## 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
	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY AGENCY	Facility ID: 00950
MEDICARE/MEDICAID PROVIDER     (L1) 245497 2.STATE VENDOR OR MEDICAID NC     (L2) 064742000		<ol> <li>NAME AND ADI</li> <li>(L3) HAVEN HON</li> <li>(L4) 1520 WYMA</li> <li>(L5) MAPLE PLA</li> </ol>	MES OF MAPLE N AVENUE		(L6) <b>55359</b>	4. TYPE OF ACTION:     7 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On Ein Vicit     9. Other
<ol> <li>5. EFFECTIVE DATE CHANGE OF O' (L9) 10/01/2004</li> </ol>	WNERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGOR 05 HHA	Y 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY     09//       8. ACCREDITATION STATUS:     0 Unaccredited     1 TJC       2 AOA     3 Other	21/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOW         18 SNF       18/19 SNI         52         (L37)       (L38)         16. STATE SURVEY AGENCY REMAIN	19 SNF (L39)	B. Not in Com Requireme ICF (L42)	uce With quirements Based On: ccceptable POC pliance with Program ents and/or Applied V IID (L43)		And/Or Approved Waivers Of The          2. Technical Personnel         3. 24 Hour RN         4. 7-Day RN (Rural SNF)         5. Life Safety Code         * Code:         A*         15. FACILITY MEETS         1861 (e) (1) or 1861 (j) (1):	EFollowing Requirements: 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12) (L15)
17. SURVEYOR SIGNATUREBrenda Fischer,	*		09/21/2015 D BY HCFA RI	(L19) EGIONAI	18. STATE SURVEY AGENCY API <u>Kate JohnsTon, Pro</u> COFFICE OR SINGLE STAT	ogram Specialist 09/14/2015 (L20)
<ul> <li>19. DETERMINATION OF ELIGIBILIT</li> <li>X 1. Facility is Eligible to P</li> <li>2. Facility is not Eligible</li> </ul>	articipate		IPLIANCE WITH C ITS ACT:	IVIL	<ol> <li>Statement of Financi</li> <li>Ownership/Control I</li> <li>Both of the Above :</li> </ol>	al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 10/01/1987 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEM BEGINNING (L41)	DATE	24. LTC AGREEME ENDING DATI (L25)		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	05-Fail to Meet Health/Safety nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: (L27)	<ul><li>27. ALTERNATIVI</li><li>A. Suspension of</li><li>B. Rescind Sus</li></ul>	of Admissions:	(L44) (L45)		04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C 03001	ARRIER NO.	(L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION ( 09/21/2015	OF APPROVAL DA	ГЕ (L33)	DETERMINATION APPRO	VAL



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, 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 - Health Regulation Division • General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us *An equal opportunity employer* 



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,

ale Compton

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

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245497	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 9/21/2015
Name	of Facility		Street Address, City, State, Zip Code	
НА	VEN 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	(Y4)	Item		(Y5)	Date	(Y4)	ltem		Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0241		09/11/2015		ID Prefix	F0282		09/11/2015		ID Prefix	F0314		09/11/2015
Reg. #	483.15(a)				Reg. #	483.20(k)(3)(ii)				Reg. #	483.25(c)		
LSC					LSC					LSC			_
				1					<u> </u>				
			Correction					Correction					Correction
ID Desfer	50000		Completed			50.005		Completed			50.005		Completed
ID Prefix			09/11/2015		ID Prefix			09/11/2015		ID Prefix			09/11/2015
-	483.25(m)(1)				-	483.60(a),(b)					483.70(h)		_
LSC					LSC					LSC			_
			<b>_</b>										
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
													_
Reg. # LSC					Reg. #					Reg. #			_
									+				_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			_
									+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
Reviewed By	r Revie	ewed B	Зу	Da	te:	Signature of	Surve	yor:	1			Date:	
State Agenc	/	E	BF/KJ	09	0/30/20	15		2079	94			09/2	21/2015
Reviewed By	/ Revie	ewed E	By	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed of	n:				Check f	or anv	Uncorrected D	efici	encies. Was	a Summary of	1	
	8/6/2015						-				to the Facility?	YES	NO

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					AND TRANSMITTAL ID: NMZ7 TE SURVEY AGENCY Facility ID: 00950
MEDICARE/MEDICAID PROVIDER N     (L1) 245497 2.STATE VENDOR OR MEDICAID NO.     (L2) 064742000 5. EFFECTIVE DATE CHANGE OF OW		<ol> <li>NAME AND ADD</li> <li>(L3) HAVEN HON</li> <li>(L4) 1520 WYMA</li> <li>(L5) MAPLE PLA</li> <li>PROVIDER/SUF</li> </ol>	MES OF MAPLE N AVENUE JIN, MN	PLAIN	4. TYPE OF ACTION:         2 (L8)           1. Initial         2. Recertification           3. Termination         4. CHOW           (L6)         55359           02         (L7)           8. Full Survey After Complaint
(L9)         10/01/2004           6.         DATE OF SURVEY         08/00           8.         ACCREDITATION STATUS:         0 Unaccredited         1 TJC           0         Unaccredited         1 Other         1 Other	5/ <b>2015</b> (L34) (L10)	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/IIE 12 RHC	13 PTIP 22 CLIA 14 CORF FISCAL YEAR ENDING DATE: (1.35)
<ol> <li>LTC PERIOD OF CERTIFICATION         From (a):         To (b):     </li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ol>	<b>52</b> (L18) <b>52</b> (L17)	X B. Not in Com	ce With quirements		And/Or Approved Waivers Of The Following Requirements:        2. Technical Personnel      6. Scope of Services Limit        3. 24 Hour RN      7. Medical Director        4. 7-Day RN (Rural SNF)      8. Patient Room Size        5. Life Safety Code      9. Beds/Room         * Code:       B*       (L12)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 52	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)
(L37) (L38)	(L39)	(L42)	(L43)		
16. STATE SURVEY AGENCY REMARI 17. SURVEYOR SIGNATURE Timothy Rhoner	nus, HFE NE	Date :	08/31/2015	(L19)	18. STATE SURVEY AGENCY APPROVAL     Date:
19. DETERMINATION OF ELIGIBILITY          1. Facility is Eligible to Par          2. Facility is not Eligible			IPLIANCE WITH CI ITS ACT:	IVIL	<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>
22. ORIGINAL DATE OF PARTICIPATION <b>10/01/1987</b>	23. LTC AGREEMI BEGINNING		<ol> <li>LTC AGREEME ENDING DATE</li> </ol>		26. TERMINATION ACTION:     (L30)       VOLUNTARY     00       INVOLUNTARY     01-Merger, Closure       01-Merger, Closure     05-Fail to Meet Health/Safety       02-Dissatisfaction W/ Reimbursement     06-Fail to Meet Agreement
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus	of Admissions:	(L25) (L44)		03-Risk of Involuntary Termination     OTHER       04-Other Reason for Withdrawal     07-Provider Status Change       00-Active
28. TERMINATION DATE:	29	. INTERMEDIARY/C 03001	(L45) ARRIER NO.		30. REMARKS
31. RO RECEIPT OF CMS-1539	(L28) 32	DETERMINATION (	OF APPROVAL DAT	(L31) TE	Posted 09/21/2015 Co.
	(L32)			(L33)	DETERMINATION APPROVAL



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;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

Haven Homes Of Maple Plain August 20, 2015 Page 2

## 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

Haven Homes Of Maple Plain August 20, 2015 Page 4

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

Haven Homes Of Maple Plain August 20, 2015 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Vate 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

	-	ID HUMAN SERVICES			FORM APPROVED
STATEMENT O	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>`</b> ,	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		245497	B. WING		08/06/2015
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
HAVEN HO	OMES OF MAPLE PLAIN			520 WYMAN AVENUE JAPLE PLAIN, MN 55359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
F 241 SS=E	as your allegation of Department's accepta enrolled in ePOC, you at the bottom of the fit form. Your electronic be used as verification Upon receipt of an accon-site revisit of your validate that substant regulations has been your verification. 483.15(a) DIGNITY A INDIVIDUALITY The facility must pror- manner and in an environment	ance. Because you are ur signature is not required rst page of the CMS-2567 submission of the POC will n of compliance. Acceptable electronic POC, an facility may be conducted to ial compliance with the attained in accordance with ND RESPECT OF Note care for residents in a vironment that maintains or ent's dignity and respect in	F 241		9/11/15
	by: Based on observatio review, the facility fai dining experience for R42, R52) with cogni not served their meal 1 of 1 residents (R18	is not met as evidenced n, interview, and document ed to ensure a dignified 4 of 4 residents (R32, R33, tive impairment who were s in a timely manner, and for ) with cognitive impairment h eating by staff while they		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 as coworkers for help if they are not availa 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	k ble
LABORATORY	 DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
Electroni	cally Signed				08/31/2015

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

PRINTED: 08/31/2015 

	S FOR MEDICARE &					O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY PLETED
		245497	B. WING		08	8/06/2015
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
HAVEN H	OMES OF MAPLE PLAIN			I520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 241	Continued From page	2 1	F 241			
	R32's quarterly Minim 7/1/15, identified R32 impairment, and requivith eating. R33's qui identified R33 had se and required limited a R42's significant char identified R42 had bo memory impairments assistance with eating 5/6/15, identified R52 term memory impairm dependent on staff fo During observation of the North Wing dining p.m., R32, R33, R42, same table in the mid 6:05 p.m. dietary aide a mobile cart into the contained pre-plated drinks to each resider 6:16 p.m. DA-A and D plated food to the three residents where R32, not seated. At 6:19 p served to the table wi but the rest of the din with the residents eat assistant (NA)-A was helping other resident providing cues to help stood by the mobile of shouted aloud acrost had "just that middle"	had severe cognitive ired extensive assistance arterly MDS dated 6/3/15, evere cognitive impairment, assistance with eating. the MDS dated 6/29/15, th long and short term , and required extensive g. R52's annual MDS dated had both long and short tents, and was totally r eating. The evening supper meal in g room on 8/3/15, at 6:03 and R52 were seated at the ldle of the dining room. At e (DA)-A and DA-B wheeled dining room which food and began to pass th in the dining room. At DA-B began serving the se other tables with R33, R42, and R52 were o.m. no food had been th R32, R33, R42, and R52 ing room had been served ing their meals. Nursing seated at a different table ts cut up their food and to them eat. DA-A and DA-B art with the plated food and the dining room to NA-A they table left" to serve, and the mobile cart. The NA-A, t offer or provide any	Γ 24 Ι	eat their meal. Because all residents who need assistance with mealtimes are po affected by the cited deficiency th director of nursing reviewed the fi expectations for dining with dignit the nurses and certified nursing assistants. Dining room audits we completed on August 14th, 18th a To enhance our currently complia operations and under the directio interim director of nurses, on Aug nursing staff received in-service t regarding state and federal requin for the dignity and respect of indi- of our residents during their dinin experience. Effective August 24th a quality as program was implemented under supervision of the interim director nurses to monitor the dining room experience. The director of nurses designated representative, includ certified nursing assistants, will p three random dining room audits for a time period of four weeks. T will continue at two times per wee four weeks. Any deficiencies will corrected on the spot, and the fin the audits will be submitted at the quality assurance committee meet further review or corrective action	e interim acility¿s cy with ere and 20th. Int n of the iust 24th raining rements viduality g esurance the of n s or ing erform a week he audits ek for be dings of e monthly etings for	

Facility ID: 00950

If continuation sheet Page 2 of 16

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/31/2015 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION		(X3) DATE	
		245497	B. WING				08/	06/2015
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
HAVEN HO	OMES OF MAPLE PLAIN				1520 WYMAN AVENUE MAPLE PLAIN, MN 553	359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	R42, and R52 still had meals. During this tin were made of R32 an dining room and watc their food. R32 had a puckered lower lip as residents eating their at the bare table in fro minutes after serving dining room, and DA- and R52 their meals. When interviewed on stated dietary staff wa R42, and R52 until ac present because they choking on their food. meal service for R32, me feel bad" because served and they have During interview on 8, stated R32, R33, R42 assistance with eating if someone isn't seate supper meal observed only one NA available and she couldn't be a R33, R42, and R52 ha before being served. "felt bad" they had to served to them and w When interviewed on director of quality (DC and R52 were to be s caregivers down there	serving began) R32, R33, d not been served their ne, several observations of R42 looking around the thing the other residents eat a furrowed brow and she watched other meal, at times looking down ont of her. At 6:28 p.m. (12 began) NA-B entered the A served R32, R33, R42, 8/3/15, at 6:45 p.m. DA-A aited to serve R32, R33, dditional NA's staff are have a higher risk of Further, DA-A stated the R33, R42, and R52 "makes e "everybody is getting to wait." /4/15, at 2:03 p.m. NA-A 2, and R52 needed g and were at risk of choking ed by them. On 8/3/15 (the d by the surveyor) their was e when the food was ready t two tables at once, so R32, ad to wait for additional help Further, NA-A stated she wait to have their meals vatch other residents eat. 8/6/15, at 12:52 p.m. the DQ)-B stated R32, R33, R2, ierved "when we have e" as they required	F	241		DEFICIENCY)		
	caregivers down there							

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If continuation sheet Page 3 of 16

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 08/31/2015 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE	
		245497	B. WING			-	08/	06/2015
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
HAVEN HO	OMES OF MAPLE PLAIN				520 WYMAN AVENUE IAPLE PLAIN, MN 5535	59		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From page create a "homelike far all the residents so as and the staff should h residents could be se STANDING WHILE F R18's quarterly Minim 6/17/15, indicated R1 impairment, had an u on both sides, and rea staff to eat. During an observation R18 was seated at a two other residents an NA-D was seated opp and was assisting the eating. At 6:22 p.m., the other two resident where she stood over until 6:25 p.m., then s table and continued a residents. At 6:31 p. and walked over to R while standing over hi opposoite side of the	e 3 shion" dining experience for a to "eat at the same time", ave gotten more help so all rved and assisted promptly. EEDING: num Data Set (MDS) dated 8 had moderate cognitive upper extremity impairment quired physical assist from n on 8/3/15, at 6:14 p.m. table in the dining room with nd nursing assitant (NA)-D. bosite the table from R18, two other residents with NA-D stood up from helping is and walked over to R18 him and assisted him to eat at back down across the ssisting the other two m., NA-D stood up again 18 and assisted him to eat im before returning to the table to assist the other two		241				
	stood up from the tab	ir meal. At 6:35 p.m., NA-D le and walked over to R18 ing over him while while 3:39 p.m						
	director of quality (DC members should have at R18's table to eat.	e been helping the residents Further, NA-D should not p while helping R18 to eat,						

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				E CONSTRUCTION	
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		245497	B. WING		08/06/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HAVEN H	OMES OF MAPLE PLAIN			1520 WYMAN AVENUE MAPLE PLAIN, MN 55359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC
F 282 SS=D	483.20(k)(3)(ii) SERV PERSONS/PER CAR		F 282		9/11/15
	must be provided by	d or arranged by the facility qualified persons in a resident's written plan of			
	by: Based on observatio review, the facility fail interventions for dent of 3 residents (R32) r had missing teeth. Findings include: R32's quarterly Minim 7/1/15, identified R32 impairment, was able required physical ass personal hygiene. R3 7/22/15, identified R3 directed staff to, "Enc own oral cares and pa set-up. Staff complet [R32] is unable to cor During observation of 6:57 a.m. nursing ass to use the restroom b wheelchair. NA-C laid chest/lap while she w and instructed R32 to	to follow directions, but istance to complete 32's dental care plan dated 2 had missing teeth and ourage Resident [R32] to do articipate with brushing after e brushing twice daily if nplete process." The morning cares on 8/5/15, at istant (NA)-C assisted R32 y helping R32 transfer to her d a clean towel on R32's as seated in the wheelchair open her mouth while NA-C with toothpaste into her		F282 Services by Qualified Person Care Plan It is the policy of this facility to provi adequate cares as the care plan sta Some of the many ways that this ha been achieved for resident #32 is b reviewing the current care plan and updating it. The care plan has been updated to instruct caregivers to co oral care as the resident is unable t complete own oral cares and partic brushing. After the surveyor reports incident all caregivers were reminde promote independence with activitie daily living and to follow the residen care plan. Caregivers were in-servit approach. Because all residents receiving phy assistance with oral cares are poter affected by the cited deficiency the coordinator will audit the caregivers assignment sheets against the care Assignment sheets will be edited to provide specific instructions on oral needs of all residents at the resider quarterly care conference. To enhance currently compliant	ide ates. as y mplete o ipate in ed the ed to es of it/s ced on vsical ntially RAI s/ plans. care

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/31/20 FORM APPROVI OMB NO. 0938-03
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245497	B. WING		08/06/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HAVEN HO	OMES OF MAPLE PLAIN	1		1520 WYMAN AVENUE	
		-		MAPLE PLAIN, MN 55359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 282	basin. NA-C then co the day with clean clo encouragement for R care, even though thi plan of care. When interviewed on stated R32 had been time", and R32's care "help brush her teeth felt R32 required "tota When interviewed on registered nurse (RN used to "ensure the r care", and staff were to complete her own care plan. During interview on 8 director of quality (DC helps to "determine s provide them", and staff	ater into a pink emesis ntinued to help R32 dress for othing. NA-C provided no 832 to complete her own oral is was identified in R32's a 8/5/15, at 10:08 a.m. NA-C missing teeth for "a long e plan just required staff to ." Further, NA-C stated she al care" for her oral cares. a 8/5/15, at 10:30 a.m. )-B stated a care plan is resident is getting the proper expected to encourage R32 oral cares as directed by the B/6/15, at 9:42 a.m. the CQ)-B stated the care plan someone's needs and how to taff should "support as much	F 28	<ul> <li>18thand the 20th nursing staff were reminded of the importance of care plan Nursing staff continue to have conversation and report on all residen and their care planned needs. On Aug 24th nursing staff was in-serviced on or plans.</li> <li>Effective August 11th, a quality assurad 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 change weekly audits of assignment sheets ar 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 compliance with the care plan. Any deficiencies will be corrected on the spand the findings of the quality assurance</li> </ul>	ts uust care nce es: nd or s the pot, ce
F 314 SS=D	(R32) by having her a oral care as directed A facility care plannin none was provided. Rights Guidelines po "Encourage resident much as possible."	ng policy was requested, but A facility General Resident licy dated 11/2012, identified, to participate in care as NT/SVCS TO	F 31	checks will be documented and submi at the monthly quality assurance committee meeting for further review o corrective action.	
00-0	Based on the compre	ehensive assessment of a nust ensure that a resident			

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PRINTED: 08/31/2015 FORM APPROVED

	S FOR MEDICARE &		()(0)			IO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	· · ·	TE SURVEY MPLETED		
		245497	B. WING		o	8/06/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
HAVEN H	OMES OF MAPLE PLAIN			1520 WYMAN AVENUE MAPLE PLAIN, MN 55359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 314		e 6 / without pressure sores	F 314	1				
	does not develop pre individual's clinical co they were unavoidabl pressure sores receiv	ssure sores unless the ndition demonstrates that e; and a resident having res necessary treatment and nealing, prevent infection and						
	by: Based on observatio review, the facility fail assess and consister	is not met as evidenced n, interview, and document ed to comprehensively ty implement pressure 1 of 3 residents (R50) who re ulcer.		F314 Treatment/Services to pre pressure sores It is the policy of this facility to p adequate cares as the care plar this case, after the surveyor rep incident with the boot it was corr	rovide n states. In orted the			
	2/18/2015, indicated a impaired. The MDS for unstageable pressure of tissue involvement because the edges ca on her right heel. The 4 centimeter (cm) x 2 indicated, the skin tiss	annot not clearly be seen) MDS identified the PU was .5 cm with no depth sue denoted as eschar		and the certified nursing assista reminded of the importance of for their assignment sheets for care interventions. Some of the many that this has been achieved for #50 is by reviewing the current of and updating it. The care plan w updated to reflect the right foam be on right lower extremity at all and foam boots on to both feet w	nts were blowing planned / ways resident care plan /as boot to times, while in			
	R50 had one stage 3 thickness skin loss), v 0.5 cm with a depth of indicated the most se granulation tissue (ne growth). The Care A Pressure Ulcers, date	dated 05/20/2015, identified pressure ulcer, (full which measured 1.2 cm x f 2.0 cm. The MDS vere tissue type was		bed. A request was sent to the to change the current dressing of the wound on the right heel. The orders were changed on August 2015. On August 17th the RAI of provided training materials for n the staging of pressure ulcers. The documentation was correct immediately to reflect the appro- wound stage. On August 17th a	orders for e dressing 12th, oordinator urses on ed oriate			

Facility ID: 00950

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				OMB NO. 0938-03
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
	245497	B. WING		08/06/2015
OVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE	
MES OF MAPLE PLAIN				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIC
Continued From page	7	F 314		
4.2 cm Stage III noted R50's Careplan, last u identified alteration in diagnosis of periphera and immobility. The ca apply foam boot to lef times, with Derma Sa to alleviate pressure) only. Review of the facil entitled: List 3 Work lis "Foam boots to Rt. [si During observation or R50 was seated in he room. R50 had a foan which was resting on foot, was covered with floor. During observation or a.m.,(NA)-E complete and the foam boot wa placed R50's right foo R50 yelled out, "Ouch up to my knee!" Both resting on the foot per out of the room for the At 8:03 a.m., R50 was participating in rehaba foam boot remained of certified occupation the removed R50's right foo complained of pain in and physical therapy a the placement of R50's	d by staff". updated 07/17/2015, skin integrity related to al neuropathy, incontinence, are plan directed staff to t lower extremity at all ver (foam protective device to right ankle while in bed acility nursing assistant care ity care plan, (undated), st, identified R50 had c]when up". 1 08/04/2015 at 2:34 p.m., r wheelchair in the activity n boot on her right foot, the foot pedal. R50's left n sock was resting on the 1 08/05/2015, at 6:57 d morning cares for R50 s on R50's left foot. NA-E t onto the foot pedal, and a, that's my sore foot! Clear of R50's feet were now dals as R50 was wheeled e morning meal. s in the therapy room abilitation exercises. The on R50's left foot. The herapy assistant (COTA)-A oot off the foot pedals. R50 her right foot. The COTA-A the director of quality	F 314	pressure ulcers. On August 27th, 2015 all pressure wounds were reviewed by the Inter Director of Nursing for accuracy on staging. All pressure wounds were accurately documented with the pre- stages. Each week the Director of Nursing review each pressure wound, this w include a review of wound character to ensure accurate staging. Any deficiencies will be corrected on the and the findings of the quality assu- checks will be documented and sul- at the monthly quality assurance committee meeting for review or corrective action. Because all residents with pressure are potentially affected by the cited deficiency the interim director of nu- audited the care planned interventi those residents. On August 13th ar August 19th the RAI coordinator compared the assignment sheets to care plan to ensure accuracy. All ca- planned interventions were updated To enhance currently compliant operations and under the direction interim director of nurses, on August 18thand the 20th nursing staff were reminded of the importance of care planned interventions, and reviewer residents who have pressure sores Nursing staff continue to have conversation and report on all residents	oper will will eristics e spot, rance bmitted e sores urses ons of nd o the are d. of the st 17th, e e d all b. dents
	Continued From page 4.2 cm Stage III notec REGULATORY OR L Continued From page 4.2 cm Stage III notec R50's Careplan, last u identified alteration in diagnosis of periphera and immobility. The c apply foam boot to left times, with Derma Sa to alleviate pressure) only. Review of the facil entitled: List 3 Work li "Foam boots to Rt. [si During observation or R50 was seated in he room. R50 had a foam which was resting on foot, was covered with floor. During observation or a.m.,(NA)-E complete and the foam boot wa placed R50's right foo R50 yelled out, "Ouch up to my knee!" Both resting on the foot per out of the room for the At 8:03 a.m., R50 was participating in rehaba foam boot remained of certified occupation the removed R50's right foo R50 yelled out, "Ouch up to my knee!" Both resting on the foot per out of the room for the At 8:03 a.m., R50 was participating in rehaba foam boot remained of certified occupation the removed R50's right foo Stated she spoke with (DOQ)-B and R50's for	S FOR MEDICARE & MEDICAID SERVICES         F DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         245497         OVIDER OR SUPPLIER         MES OF MAPLE PLAIN         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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	SPOR MEDICARE & MEDICAID SERVICES         PEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPL A. BUILDING.         245497       B. WING         OVIDER OR SUPPLIER       245497         MES OF MAPLE PLAIN       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 7       F 314         4.2 cm Stage III noted by staff".       RSO'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 care plan, (undated), entitled: List 3 Work list, identified R50 had "Foam boots to Rt. [sic]When up".         During observation on 08/05/2015, at 6:57 a.m.,(NA)-E completed morning cares for R50 and the foam boot to not 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 rehababilitation exercises. The foam boot remained on R50's left foot. The certified occupa	CENTIFICATION NUMBER:       (X1) PROVIDERSUPPLERCLA.       (X2) MULTIPLE CONSTRUCTION         245497       B. WING         OVIDER OR SUPPLER       STREET ADDRESS, CITY, STATE, 2IP CODE         MES OF MAPLE PLAIN       STREET ADDRESS, CITY, STATE, 2IP CODE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PERCIENCE OF VILL REGULATORY OR LSC IDENTIFYING INFORMATION)       D         Continued From page 7       F 314         RSO'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 from boot to left lower externity at all times, with Derma Saver (from protective device to alleviate pressure) to right ankle while in bed only. Review of the facility care plan, (indated), entitide: List 3 Work list, identified RSO had "Foam boots to. RL [sic]When up".       Each week the Director of Nursing review each pressure wound, kits to conservation on 08/05/2015, at 6:57 a.m., (NA) E completed morning cares for R50 and the foat podus as RSO was wheeld out of the room for the morning meal.       Because all residents with pressure are potentially affected by the cited officiency the interim director of nursing those residents. On August 13th an Algo self thort The COTA-A and the foat perceives. The foam boot remained on R50's left foot. The certified occupation therapy assistant (COTA)-A eretified occupation therapy assistit (PTA)-A discussed the placement of R50's foam boot. The COTA-A

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI	E CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		245497	B. WING		08/06/2015
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HAVEN HO	OMES OF MAPLE PLAIN		1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 314	Continued From page	8	F 314	4	
	DOQ-B stated that R heel and the foam bor right foot. DOQ-B stat the staff and check R plan so they were cor Review of the facility dated 07/15/2015, incoresident has a stage 2 heel progressive he round with .4 cm dept right foot when up and cushion in bed to prevare area" During observation or licensed practical num nurse (RN)-C provide LPN-A described R50 1 cm, peri wound (are	Nursing Progress Note dicated "Wound review, 2 pressure ulcer on her right ealing and is currently 1 cm th Wears foam boot to d Derma-saver circle vent pressure to the wound n 08/05/2015 at 2:13 p.m. se (LPN)-A and registered of wound care for R50. D's pressure ulcer as 1 cm x ea surrounding wound and moist, the widest area		program was implemented under the supervision of the director of nurses monitor the implementation of the planned interventions. The director nurses or designated quality assure representative will perform the follow systematic changes: weekly review interventions of those residents will wounds. This will be ongoing. Nur be randomly checking that the interventions are physically in place they perform the dressing changes deficiencies will be corrected on the and the findings of the quality assurance committee meeting for review or corrective action.	es to care r of ance owing v of all th ses will e when s. Any e spot, urance
	DOQ-A, stated that R have remained as unst II as identified in the 7 DOQ-A stated, they a pressure ulcers (stagi pressure ulcers). Although R50 was ide unstageable pressure	ing of a granulating healing			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIE	PLE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		3	COMPLETED
		245497	B. WING		08/06/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HAVEN HO	OMES OF MAPLE PLAIN			1520 WYMAN AVENUE MAPLE PLAIN, MN 55359	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIO
F 314	Continued From page staging to ensure the unstaged pressure ule	current status of the	F 31	4	
F 332 SS=D	Documentation review "The Care Plan for Sk and revised based on resident." "Update Ne as needed."	ed: Elim Care Pressure Ulcer wed June 2014 indicated: kin Integrity is to be reviewed treatment and needs of the urse Aide assignment sheet OF MEDICATION ERROR ORE	F 33	32	9/11/15
	The facility must ensumedication error rates	ure that it is free of s of five percent or greater.			
	by: Based on observation review, the facility fail were provided in accor physician orders for 1 observed during the s administration pass w (percent) medication	of 9 residents (R3) survey medication /hich resulted in 11%		F332 Free of Medication Error Rat 5% or more It is the policy of this facility to prov medications to our residents with e rates of 5% or less. After the surve reported that there was a potential that LPN was reminded to be cauti and to confirm identity of residents	ide rror eyor error ous during
	05/18/2015 and was n impaired. During observation of 08/03/2015 at 5:54 p. (LPN)- B prepared me included multivitamin	Im Data Set (MDS) dated moderately cognitively The medication pass on m. licensed practical nurse edications for R31, which one tablet, Colace 100 mg ftener), and one tablet of		<ul> <li>med pass. There had not been preconcerns with this LPN¿s medicatia administration. Some of the many withis has been achieved is with in-seand supportive trainings for all those administer medications.</li> <li>Because all residents receiving medication administration are pote affected by the cited deficiency, on 18th, 19th and 24th random observand audits were completed of the</li> </ul>	on ways ervices se who ntially August

Facility ID: 00950

If continuation sheet Page 10 of 16

	S FOR MEDICARE &				
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245497	B. WING		08/06/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HAVEN HO	OMES OF MAPLE PLAIN			1520 WYMAN AVENUE MAPLE PLAIN, MN 55359	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIC
F 332	Continued From page	e 10	F 33	2	
F 425 SS=D	in a clear plastic cup. R31, whose medication administration) and pl R3, along with a glass hand on cup to take the took R31's medication prior to ingestion of R identified these were for R3's and immedia medications. LPN-B pr medication which was During interview on 0 LPN-B stated he almost medications to R3. In an interview on 08/ Director of Quality (Dr been no previous con- errors for LPN-B. As a concern with an indivi- re-education." Review of the facility's Dose Preparation and policy, (last reviewed "Facility staff should: medication, at the cor- route, at the correct ra- the correct resident."	orepared the correct is then administered to R31. 8/03/2015 at 6:00 p.m. ost administered the wrong 05/2015 at 01:35 p.m. the OQ)-A stated there has ocerns about any medicaiton a facility, if there is a idual, "we have done written idual, "we have done written s policy, entitled: General d Medication Administration 01/01/2013), indicated that Verify each time a itered that it is the correct rect dose, at the correct ate, at the correct time, for IACEUTICAL SVC -	F 42	medication pass and documentation To enhance already currently compli operations and under the supervision the interim director of nurses, on Aug 18th, 19th and 20th the practical guid ¿Prevention of Medication Errors; we reviewed with staff. On August 24th in-service was held with trained medication assistants and the nurse medication administration and medic errors. The training emphasizes prop technique to prevent medication errors Effective August 11th a quality assur program was implemented under the supervision of the director of nurses monitor the rate of medication errors director of nurses or designated qua assurance representative will perform following systematic changes: weekled medication pass audit for four weeks ongoing support and training, implementation of every shift MAR a starting on August 26th, 2015, weekled review of medication errors and will provide further training and support for trained medication assistants. Any deficiencies will be corrected on the and the findings of the quality assurance committee meeting for review or corrective action.	ant on of g 17, de to vas an s on cation ber ors. ance e to c. The lity m the y s, udits ly for the spot, ance
	The facility must prov	ide routine and emergency to its residents, or obtain			

Event ID: NMZ711

If continuation sheet Page 11 of 16

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES. FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 245497 B. WING 08/06/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1520 WYMAN AVENUE** HAVEN HOMES OF MAPLE PLAIN MAPLE PLAIN, MN 55359 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 425 Continued From page 11 F 425 §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 It is the policy of this facility to provide facility failed to ensure current physician's orders medications to our residents in an were accurately transcribed to the facility's accurate fashion. After the surveyor medication administration record (MAR) for 1 of 1 reported that there was a transcription resident (R21), who received Lidoderm patches error the nurse corrected it immediately. for pain. Then on August 10th, the order was changed and was discontinued on August Findings include: 23rd. Some of the many ways this has been achieved is with in-services and R21's quarterly minimum data set (MDS), dated supportive trainings for those who 6/17/15, indicated she was cognitively intact and administer medications. complained of pain rated ten out of ten almost Because all residents receiving constantly which affected her ability to sleep, and medication administration are potentially limited her day to day activities. R21's care plan affected by the cited deficiency, on August dated, 7/21/15, indicated a risk for alteration in 18th, 19th and 24th random observations comfort related to diagnosis of degenerative joint and audits were completed of the disease, exhibited by verbal and non-verbal signs medication pass, transcription and and symptoms of pain. documentation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00950

PRINTED: 08/31/2015

		(X2) MI II TIE		ONSTRUCTION		TE SURVEY
	IDENTIFICATION NUMBER:	· /			· · ·	MPLETED
	245497	B. WING				08/06/2015
VIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
ES OF MAPLE PLAIN		1520 WYMAN AVENUE MAPLE PLAIN, MN 55359				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETIO DATE
continued From page	e 12	F 42	25			
teview of R21's Phys /31/15, directed staff dhesive patch, one to very morning to low iagnosis of Spondylo ccompanied by pain urther review of R21 dentified an order wa ax) on 6/29/15 for, "I e very effective for h hange order to wear atches to low back a very 24 hours?" The s above." The chang egistered nurse (RN) eveiw of R21's medi MAR) for the month of irected staff to apply -3 patches topical or urther indicated R21 atches 12 days durin our times During the esident did not receiva aily, as directed by th hange on 6/29/15. During an interview of aceives one to three er level of pain.	Additional official sectors of the s			operations and under supervision of f interim director of nurses, on Aug 17, 18th, 19th and 20th the practical guid ¿Prevention of Medication Errors; wa reviewed with staff. On August 24th a in-service was held with trained medication assistants and the nurses medication administration and medica errors. The training emphasizes prop technique to prevent medication error Effective August 11th a quality assura program was implemented under the supervision of the director of nurses t monitor the rate of medication errors. director of nurses or designated quali assurance representative will perform 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 fo trained medication assistants. Any deficiencies will be corrected on the s and the findings of the quality assura checks will be documented and subr at the monthly quality assurance committee meeting for review or	he e to as n on ation er s. ince o The ty the ty o the y or the spot, nce	
	FOR MEDICARE & I DEFICIENCIES DRRECTION VIDER OR SUPPLIER ES OF MAPLE PLAIN SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR L Continued From page Review of R21's Phys /31/15, directed staff dhesive patch, one t very morning to low iagnosis of Spondylc ccompanied by pain urther review of R21 dentified an order wa fax) on 6/29/15 for, "I e very effective for h hange order to wear atches to low back a very 24 hours?" The s above." The chang egistered nurse (RN) Review of R21's medi MAR) for the month of irected staff to apply -3 patches topical or urther indicated R21 atches 12 days durin our times During the esident did not receiv aily, as directed by th hange on 6/29/15. During an interview of aceives one to three er level of pain.	DRRECTION         IDENTIFICATION NUMBER:           245497           VIDER OR SUPPLIER           ES OF MAPLE PLAIN           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)           Continued From page 12           Review of R21's Physician Order Report: 7/1/15 - /31/15, directed staff to apply "Lidoderm dhesive patch, one to three patches; topical very morning to low back twice daily due to iagnosis of Spondylosis" (spinal degeneration ccompanied by pain).           urther review of R21's physicians orders tentified an order was received via facsimile 'ax) on 6/29/15 for, "Lidoderm patches seem to e very effective for her [R21's] pain." "Can we hange order to wear 24 hrs a day?" "Apply 3 atches to low back and remove and replace very 24 hours?" The physician responded, "OK s above." The change order was noted by egistered nurse (RN)-A on 6/30/15.           Review of R21's medication administration record MAR) for the month of July and August 2015 irected staff to apply Lidoderm adhesive patch; -3 patches topical once per day. The MAR urther indicated R21 received only two Lidoderm atches 12 days during the month of July and our times During the month of August 2015. The esident did not receive three Lidoderm patches aily, as directed by the new physician order hange on 6/29/15.           uring an interview on 8/4/15, at 2:53 p.m., ained medication aide (TMA)-A stated, R21 eceives one to three Lidoderm patches based on	FOR MEDICAID SERVICES         DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         Ad5497         DETIFICATION NUMBER:         245497         DETIFICATION NUMBER:         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         DETIFYING INFORMATION)         TE 42         F 42         Review of R21'S Physician Order Report: 7/1/15 - /31/15, directed staff to apply "Lidoderm dhesive patch, one to three patches; topical very morning to low back twice daily due to iagnosis of Spondylosis" (spinal degeneration ccompanied by pain).         urther review of R21'S physicians orders lentified an order was received via facsimile 'ax) on 6/29/15 for, "Lidoderm patches seem to e very effective for her [R21'S] pain." "Can we hange order to wear 24 hrs a day?" "Apply 3 atches to low back and remove and replace very 24 hours?" The physician responded, "OK s above." The change order was noted by agistered nurse (RN)-A on 6/30/15.         teview of R21's medication administration record WAR) for the month of July and August 2015. The seident did not receive three Lidoderm patches aily, as directed by the new physician order hange on 6/29/15.         turing an interview on 8/4/15, at 2:53 p.m., ained medication aide (TMA)-A stated, R21 secieves one to three Lidoderm patches based on er level of pain.         urting an interview on	FOR MEDICARD SERVICES         DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         AUDER 06 SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 12         F 425         Autom to three patches; topical wery morning to low back twice daily due to iagnosis of Spondylosis" (spinal degeneration ccompanied by pain).         urther review of R21's physicians orders lentified an order was received via facsimile 'ax) on 6/29/15 for, "Lidoderm patches seem to e very effective for her (R21's) pain." "Can we hange order to wear 24 hrs a day?" "Apply 3 atches to low back and remove and replace very 24 hours?" The physician responded, "OK s above." The change order was noted by egistered nurse (RN)-A on 6/30/15.         teview of R21's medication administration record MAR) for the month of July and August 2015 irect	FOR MEDICARE & MEDICAID SERVICES         DEFICIENCIES       [X1] PROVIDER/SUPPLERCIA         DERIFICATION NUMBER       [X2] MULTIPLE CONSTRUCTION         A BUILDING	FOR MEDICARE & MEDICAID SERVICES     OND       PERCENCISE     (2) MULTIPLE CONSTRUCTION     (3) D       DEPROFENCISE     (2) MULTIPLE CONSTRUCTION     (3) D       A BUILDING     (2) MULTIPLE CONSTRUCTION     (3) D       A BUILDING     (3) D     (2) MULTIPLE CONSTRUCTION     (3) D       A BUILDING     (3) D     (3) D     (2) MULTIPLE CONSTRUCTION     (3) D       A BUILDING     (3) D     (3) D     (2) MULTIPLE CONSTRUCTION     (3) D       A BUILDING     (3) D     (3) D     (3) D     (2) MULTIPLE CONSTRUCTION     (3) D       MEED OF MAPLE PLAIN     STREET ADDRESS, CITY, STATE, 2IP CODE     (3) D     (2) MULTIPLE CONSTRUCTION     (3) D       MEED OF MAPLE PLAIN     STREET ADDRESS, CITY, STATE, 2IP CODE     (3) D     (2) D     (2) D       SUMMAY STATEMENT OF DEPRIMENTS     (2) D     (2) D     (2) D     (2) D       Continued From page 12     (2) D     (2) D     (2) D     (2) D     (2) D       teview of R21's Physician Order Report, 71/1/5 -     (3) 1/5, directed staff to apply 'Lidoderm dremained and and under supervision of the interim director of nurses, on Aug 17, dift, 11 D and Ally apply 3     (3) D     (2) P     (2) P       atches to low back and remove and replace     (2) D     (2) P     (2) D     (2) P       every diffictive for her [R21'S] pain, "Can we hange order

Facility ID: 00950

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	-	D HUMAN SERVICES MEDICAID SERVICES			F	ITED: 08/31/2015 ORM APPROVED NO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) I	DATE SURVEY COMPLETED
		245497	B. WING			08/06/2015
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, Z	IP CODE	
HAVEN HO	OMES OF MAPLE PLAIN			520 WYMAN AVENUE APLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 425	Continued From page transcription error."	13	F 425			
	of quality (DOQ)- A st transcribing an order i get the order, then do stated that faxed orde noted and transcribed	is as follows: " the nurses the order." She further rs should come in and be i immediately. DOQ- A system in place to double				
	Orders into Resident I December 2009, direct from a signed order to steps: Enter the order electronic medical rect order page that the or the order in electronic comparing the order of the MAR, and, a seco each order on the orig appropriate MAR sheet initial and date. 483.70(h)	Inc. policy titled: Entry of Medical Record, dated cted staff when working o complete the following r into the resident's cord, sign off on the original der has been entered, verify medical record by visually on the order page, print out nd nurse is to verify that ginal page appears on the et with second nurse to SANITARY/COMFORTABL	F 465			9/11/15
	The facility must provi sanitary, and comforta residents, staff and th	able environment for				
	by: Based on observation review, the facility fail	is not met as evidenced n, interview and document ed to ensure resident cleaned and maintained in		F 465 Safe/Environmental/Sar Environments	nitary/Comfortable	

Event ID: NMZ711

Facility ID: 00950

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMP	PLETED
		245497	B. WING		08/	06/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
HAVEN H	OMES OF MAPLE PLAIN			1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 465		e 14 on 2 of 4 wings (east and	F 46	65 It is the policy of this faci	lity to provide a	
	south) which had the residents (R23, R18, in the east and south mechanical lifts. Findings include: During the initial tour 08/03/15 at 1:15 p.m. Stander, (a device us was in the hallway wi on the lift stand. The leaving an approxima plastic remote casing white medical paper to stains. During observation on 08/04/15, at 4:00 p.m the hallway that had p a U fork. The right arr end that was cracked plastic end was cover that was coming off, e which faced any resid mechanical lift. During observation on nursing assistant (NA with the EZ Way stan case taped together. "the remote itself is fa still work." NA-J then apart for at least two	potential to affect 5 R57, R62 and R1) residing wing who utilized the on the east wing on , a mechanical lift, EZ Way ed for transferring residents) th a remote control hanging control case was separated, itely 1/8 inch gap. The was held together with tape that had tan and gray n the south wing on an EZ Way Stander was in badded lift arms shaped like m, had a plastic cover on the with jagged edges. The red with black electrical tape exposing the jagged edges, dent who used the n 8/03/15, at 3:25 p.m., A)-J was transferring R23 d lift that had the remote During interview NA-J stated alling apart, the buttons do a stated the remote has been weeks.		<ul> <li>It is the policy of this fact safe clean comfortable e our residents. After the sout the defect in the remomentation of the pagged edge on the lit. This deficiency would hat affect any residents utilize equipment. On August 14 representative from the lit visited the facility to evalue equipment and facility new mechanical lift to remove the program was implemented will be purchasing 2 new 1 new mechanical lift to remove the audit of current August 27th and will con monthly audits to ensure compliance.</li> <li>Effective August 11th a query program was implemented supervision of the environ director to monitor the m The environmental service designated representative following systematic charmechanical lift audits and deficiencies will be corre and the findings of the query committee meeting for recorrective action.</li> </ul>	anvironment for surveyor pointed ote control the was notified and trol and covered ift arm. we the potential to ting facility lift 8th, the ift manufacturer uate current eeds. The facility replace current ce director will t equipment by duct ongoing continued quality assurance ed under the nmental services echanical lifts. ces director or re will perform the nges: monthly d cleaning. Any cted on the spot, uality assurance ed and submitted surance	
	List Sheet (nursing as	g assistant South and East ssistant care sheet), at R23, R18, R57,R62 and				

Facility ID: 00950

If continuation sheet Page 15 of 16

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/31/2015 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		245497	B. WING			08/	/06/2015
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HAVEN H	OMES OF MAPLE PLAIN				1520 WYMAN AVENUE MAPLE PLAIN, MN 55359		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	R1 all used an EZ Wa During interview on 8 maintenance director of the issues with bott broken remote on 8/3 end of the lift arm beir replace these lifts for replaced any part of t planning on replacing In review of the manu EZ Way stand Operat 3/11/09, directions we check for any damage Repair as necessary. The facilities cleaning Cleaning policy dated residents lifts will be on needed. The policy in disinfectant, wipe dow	ay stand lift for transfers. /4/15, at 4:15 p.m., the (MD) stated he was aware h lifts. "I fixed the lift with the /15 and was aware of the ng broken." They need to along time, and have he lifts and the facility was the lifts. If actures instruction, entitled: tors Instructions, revised ere given to "do a visual ed, missing or loose parts. " policy, entitled: Lift 17/21/14, indicated all cleaned weekly and as ndicated to use house ray entire lift using vn lift using a micro fiber for repairs as needed and	F	465			

Facility ID: 00950

If continuation sheet Page 16 of 16

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		00950	B. WING		08/06/2015	
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI	E. ZIP CODE	00/00/2015	
		1520 WY	MAN AVENUE			
	OMES OF MAPLE PLAIN	MAPLE	PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	
2 000	Initial Comments		2 000			
	*****ATTEN	ITION*****				
	NH LICENSING C	ORRECTION ORDER				
	144A.10, this correct pursuant to a survey found that the deficie herein are not correct not corrected shall be with a schedule of fin the Minnesota Depar Determination of whe corrected requires cor requirements of the r number and MN Rule When a rule contains comply with any of th lack of compliance. I re-inspection with an result in the assessm	ether a violation has been				
	that may result from orders provided that	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a t for non-compliance.				
	receipt of State licens the Minnesota Depar Informational Bulletin	participate in the electronic sure orders consistent with tment of Health n 14-01, available at ite.mn.us/divs/fpc/profinfo/inf licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwa Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.		

Electronically Signed

STATE FORM

6899

08/31/15

Ainnesota Departr TATEMENT OF DEFICIE ND PLAN OF CORREC	NCIES ()	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00950	B. WING		08/	06/2015
IAME OF PROVIDER OF	RSUPPLIER	STREET A	DDRESS, CITY, ST/	ATE, ZIP CODE		
IAVEN HOMES OF		1520 WY	MAN AVENUE			
		MAPLE	PLAIN, MN 5538	59		
	ACH DEFICIENCY N	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 000 Continue	ed From page 1		2 000			
Departmyou electric is necession enter the text. You State lic corrected Minnesce Minnesce Minnesce On Augu Departmenthe folloo Please is correction and ider Minnesce the State federal is assigned Nursing The assis column estatute/m "Summa and replicorrection findings after the evidence are the State FOURTH" PROVID	ent of Health of tronically. Altho sary for State S e word "corrected must then indi- ensure process on date, the da d prior to electro ta Department st 3-6, 2015, s ent's staff, visit wing correction ndicate in your in that you have tify the date whi ta Department e Licensing Cor- oftware. Tag nu to Minnesota s Homes. gned tag numb entitled "ID Pre- ule out of comp ry Statement of aces the "To Co- n order. This co- which are in vice statement, "The by." Following Suggested Meth- riod for Correcti E DISREGARD H COLUMN WHO DER'S PLAN O	aurveyors of this ed the above provider and orders are issued. electronic plan of a reviewed these orders, een they will be completed. of Health is documenting rection Orders using umbers have been state statutes/rules for er appears in the far left fix Tag." The state liance is listed in the f Deficiencies" column omply" portion of the olumn also includes the olation of the state statute is Rule is not met as the surveyors findings nod of Correction and on. THE HEADING OF THE		The assigned tag number appear far left column entitled "ID Prefit The state statute/rule out of com- listed in the "Summary Stateme Deficiencies" column and replace Comply" portion of the correction This column also includes the fit which are in violation of the state after the statement, "This Rule is as evidence by." Following the se findings are the Suggested Meth Correction and Time period for Correction and Time period for Correction PLEASE DISREGARD THE HE THE FOURTH COLUMN WHIC STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLIE FEDERAL DEFICIENCIES ONL WILL APPEAR ON EACH PAGE THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT VIOLATIONS OF MINNESOTA STATUTES/RULES.	ix Tag." npliance is nt of ces the "To n order. ndings e statute s not met surveyors hod of Correction. ADING OF H OF S TO .Y. THIS E. TO TION FOR	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY IPLETED
		00950	B. WING		08	8/06/2015
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
AVEN HO	OMES OF MAPLE PLAIN		'MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From page	2	2 000			
		IIREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.				
2 302	MN State Statute 144 or related disorder tra	.6503 Alzheimer's disease in	2 302			9/11/15
	ALZHEIMER'S DISE DISORDER TRAININ MN St. Statute 144.6	IG:				
	care staff					
	related disorders; (2) assistance with ac	Alzheimer's disease and				
	written or electronic for training program, the trained, the frequency topics covered.	ills. rovide to consumers in orm a description of the categories of employees y of training, and the basic ocument compliance with				
		t is not met as evidenced				

(EACH DEFICIENC) REGULATORY OR L	1520 WY MAPLE F ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING DDRESS, CITY, ST/ MAN AVENUE PLAIN, MN 5535 ID PREFIX TAG		08/06/2015
SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	STREET A 1520 WY MAPLE F ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	MAN AVENUE PLAIN, MN 5538 ID PREFIX	9 PROVIDER'S PLAN OF CORRECTION	
SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	MAPLE F ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PLAIN, MN 5538	PROVIDER'S PLAN OF CORRECTION	
(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		
	0		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	nd document review, the	2 302	Corrected.	
nformation regarding ementia training, inc aining program, the ained, the frequency opics covered in the lectronic form. This	of training and the basic training in a written or had the potential to affect			
indings include:				
rogram, indicated the ocumentation that id rovided a descriptior rogram, the categori	ere was no information or entified consumers were n of Alzheimer's training es of employees trained, the			
lirector of quality (DC eceive dementia trair eceive the informatio esides notifying fami	DC)-A stated, the staff ning but the families do not n. The DOC-A stated, lies we have a memory care			
OON or designee cou taff training to the resonsumer/family infor esignee could education	ld add information regarding sident admission packet for mation. The DON or ate staff and conduct audits			
IME PERIOD FOR ( 21) days.	CORRECTION: Twenty-one			
	ained, the frequency ppics covered in the lectronic form. This il residents in the faci indings include: eview of the facility's rogram, indicated the ocumentation that id rovided a description rogram, the categori equency of training a overed. uring an interview of rector of quality (DC eceive dementia train eceive the informatio esides notifying fami ing, no family educa lzheimer's training. UGGESTED METHO ON or designee could aff training to the resonsumer/family infor esignee could educa o ensure compliance	eview of the facility's Alzheimer's training rogram, indicated there was no information or boumentation that identified consumers were rovided a description of Alzheimer's training rogram, the categories of employees trained, the equency of training and the basic topics overed. uring an interview on 8/5/15, at 1:00 p.m., the rector of quality (DOC)-A stated, the staff eceive dementia training but the families do not eceive the information. The DOC-A stated, esides notifying families we have a memory care ing, no family education was provided regarding lzheimer's training. UGGESTED METHOD OF CORRECTION: The ON or designee could add information regarding raff training to the resident admission packet for onsumer/family information. The DON or esignee could educate staff and conduct audits o ensure compliance. IME PERIOD FOR CORRECTION: Twenty-one 21) days.	ained, the frequency of training and the basic opics covered in the training in a written or lectronic form. This had the potential to affect I residents in the facility. indings include: eview of the facility's Alzheimer's training rogram, indicated there was no information or ocumentation that identified consumers were rovided a description of Alzheimer's training rogram, the categories of employees trained, the equency of training and the basic topics overed. uring an interview on 8/5/15, at 1:00 p.m., the frector of quality (DOC)-A stated, the staff eccive dementia training but the families do not accive the information. The DOC-A stated, esides notifying families we have a memory care ing, no family education was provided regarding Izheimer's training. UGGESTED METHOD OF CORRECTION: The ON or designee could add information regarding iaff training to the resident admission packet for onsumer/family information. The DON or esignee could educate staff and conduct audits o ensure compliance. IME PERIOD FOR CORRECTION: Twenty-one 21) days.	ained, the frequency of training and the basic pics covered in the training in a written or lectronic form. This had the potential to affect I residents in the facility. indings include: eview of the facility's Alzheimer's training rogram, indicated there was no information or ocumentation that identified consumers were rovided a description of Alzheimer's training rogram, the categories of employees trained, the equency of training and the basic topics overed. uring an interview on 8/5/15, at 1:00 p.m., the rector of quality (DOC)-A stated, the staff secieve dementia training but the families do not coeive dementia training but the families do not coeive the information. The DOC-A stated, esides notifying families we have a memory care ing, no family education was provided regarding Izheimer's training. UGGESTED METHOD OF CORRECTION: The ON or designee could add information regarding aff training to the resident admission packet for onsumer/family information. The DON or esignee could educate staff and conduct audits e nsure compliance. IME PERIOD FOR CORRECTION: Twenty-one 11) days.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		00950	B. WING		08/06/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
HAVEN HO	OMES OF MAPLE PLAIN		MAN AVENUE PLAIN, MN 553	59	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLET
2 565	Continued From page	÷ 4	2 565		
2 565		Subp. 3 Comprehensive	2 565		9/11/15
		prehensive plan of care ersonnel involved in the			
	by: Based on observation review, the facility fail	t is not met as evidenced n, interview, and document ed to ensure care planned al care were followed for 1		Corrected.	
		eviewed for dental and who			
	Findings include:				
	7/1/15, identified R32 impairment, was able required physical assi personal hygiene. R3 7/22/15, identified R3. directed staff to, "Enc own oral cares and pa	to follow directions, but istance to complete 32's dental care plan dated 2 had missing teeth and ourage Resident [R32] to do articipate with brushing after e brushing twice daily if			
	6:57 a.m. nursing ass to use the restroom b wheelchair. NA-C laid chest/lap while she w and instructed R32 to	morning cares on 8/5/15, at istant (NA)-C assisted R32 y helping R32 transfer to her d a clean towel on R32's as seated in the wheelchair open her mouth while NA-C with toothpaste into her d R32's teeth for			

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00950					(X3) DATE SURVEY COMPLETED	
		B. WING				
			DDRESS, CITY, STATE,		30	8/06/2015
		1520 W)		,211 000E		
IAVEN HO	OMES OF MAPLE PLAIN	MAPLE	PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
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.					
	used to "ensure the re care", and staff were	8/5/15, at 10:30 a.m. )-B stated a care plan is esident is getting the proper expected to encourage R32 oral cares as directed by the				
	director of quality (DC helps to "determine s provide them", and st independence" as po	/6/15, at 9:42 a.m. the OQ)-B stated the care plan omeone's needs and how to aff should "support as much ssible with the resident ttempt to complete her own by her plan of care.				
	none was provided. A Rights Guidelines pol	g policy was requested, but A facility General Resident icy dated 11/2012, identified, to participate in care as				
	The Director of Nursin	OD OF CORRECTION: ng and/or designee could ect care staff the importance				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00950	B. WING		08/06/2015	
IAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE		
IAVEN H	OMES OF MAPLE PLAIN		'MAN AVENUE PLAIN, MN 55359			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
2 565	Continued From page	9 6	2 565			
		dualize resident care plans. rmed to ensure compliance.				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
2 900	MN Rule 4658.0525 S Ulcers	Subp. 3 Rehab - Pressure	2 900		9/11/15	
	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:					
	without pressure sore pressure sores unless condition demonstrate	s the individual's clinical				
	receives necessary t	has pressure sores reatment and services to vent infection, and prevent oping.				
	by: Based on observatior review, the facility fail assess and consisten	t is not met as evidenced n, interview, and document ed to comprehensively tly implement pressure 1 of 3 residents (R50) who e ulcer.		Corrected.		
		uum data set (MDS) dated she had moderate cognitive				

STATE FORM

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00950	B. WING		08	/06/2015
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
AVEN HO	OMES OF MAPLE PLAIN		YMAN AVENUE PLAIN, MN 55359			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	D THE APPROPRIATE	COMPLE DATE
2 900	Continued From page	e 7	2 900			
	impaired. The MDS f	urther indicated R50 had an				
	unstageable pressure	e ulcer (PU) (indicates extent				
		t cannot be assessed				
	0	annot 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					
		on cushion and mattress, and				
		lister to RT [right] Heel 5 x				
	4.2 cm Stage III note R50's Careplan, last					
		skin integrity related to				
		al neuropathy, incontinence,				
	• • •	care plan directed staff to				
		ft lower extremity at all				
		aver (foam protective device				
		to right ankle while in bed				
		acility nursing assistant care				
	· · · · · · · · · · · · · · · · · · ·	ility care plan, (undated),				
		list, identified R50 had				
	"Foam boots to Rt. [s					
	•	n 08/04/2015 at 2:34 p.m.,				
		er wheelchair in the activity m boot on her right foot,				
		the foot pedal. R50's left				
		th sock was resting on the				
	floor.					
		n 08/05/2015, at 6:57				
		ed morning cares for R50				
	and the foam boot wa	as on R50's left foot. NA-E				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00050	B. WING		08/06/2015		
	F PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		08	/06/2015			
		1520 W)	MAN AVENUE	,			
AVEN HO	OMES OF MAPLE PLAIN	MAPLE	PLAIN, MN 55359				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE	
2 900	Continued From page 8 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 rehababilitation 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.		2 900				
	DOQ-B stated that R heel and the foam bo right foot. DOQ-B stat	8/05/2015, at 8:09 a.m., 50's wound was on her right ot should be placed on her ted that she would educate 50's assignment and care rect.					
	dated 07/15/2015, inc resident has a stage 2 heel progressive he round with .4 cm dep right foot when up an	Nursing Progress Note dicated "Wound review, 2 pressure ulcer on her right ealing and is currently 1 cm th Wears foam boot to d Derma-saver circle vent pressure to the wound					
	licensed practical nur nurse (RN)-C provide LPN-A described R50	n 08/05/2015 at 2:13 p.m. se (LPN)-A and registered d wound care for R50. J's pressure ulcer as 1 cm x ea surrounding wound					

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00950					(X3) DATE SURVEY COMPLETED	
			B. WING			
AME OF PE	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,		08	/06/2015
		1520 W)	MAN AVENUE			
		MAPLE	PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET 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).					
	foam boot was not im plan of care to prever and promote healing.	e ulcer on her right heel, the pplemented according to the nt further skin breakdown Furthermore, the facility has ssed R50 pressure ulcer current status of the				
	Documentation review "The Care Plan for SI and revised based or	ed: Elim Care Pressure Ulcer wed June 2014 indicated: kin Integrity is to be reviewed a treatment and needs of the urse Aide assignment sheet				
	The Director of Nursin review interventions f	OD OF CORRECTION: ng and/or Designee could for pressure ulcer prevention e that the interventions are pplied.				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION (A	X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER	00950 STREET A	DDRESS, CITY, STA	I	08/06/2015	
		1520 WY				
IAVEN HO	OMES OF MAPLE PLAIN	MAPLE	PLAIN, MN 5535	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
21426	Continued From page	e 10	21426			
21426	21426 MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control		21426		9/11/15	
	current tuberculosis in issued by the United S Control and Preventio Tuberculosis Eliminat Morbidity and Mortalit This program must in infection control plan unpaid employees, co residents, and volunte Health shall provide to regarding implementa	ram according to the most infection control guidelines States Centers for Disease on (CDC), Division of ion, as published in CDC's ry Weekly Report (MMWR). clude a tuberculosis that covers all paid and ontractors, students, eers. The Department of echnical assistance ation of the guidelines. ce with this subdivision must				
	by: Based on interview an facility failed to ensure tuberculin skin test (T 5 residents (R49, R57	ST) was completed for 3 of 7, R12) and 2 of 5		Audit was completed on all employees and residents. Any employee who is missing compone of their TB screening are completing a		
		A-H) reviewed for vention and management.		new 2-step process. Any resident who is missing components of their TB screeni are completing a new 2-step process.		
	Findings include: RESIDENTS:			Initiated a new protocol to ensure residents compliance which includes us electronic records for TB screening	ing	
	R49's Baseline TB Sc			documentation. Weekly audits 4x to ensure compliance.		

Minnesota Departm STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00950	B. WING		08	/06/2015
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
AVEN HO	OMES OF MAPLE PLAIN		YMAN AVENUE 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21426	Continued From page	e 11	21426			
	recorded results for t	5/15. The space identified to				
	identified R49 receive 6/15/15, however the flowsheet to record th numerous "X" markin	wsheet dated June 2015, ed the 2nd step TST on e space identified on the he results was filled in with ngs and did not identify a result, nor any millimeters of				
	induration left by the R57's Baseline TB S dated 7/19/15, identit recorded results for t	test to determine a result. creening for Residents form fied R57 did not have any he 2nd step TST 9/15. The space identified to				
	identified R57 receive 7/19/15, however the flowsheet to record th numerous "X" markin positive or negative r	wsheet dated July 2015, ed the 2nd step TST on e space identified on the he results was filled in with hgs and did not identify a result, nor any millimeters of test to determine a result.				
	dated 7/6/15, identified recorded results for t	15. The space identified to				
	identified R12 receive 7/6/15, however the s flowsheet to record th numerous "X" markin positive or negative r	wsheet dated July 2015, ed the 2nd step TST on space identified on the he results was filled in with ngs and did not identify a result, nor any millimeters of test to determine a result.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00950	B. WING		08	08/06/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE			
HAVEN HO	OMES OF MAPLE PLAIN		MAN AVENUE PLAIN, MN 55359				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21426	Continued From page	e 12	21426				
	EMPLOYEES:						
	dated 6/18/15, identif step TST completed. administration and re NA-H Baseline TB So Workers (HCWs) forr NA-H did not have a	Care Workers (HCWs) form ied NA-G did not have a 2nd The space to record the sult of the test was blank. creening for Health Care n dated 7/10/15, identified 2nd step TST completed. the administration and result					
	of quality (DOQ)-A st better tracking syster TST's were being cor	8/6/15, at 1:03 p.m. director ated the facility needed "a n" to ensure the 2nd step mpleted. Residents and a two step TST completed, ors "got missed."					
	HCW's must receive test." In addition, the	evention and Control I 2/20/09, identified, "All a two-step tuberculin skin policy identified, "All ve baseline TB screening					
21545	MN Rule 4658.1320	A.B.C Medication Errors	21545			9/11/15	
	percent as described Guidelines for Code of 42, section 483.25 (m the State Operations	error rate is less than five in the Interpretive of Federal Regulations, title n), found in Appendix P of					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		00950	B. WING		08/06/20	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
IAVEN HO	OMES OF MAPLE PLAIN		MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From page	e 13	21545			
	purposes of this part, (1) a discrepand prescribed and what administered to resid (2) the administr medications. B. It is free of an error. A significant m (1) an error wh discomfort or jeopard safety; or (2) medication requires the medicati be titrated to a specif medication error coul precipitate a reoccurr toxicity. All medication prescribed. An incide error report must be fi that occurs. Any sign resident reactions mu physician or the phys resident or the reside designated represent must be made in the C. All medication prescribed. An incide report must be filed for occurs. Any significat resident reactions mu physician or the phys resident reactions mu physician or the phys resident reactions mu physician or the phys resident reactions mu	y significant medication nedication error is: nich causes the resident lizes the resident's health or n from a category that usually on in the resident's blood to ic blood level and a single d alter that level and rence of symptoms or ns are administered as lent report or medication filed for any medication error nificant medication errors or ust be reported to the sician's designee and the ent's legal guardian or tative and an explanation resident's clinical record. as are administered as ent report or medication error to any medication error that ant medication errors or				
	This MN Requiremer	nt is not met as evidenced				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00950	B. WING		08/06/2015	
NAME OF PF	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE		
HAVEN HO	OMES OF MAPLE PLAIN		(MAN AVENUE PLAIN, MN 5535	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From page	e 14	21545			
		of 9 residents (R3) survey medication hich resulted in 11%		Corrected.		
	Findings include:					
		Im Data Set (MDS) dated moderately cognitively				
	08/03/2015 at 5:54 p. (LPN)- B prepared main included multivitamin one capsule (stool so vitamin D3 1000 units in a clear plastic cup. R31, whose medication administration) and pl R3, along with a glass hand on cup to take the took R31's medication prior to ingestion of R identified these were for R3's and immedia medications. LPN-B p medication which was During interview on 0	brepared the correct s then administered to R31. 8/03/2015 at 6:00 p.m.				
	medications to R3. In an interview on 08/ Director of Quality (D	05/2015 at 01:35 p.m. the OQ)-A stated there has cerns about any medicaiton				

STATE FORM

	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00950	B. WING		08	3/06/2015
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
IAVEN H	OMES OF MAPLE PLAIN		'MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
21545	e e number i renn page	e 15 idual, "we have done written	21545			
	Dose Preparation and policy, (last reviewed "Facility staff should: medication is adminis medication, at the cor	s policy, entitled: General d Medication Administration 01/01/2013), indicated that Verify each time a stered that it is the correct rrect dose, at the correct ate, at the correct time, for				
	The Director of Nursin inservice staff assigned	these were being				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
21685	MN Rule 4658.1415 S Housekeeping, Opera		21685			9/11/15
	including walls, floors systems, and equipm continuous state of go with regard to the hea	ood repair and operation alth, comfort, safety, and dents according to a written				
	This MN Requiremen	t is not met as evidenced				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00950	B. WING		08/06/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	• • •	
HAVEN HO	OMES OF MAPLE PLAIN					
			PLAIN, MN 55359	PROVIDER'S PLAN OF CORF		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE
21685	Continued From page	e 16	21685			
	review, the facility fail mechanical lifts were proper working order south) which had the residents (R23, R18, in the east and south mechanical lifts. Findings include: During the initial tour 08/03/15 at 1:15 p.m. Stander, (a device us was in the hallway with on the lift stand. The leaving an approximal plastic remote casing	R57, R62 and R1) residing wing who utilized the		Corrected.		
	the hallway that had p a U fork. The right arr end that was cracked plastic end was cover that was coming off, e which faced any resid mechanical lift. During observation or nursing assistant (NA	. an EZ Way Stander was in badded lift arms shaped like m, had a plastic cover on the with jagged edges. The red with black electrical tape exposing the jagged edges, lent who used the n 8/03/15, at 3:25 p.m., .)-J was transferring R23				
	case taped together. "the remote itself is fa	d lift that had the remote During interview NA-J stated alling apart, the buttons do stated the remote has been weeks.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00950	B. WING		08/06/2015	
NAME OF PR	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
IAVEN HO	OMES OF MAPLE PLAIN		(MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
21685	List Sheet (nursing as undated, identified that R1 all used an EZ Wat During interview on 8/3 maintenance director of the issues with both broken remote on 8/3 end of the lift arm bein replace these lifts for replaced any part of the planning on replacing In review of the manu EZ Way stand Operate 3/11/09, directions we check for any damage Repair as necessary. <sup>17</sup> The facilities cleaning Cleaning policy dated residents lifts will be on needed. The policy in disinfectant, wipe dow cloth, check entire lift to report repairs to mat SUGGESTED METHE The Administrator and the facility's processe maintenance and inse	a assistant South and East assistant care sheet), at R23, R18, R57,R62 and ay stand lift for transfers. /4/15, at 4:15 p.m., the (MD) stated he was aware h lifts. "I fixed the lift with the /15 and was aware of the ng broken." They need to along time, and have he lifts and the facility was the lifts. factures instruction, entitled: tors Instructions, revised are given to "do a visual ed, missing or loose parts." " policy, entitled: Lift 17/21/14, indicated all cleaned weekly and as ndicated to use house ray entire lift using vn lift using a micro fiber for repairs as needed and aintenance staff. OD OF CORRECTION: d/or designee could review s for preventative ervice responsible staff. system to consistently nce/cleanliness of	21685			

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SURVEY COMPLETED
		00950	B. WING		08/06/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE	
HAVEN H	OMES OF MAPLE PLAIN		YMAN AVENUE PLAIN, MN 553	59	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21685	Continued From page	: 18	21685		
	(21) days.				
21805	MN St. Statute 144.68 Residents of HC Fac.		21805		9/11/15
	residents have the rig courtesy and respect	treatment. Patients and ht to be treated with for their individuality by ons providing service in a			
	by: Based on observation review, the facility fail dining experience for R42, R52) with cognit not served their meals 1 of 1 residents (R18)	t is not met as evidenced n, interview, and document ed to ensure a dignified 4 of 4 residents (R32, R33, vive impairment who were is in a timely manner, and for with cognitive impairment in eating by staff while they		Corrected.	
	Findings include:				
	LACK OF TIMELY ME	EAL SERVICE:			
	7/1/15, identified R32 impairment, and requivith eating. R33's qui identified R33 had se and required limited a R42's significant char identified R42 had bo memory impairments, assistance with eating	ired extensive assistance arterly MDS dated 6/3/15, evere cognitive impairment, assistance with eating. age MDS dated 6/29/15, th long and short term , and required extensive g. R52's annual MDS dated had both long and short			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00950	B. WING		08	8/06/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	1	
HAVEN HO	OMES OF MAPLE PLAIN		MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
TAG 21805	Continued From page dependent on staff fo During observation of the North Wing dining p.m., R32, R33, R42, same table in the mid 6:05 p.m. dietary aide a mobile cart into the contained pre-plated drinks to each resider 6:16 p.m. DA-A and D plated food to the three residents where R32, not seated. At 6:19 p served to the table wi but the rest of the din with the residents eat assistant (NA)-A was helping other resident providing cues to help stood by the mobile of shouted aloud across had "just that middle continued waiting by DA-A, or DA-B did no assistance to R32, R3 continued to sit and w p.m. (9 minutes after R42, and R52 still har meals. During this tir were made of R32 ar	e 19 r eating. f the evening supper meal in g room on 8/3/15, at 6:03 and R52 were seated at the ddle of the dining room. At e (DA)-A and DA-B wheeled dining room which food and began to pass at in the dining room. At DA-B began serving the se other tables with R33, R42, and R52 were o.m. no food had been th R32, R33, R42, and R52 ing room had been served ing their meals. Nursing seated at a different table ts cut up their food and to them eat. DA-A and DA-B art with the plated food and the dining room to NA-A they table left" to serve, and the mobile cart. The NA-A, t offer or provide any	21805			
	at the bare table in from minutes after serving					

	a Department of Healt of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00950	B. WING		08	8/06/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE, 2	ZIP CODE	• • •	
HAVEN H	OMES OF MAPLE PLAIN		MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	stated dietary staff wa R42, and R52 until ac present because they choking on their food meal service for R32, me feel bad" because served and they have During interview on 8 stated R32, R33, R42 assistance with eating if someone isn't seate supper meal observe only one NA available and she couldn't be a R33, R42, and R52 h before being served.	8/3/15, at 6:45 p.m. DA-A aited to serve R32, R33, dditional NA's staff are y have a higher risk of . Further, DA-A stated the , R33, R42, and R52 "makes e "everybody is getting to wait."	21805			
	When interviewed on director of quality (DC and R52 were to be s caregivers down ther assistance to eat. Th create a "homelike fa all the residents so as and the staff should h residents could be se STANDING WHILE F R18's quarterly Minim 6/17/15, indicated R1	the staff are expected to shion" dining experience for s to "eat at the same time", have gotten more help so all erved and assisted promptly. EEDING: hum Data Set (MDS) dated 8 had moderate cognitive upper extremity impairment				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00950	B. WING		08	/06/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		100/2013
HAVEN H	OMES OF MAPLE PLAIN		MAN AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX     (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIENCY		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
21805	Continued From page During an observation R18 was seated at a two other residents an NA-D was seated opp and was assisting the eating. At 6:22 p.m., the other two residents where she stood over until 6:25 p.m., then s table and continued a residents. At 6:31 p. and walked over to R while standing over to poposoite side of the residents to finish the stood up from the tab to help him eat, stand helping him eat until 6 During an interview o director of quality (DC members should have at R18's table to eat. have been standing u "I would expect them SUGGESTED METH The Director of Nursin review dining room se inregards to resident	e 21 n on 8/3/15, at 6:14 p.m. table in the dining room with nd nursing assitant (NA)-D. posite the table from R18, e two other residents with NA-D stood up from helping ts and walked over to R18 r him and assisted him to eat sat back down across the assisting the other two m., NA-D stood up again 18 and assisted him to eat im before returning to the table to assist the other two ir meal. At 6:35 p.m., NA-D le and walked over to R18 ting over him while while 5:39 p.m n 8/6/15, at 12:52 p.m. the DQ)-A stated two staff e been helping the residents Further, NA-D should not up while helping R18 to eat,	21805	DEFICIE		

DEPART CENTER	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ICES F5	4970	24	FORM	08/14/2015 1 APPROVED 2. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1 · ·	PLE CONSTRUCTION	(X3) DATE S COMPLE	
		245497		B. WING		08/0	5/2015
				RESS, CITY, S Y <b>MAN AVE</b>	TATE, ZIP CODE		
	IOMES OF MAPLE	PLAIN		PLAIN, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000			1
	FIRE SAFETY						
	Minnesota Departm Marshal Division on of this survey, Have found in compliance participation in Med Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	n Homes of Maple F with the requirement icare/Medicaid at 42 Life Safety from Fire onal Fire Protection	Fire t the time Plain was nts for CFR, , and the Safety				
	Haven Homes of Ma with no basement. T at 2 different times. constructed in 1967 Type II(000) constru- was constructed to the determined to be of Because the original meet the construction buildings, the facility building.	The building was con The original building and was determined action. In 1999, an ac the southeast and w Type II(000) constru I building and the 1 a on type allowed for e	istructed was d to be of ddition as action. addition xisting				
	The building has a c sprinkler system. Th system that consists corridors and areas monitored for fire de facility has a capacit 43 at the time of the	ne facility has a fire a s of smoke detection open to the corridor partment notification by of 52 and had a co	llarm in the s that is n. The				
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESE	NTATIVE'S SIGI		TITLE		(X6) DATE

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

	MENT OF HEALTH					FORM	08/14/2015 APPROVED . 0938-0391
STATEMEN		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	JRVEY
		245497		B. WING		08/0	5/2015
1	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
HAVEN	HOMES OF MAPLE	PLAIN		YMAN AVE Plain, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000		age 1 42 CFR, Subpart 48	3.70(a) is	K 000	DEFICIENCY)		
						If agotinuation a	

FORM CMS-2567(02-99) Previous Versions Obsolete



Protecting, Maintaining and Improving the Health of Minnesotans

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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Haven Homes Of Maple Plain August 20, 2015 Page 2

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,

ate Comston

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
				BUILDING:		
		00950	B. WING		08/06/2015	
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
AVEN HO	OMES OF MAPLE PLAIN		(MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	
2 000	Initial Comments		2 000			
	*****ATTENTION******					
	NH LICENSING CORRECTION ORDER					
	144A.10, this correcti pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fin the Minnesota Depart	innesota Statute, section on order has been issued If, upon reinspection, it is ney or deficiencies cited ted, a fine for each violation e assessed in accordance es promulgated by rule of tment of Health.				
	corrected requires co requirements of the re number and MN Rule When a rule contains comply with any of the lack of compliance. Le re-inspection with any result in the assessm					
	that may result from r orders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.				
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electronic sure orders consistent with tment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/inf licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwa Tag numbers have been assigned to Minnesota state statutes/rules for Nurs Homes.		

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00950	B. WING		08/06/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
HAVEN H	OMES OF MAPLE PLAIN		MAN AVENUE PLAIN, MN 5538	59		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE	
2 000	Continued From page	e 1	2 000			
	you electronically. Al is necessary for State enter the word "corre- text. You must then in State licensure proce completion date, the corrected prior to elec Minnesota Department On August 3-6, 2015 Department's staff, vi the following correction Please indicate in you correction that you has and identify the date Minnesota Department the State Licensing C federal software. Tag assigned to Minnesot Nursing Homes. The assigned tag nur column entitled "ID F statute/rule out of cor "Summary Statement and replaces the "To correction order. This findings which are in after the statement, " evidence by." Followi are the Suggested Ma Time period for Corre PLEASE DISREGAR FOURTH COLUMN V "PROVIDER'S PLAN	<ul> <li>b. surveyors of this</li> <li>sited the above provider and on orders are issued.</li> <li>ar electronic plan of ave reviewed these orders, when they will be completed.</li> <li>ant of Health is documenting</li> <li>correction Orders using numbers have been the state statutes/rules for</li> <li>a state statutes/rules for</li> <li>ber appears in the far left</li> <li>Prefix Tag." The state mpliance is listed in the to f Deficiencies" column Comply" portion of the scolumn also includes the violation of the state statute This Rule is not met as ng the surveyors findings ethod of Correction and the tot.</li> <li>D THE HEADING OF THE WHICH STATES, OF CORRECTION." THIS CAL DEFICIENCIES ONLY.</li> </ul>		The assigned tag number appears far left column entitled "ID Prefix Ta The state statute/rule out of compla listed in the "Summary Statement of Deficiencies" column and replaces Comply" portion of the correction on This column also includes the findir which are in violation of the state st after the statement, "This Rule is no as evidence by." Following the surv findings are the Suggested Method Correction and Time period for Com PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY." WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTIO VIOLATIONS OF MINNESOTA STA STATUTES/RULES.	ag." ance is f the "To der. ngs atute ot met eyors of rection. NG OF	

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00950	B. WING		08/06/2015	
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
AVEN HO	OMES OF MAPLE PLAIN		'MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From page	2	2 000			
		IREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.				
2 302	MN State Statute 144 or related disorder tra	.6503 Alzheimer's disease in	2 302			
	ALZHEIMER'S DISEA DISORDER TRAININ MN St. Statute 144.65	G:				
	care staff					
( ( ( ( ( ( ( ( ( ( )	related disorders; (2) assistance with ac (3) problem solving w and	Alzheimer's disease and tivities of daily living; ith challenging behaviors;				
	written or electronic for training program, the trained, the frequency topics covered.	ills. rovide to consumers in orm a description of the categories of employees v of training, and the basic ocument compliance with				
	This MN Requiremen by:	t is not met as evidenced				

STATE FORM

		IDENTIFICATION NUMBER:	COVIDER/SUPPLIER/CLIA         (X2) MULTIPLE CONSTRUCTION           ENTIFICATION NUMBER:         A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		00950			08	/06/2015
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, YMAN AVENUE	ZIP CODE		
AVEN HO	OMES OF MAPLE PLAIN	N	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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
2 302	Continued From pag	e 3	2 302			
<ul> <li>2 302 Continued From page 3 Based on interview and document review, the facility failed to ensure consumers were proviiinformation regarding Alzheimer's disease an dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basis topics covered in the training in a written or electronic form. This had the potential to affer all residents in the facility.</li> <li>Findings include: Review of the facility's Alzheimer's training program, indicated there was no information of documentation that identified consumers were provided a description of Alzheimer's training program, the categories of employees trained frequency of training and the basic topics covered.</li> <li>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 a receive the information. The DOC-A stated, besides notifying families we have a memory wing, no family education was provided regar Alzheimer's training.</li> <li>SUGGESTED METHOD OF CORRECTION: DON or designee could add information regard staff training to the resident admission packet consumer/family information. The DON or designee could educate staff and conduct aud to ensure compliance.</li> <li>TIME PERIOD FOR CORRECTION: Twenty-(21) days.</li> </ul>	re consumers were provided g Alzheimer's disease and cluding a description of the e categories of employees by of training and the basic e training in a written or s had the potential to affect acility. T's Alzheimer's training here was no information or dentified consumers were on of Alzheimer's training ries of employees trained, the					
	director of quality (Du receive dementia tra receive the informati besides notifying fan wing, no family educ	OC)-A stated, the staff ining but the families do not on. The DOC-A stated, nilies we have a memory care				
	DON or designee co staff training to the re consumer/family info designee could educ	uld add information regarding esident admission packet for ormation. The DON or eate staff and conduct audits				
		CORRECTION: Twenty-one				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		00950			08	/06/2015
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, <b>YMAN AVENUE</b>	ZIP CODE		
AVEN HO	OMES OF MAPLE PLAIN	N	PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 565	Continued From pag	e 4	2 565			
2 565	MN Rule 4658.0405 Plan of Care; Use	Subp. 3 Comprehensive	2 565			
- - - - - - - - - - - - - - - - - - -	Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.					
	by: Based on observatio review, the facility fai interventions for den	nt is not met as evidenced n, interview, and document iled to ensure care planned tal care were followed for 1 reviewed for dental and who				
	Findings include:					
	7/1/15, identified R32 impairment, was able required physical ass personal hygiene. R 7/22/15, identified R3 directed staff to, "En- own oral cares and p	32's dental care plan dated 32 had missing teeth and courage Resident [R32] to do participate with brushing after the brushing twice daily if				
	6:57 a.m. nursing as to use the restroom b wheelchair. NA-C la chest/lap while she v and instructed R32 to					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00950	B. WING		08/06/2015	
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	1 00	00/2013
	OMES OF MAPLE PLAIN	1520 WY	MAN AVENUE			
		MAPLE	PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From page	e 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.					
	stated R32 had been time", and R32's care "help brush her teeth.	8/5/15, at 10:08 a.m. NA-C missing teeth for "a long plan just required staff to "Further, NA-C stated she al 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.					
	director of quality (DC helps to "determine s provide them", and st independence" as po	/6/15, at 9:42 a.m. the DQ)-B stated the care plan omeone's needs and how to aff should "support as much ssible with the resident attempt to complete her own by her plan of care.				
	none was provided. A Rights Guidelines pol	g policy was requested, but A facility General Resident licy dated 11/2012, identified, to participate in care as				
	The Director of Nursi	OD OF CORRECTION: ng and/or designee could ect care staff the importance				

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00950	B. WING		08	/06/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
HAVEN HO	OMES OF MAPLE PLAIN					
	SUMMARY ST		PLAIN, MN 55359	PROVIDER'S PLAN O	E CORRECTION	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From page	9 6	2 565			
		dualize resident care plans. rmed to ensure compliance.				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
2 900	MN Rule 4658.0525 S Ulcers	Subp. 3 Rehab - Pressure	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:					
	without pressure sore pressure sores unless condition demonstrate	s the individual's clinical				
	receives necessary t	<ul> <li>b has pressure sores</li> <li>reatment and services to</li> <li>vent infection, and prevent</li> <li>oping.</li> </ul>				
	by: Based on observatior review, the facility fail assess and consisten	t is not met as evidenced n, interview, and document ed to comprehensively tly implement pressure 1 of 3 residents (R50) who re ulcer.				
		num data set (MDS) dated she had moderate cognitive				

Minnesota Department of Health STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00950	B. WING		08	/06/2015
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
AVEN HO	OMES OF MAPLE PLAIN		(MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A		TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 900	Continued From page	e 7	2 900			
	impaired. The MDS fr unstageable pressure of tissue involvement because the edges c on her right heel. The 4 centimeter (cm) x 2 indicated, the skin tis (which is a dry scab of R50's quarterly MDS R50 had one stage 3 thickness skin loss), 0.5 cm with a depth of indicated the most se granulation tissue (ne growth). The Care A Pressure Ulcers, date R50 was at risk for lo pressure redistributio R50 had, "Popped BI 4.2 cm Stage III note R50's Careplan, last identified alteration in diagnosis of peripher and immobility. The of apply foam boot to le times, with Derma Sa to alleviate pressure) only. Review of the f sheet, part of the faci entitled: List 3 Work I "Foam boots to Rt. [s During observation o R50 was seated in he room. R50 had a foat which was resting on foot, was covered wit floor. During observation o	urther indicated R50 had an e ulcer (PU) (indicates extent c cannot be assessed annot not clearly be seen) e MDS identified the PU was 2.5 cm with no depth sue denoted as eschar or slough tissue). , dated 05/20/2015, identified pressure ulcer, (full which measured 1.2 cm x of 2.0 cm. The MDS evere tissue type was ew connective tissue Area Assessment (CAA) for ed 12/05/2014, indicated uss of skin integrity, utilized a on cushion and mattress, and lister to RT [right] Heel 5 x d by staff". updated 07/17/2015, n skin integrity related to ral neuropathy, incontinence, care plan directed staff to ft lower extremity at all aver (foam protective device to right ankle while in bed facility nursing assistant care lity care plan, (undated), ist, identified R50 had				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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		00950			08	/06/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
AVEN HO	OMES OF MAPLE PLAIN		PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From page	8	2 900			
	2 900 Continued From page 8 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 rehababilitation 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.					
	DOQ-B stated that R heel and the foam bo right foot. DOQ-B stat	8/05/2015, at 8:09 a.m., :50's wound was on her right ot should be placed on her ted that she would educate 50's assignment and care rrect.				
	dated 07/15/2015, inc resident has a stage 2 heel progressive he round with .4 cm dep right foot when up an	Nursing Progress Note dicated "Wound review, 2 pressure ulcer on her right ealing and is currently 1 cm th Wears foam boot to d Derma-saver circle vent pressure to the wound				
	licensed practical nur nurse (RN)-C provide LPN-A described R50	n 08/05/2015 at 2:13 p.m. se (LPN)-A and registered ed wound care for R50. 0's pressure ulcer as 1 cm x ea surrounding wound				

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		N (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00950	B. WING			000/0045
IAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	00	8/06/2015
IAVEN H	OMES OF MAPLE PLAIN		MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 900	opening) 1 cm white a measuring 1 cm in wi During interview at 08 DOQ-A, stated that R have remained as una II as identified in the 7 DOQ-A stated, they a pressure ulcers (stagi pressure ulcers). Although R50 was ide unstageable pressure foam boot was not im plan of care to prever and promote healing. not consistently asses staging to ensure the unstaged pressure ulcers staging to ensure the unstaged pressure ulcers A facility policy, entitle Documentation review "The Care Plan for Sk and revised based on resident." "Update N as needed." SUGGESTED METH The Director of Nursin review interventions f and healing, to assure appropriately being a	and moist, the widest area dth on edges. 3/05/2015, at 2:25 p.m. at, 2:50's pressure ulcer "should stageable", and not a stage 7/15/2015 progress notes. are not to backstage ing of a granulating healing entified as having an a ulcer on her right heel, the plemented according to the at further skin breakdown Furthermore, the facility has ssed R50 pressure ulcer current status of the cer. ed: Elim Care Pressure Ulcer wed June 2014 indicated: kin Integrity is to be reviewed a treatment and needs of the urse Aide assignment sheet OD OF CORRECTION: ng and/or Designee could for pressure ulcer prevention e that the interventions are	2 900	DEFICIE	NCY)	

00950     B. WING     08/06/201       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     08/06/201       HAVEN HOMES OF MAPLE PLAIN     1520 WYMAN AVENUE MAPLE PLAIN, MN 55359     1520 WYMAN AVENUE       (X4) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL     ID PREFIX     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE     COM		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
WHE OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       1520 WYMAN AVENUE MAPLE PLAIN, MN 55359       0410 PFEITIN TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MAST BE PRECIEDED BY FULL RECOULTORY OR LISC IDENTIFYING INFORMATION)     PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MAST BE PRECIEDED BY FULL RECOULTORY OR LISC IDENTIFYING INFORMATION)     PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MAST BE PRECIEDED BY FULL RECOULTORY OR LISC IDENTIFYING INFORMATION)     PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY)     CONTINUED (EACH DEPICIENCY)     PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY)     CONTINUED (EACH DEPICIENC			00950	B. WING		00/00/00	
MAPLE PLAIN       MAPLE PLAIN, MN 55359       CMUID TVG     SUMMARY STATEMENT OF DEFICIENCIES RECULATION VISI TE RECEDED BY FULL RECULATION VISIT ER RECEDED BY FULL RECULATION OR LSC DENTIFYING INFORMATION)     PROVIDENTS FLAN OF CORRECTION RECULATION VISIT ER RECEDED BY FULL RECULATION VISIT EN RECULATION VISIT ER RECEDED BY RECULATION ON LEVER VISIT EN RECEDED BY FULL RECULATION VISIT EN RECULATION VISIT ER RECEDED BY RECULATION VISIT EN RECULATION VISIT ER RECEDED BY RECULATION VISIT EN RECULATION VISIT EN RECULATION VISIT EN RECEDED BY RECULATION VISIT EN RECULATION VISIT EN RECULATION VISIT EN RECULATION VISIT EN RECULATION VISIT ON THE AS EVIDENCES IN Based on interview and document review the facility field Consure are equired two step tuberculins kin test (TST) was completed for 3 of S residents (R48, R57, R712) and 2 of 5 employees (NA-G, NA-H) reviewed for tuberculins (TB) prevention and management.	NAME OF PF	ROVIDER OR SUPPLIER				00	/00/2015
DAIL PRETX TAG         SUMMARY STATEMENT OF DEFICENCIES (EACH CORRECTIVE APPRICIPATION)         D PRETX TAG         PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE APPRICIPATION)         CON (EACH CORRECTIVE APPRICIPATION)           21426         Continued From page 10         21426         21426           21428         MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control         21426         21426           (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control pagma coording 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 tuberculosis in test (TST) was completed for 3 of 5 residents (R48, R57, R12) and 2 of 5 employees (NA-G, NA-H) reviewed for tuberculosis (TB) prevention and management.         This MIN requirement and management.	HAVEN HO	OMES OF MAPLE PLAIN					
21426       NN St. Statute 144A.04 Subd. 3 Tuberculosis       21426         (a) A nursing home provider must establish and maintain a comprehensive tuberculosis       21426         (a) A nursing home provider must establish and maintain a comprehensive tuberculosis       21426         (a) A nursing home provider must establish and maintain a comprehensive tuberculosis       21426         (a) A nursing home provider must establish and maintain a comprehensive tuberculosis       21426         (a) A nursing home provider must establish and maintain a comprehensive tuberculosis       21426         (b) Tuberculosis linetcino control guidelines       21426         (c) 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 tuberculosis (TB) reversion and management.       Set employees (NA-G, NA-H) reviewed for tuberculosis (TB) prevention and management.	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control gragma 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 guidelines, infection control guidelines, 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 tuberculosis (TB) was completed for 3 of 5 residents (TA9, R57, R12) and 2 of 5 employees (NA-G, NA-H) reviewed for tuberculosis (TB) prevention and management.	21426	Continued From page	e 10	21426			
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.	21426 MN St. Statute 144A.04 Subd. 3 Tubero			21426			
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.		infection control prog current tuberculosis in issued by the United Control and Prevention Tuberculosis Eliminat Morbidity and Mortali This program must in infection control plan unpaid employees, con residents, and volunt Health shall provide the regarding implementation (b) Written compliant	ram according to the most nfection control guidelines States Centers for Disease on (CDC), Division of tion, as published in CDC's ty Weekly Report (MMWR). Include a tuberculosis that covers all paid and ontractors, students, eers. The Department of rechnical assistance ation of the guidelines.				
Findings include:		by: Based on interview a facility failed to ensur tuberculin skin test (T 5 residents (R49, R5 employees (NA-G, N	nd document review the re a required two step TST) was completed for 3 of 7, R12) and 2 of 5 A-H) reviewed for				
RESIDENTS:		-					
R49's Baseline TB Screening for Residents form							

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00950	ADDRESS, CITY, STATE,		08	/06/2015
		1520 W				
AVEN HO	DMES OF MAPLE PLAIN		PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE
21426	Continued From page	e 11	21426			
	recorded results for t administered on 6/15 record the results wa	i/15. The space identified to s left blank.				
	identified R49 receive 6/15/15, however the flowsheet to record the numerous "X" markin positive or negative r	wsheet dated June 2015, ed the 2nd step TST on e space identified on the ne results was filled in with ogs and did not identify a esult, nor any millimeters of test to determine a result.				
	dated 7/19/15, identifind recorded results for t	/15. The space identified to				
	identified R57 receive 7/19/15, however the flowsheet to record the numerous "X" markin positive or negative r	wsheet dated July 2015, ed the 2nd step TST on e space identified on the ne results was filled in with ngs and did not identify a esult, nor any millimeters of test to determine a result.				
	dated 7/6/15, identified recorded results for t	15. The space identified to				
	identified R12 receive 7/6/15, however the s flowsheet to record th numerous "X" markin positive or negative r	wsheet dated July 2015, ed the 2nd step TST on space identified on the ne results was filled in with ngs and did not identify a esult, nor any millimeters of test to determine a result.				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00950	B. WING		08/06/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
HAVEN HO	OMES OF MAPLE PLAIN		MAN AVENUE PLAIN, MN 55359			
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE
21426	Continued From page	e 12	21426			
	EMPLOYEES:					
	dated 6/18/15, identif step TST completed.	A)-G's Baseline TB Care Workers (HCWs) form ied NA-G did not have a 2nd The space to record the sult of the test was blank.				
	Workers (HCWs) forr NA-H did not have a	creening for Health Care n dated 7/10/15, identified 2nd step TST completed. the administration and result				
	of quality (DOQ)-A st better tracking syster TST's were being cor	8/6/15, at 1:03 p.m. director ated the facility needed "a n" to ensure the 2nd step mpleted. Residents and a two step TST completed, ors "got missed."				
	HCW's must receive test." In addition, the	evention and Control I 2/20/09, identified, "All a two-step tuberculin skin policy identified, "All re baseline TB screening				
21545	MN Rule 4658.1320	A.B.C Medication Errors	21545			
	percent as described Guidelines for Code of 42, section 483.25 (m the State Operations	error rate is less than five in the Interpretive of Federal Regulations, title n), found in Appendix P of				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
IAVEN HO	OMES OF MAPLE PLAIN		'MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From page	e 13	21545			
	purposes of this part, (1) a discrepand prescribed and what administered to resid (2) the administr medications. B. It is free of an error. A significant m (1) an error wh discomfort or jeopard safety; or (2) medication requires the medicati be titrated to a specif medication error coul precipitate a reoccurr toxicity. All medicatio prescribed. An incid error report must be f that occurs. Any sign resident reactions mu physician or the phys resident or the reside designated represent must be made in the C. All medication prescribed. An incide report must be filed for occurs. Any significar resident reactions mu physician or the phys resident reactions mu physician or the phys resident reactions mu	y significant medication hedication error is: hich causes the resident lizes the resident's health or from a category that usually on in the resident's blood to ic blood level and a single d alter that level and rence of symptoms or ns are administered as ent report or medication filed for any medication error hificant medication errors or ust be reported to the bician's designee and the ent's legal guardian or tative and an explanation resident's clinical record. Is are administered as ent report or medication error bis are administered as ent report or medication error tative and an explanation resident's clinical record.				
	This MN Requiremer	it is not met as evidenced				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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		00950	B. WING		80	/06/2015
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
AVEN HO	OMES OF MAPLE PLAIN		'MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From page	e 14	21545			
		of 9 residents (R3) survey medication /hich resulted in 11%				
		um Data Set (MDS) dated moderately cognitively				
	08/03/2015 at 5:54 p. (LPN)- B prepared me included multivitamin one capsule (stool so vitamin D3 1000 units in a clear plastic cup. R31, whose medication administration) and pl R3, along with a glass hand on cup to take th took R31's medication prior to ingestion of R identified these were for R3's and immedia medications. LPN-B p medication which was	prepared the correct s then administered to R31.				
	LPN-B stated he almomedications to R3.	8/03/2015 at 6:00 p.m. ost administered the wrong /05/2015 at 01:35 p.m. the OQ)-A stated there has				
		cerns about any medicaiton				

STATEMEN1	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00950	B. WING		08	8/06/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
AVEN HO	OMES OF MAPLE PLAIN		'MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From page	9 15	21545			
	concern with an indivi re-education."	idual, "we have done written				
	Dose Preparation and policy, (last reviewed "Facility staff should: medication is adminis medication, at the cor	s policy, entitled: General d Medication Administration 01/01/2013), indicated that Verify each time a tered that it is the correct rect dose, at the correct ate, at the correct time, for				
	The Director of Nursin inservice staff assigner remember to check th	-				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
21685	MN Rule 4658.1415 S Housekeeping, Opera		21685			
	including walls, floors systems, and equipm continuous state of go with regard to the hea	ood repair and operation alth, comfort, safety, and dents according to a written				
	This MN Requiremen	t is not met as evidenced				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00950	B. WING		08/06/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE	•	
HAVEN HO	OMES OF MAPLE PLAIN					
			PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21685	Continued From page	e 16	21685			
	review, the facility fail mechanical lifts were proper working order south) which had the residents (R23, R18, in the east and south mechanical lifts. Findings include: During the initial tour 08/03/15 at 1:15 p.m. Stander, (a device us was in the hallway wi on the lift stand. The leaving an approxima plastic remote casing	R57, R62 and R1) residing wing who utilized the				
	the hallway that had p a U fork. The right arr end that was cracked plastic end was cover that was coming off, e which faced any resid mechanical lift.	an EZ Way Stander was in badded lift arms shaped like m, had a plastic cover on the with jagged edges. The red with black electrical tape exposing the jagged edges,				
	nursing assistant (NA with the EZ Way stan case taped together. "the remote itself is fa	A)-J was transferring R23 d lift that had the remote During interview NA-J stated alling apart, the buttons do a stated the remote has been				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			SURVEY PLETED
		00950	B. WING		08/06/2015	
IAME OF PF	ROVIDER OR SUPPLIER		I .DDRESS, CITY, STATE,	ZIP CODE		100/2013
IAVEN HO	MES OF MAPLE PLAIN		MAN AVENUE			
			PLAIN, MN 55359	PROVIDER'S PLAN O		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From page	e 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.					
ז 1 1 1 1 1 1 1						
	EZ Way stand Operat 3/11/09, directions we	factures instruction, entitled: tors Instructions, revised ere given to "do a visual ed, missing or loose parts. "				
	residents lifts will be oneeded. The policy in disinfectant and to sp disinfectant, wipe down	17/21/14, indicated all cleaned weekly and as ndicated to use house ray entire lift using vn lift using a micro fiber for repairs as needed and				
	The Administrator and the facility's processe maintenance and inse	ervice responsible staff. system to consistently nce/cleanliness of				
nonot- D	TIME PERIOD FOR (	CORRECTION: Twenty-one				

	a Department of Health					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
		00950	B. WING		08	/06/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	OMES OF MAPLE PLAIN	1520 W)	MAN AVENUE			
		MAPLE	PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21685	Continued From page	: 18	21685			
	(21) days.					
21805	MN St. Statute 144.68 Residents of HC Fac.		21805			
	residents have the rig courtesy and respect	treatment. Patients and ht to be treated with for their individuality by ons providing service in a				
	by: Based on observation review, the facility fail dining experience for R42, R52) with cognit not served their meals 1 of 1 residents (R18)	t is not met as evidenced a, interview, and document ed to ensure a dignified 4 of 4 residents (R32, R33, ive impairment who were s in a timely manner, and for with cognitive impairment a eating by staff while they				
	Findings include:					
	LACK OF TIMELY ME	EAL SERVICE:				
	7/1/15, identified R32 impairment, and requi- with eating. R33's qui- identified R33 had se and required limited a R42's significant char- identified R42 had bo- memory impairments, assistance with eating	ired extensive assistance arterly MDS dated 6/3/15, evere cognitive impairment, ssistance with eating. age MDS dated 6/29/15,				

STATEMEN	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00950	B. WING		0.0	8/06/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
HAVEN H	OMES OF MAPLE PLAIN	1520 WY	MAN AVENUE			
		MAPLE	PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From page	e 19	21805			
	dependent on staff for	r eating.				
	the North Wing dining p.m., R32, R33, R42, same table in the mid 6:05 p.m. dietary aide a mobile cart into the contained pre-plated drinks to each resider 6:16 p.m. DA-A and D plated food to the three residents where R32, not seated. At 6:19 p served to the table wi but the rest of the dini with the residents eat assistant (NA)-A was helping other resident providing cues to help stood by the mobile c shouted aloud acrost had "just that middle t continued waiting by the DA-A, or DA-B did no assistance to R32, R3 continued to sit and w p.m. (9 minutes after R42, and R52 still had meals. During this tim were made of R32 and dining room and watch their food. R32 had a puckered lower lip as residents eating their at the bare table in from minutes after serving	food and began to pass ant in the dining room. At DA-B began serving the see other tables with R33, R42, and R52 were .m. no food had been th R32, R33, R42, and R52 ing room had been served ing their meals. Nursing seated at a different table ts cut up their food and the dining room to NA-A they table left" to serve, and the mobile cart. The NA-A, t offer or provide any 33, R42, or R52, who vait for their meals. At 6:25 serving began) R32, R33, d not been served their ne, several observations of R42 looking around the thing the other residents eat a furrowed brow and				

STATEMEN	ta Department of Healtl	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		00950	B. WING		08	8/06/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
HAVEN H	OMES OF MAPLE PLAIN		MAN AVENUE PLAIN, MN 55359			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21805	Continued From page	e 20	21805			
	stated dietary staff wa R42, and R52 until ac present because they choking on their food meal service for R32, me feel bad" because served and they have During interview on 8 stated R32, R33, R42 assistance with eating if someone isn't seate supper meal observe only one NA available and she couldn't be a R33, R42, and R52 h before being served. "felt bad" they had to served to them and w When interviewed on director of quality (D0 and R52 were to be s caregivers down them assistance to eat. Th create a "homelike fa all the residents so as and the staff should h residents could be se STANDING WHILE F R18's quarterly Minim 6/17/15, indicated R1 impairment, had an u	<ul> <li>/4/15, at 2:03 p.m. NA-A</li> <li>2, and R52 needed</li> <li>g and were at risk of choking</li> <li>ed by them. On 8/3/15 (the</li> <li>d by the surveyor) their was</li> <li>e when the food was ready</li> <li>at two tables at once, so R32,</li> <li>ad to wait for additional help</li> <li>Further, NA-A stated she</li> <li>wait to have their meals</li> <li>vatch other residents eat.</li> <li>8/6/15, at 12:52 p.m. the</li> <li>DQ)-B stated R32, R33, R2,</li> <li>served "when we have</li> <li>e" as they required</li> <li>ne staff are expected to</li> <li>shion" dining experience for</li> <li>is to "eat at the same time",</li> <li>have gotten more help so all</li> <li>erved and assisted promptly.</li> </ul>				

	a Department of Healti OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
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21805	R18 was seated at a two other residents at NA-D was seated opp and was assisting the eating. At 6:22 p.m., the other two residen where she stood over until 6:25 p.m., then s table and continued a residents. At 6:31 p. and walked over to R while standing over h opposoite side of the residents to finish the stood up from the tab to help him eat, stand helping him eat until 6 During an interview of director of quality (DC members should have at R18's table to eat. have been standing u "I would expect them SUGGESTED METH The Director of Nursin review dining room se inregards to resident	n on 8/3/15, at 6:14 p.m. table in the dining room with nd nursing assitant (NA)-D. posite the table from R18, two other residents with NA-D stood up from helping ts and walked over to R18 r him and assisted him to eat back down across the assisting the other two m., NA-D stood up again 18 and assisted him to eat im before returning to the table to assist the other two ir meal. At 6:35 p.m., NA-D le and walked over to R18 ting over him while while 6:39 p.m n 8/6/15, at 12:52 p.m. the DQ)-A stated two staff e been helping the residents Further, NA-D should not up while helping R18 to eat,	21805			