapy assistant (PTA)-A discussed the placement of R50's foam boot. The COTA-A stated she spoke with the director of quality (DOQ)-B and R50's foam boot should be on the right foot, and not the left foot. R50's foam boot was changed from the left foot to the right foot by COTA-A.

During interview on 08/05/2015, at 8:09 a.m., DOQ-B stated that R50's wound was on her right heel and the foam boot should be placed on her right foot. DOQ-B stated that she would educate the staff and check R50's assignment and care plan so they were correct.

Review of the facility Nursing Progress Note dated 07/15/2015, indicated "Wound review, resident has a stage 2 pressure ulcer on her right heel... progressive healing and is currently 1 cm round with .4 cm depth.... Wears foam boot to right foot when up and Derma-saver circle cushion in bed to prevent pressure to the wound area.."

During observation on 08/05/2015 at 2:13 p.m. licensed practical nurse (LPN)-A and registered nurse (RN)-C provided wound care for R50. LPN-A described R50's pressure ulcer as 1 cm x 1 cm, peri wound (area surrounding wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE MAPLE PLAIN, MN 55359**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 9	2 900		

opening) 1 cm white and moist, the widest area measuring 1 cm in width on edges.

During interview at 08/05/2015, at 2:25 p.m. at, DOQ-A, stated that R50's pressure ulcer "should have remained as unstageable", and not a stage II as identified in the 7/15/2015 progress notes. DOQ-A stated, they are not to backstage pressure ulcers (staging of a granulating healing pressure ulcers).

Although R50 was identified as having an unstageable pressure ulcer on her right heel, the foam boot was not implemented according to the plan of care to prevent further skin breakdown and promote healing. Furthermore, the facility has not consistently assessed R50 pressure ulcer staging to ensure the current status of the unstaged pressure ulcer.

A facility policy, entitled: Elim Care Pressure Ulcer Documentation reviewed June 2014 indicated: "The Care Plan for Skin Integrity is to be reviewed and revised based on treatment and needs of the resident." "Update Nurse Aide assignment sheet as needed."

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing and/or Designee could review interventions for pressure ulcer prevention and healing, to assure that the interventions are appropriately being applied.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ____ B. WING ____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 10	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a required two step tuberculin skin test (TST) was completed for 3 of 5 residents (R49, R57, R12) and 2 of 5 employees (NA-G, NA-H) reviewed for tuberculosis (TB) prevention and management. Findings include: RESIDENTS: R49's Baseline TB Screening for Residents form	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE MAPLE PLAIN, MN 55359**

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21426	Continued From page 11 dated 6/15/15, identified R49 did not have any recorded results for the 2nd step TST administered on 6/15/15. The space identified to record the results was left blank. R49's Medication Flowsheet dated June 2015, identified R49 received the 2nd step TST on 6/15/15, however the space identified on the flowsheet to record the results was filled in with numerous "X" markings and did not identify a positive or negative result, nor any millimeters of induration left by the test to determine a result. R57's Baseline TB Screening for Residents form dated 7/19/15, identified R57 did not have any recorded results for the 2nd step TST administered on 7/19/15. The space identified to record the results was left blank. R57's Medication Flowsheet dated July 2015, identified R57 received the 2nd step TST on 7/19/15, however the space identified on the flowsheet to record the results was filled in with numerous "X" markings and did not identify a positive or negative result, nor any millimeters of induration left by the test to determine a result. R12's Baseline TB Screening for Residents form dated 7/6/15, identified R12 did not have any recorded results for the 2nd step TST administered on 7/6/15. The space identified to record the results was left blank. R12's Medication Flowsheet dated July 2015, identified R12 received the 2nd step TST on 7/6/15, however the space identified on the flowsheet to record the results was filled in with numerous "X" markings and did not identify a positive or negative result, nor any millimeters of induration left by the test to determine a result.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21426	Continued From page 12 EMPLOYEES: Nursing assistant (NA)-G's Baseline TB Screening for Health Care Workers (HCWs) form dated 6/18/15, identified NA-G did not have a 2nd step TST completed. The space to record the administration and result of the test was blank. NA-H Baseline TB Screening for Health Care Workers (HCWs) form dated 7/10/15, identified NA-H did not have a 2nd step TST completed. The space to record the administration and result of the rest was blank. When interviewed on 8/6/15, at 1:03 p.m. director of quality (DOQ)-A stated the facility needed "a better tracking system" to ensure the 2nd step TST's were being completed. Residents and HCW's should have a two step TST completed, and the identified errors "got missed." A facility Standard Guidelines for Facility Tuberculosis (TB) Prevention and Control Program policy dated 2/20/09, identified, "All HCW's must receive a two-step tuberculin skin test." In addition, the policy identified, "All residents must receive baseline TB screening ... and a two step TST..."	21426		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE MAPLE PLAIN, MN 55359**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 13 incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by:	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 14 Based on observation, interview, and document review, the facility failed to ensure medications were provided in accordance with signed physician orders for 1 of 9 residents (R3) observed during the survey medication administration pass which resulted in 11% (percent) medication error rate. Findings include: R3's quarterly Minimum Data Set (MDS) dated 05/18/2015 and was moderately cognitively impaired. During observation of the medication pass on 08/03/2015 at 5:54 p.m. licensed practical nurse (LPN)- B prepared medications for R31, which included multivitamin one tablet, Colace 100 mg one capsule (stool softener), and one tablet of vitamin D3 1000 units (supplement) and placed in a clear plastic cup. LPN-B approached R3, (not R31, whose medications LPN-B prepared for administration) and placed medications in front of R3, along with a glass of water. R3 placed her hand on cup to take the medications. Before R3 took R31's medication, the surveyor intervened prior to ingestion of R31's medication. LPN-B identified these were not the correct medications for R3's and immediately disposed the medications. LPN-B prepared the correct medication which was then administered to R31. During interview on 08/03/2015 at 6:00 p.m. LPN-B stated he almost administered the wrong medications to R3. In an interview on 08/05/2015 at 01:35 p.m. the Director of Quality (DOQ)-A stated there has been no previous concerns about any medicaiton errors for LPN-B. As a facility, if there is a	21545		

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	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21545	Continued From page 15 concern with an individual, "we have done written re-education." Review of the facility's policy, entitled: General Dose Preparation and Medication Administration policy, (last reviewed 01/01/2013), indicated that "Facility staff should: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident." SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or Designee could inservice staff assigned medication pass to remember to check the "3 Rights" when setting up and giving medications. Audits could be performed to ensure these were being consistently implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21685	Continued From page 16 by: Based on observation, interview and document review, the facility failed to ensure resident mechanical lifts were cleaned and maintained in proper working order on 2 of 4 wings (east and south) which had the potential to affect 5 residents (R23, R18, R57, R62 and R1) residing in the east and south wing who utilized the mechanical lifts. Findings include: During the initial tour on the east wing on 08/03/15 at 1:15 p.m., a mechanical lift, EZ Way Stander, (a device used for transferring residents) was in the hallway with a remote control hanging on the lift stand. The control case was separated, leaving an approximately 1/8 inch gap. The plastic remote casing was held together with white medical paper tape that had tan and gray stains. During observation on the south wing on 08/04/15, at 4:00 p.m. an EZ Way Stander was in the hallway that had padded lift arms shaped like a U fork. The right arm, had a plastic cover on the end that was cracked with jagged edges. The plastic end was covered with black electrical tape that was coming off, exposing the jagged edges, which faced any resident who used the mechanical lift. During observation on 8/03/15, at 3:25 p.m., nursing assistant (NA)-J was transferring R23 with the EZ Way stand lift that had the remote case taped together. During interview NA-J stated "the remote itself is falling apart, the buttons do still work." NA-J then stated the remote has been apart for at least two weeks.	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21685	Continued From page 17	21685		

Continued From page 17

Review of the nursing assistant South and East List Sheet (nursing assistant care sheet), undated, identified that R23, R18, R57,R62 and R1 all used an EZ Way stand lift for transfers.

During interview on 8/4/15, at 4:15 p.m., the maintenance director (MD) stated he was aware of the issues with both lifts. "I fixed the lift with the broken remote on 8/3/15 and was aware of the end of the lift arm being broken." They need to replace these lifts for along time, and have replaced any part of the lifts and the facility was planning on replacing the lifts.

In review of the manufactures instruction, entitled: EZ Way stand Operators Instructions, revised 3/11/09, directions were given to "do a visual check for any damaged, missing or loose parts. Repair as necessary."

The facilities cleaning policy, entitled: Lift Cleaning policy dated 7/21/14, indicated all residents lifts will be cleaned weekly and as needed. The policy indicated to use house disinfectant and to spray entire lift using disinfectant, wipe down lift using a micro fiber cloth, check entire lift for repairs as needed and to report repairs to maintenance staff.

SUGGESTED METHOD OF CORRECTION:
The Administrator and/or designee could review the facility's processes for preventative maintenance and inservice responsible staff. They could develop a system to consistently monitor the maintenance/cleanliness of mechanical lifts in the facility.

TIME PERIOD FOR CORRECTION: Twenty-one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 18 (21) days.	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a dignified dining experience for 4 of 4 residents (R32, R33, R42, R52) with cognitive impairment who were not served their meals in a timely manner, and for 1 of 1 residents (R18) with cognitive impairment who was assisted with eating by staff while they were standing. Findings include: LACK OF TIMELY MEAL SERVICE: R32's quarterly Minimum Data Set (MDS) dated 7/1/15, identified R32 had severe cognitive impairment, and required extensive assistance with eating. R33's quarterly MDS dated 6/3/15, identified R33 had severe cognitive impairment, and required limited assistance with eating. R42's significant change MDS dated 6/29/15, identified R42 had both long and short term memory impairments, and required extensive assistance with eating. R52's annual MDS dated 5/6/15, identified R52 had both long and short term memory impairments, and was totally	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

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21805	Continued From page 19 dependent on staff for eating. During observation of the evening supper meal in the North Wing dining room on 8/3/15, at 6:03 p.m., R32, R33, R42, and R52 were seated at the same table in the middle of the dining room. At 6:05 p.m. dietary aide (DA)-A and DA-B wheeled a mobile cart into the dining room which contained pre-plated food and began to pass drinks to each resident in the dining room. At 6:16 p.m. DA-A and DA-B began serving the plated food to the three other tables with residents where R32, R33, R42, and R52 were not seated. At 6:19 p.m. no food had been served to the table with R32, R33, R42, and R52 but the rest of the dining room had been served with the residents eating their meals. Nursing assistant (NA)-A was seated at a different table helping other residents cut up their food and providing cues to help them eat. DA-A and DA-B stood by the mobile cart with the plated food and shouted aloud acros the dining room to NA-A they had "just that middle table left" to serve, and continued waiting by the mobile cart. The NA-A, DA-A, or DA-B did not offer or provide any assistance to R32, R33, R42, or R52, who continued to sit and wait for their meals. At 6:25 p.m. (9 minutes after serving began) R32, R33, R42, and R52 still had not been served their meals. During this time, several observations were made of R32 and R42 looking around the dining room and watching the other residents eat their food. R32 had a furrowed brow and puckered lower lip as she watched other residents eating their meal, at times looking down at the bare table in front of her. At 6:28 p.m. (12 minutes after serving began) NA-B entered the dining room, and DA-A served R32, R33, R42, and R52 their meals.	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ___ B. WING ___	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	**1520 WYMAN AVENUE MAPLE PLAIN, MN 55359**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 20	21805		

When interviewed on 8/3/15, at 6:45 p.m. DA-A stated dietary staff waited to serve R32, R33, R42, and R52 until additional NA's staff are present because they have a higher risk of choking on their food. Further, DA-A stated the meal service for R32, R33, R42, and R52 "makes me feel bad" because "everybody is getting served and they have to wait."

During interview on 8/4/15, at 2:03 p.m. NA-A stated R32, R33, R42, and R52 needed assistance with eating and were at risk of choking if someone isn't seated by them. On 8/3/15 (the supper meal observed by the surveyor) their was only one NA available when the food was ready and she couldn't be at two tables at once, so R32, R33, R42, and R52 had to wait for additional help before being served. Further, NA-A stated she "felt bad" they had to wait to have their meals served to them and watch other residents eat.

When interviewed on 8/6/15, at 12:52 p.m. the director of quality (DOQ)-B stated R32, R33, R2, and R52 were to be served "when we have caregivers down there" as they required assistance to eat. The staff are expected to create a "homelike fashion" dining experience for all the residents so as to "eat at the same time", and the staff should have gotten more help so all residents could be served and assisted promptly.

STANDING WHILE FEEDING:

R18's quarterly Minimum Data Set (MDS) dated 6/17/15, indicated R18 had moderate cognitive impairment, had an upper extremity impairment on both sides, and required physical assist from staff to eat.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00950	A. BUILDING: ______ B. WING ______	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HOMES OF MAPLE PLAIN	1520 WYMAN AVENUE MAPLE PLAIN, MN 55359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 21	21805		

Continued From page 21

During an observation on 8/3/15, at 6:14 p.m. R18 was seated at a table in the dining room with two other residents and nursing assitant (NA)-D. NA-D was seated opposite the table from R18, and was assisting the two other residents with eating. At 6:22 p.m., NA-D stood up from helping the other two residents and walked over to R18 where she stood over him and assisted him to eat until 6:25 p.m., then sat back down across the table and continued assisting the other two residents. At 6:31 p.m., NA-D stood up again and walked over to R18 and assisted him to eat while standing over him before returning to the opposoite side of the table to assist the other two residents to finish their meal. At 6:35 p.m., NA-D stood up from the table and walked over to R18 to help him eat, standing over him while while helping him eat until 6:39 p.m..

During an interview on 8/6/15, at 12:52 p.m. the director of quality (DOQ)-A stated two staff members should have been helping the residents at R18's table to eat. Further, NA-D should not have been standing up while helping R18 to eat, "I would expect them to be sitting down."

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing and/or designee could review dining room service and inservice the staff inregards to resident meal service and assistance

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