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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SY26

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00226

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245462**

2.STATE VENDOR OR MEDICAID NO.
(L2) **731342000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MARANATHA CARE CENTER**
(L4) **5409 69TH AVENUE NORTH**
(L5) **BROOKLYN CENTER, MN** (L6) **55429**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **97** (L18)

13.Total Certified Beds **97** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	97			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sue Miller, HFE NE II 10/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/21/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245462

Electronically Delivered: October 24, 2014

Ms. Anne O'Connor, Administrator
Maranatha Care Center
5409 - 69th Avenue North
Brooklyn Center, Minnesota 55429

Dear Ms. O'Connor:

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 October 3, 2014 the above facility is certified for:

97 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 97 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: October 24, 2014

Ms. Anne O'Connor, Administrator
Maranatha Care Center
5409 - 69th Avenue North
Brooklyn Center, Minnesota 55429

RE: Project Number S5462025

Dear Ms. O'Connor:

On September 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 11, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 21, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 7, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 3, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 11, 2014, effective October 3, 2014 and therefore remedies outlined in our letter to you dated September 24, 2014, 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 about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: October 24, 2014

Ms. Anne O'Connor, Administrator
Maranatha Care Center
5409 - 69th Avenue North
Brooklyn Center, Minnesota 55429

Re: Reinspection Results - Project Number S5462025

Dear Ms. O'Connor:

On October 21, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 11, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245462	A. Building B. Wing	10/21/2014

Name of Facility	Street Address, City, State, Zip Code
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **10/03/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **10/03/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **10/03/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/03/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/03/2014**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **10/03/2014**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **10/03/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **10/03/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	10/24/2014	03023	10/21/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/11/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245462	A. Building B. Wing — 03 - KITCHEN AND CHAPEL	10/7/2014

Name of Facility	Street Address, City, State, Zip Code
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	10/03/2014	ID Prefix Reg. # NFPA 101 LSC K0069	10/03/2014	ID Prefix Reg. # NFPA 101 LSC K0144	10/03/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/AK	10/24/2014	28120	10/07/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/16/2014

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00226	A. Building B. Wing	10/21/2014

Name of Facility	Street Address, City, State, Zip Code
MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **10/03/2014**	ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp.** LSC	Correction Completed **10/03/2014**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **10/03/2014**
ID Prefix **20930** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **10/03/2014**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **10/03/2014**	ID Prefix **21810** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **10/03/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	10/24/2014	03023	10/21/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/11/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SY26

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00226

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245462**

2.STATE VENDOR OR MEDICAID NO.
(L2) **731342000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MARANATHA CARE CENTER**
(L4) **5409 69TH AVENUE NORTH**
(L5) **BROOKLYN CENTER, MN** (L6) **55429**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/11/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **97** (L18)

13.Total Certified Beds **97** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	97			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 10/07/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/15/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 24, 2014

Ms. Anne O'Connor, Administrator
Maranatha Care Center
5409 - 69th Avenue North
Brooklyn Center, Minnesota 55429

RE: Project Number S5462025

Dear Ms. O'Connor:

On September 11, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

Please note, it is your responsibility to share the information contained in this letter and the results of this visit

with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 21, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 21, 2014 the following remedy will be imposed:

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

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.

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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 December 11, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 11, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email:pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R3) was treated with dignity regarding bladder continence when assistance was requested by the resident from facility staff. Findings include: On 9/9/14, at 11:28 a.m. when R3 was asked during interview if she was being treated with respect and dignity, R3 did not answer the question spontaneously, R3 shook head and stated about calling for help "early this morning"	F 241	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of	10/3/14

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

Electronically Signed | 10/03/2014

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F 241	Continued From page 1 and put on the call light. R3 stated "two girls" came in to the room and told her to get up. R3 reminded the staff she could not get up by herself and needed help to do so, but the staff left without attending to R3's needs. R3 stated she put the call light on again, then staff came in and "shut it off" without helping R3. R3 was observed to be teary-eyed as she talked about what happened that morning. R3 wiped own tears, took some pauses and continued to talk about having felt sick and getting the bed wet. R3 stated, "I was crying, I never wet the bed like that before." R3 pointed to one pillow (without a pillow case) lying at the head of the bed and described the bed was wet all the way up to her pillow. R3 stated, "I felt so bad." R3's electronic Admission Record dated 4/29/14, indicated R3 had diagnoses to include dementia without behavioral disturbance, acute respiratory failure, difficulty in walking, generalized pain, and muscle weakness. R3's Care Area Assessments (CAAs) dated 5/6/14, indicated R3 had deficits in performing activities of daily living (ADLs) related to weakness and pain secondary to history of fall and had impaired mobility, ambulation, decreased balance, strength and activity tolerance; R3 was incontinent of bowel and bladder related to decreased mobility, R3 could not get to the bathroom fast enough due to her pain, and R3 was noted to prefer calling staff for assistance rather than prompting her to go to the bathroom; R3 was at risk for falls, was noted to be unable to transfer and ambulate without assistance, and was alert and able to make needs known. R3's care plan dated 5/20/14, indicated R3 had	F 241	Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. It is the practice of Maranatha Care Center to promote care for residents in a manner and environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality. R3's concerns were reported to the appropriate state and county agencies on 9/9/14 with a full investigation being completed and submitted to the Office of Health Facility Complaints (OHFC). The facility received a disposition letter from OHFC requiring no further action on 9/23/14. Education provided to the staff involved on 9/18/14. Education completed for facility staff on October 3rd and ongoing. To identify other potentially impacted residents, resident interviews will be completed with 10% of residents by Household Coordinators weekly. Audits will be reviewed and reported to the QA committee with appropriate action plans as indicated. Administrator, DON and/or designee will be responsible for ongoing compliance. Date certain for the purposes of ongoing	

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F 241	Continued From page 2 ADL performance deficit and was to be encouraged to use call light to call for assistance. R3's care plan described R3 as continent of bowel and bladder, the facility identified R3 as being able to communicate needs to use the restroom and needed assistance of one staff for toileting. The care plan further indicated R3 may display urinary incontinence due to decreased physical mobility and needed staff assistance for urgency. The care plan indicated R3 verbalized false accusations. R3's Minimum Data Set (MDS) dated 8/1/14, depicted R3 as having minimal hearing loss when in a noisy setting or when spoken to in a soft voice. The MDS also identified R3 as having clear speech, making herself understood and had the ability to comprehend others verbal intent. A review of the facility's call light log for 9/9/14, revealed the following: -At 3:59 a.m. R3's call light was turned on. -At 4:06 a.m. R3's call light was canceled in room. -At 4:07 a.m. R3's call light was turned on again. -At 4:11 a.m. R3's call light cord was pulled out from wall. -At 4:12 a.m. R3's call light was canceled in room. Even though the care plan depicted R3 as stating false accusations, the call light log clearly identified the resident had utilized the call light on the early morning of 9/9/14. The facility's undated Nursing Assistant Care Sheet indicated R3 needed assist of one staff for toileting and directed staff to assist R3 with morning cares.	F 241	compliance is 10/15/14.	

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F 241	Continued From page 3 On 9/11/14, at 1:46 a.m. when incident between staff and R3 was brought to the interim clinical administrator (ICA) and the administrator, the ICA stated, "I would expect the staff to check the care plan and give her assistance out of bed." The administrator also agreed staff were expected to follow care plan and meet R3's needs. The ICA and administrator stated the facility did not have specific policy for dignity, but stated dignity was reflected in all policies of the facility.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R143) had their call light readily accessible. Findings include: On 9/8/14, at 3:28 p.m. during R143's room observation the call light was observed to be laying on the floor by the head of bed slightly behind the night stand and in between the bed night stand. R143 was observed to be in the room as R143 was coming ambulating down the hallway from her room towards the dining room.	F 246	It is the practice of Maranatha Care Center to provide services to those residing in our facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. R143 has had her call light appropriately placed within reach. The policy for call lights was reviewed and is current.	10/3/14

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F 246	Continued From page 4 On 9/9/14, at 9:15 a.m. to approximately 1:15 p.m. R143's call light was still observed to remain on the floor behind the night stand not accessible. On 9/9/14, at approximately 3:45 p.m. during the environmental tour, the administrator verified the call light was on the floor and picked it off the floor from behind the night stand. When asked what her expectation was for call light accessibility, the administrator stated "all call lights have to be at reach at all times regardless if resident is able to use it or not." The falls Care Area Assessment dated 2/21/14, identified R143 was at risk for falls and directed staff to remind R143 to call for assistance and use her wheelchair and keep call light and commonly used articles within reach. R143's quarterly Minimum Data Set (MDS) dated 8/4/14, indicated R143 had moderately impaired cognition. In addition, the MDS indicated R143 used a walker for locomotion and had fallen in the last two to six months in which R143 sustained a fractured hip. R143's care plan dated 8/13/14, identified R143 was at risk for fall related to incontinence, history of falls and unsteady gait at times. The care plan directed staff, "Be sure my call light is within reach encourage me to use it for assistance as needed." Call Light policy modified 10/10, directed, "Position the call light conveniently for the resident to use..."	F 246	To identify other potentially impacted residents, a full house audit for call light placement was completed. To assure compliance, all staff education will be completed regarding accessibility to call lights. Weekly audits reflective of 10% of residents on each household will be completed to assure ongoing compliance. Results of the audits will be reported to the facility QA committee. Administrator, DON and/or designee will be responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10/15/14.	
F 278	483.20(g) - (j) ASSESSMENT	F 278		10/3/14

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F 278 SS=D	Continued From page 5 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accurate assessments and intervention were reflected in the Minimum Data Set (MDS) for 1 of 2 residents (R15) who had a coccyx pressure ulcer.	F 278	It is the practice of Maranatha Care Center that resident assessments accurately reflect the resident's status. R15 will have the MDS modified to reflect correct staging of the wound.	

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F 278	Continued From page 6 Findings include: R15's electronic admission record dated 3/18/13, indicated R15 had diagnoses which included abnormal posture, anemia, hemiplegia (paralysis on one side) affecting non-dominant side due to cerebrovascular disease, neurogenic bladder, and pain in joints. The admission care plan dated 3/18/13, revealed R15 was admitted with a pressure ulcer on the coccyx. The facility conducted a Tissue Tolerance (Bed) algorithm dated 7/5/13. The algorithm noted the resident was not independent in mobility/positioning. The algorithm was also checked for "No discoloration is present after resident has been in the same position for three hours on skin. Consider to care plan to reposition every three hours." However, the analysis noted, "Resident on repositioning every 2 hrs [hours] in bed." The facility conducted a Tissue Tolerance (Chair) algorithm (a tool used to determine repositioning schedule), undated. The algorithm noted the resident was not independent in mobility/positioning. The algorithm was also checked for "No discoloration is present after resident has been in the same position for three hours on skin. Consider to care plan to reposition every three hours." However, the analysis noted, "Resident is on every 2 hrs Repo. [repositioning] when up in w/c [wheelchair] & when in bed." The medical record lacked evidence of another Tissue Tolerance algorithm being completed after R15 developed the Stage 2 pressure on the coccyx. Both Tissue Tolerance algorithm' s for the bed and chair indicated the algorithm was "To be completed upon, admission, annually and with	F 278	To identify other potentially impacted residents, all residents with wounds will have an audit of the most recent MDS for accuracy. To assure continued compliance, education will be provided to the RN's responsible for MDS coding. Weekly randomized audits of 6 completed MDS's will be completed for coding accuracy. The policy completion of the MDS was reviewed and is current. Audit results will be reported to the facility QA committee. DON and/or designee will be responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10/15/14.	

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significant change in status, upon emergence of pressure ulcer and changes with pressure surfaces." Copies were requested of the facility when R15 developed the pressure ulcer on 7/29/14, and no further documents were provided.

A Comprehensive Skin Risk Data Collection (CSRDC) dated 3/7/14, completed for R15 indicated R15 had a Braden Risk score of 13, which meant R15 was at moderate risk for developing pressure ulcer. It was further noted in the CSRDC that R15 also had chronic pressure ulcer to coccyx which was inherited and was stable. Copies of the CSRDC and the Braden Risk were requested of the facility when R15 developed the pressure ulcer on 7/29/14, and no further documents were provided.

R15's pressure ulcer Care Area Assessments (CAAs) dated 3/13/14, indicated R15 had a stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer could be superficial and presents clinically as an abrasion, blister, or shallow crater) on the coccyx and was at risk for further skin breakdown due to bowel incontinence, use of Foley catheter and decreased mobility. The CAAs indicated R15 needed the assistance of two staff for mobility in bed; staff would check skin on shower days and as scheduled; and care plan to address pressure ulcer to avoid complications and minimize risks.

A Wound Assessment Flow Sheet dated 4/13/14, was completed for R15's pressure ulcer on the coccyx. The assessment indicated the wound was 95% granulated and had 5% slough. The 4/13/14, was the date of the last assessment noted for the wound. There was no Wound

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Assessment Flow Sheet completed for the wound that subsequently developed on 7/29/14. Wound Assessment Flow Sheet copies were requested of the facility when R15 developed the pressure ulcer on 7/29/14, and no further documents were provided.

R15's quarterly MDS dated 6/9/14, identified R15 to have a stage II pressure ulcer with granulation tissue, needed extensive assistance of one staff for repositioning, transfers, toileting, and personal hygiene. R15's quarterly MDS also indicated R15 had severe cognitive impairment.

The Wound Consultation dated 7/8/14, indicated the coccyx ulcer was a Stage 3 (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue). The facility noted "called chronic ST II [stage 2] but had slough." The granulation was at 90% and the slough was at 10%. The wound measured 0.7 x 0.3 x 0.2 cm.

A review of the Nurses' Progress Notes revealed the history of R15's coccyx pressure ulcer, as follows:
-On 7/25/14, R15's coccyx pressure wound was assessed by the wound team as resolved. The noted depicted continued interventions put in place included: wheelchair cushion, repositioning, air mattress and observation of the area.
-On 7/29/14, the interim clinical administrator (ICA) wrote a progress note that indicated R15 had another pressure ulcer developed to coccyx described as, "unstageable" (full-tissue thickness loss in which the base of the ulcer is covered by slough or an eschar and, therefore, the true depth

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of the damage cannot be estimated until these are removed) area present on coccyx that measured 1 cm in length and 0.6 cm, bed of wound covered in slough, surrounding skin with scar tissue and presence of redness between wound and rectum.

The Wound Consultation dated 7/29/14, indicated the coccyx ulcer was unstageable with 100% slough. The measurement was 1.0 x 0.6 x 0.1 and the edges were rolled. The note indicated the "slough has resurfaced." The recommendations revealed the goal was to "protect as goal may not be [sic] to heal but maintain current status."

The Wound Consultation sheet dated 8/12/14, indicated R15's coccyx pressure ulcer was 2.6 x 0.5 cm and was superficial. The stage was identified as "MA" (the key for MA was not available on the form). The wound base was at 100% slough with scant drainage. The edges were macerated and scarred.

The Wound Consultation sheet dated 8/26/14, indicated R15's coccyx pressure ulcer was "non-stage [unstageable]" and at 100% slough, loosening with slight drainage. The measurement was 1.3 x 0.5 cm. The consult indicated R15 was to be turned and repositioned every two hours.

The MDS dated 9/4/14, revealed R15 had one Stage 2 pressure ulcer and the pressure ulcer was there upon admission. The MDS did identify R15 as being at risk for development of pressure ulcers. The MDS also lacked evidence of the unstageable pressure ulcer that was identified by the facility on 7/29/14, when the new pressure ulcer developed and again on 8/26/14, as identified on the Wound Consultation sheet. In

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addition, the MDS lacked evidence R15 was on a turning and repositioning program as that section was left blank.

When interviewed on 9/10/14, at 7:48 a.m. LPN-A verified R15's pressure wound had been there for a "long time." LPN-A stated interdisciplinary team (IDT) do wound rounds every Tuesdays where wound measurements were done. LPN-A stated she did not measure the wound but stated the wound was at Stage 2.

On 9/11/14, at 10:10 a.m. NA-D checked her nursing assistant care sheet and stated R15 was supposed to be repositioned every two hours.

On 9/11/14, at 10:20 a.m. RN-E stated he would expect a resident with pressure ulcer to be repositioned according to care plan and further stated R15 should have been repositioned every two hours per R15's care plan.

On 9/11/14, at 10:29 a.m. RN-D was interviewed and acknowledged R15 had chronic pressure ulcer to coccyx, and that different treatments had been tried and the pressure ulcer would "get better" but would open up again. RN-D verified R15's care plan interventions indicated the resident would be repositioned every two hours, but that R15 was not repositioned accordingly given the time R15 was brought out from her room until that time on 9/11/14.

The facility's Skin Risk Policy modified on 8/13, directed the facility staff to complete a new Braden Scale, a new Comprehensive Data Collection Tool, and a new tissue Tolerance algorithm with the onset of a new pressure ulcer, and care plan interventions according to the

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F 278	Continued From page 11 resident and/or individual risk factors. The policy was not followed for R15 when a new pressure ulcer was developed on 7/29/14. The policy further directed staff to establish individualized repositioning schedule if a resident was unable to move. R15's newly re-opened Stage 2 pressure area was not properly re-assessed by the facility as the facility did not follow the policy "to properly identify, re-assess and monitor residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for ulcers according industry standards of care."	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide every two hours repositioning as directed by the care plan for 1 of 2 residents (R15) reviewed for pressure ulcers; in addition, the facility failed to follow the care plan for 1 of 1 resident (R143) whose call light was not accessible reviewed for environmental concerns. Findings include: Pressure ulcer: R15's electronic admission record dated 3/18/13,	F 282	It is the practice of Maranatha Care Center that the services provided and arranged by the facility are provided by qualified persons in accordance with the resident's written plan of care. R15 and R143 have had their care plans reviewed and updated if applicable. All resident care plans are reviewed and updated in conjunction with the RAI process.	10/3/14

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F 282	Continued From page 12 indicated R15 had diagnoses which included abnormal posture, anemia, and hemiplegia (paralysis on one side) affecting non-dominant side due to cerebrovascular disease. A Comprehensive Skin Risk Data Collection (CSRDC) dated 3/8/14, completed for R15 indicated R15 had moderate risk for development of pressure ulcers and R15 had a chronic pressure ulcer to coccyx. A review of the Nurses' Progress Notes dated 7/25/14, indicated chronic pressure ulcer on coccyx had resolved. However, on 7/29/14, a Nurse's Progress Note indicated R15 had developed another unstageable pressure ulcer to coccyx area which measured 1 centimeter (cm) in length and 0.6 cm in width. The note described the wound bed as covered with slough, the surrounding skin with scar tissue and described the presence of redness between the wound and R15's rectum. R15's care plan revised on 7/31/14,addressed the importance of frequent repositioning and directed staff to reposition R15 every two hours during the day and two times at night. The undated Nursing Assistant Care Sheet for Team 2, Northern Lights Lane, indicated R15 as non-ambulatory and needed assistance of two staff for transfers, toileting and repositioning. The Care Sheet directed staff to reposition R15 every two hours. During a continuous observation on 9/11/14, at 7:10 a.m. to 10:05 a.m. R15 had not been repositioned for two hours and 55 minutes since first observed in wheelchair grooming self in front	F 282	The policy for care plans was reviewed and is current. Clinical staff were educated on following the care plan, the use of interventions and the location of care plan information on 10/3/14 and ongoing. Audits will be completed on following the care plan and placement of resident's call lights on 10% of residents. Audit results will be reported to the facility QA committee. DON and/or designee will be responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10/15/14.	

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F 282	Continued From page 13	F 282		

of mirror in her room. This was 55 minutes over the time as directed by the care plan.

On 9/11/14, at 10:10 a.m. nursing assistant (NA)-D checked Nursing Assistant Care Sheet kept in her pocket and stated R15 was supposed to be repositioned every two hours.

On 9/11/14, at 10:20 a.m. registered nurse (RN)-E stated he expected a resident with pressure ulcer to be repositioned according to care plan. RN-E further stated R15 should have been repositioned every two hours as directed by care plan.

On 9/11/14, at 10:29 a.m. RN-D stated R15 had a chronic pressure ulcer to coccyx and different treatments were tried and the pressure ulcer "got better" then re-opened up again. RN-D verified interventions in R15's care plan included repositioning every two hours, but R15 had not been repositioned according to the care plan.

On 9/11/14, at 3:22 p.m. the interim clinical administrator (ICA) acknowledged facility staff should have followed the care plan as directed on repositioning R15 every two hours according to the care plan.

The facility's Resident Care Plan/"I" Care Plan Policy and Procedure modified on 6/14, provided guidelines for staff to coordinate all cares which are necessary to accomplish goals in meeting the needs of the resident, and to communicate vital information and assign care for all disciplines.

Call light:
On 9/8/14, at 3:28 p.m. during R143's room observation the call light was observed on the

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F 282	Continued From page 14 floor by the head of bed slightly behind the night stand and in between the bed night stand. R143 was observed coming ambulating down the hallway from her room towards the dining room. On 9/9/14, at 9:15 a.m. to approximately 1:15 p.m. R143's call light was observed to remain on the floor behind the night stand not accessible to the resident. On 9/9/14, at approximately 3:45 p.m. during the environmental tour the administrator verified the call light was on the floor and picked it off the floor from behind the night stand. When asked what her expectation was for call light accessibility, the administrator stated "all call lights have to be at reach at all times regardless if resident is able to use it or not." R143's care plan dated 8/13/14, identified R143 was at risk for falls related to incontinence, history of falls and unsteady gait at times. The care plan directed, "Be sure my [R143's] call light is within reach encourage me to use it for assistance as needed." Call Light policy dated as last modified on 10/10, directed, "Position the call light conveniently for the resident to use..."	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		10/3/14

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F 314	Continued From page 15 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to promote healing and prevent further skin breakdown for 1 of 2 residents (R15) in the sample reviewed for pressure ulcers. This resulted in actual harm, as R15 had a recurrent pressure ulcer. Findings include: On 9/10/14, at 7:18 a.m. R15 was observed lying in bed awake. Nursing assistant (NA)-C and licensed practical nurse (LPN)-A was in R15's room to help R15 get up from bed. With R15's permission, the surveyor observed a pressure ulcer on R15's coccyx with LPN-A. LPN-A stated she had "just changed" the dressing to R15's coccyx. The wound dressing was dated 9/10 and was intact. LPN-A carefully opened the adhesive dressing to be checked. The wound was observed to have no drainage however, a yellow discoloration was observed on the dressing which LPN-A identified as being from Medihoney, a gel wound treatment. During observations of R15 on 9/11/14, from 7:10 a.m. to 7:25 a.m., R15 was observed in her room seated on a cushion in the wheelchair. -At 7:26 a.m. registered nurse (RN)-D, entered R15's room and was observed to give R15 some medications, then left when R15 took all the medications.	F 314	It is the practice of Maranatha Care Center to provide necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. R15 has had a comprehensive reassessment of her skin risk and support surfaces on 10/2/14. All residents are assessed for potential and actual alteration in skin risk with the RAI process along with the emergence of a new wound. To identify other potentially impacted residents, all residents with pressure ulcers have had an audit of the risk assessment and interventions, the residents with wounds have been reassessed as needed. The policy for skin risk was reviewed and is current. Education has been provided to all nurses regarding the assessment of and interventions for residents at risk for skin alterations and those with current alterations. Education was provided to clinical staff responsible on following the care plan.	

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F 314	Continued From page 16 -From 7:27 a.m. to 8:00 a.m. R15 remained in her room alone, seated in front of a mirror grooming herself. -At 8:01 a.m. NA-B and NA-M were observed to enter R15's room, NA-B approached R15 and put her dentures in and changed her shirt. NA-M then pushed R15 out to the hallway at 8:05 a.m., and to the Northern Lights Lane (NLL) unit television (TV) area/lounge. During that observation, R15 was not off-loaded from her wheelchair, nor was she repositioned. -From 8:06 a.m. to 8:35 a.m. R15 remained seated in wheelchair in the same spot in the TV lounge. R15 remained in the same position in her wheelchair and did not receive assistance, nor reposition herself. -At 8:35 a.m. RN-E approached where R15's wheelchair was parked in the NLL TV lounge. RN-E was observed to speak briefly to R15, and then to push R15 to the dining room area towards R15's table. R15 was not off-loaded or repositioned and did not reposition herself. -From 8:49 a.m. to 9:20 a.m. R15 remained seated in wheelchair at the dining room, slowly working on breakfast with the use of right hand. -At 9:25 a.m. NA-B wheeled R15 away from the dining table towards the NLL TV area. NA-B left R15 in front of TV at the NLL TV area. -At 9:32 a.m. NA-B returned to push R15's wheelchair away from NLL TV area towards hallway going past the first floor nurses' station and to the elevators. NA-B stated she was to take R15 to the 3rd floor for an activity. -At 9:34 a.m. R15 was observed in the 3rd floor activity room with other residents where a female staff member was reading the newspaper. R15 was not off-loaded nor repositioned and did not reposition herself. -At 9:43 a.m. R15 was still seated in wheelchair,	F 314	Weekly audits of skin assessments and interventions to be completed by wound team. Audits will be completed on following the care plan on 10% of residents. Audits of repositioning will be completed weekly on 10% of residents. All audits will be forwarded to the facility QA committee. DON and/or designee will be responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10/15/14	

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was calm and appeared to be listening to the reader at the news reading activity.
-At 10:02 a.m. RN-D was notified by the surveyor that R15 had been seated in the wheelchair since 7:25 a.m., and requested that R15 be assessed for skin condition.
-At 10:03 a.m. R15 was pushed to the common area in Room 112 by NA-M and RN-E. The two staff members left R15 seated in the wheelchair in the common area/hallway.
-At 10:05 a.m. RN-D, RN-E and NA-D, were observed to enter R15's room with her permission. R15 also gave permission for the staff to check the skin on her buttocks. R15 was transferred from her wheelchair to her bed with the use of a gait belt by RN-D, RN-E and NA-D. RN-D confirmed the dressing on R15's wound was from 9/10/14. RN-E assessed the pressure wound on R15's buttocks and described the open area on R15's as having 90% slough and slight redness on the surrounding skin up to the open area. The skin over the rest of the buttocks was clear, dry, intact, and the skin was blanchable. Although the resident had been observed from 7:10 a.m.-10:05 a.m. on 9/11/14, a period of 2 hours and 55 minutes, she was not offered, or encouraged, to be repositioned during that time.

R15's electronic admission record dated 3/18/13, indicated R15 had diagnoses which included abnormal posture, anemia, hemiplegia (paralysis on one side) affecting non-dominant side due to cerebrovascular disease, neurogenic bladder, and pain in joints. The admission care plan dated 3/18/13, revealed R15 had been admitted with a pressure ulcer to the coccyx.

A review of the Nurses' Progress Notes from the facility's last recertification survey exited in June

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F 314	Continued From page 18 2013 forward, indicated R15 had a pressure ulcer on her coccyx as of 6/19/13. The Nurses' Progress Notes revealed R15's pressure ulcer on coccyx persisted through assessment dates beginning 6/19/13 until 7/25/14. The pressure ulcer had fluctuated in its stages of healing as evidenced by varied measurements pulled from the interdisciplinary/wound team progress notes as follows: -On 6/19/13, R15's coccyx pressure wound measured 1.5 centimeters (cm) X 0.5 cm X 0.3 cm. -On 12/5/13, R15's coccyx pressure wound measured 2.7 cm X 0.9 cm X 0.4 cm. -On 6/3/14, R15's coccyx pressure wound measured 0.3 cm X 0.3 cm X 0.2 cm. -On 7/8/14, R15's coccyx pressure wound measured 0.7 cm X 0.3 cm X 0.2 cm. -On 7/25/14, the documentation indicated the wound team had determined R15's coccyx pressure wound was resolved. The notes indicated continued interventions were to include: a wheelchair cushion, repositioning, air mattress and routine observations of the area. - On 7/29/14, a Nurses' Progress Note written by the interim clinical administrator (ICA) indicated R15 had a pressure ulcer on the coccyx described as, "unstageable" (full-tissue thickness loss in which the base of the ulcer is covered by slough or an eschar and, therefore, the true depth of the damage cannot be estimated until these are removed) area present on coccyx that measured 1 cm in length and 0.6 cm, bed of wound covered in slough, surrounding skin with scar tissue and presence of redness between wound and rectum. The facility had conducted an assessment 7/5/13 on a form entitled, Tissue Tolerance (Bed) (a tool	F 314		

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used to determine repositioning schedule). The assessment documentation indicated the resident was not independent in mobility/positioning. The form was also checked for "No discoloration is present after resident has been in the same position for three hours on skin. Consider to care plan to reposition every three hours." However, the analysis included, "Resident on repositioning every 2 hrs [hours] in bed."

The facility had also completed a Tissue Tolerance (Chair), which was undated. The documentation on that form indicated the resident was not independent in mobility/positioning. But was also checked for "No discoloration is present after resident has been in the same position for three hours on skin. Consider to care plan to reposition every three hours." However, the analysis included, "Resident is on every 2 hrs Repo. [repositioning] when up in w/c [wheelchair] & when in bed." The medical record lacked evidence of any other Tissue Tolerance documents having been completed. Directions on the Tissue Tolerance document indicated it was "To be completed upon, admission, annually and with significant change in status, upon emergence of pressure ulcer and changes with pressure surfaces." The surveyor requested to review any further assessments following recurrence of R15's pressure ulcer on 7/29/14, and no further documents were provided.

An occupational therapy flow sheet, Rehabilitation Daily Flow Sheet dated 12/13/13, indicated R15 had trial use of a Broda chair (a tilt and recline positioning chair) for improved resident repositioning and protection of skin integrity. According to record documentation, the chair had been formally assigned to R15 on 12/16/13, after

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R15 had demonstrated improved repositioning with the chair.

A Comprehensive Skin Risk Data Collection (CSRDC) had been completed for R15 on 3/7/14, and indicated R15 had a Braden Risk score of 13 (indicated moderate risk for pressure ulcer development). The CSRDC also indicated R15 had a history of chronic pressure ulcer to the coccyx which was identified as inherited and stable. The surveyor requested to review any further assessments following recurrence of R15's pressure ulcer on 7/29/14, and no further documents were provided.

A Care Area Assessment (CAA) dated 3/13/14, indicated R15 had a stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer could be superficial and presents clinically as an abrasion, blister, or shallow crater) on the coccyx, and that the resident was at risk for further skin breakdown due to bowel incontinence, use of Foley catheter and decreased mobility. The CAA indicated R15 needed the assistance of two staff for mobility in bed; staff would check skin on shower days and as scheduled; and care plan to address pressure ulcer to avoid complications and minimize risks.

A Wound Assessment Flow Sheet was completed 7/25/14, which indicated R15's pressure ulcer had healed. However, there was no Wound Assessment Flow Sheet completed for the wound that subsequently re-developed on 7/29/14.

R15's quarterly Minimum Data Set (MDS) dated 6/9/14, identified R15 as having a Stage 2 pressure ulcer with granulation tissue, which needed extensive assistance of one staff for

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F 314	Continued From page 21 repositioning, transfers, toileting, and personal hygiene. The progress notes from the physician and geriatric nurse practitioner (GNP) entitled, Geriatric Services of Minnesota Progress Notes were reviewed from 7/7/14 through 9/11/14. The notes included: - On 7/7/14, "Res. [resident] has coccyx wound seen by wound nurse & reported as stable. Size of wound has decreased [arrow downward image] in size 1.1 cm x 0.8 cm, currently 0.4 cm x 0.2 cm." - On 8/8/14, "Nsg [nursing] request to assess wound of 7/29/14, 1 cm x 0.6 cm. Wound RN [registered nurse] involved." Also noted was "Coccyx wound: red, blanchable, no drainage [circle with a line drawn through it to depict no], no edema, shallow ulcer, no bruising." The GNP wrote a plan for the staff to follow: "keep skin clean & dry, keep HOB [head of bed] < [less than] 30 degrees, change position q [every] 2 [hours], continue with current wound care orders." - On 9/5/14, the physician notes indicated the wound was "shallow coccyx wound per GNP note 8/8/14." Documentation from a Wound Consultation dated 7/8/14, indicated the coccyx ulcer was a Stage 3 (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue). The facility documented, "chronic ST II [stage 2] but had slough." According to this documentation, the granulation was at 90% and the slough was at 10%, and the wound measured 0.7 cm x 0.3 cm x 0.2 cm.	F 314		

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A Wound Consultation note dated 7/29/14, indicated the resident had an unstageable coccyx ulcer with 100% slough. The measurement was 1.0 cm x 0.6 cm x 0.1 cm and the edges were described as rolled. The note indicated, "slough has resurfaced." The recommendations revealed the goal was to "protect as goal may not be [sic] to heal but maintain current status."

A Physician's Order dated 7/31/14, directed staff to treat R15's pressure ulcer on coccyx "cleanse with wound cleanser, pat dry, paint wound base with silver nitrate 10% ointment [antiseptic wound cauterization], zinc oxide [used to severely chapped skin, or other minor skin irritations] to peri-wound to protect, cover with Mepilex Sacrum [an all-in-one foam dressing that effectively absorbs and retains wound fluid (exudate) but keeps the wound sufficiently moist], seal dressing with Skin-Prep [a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films] around edges of dressing." On 8/12/14, the doctor ordered the application of Medihoney (used to help wounds that have stalled under first-line treatment to progress towards healing) to R15's coccyx wound instead of the silver nitrate ointment, which had been unavailable since ordered on 7/31/14. Until then the product became available, staff was directed to use the previous wound treatment orders.

R15's care plan revised on 7/31/14, indicated R15 had a chronic pressure ulcer to coccyx. The care plan interventions directed facility staff to: complete treatments as ordered and monitor for effectiveness; follow facility policies and doctor's orders for skin care regime; provide information

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MARANATHA CARE CENTER	5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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to R15 about the importance of frequent repositioning; and finally, reposition R15 every two hours during the day and two times at night. The care plan lacked evidence that R15 could off load/reposition self in the wheelchair and lacked evidence of any new interventions implemented to minimize/prevent an increase in size for the recurrent unstageable pressure ulcer to the coccyx.

A Wound Consultation sheet dated 8/12/14, indicated R15's coccyx pressure ulcer was 2.6 x 0.5 cm and was superficial. The stage was identified as "MA" (the key for MA was not available on the form). The wound base was at 100% slough with scant drainage. The edges were macerated and scarred.

The Wound Consultation sheet dated 8/26/14, indicated R15's coccyx pressure ulcer was "non-stage [unstageable]" and at 100% slough, loosening with slight drainage. The measurement was 1.3 x 0.5 cm. The consult documentation indicated R15 was to be turned and repositioned every two hours.

The MDS dated 9/4/14, revealed R15 had one Stage 2 pressure ulcer and that the pressure ulcer was there upon admission. The MDS did identify R15 as being at risk for development of pressure ulcers. The MDS did not identify that R15 had a Stage 3 pressure ulcer that was identified by the facility on 7/8/14. The MDS also lacked evidence of the unstageable pressure that was identified by the facility on 7/29/14, when the new pressure ulcer developed, and again on 8/26/14, as identified on the Wound Consultation sheet. In addition, the MDS lacked evidence R15 was on a turning and repositioning program as

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that section was left blank. The MDS also lacked evidence that there was a previous healed pressure ulcer identified on 7/25/14, as per the progress note which indicated the coccyx pressure ulcer had been resolved.

The facility's undated Nursing Assistant Care Sheet for Team 2, Northern Lights Lane, described R15 as non-ambulatory and requiring assistance of two staff for transfers, toileting and repositioning. The Nursing Assistant Care Sheet directed staff to reposition R15 every two hours.

When interviewed on 9/10/14, at 7:48 a.m. LPN-A verified R15's pressure wound had been there for a "long time." LPN-A stated interdisciplinary team (IDT) do wound rounds every Tuesdays where wound measurements were done. LPN-A stated she did not measure the wound but stated the wound was at Stage 2.

On 9/11/14, at 10:10 a.m. NA-D checked her nursing assistant care sheet and stated R15 was supposed to be repositioned every two hours.

On 9/11/14, at 10:20 a.m. RN-E stated he would expect a resident with pressure ulcer to be repositioned according to care plan and further stated R15 should have been repositioned every two hours per R15's care plan.

On 9/11/14, at 10:29 a.m. RN-D was interviewed and acknowledged R15 had chronic pressure ulcer to coccyx, and that different treatments had been tried and the pressure ulcer would "get better" but open up again. RN-D verified R15's care plan interventions indicated the resident would be repositioned every two hours, but that R15 was not repositioned accordingly given the

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F 314	Continued From page 25 time R15 was brought out from her room until that time today. On 9/11/14, at 3:22 p.m. the ICA acknowledged that facility staff should follow the intervention to reposition R15 every two hours according to R15's care plan. The facility's Skin Risk Policy modified on 8/13, directed the facility staff to complete a new Braden Scale, a new Comprehensive Data Collection Tool, and a new tissue Tolerance algorithm with the onset of a new pressure ulcer, and care plan interventions according to the resident and/or individual risk factors. The policy was not followed for R15 when a new pressure ulcer was developed on 7/29/14. The policy further directed staff to establish individualized repositioning schedule if a resident was unable to move. R15's newly re-opened Stage 2 pressure area was not properly re-assessed by the facility as the facility did not follow the policy "to properly identify, assess and monitor residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for ulcers according industry standards of care" nor did R15 receive repositioning in a timely manner.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition	F 322		10/3/14

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F 322	Continued From page 26 demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R121) had a feeding tube checked for proper placement prior to administering medications. Findings include: R121's tube feeding Physician's Order sheet dated 7/30/14, directed staff to check feeding tube placement "before tube feeding, flushes and medication administration" by aspirating residual (checking for residual stomach contents to determine proper placement of the tube feeding). During the medication observation on 9/9/14, at 3:39 p.m. the registered nurse (RN)-H prepared Potassium Chloride (potassium supplement) 7.5 milliliter (ml), Metoprolol (used to treat high blood pressure) 25 milligrams (mg) and Levetiracetam (used to treat seizures) 500 mg. RN-H crushed the Metoprolol and Levetiracetam tablets	F 322	It is the practice of Maranatha Care Center that a resident who receives feeding via gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and naso-pharyngeal ulcers and to restore, if possible, normal eating skills. Education was provided to the nurse upon notification. The policy for Gastrostomy Tube Placement was reviewed and is current. All nurses have been re-educated on checking placement of the gastrostomy tube according to the policy. Three weekly observation audits will be completed to assure ongoing compliance.	

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F 322	Continued From page 27 individually and added 10 ml of water to each cup to dissolve the medications. RN-H explained R121 the procedure, flushed the feeding tube with 30 ml of water, administered the medications, and flushed the tube with 30 ml of water in between the medications. The RN-H did not check the feeding tube placement prior to medication administration. During interview on 9/9/14, at 3:55 p.m. the RN-H verified she did not check the feeding tube placement prior the medication administration. RN-H explained she didn't check the feeding tube placement because she just administered the tube feeding at 3:00 p.m. RN-H further explained since the 4:00 p.m. medication administration was so close to the feeding she "didn't need to check for the same thing." RN-H stated the medication administration record (MAR) included the "Gastrostomy Medication Administration" policy dated as modified in July 2013. RN-H verified the procedure included instructions for staff to, "Test for correct placement of gastrostomy tube." RN-H acknowledged she did not check the feeding tube placement before medication administration. During interview on 9/11/14, at 12:04 p.m. RN-B stated staff were expected to follow the facility's policy and procedure regarding feeding tube placement check before each medication administration or tube feeding. The RN-B verified per the Gastrostomy Tube Placement policy staff was expected to check the tube placement before each medication administration by checking the residual with a syringe. The facility's Gastrostomy Tube Placement policy dated last modified in November 2010, indicated	F 322	Audit results will be reported to the facility QA committee. DON and/or designee will be responsible for ongoing compliance. Date certain for the purposes of ongoing compliance is 10/15/14.	

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F 322	Continued From page 28 the purpose of the tube placement check was "to assure adequate placement of gastrostomy tube prior to administration of medications."	F 322		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding	F 334		10/3/14

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F 334	Continued From page 29 the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure 3 of 5 residents (R7, R103, R36) were offered and/or received the Influenza vaccination. Findings include:	F 334	It is the practice of Maranatha Care Center that all residents are offered the influenza immunization October 1-March 31 annually unless the immunization is contraindicated or the resident has already been immunized during this time	

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F 334	Continued From page 30 R7 was admitted to the facility on 9/10/13, and remained in the facility. No documentation was provided to indicate R7 was offered the annual influenza vaccine. R103 was admitted to the facility on 5/10/12, and remained in the facility. The record indicated R103's representative requested the annual Influenza vaccine to be given and signed the Influenza Vaccination Consent form on 9/24/13. However, no documentation was provided to indicate R103 had received the Influenza vaccine. R36 was admitted to the facility on 9/10/13, and remained in the facility. R36's medical record lacked documentation to indicate the Influenza vaccination had ever been received, or offered and refused. During interview on 9/11/14, at 10:43 a.m. the clinical coordinator/registered nurse (RN)-B stated the influenza vaccine was offered to everybody, unless there was evidence in the medical record that resident had received it outside of the facility. RN-B verified R103's responsible party signed the Influenza Vaccination Consent form on 9/24/13, indicating "I would like my family member/friend to receive the flu shot", however no documentation was provided to indicate R103 had received the Influenza vaccine. On 9/11/14, at 12:07 p.m. RN-B stated she could not find any information if R7 and R36 have received or were offered the Influenza vaccine. The Influenza Vaccination policy dated January 2009, indicated, "It is the policy of this facility that	F 334	period. R7, R103, R36 have been offered the influenza immunization and provided education on the risks and benefits. All residents and/or responsible parties have had educational information provided and been offered the ability to participate in this year's annual influenza immunization. The policy for Influenza Immunization has been reviewed and is current. To assure ongoing compliance, each admission will be audited for review of influenza immunization status and offered if needed according to the policy. Audit results will be reported to the facility QA committee. DON and/or designee will be responsible for ongoing compliance. Date certain for purposes of ongoing compliance is 10/15/14.	

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F 334	Continued From page 31 annually residents will be offered immunization against influenza." The policy also indicated "the vaccine program runs from early October through March 31st", and that "residents will be encouraged to have the vaccine." Per the policy, documentation in the medical record should include the education provided, vaccine administration, resident refusal and education of risk versus benefits.	F 334		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and document	F 353	It is the practice of Maranatha Care	10/3/14

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F 353	Continued From page 32 review with residents, family, and staff, the facility failed to ensure sufficient qualified nursing staff was available to meet the needs of residents observed/interviewed (R15, R218, R3, R168, R208, R17, R134, R11) as well as family member voiced concerns regarding lack of staff persons to assure resident needs were met timely. This had the potential to affect 89 of 89 residents that resided at the facility. Findings include: Pressure ulcer: R15's quarterly Minimum Data Set (MDS) dated 6/9/14, identified R15 to have a stage II pressure ulcer with granulation tissue, needed extensive assistance of one staff for repositioning, transfers, toileting, and personal hygiene. R15's quarterly MDS also indicated R15 had severe cognitive impairment. The MDS dated 9/4/14, revealed R15 had one Stage 2 pressure ulcer and the pressure ulcer was there upon admission. The MDS did identify R15 as being at risk for development of pressure ulcers. The MDS did not indicate R15 had a Stage 3 pressure ulcer that was identified by the facility on 7/8/14. The MDS also lacked evidence of the unstageable pressure that was identified by the facility on 7/29/14, when the new pressure ulcer developed and again on 8/26/14, as identified on the Wound Consultation sheet. In addition, the MDS lacked evidence R15 was on a turning and repositioning program as that section was left blank. The MDS also lacked evidence that there was a previous healed pressure ulcer identified on 7/25/14, as per the progress note which indicated the coccyx pressure ulcer had been resolved.	F 353	Center to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. R15 has had a comprehensive reassessment of her skin risk and support surfaces on 10/2/14. R3's concerns were reported to the appropriate state and county agencies on 9/9/14 with a full investigation being completed and submitted to the Office of Health Facility Complaints (OHFC). The facility received a disposition letter from OHFC stating no further action was needed on 9/23/14. Education provided to the staff involved on 9/18/14. R218's concerns were reported to the appropriate state and county agencies on 9/2/14 with a full investigation being completed and submitted to the Office of Health Facility Complaints (OHFC). The facility received a disposition letter from OHFC stating no further action was needed on 9/9/14. R168, R208, R17, R134 and R11 were interviewed and concerns addressed. Plan was initiated and residents were educated/informed of plan in place. Maranatha Administration has reviewed ancillary staff assignments and schedules to determine areas where additional	

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F 353	Continued From page 33 On 9/10/14, at 7:18 a.m. R15 was observed lying in bed awake. Nursing assistant (NA)-C and licensed practical nurse (LPN)-A was in R15's room to help R15 get up from bed. With R15's permission, the surveyor observed a pressure wound on R15's coccyx with LPN-A. LPN-A stated she had "just changed" the dressing to R15's coccyx. The wound dressing was dated 9/10 and was intact. LPN-A carefully opened the adhesive dressing to be checked. Observation of the wound no drainage however, a yellow discoloration was observed on the dressing and was identified by LPN-A as a Medihoney treatment. On 9/11/14, from 7:10 a.m. to 7:25 a.m. R15 was observed in her room seated on a cushion in the wheelchair. -At 7:26 a.m. registered nurse (RN)-D, entered R15's room and was observed to give R15 some medications, then left when R15 took all the medications. -From 7:31 a.m. to 7:58 a.m. R15 remained in room alone, was in front of mirror and continued grooming herself. -At 8:01 a.m. NA-B and NA-M entered R15's room, NA-B approached R15 and put R15's dentures in R15's mouth, and changed R15's shirt. NA-M pushed R15 out to the hallway and to the Northern Lights Lane (NLL) unit television (TV) area/lounge. During that observation, R15 was not off-loaded from wheelchair nor repositioned from original position. -From 8:06 a.m. to 8:35 a.m. R15 remained seated in wheelchair on the same spot at the TV lounge and watching TV. R15 was calm and still in the same position in wheelchair. R15 did not reposition herself.	F 353	support can be added. Interviews will be conducted with 10% of residents and family members reflective of 10% of residents weekly to determine times of greatest resident need. Staff interviews involving three staff on each household representing each shift will be completed weekly to assist in determining times of greatest resident need. Interviews will be reviewed with the interdisciplinary team to facilitate any identified changes in staffing assignments. Resident meetings, conducted weekly for 8 weeks, will be held to discuss staffing patterns and adjustment plans as well as to gain feedback from residents on the effectiveness of adjustments. The call-in policy has been reviewed and is current. The policy has been reviewed with the Staffing Coordinators and all direct care staff have been re-educated on the process. The call light response policy has been reviewed and remains current. All staff have been educated on call light response and meeting resident needs. Weekly audits will be completed for call light timing on 10% of residents on each household. Interview results and feedback from resident meetings will be discussed at the facility QA committee.	

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F 353	Continued From page 34 -At 8:35 a.m. RN-E approached where R15 was parked in wheelchair at the NLL TV lounge and talked briefly to R15. RN-E was observed to push R15 to the dining room area towards R15's table. R15 was not off-loaded nor repositioned from original position in wheelchair, nor did R15 reposition herself. -From 8:49 a.m. to 9:20 a.m. R15 remained seated in wheelchair at the dining room, slowly working on breakfast with the use of right hand. -At 9:25 a.m. NA-B wheeled R15 away from the dining table towards the NLL TV area. NA-B left R15 in front of TV at the NLL TV area. -At 9:32 a.m. NA-B returned to push R15's wheelchair away from NLL TV area towards hallway going past the first floor nurses' station and to the elevators. NA-B stated she was to take R15 to the 3rd floor for an activity. -At 9:34 a.m. R15 was at the 3rd floor activities' room with other residents where a female staff member was reading the newspaper. R15 was not off-loaded nor repositioned from wheelchair. R15 did not reposition herself. -At 9:43 a.m. R15 was still seated in wheelchair, was calm and appeared to be listening to the reader at the news reading activity. -At 9:59 a.m. RN-D was notified that R15 had been seated in the wheelchair from 7:25 a.m. to 10:05 a.m. and requested that R15 be assessed for skin condition. -At 10:03 a.m. R15 was pushed to common area in Room 112 by NA-M and RN-E. The two staff members left R15 seated in wheelchair in the common area/hallway. -At 10:05 a.m. RN-D and NA-D, entered common area in R15's room. R15 gave permission for skin check on her buttocks. R15 was transferred from wheelchair to bed by use of gait belt by RN-D, RN-E and NA-D. RN-D confirmed dressing on	F 353	Administrator, DON and/or designee will be responsible for compliance. Date certain for the purposes of ongoing compliance is 10/15/14.	

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F 353	Continued From page 35 wound was from 9/10/14, RN-E assessed pressure wound on R15's buttocks and described that open area on R15's coccyx had 90% slough, slight redness on surrounding skin up to the open area, skin to rest of buttocks clear dry, intact, with creases from diaper and skin was blanchable. R15 went two hours and 55 minutes without repositioning. Stage 1 family interview On 9/8/14, at 7:00 p.m. during interview when asked if family member (F)-A felt there was enough staff available to make sure your family member get the care and assistance they need without having to wait a long time, F-A stated "call lights can be a challenge to answer at times and it can take a long time before they could answer it and if they come they would indicate they would come back and they don't come back. I usually get on their case. " Stage 1 Resident Interviews R218's Brief Interview for Mental Status (BIMS) assessment dated 8/28/14, indicated R218 had intact cognition. Medicare/Skilled Note dated 9/5/14, indicated R218 required assist of one activities of daily living and two assist with transfers, toileting and bed mobility. In addition Progress Notes dated 8/25/14, through 9/11/14, indicated R218 was pleasant and cooperative with cares. On 9/8/14, at 3:45 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R218 stated, "On night shift have to wait a long time, staff say they are very busy and say will come back to you but don't ... I called my daughter at	F 353		

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	245462	A. BUILDING _____ B. WING _____	09/11/2014

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F 353	Continued From page 36 1:15 a.m. one time after they put me on a plastic sharp bedpan and didn't take me off till 4:00 a.m. on a weekend. Staff flip name tags or don't wear them, I told [registered nurse, RN-A], one night and two nights later was good, told [RN-A] again today third time, and he said he would investigate some. [I] tried to tell the social worker and she said she would get back to me ...I have had to go in my pants a couple of times a little and in bed when bedpan was not positioned correctly. R218 further stated now she gets up to the bathroom with two assist and "staff at night hurries me, but they never hurry themselves." R3's quarterly MDS dated 8/1/14, indicated cognition was moderately impaired and required extensive physical assistance of one staff with dressing, toileting, transfers and personal hygiene. In addition the MDS indicated R3 used both a walker and wheelchair for mobility and had no behaviors. On 9/9/14, at 11:28 a.m. during interview when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time. R3 stated, "They always say they are in a hurry just like this morning, so I just don't know if they have enough staff." R3 stated she called for help "early this morning" and put on the call light. R3 stated "two girls" came in to the room and told her to get up. R3 reminded the staff she could not get up by herself and needed help to do so, but the staff left without attending to R3's needs. R3 stated she put the call light on again, then staff came in and "shut it off" without helping R3. R3 was observed	F 353		

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to be teary-eyed as she talked about what happened that morning. R3 wiped own tears, took some pauses and continued to talk about having felt sick and getting the bed wet. R3 stated, "I was crying, I never wet the bed like that before." R3 pointed to one pillow (without a pillow case) lying at the head of the bed and described the bed was wet all the way up to her pillow. R3 stated, "I felt so bad."

On 9/9/14, at 11:34 a.m. during interview when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R3 stated, "They always say they are in a hurry just like this morning, so I just don't know if they have enough staff."

R168's quarterly MDS dated 6/12/14, indicated cognition was intact was independent but also required physical supervision oversight of one staff with toileting and personal hygiene and used a walker for mobility and had no behaviors.

On 9/9/14, at 10:05 a.m. during interview when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R168 stated, "Sometimes I wait an hour to eat..."

R208's MDS dated 8/19/14, indicated cognition was intact and required extensive physical assistance of one to two staff with dressing, toilet use, bed mobility, transfers and personal hygiene. In addition, the MDS indicated R208 used a wheelchair for mobility and had functional limitation of range motion on one side upper and

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F 353	Continued From page 38 lower extremity and had no behaviors. On 9/8/14, at 4:51 p.m. during interview when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R208 stated, "They need more staff in morning and evening." R17's quarterly MDS dated 6/17/14, indicated cognition was severely impaired and required extensive physical assistance of one staff with dressing, toileting, transfers and personal hygiene and had no behaviors. On 9/8/14, at 4:13 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R17 stated, "I don't think they got enough staff because they always say that somebody has called-in sick and they don't replace them once in awhile they do." R134's quarterly MDS dated 8/4/14, indicated cognition was severely impaired and required extensive physical assistance of one to two staff with dressing, toileting, transfers and personal hygiene. In addition the MDS indicated R3 used both a walker and wheelchair for mobility and had no behaviors. On 9/8/14, at 6:28 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R134 stated, "Sometime have to wait for a long time	F 353		

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F 353	Continued From page 39 after putting call light on." R11's quarterly MDS dated 6/12/14, indicated cognition was intact and required extensive physical assistance of one staff with dressing, toileting and personal hygiene; had a functional limitation in ROM to both lower extremities and in addition used wheelchair for mobility and had no behaviors. On 9/8/14, at 6:48 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R11 stated, "They have tried to cut down the help and its very noticeable." On 9/9/14, at approximately 2:30 p.m. a resident who requested to remain anonymous indicated to surveyor the bedside water mugs had not been changed since Sunday 9/7/14, and this had been a problem which had been brought up at the resident council and the unit staff, but had not resolved and the resident thought was related to staffing. The anonymous resident further stated on the next resident council this was going to be brought to the facility attention. Random call light observation 3rd floor On 9/10/14, at 7:35 a.m. observed call light in R97's room on. The hallway light to room was on and R97 was observed lying in bed with an adaptive call light lying on top of the bedding. -At approximately 7:40 a.m. observed nursing assistant (NA)-A walking down the hallway towards R97's room as she was walking trained medication aide (TMA)-A was overheard in a high tone of voice, "Are you going to get [R97] call	F 353		

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F 353	Continued From page 40 light?" and NA-A replied, "Yeah" as she continued to walk into R97's room. -At approximately 7:41 a.m. NA-A came right out was observed cleansing her hands at the door and walked away from the room after answering the call light. When interviewed on 9/10/14, at 7:41 a.m. NA-A stated R97 was a sleep and had probably bumped her call light in her sleep. -At 7:42 a.m. again R97's call light was observed on and NA-A went into the room briefly spoke with R97 then shut the door after putting the light on. When interviewed on 9/10/14, at 7:47 a.m. NA-A came out of R97's room when asked what assistance R97 required, NA-A stated R97 had bumped the call light the first time she had been in the room and when she went in the second time, R97 had indicated she needed to use the bed pan. NA-A stated R97 had thought she was about to get up soon and would use the bed pan then but had told NA-A to still put her on the bed pan anyway. When asked when a resident call light was on and if NA-A would just turn it off without asking the resident or meeting the need, NA-A stated she was supposed to ask and not assume, but had thought resident had bumped the call light. Staff interviews When interviewed on 9/9/14, at approximately 2:13 p.m. the administrator stated she was aware of the ice machine on 3rd Floor was malfunctioning and had spoken with the environmental service director to get a replacement. When asked how come the staff would not get the ice from another floor, administrator stated it was challenging and the	F 353		

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residents who had the problem were those that got ice for themselves from the machine. When asked about the other residents who were not able to get the water for themselves and never got fresh water administrator referred surveyor to resident council minutes.

On 9/11/14, at 10:45 a.m. an interview was conducted with the staffing coordinator (SC) and interim clinical administrator (ICA).
- When asked how the facility determined the staffing pattern SC stated "by the grid we have for each floor" as she showed sheets which indicated the census and staffing patterns.
- When asked who did staffing when SC was not at the facility SC stated, "We had a girl for back up and she quit a week ago and someone else is being trained in."
- When asked if the facility used pool staffing to supplement for sick calls or other leaves both SC and ICA indicated the facility did not use pool.
- When asked who handled the sick calls SC stated "they are supposed to call me or their supervisor who would fill the sick call sheet.
- When asked what happened when the census was low and if the facility flexed down ICA stated the facility would flex with census but there was flexibility with acuity with census.
- When asked if staffing was tracked and trended with incidents such as falls, infections among others and if there any patterns with staffing ICA stated falls were discussed on the daily interdisciplinary team meetings (IDT) and "we try to ask the five whys."
- When asked if staffing concerns had been identified or reported to management ICA stated "Staff have had concerns for being sent home due to low census and low acuity and this reflects on their pay check but no workload particular

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concerns except for one nurse who has requested to receive more training as she is being moved to a different unit transitional care unit (TCU) from long term unit." ICA also indicated falls stated falls had decreased in the last quarter and anytime "we have had a call light concern we have had to run the report for the resident with concern and a grievance is completed per the facility grievances policy is followed."
- When asked about the facility employee turnover rate, open positions, and if both were being reported to quality assurance meeting in the last quarter ICA stated, "We have had an increase in the turnover rate." ICA also indicated the facility had "a staffing meeting on Thursday where we discuss the turnover rate and the positions being offered." SC provided a list of open nursing positions for both licensed nurses and nursing assistant (NA's) which showed the facility had five part time NA positions on all shifts combined open and four part time and one full time nurses positions open also.
- When asked if ICA or corporate did exit interviews, ICA stated they had not done them personally and corporate does not do them, "but if the staff are not meeting our standards we have to let them go."

On 9/11/14, at approximately 12:17 a.m. both the administration and ICA approached surveyor indicated the call log for the last six months was eleven thousand pages. Administrator stated usually when a call light concern had been brought up by residents the log was printed out and a grievance form was completed accordingly. Administrator further indicated in the past the facility was printing the call light logs and would go through them and made an interactive posting

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for the staff.
- When asked if any of those were available, she stated there was no record of it.
- When asked if the facility did audits of the staff doing them on the floor over a period of time during the shift, the administrator stated the facility did not do that.
- When asked since the audits were not being done on the floors by the staff, if she knew if the resident needs had been met, the administrator stated she thought when the staff answered the call light the resident need had been met.

On 9/11/14, at 12:47 p.m. the administrator approached surveyors stated the facility did not have a specified staffing policy, but rather followed the grind and acuity guide that SC had provided earlier.

When interviewed on 9/11/14, at 2:18 p.m. RN-B stated her expectation was that all staff was to answer the call lights and when they went to the resident room they were supposed to make sure the resident need was met before leaving the room. RN-B further stated she did not expect a staff to stop in the middle when assisting another resident to answer the call light, but she expected other staff on the unit not occupied to answer the call lights.

When interviewed on 9/11/14, at 3:53 p.m. ICA stated she would have expected the staff to answer the call lights promptly and meet the need and would also expect them to come back to the resident room if the staff had been in the room and turned off the light and indicated they were coming back.

Review of Resident/Visitor Occurrence Reports

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F 353	Continued From page 44 provided by the facility dated 2/1/14, through 9/9/14, revealed the following: - Resident/Visitor Occurrence Report dated 6/30/14, at 11:10 p.m. for R105 revealed R105 had indicated he had to use the bathroom and had put the call light on but staff had not responded so he thought he was able to self-transfer as staff was probably helping another resident. Follow up call light log revealed R105's call light had been put on at 10:51 p.m. which was over nineteen minutes to R105's falls. RN-A indicated he would follow-up with staff regarding call light response time. - Resident/Visitor Occurrence Report dated 7/21/14, at 6:50 a.m. indicated R153 had been found kneeling on the floor leaning over the bed. Follow-up education facility investigation indicated R153 was at risk for falls related to being restless while in bed and confusion. The investigation further indicated, "His current care plan is to be up by [6:00] due to this reason. The night prior to this the Night shift was not able to assist him out of bed [due to] d/t staffing issues, though day shift was more than adequately staffed, [R153] should have been the priority for AM cares this morning to prevent this from happening ..." Although the staff were filling a report of when, where, and what time last resident had been seen before the fall/incident, the forms lacked indication of the last time resident had been toileted, lacked where the call light was, as most of the reports identified residents had to use the bathroom and most had been found on the bathroom floors at different times of the day. Secondly resident supervision had been identified as residents had been left in the room for an extended period of time before staff returned to	F 353		

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F 353	Continued From page 45 assist. Review of Resident/Family/Staff-Quality Concern Forms provided by the facility dated between 4/23/14, to 8/27/14, revealed concerns of call light response time, meeting the needs and coming back after leaving unanswered call light had been brought up to the facility by alert residents and a family member multiple times and signed off by the administrator. Although the facility had indicated staff education had been provided and the call light logs had been reviewed, there was no evidence of follow ups completed to ensure resident needs had been met despite the call lights being answered timely, as indicated on the investigations. A review of the Monthly Resident Council Minutes and responses from 6/12/13, through 8/27/14, revealed the following: - On 2/26/14, the minute's new business concerns: "Call lights can take a long time to answer, more than the goal of 5 minutes. One resident felt like staff made her wait longer so that they would only have to come to her room once to get her ready for bed. [Household coordinator] HHC will follow-up with the resident and this concern ..." One of the staff explained the new call light system had reports that can be pulled to look at call light times; trends, average call light times, and indicated the household coordinator would be looking at these reports on a regular basis. - A minutes on 3/26/14, the subject of call lights concern was omitted from the old business. In addition on the new business several concerns were brought up: "Staff aren't always giving residents the amount of time they need to finish their meals and are	F 353		

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F 353	Continued From page 46 taking their plate away before they are done eating. Staff telling resident that "They'll be back in a minute, I have to finish up something" and they may or may not come back. Staff will come in, shut the call light off and not answer/meet the resident's need." Response/action to be taken to all three concerns was indicated as "Staff education." - The minutes on 4/30/14, call lights and/or staffing concerns were omitted from the old business minutes. - The minutes on 5/28/14, new business indicated, "Call light response time has slowed down again. Residents will request pain medications & not receive it in a timely manner" response indicated the household coordinators "will continue to audit call light times & provide staff education & training." In addition new business: "Blue mugs aren't being passed twice a shift on third floor" and the response was the staff who took the minutes was to inform the household coordinators "so they can begin to audit this." - The minutes on 6/25/14, old business both the concern for call lights and blue water mugs were revisited again with the response both had been added to the all staff meeting agenda for re-education on the call light expectation and quality improvement (QI) meetings for each floor respectively. - The minutes on 7/30/14, old business call light response time was and blue water mugs being passed were brought up but both were never new business on the council minutes from 6/25/14, but were both old and new business from the 5/28/14, minutes. - The minutes for 8/27/14, old business concern of call lights timely answering and the blue fresh	F 353		

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F 353	Continued From page 47 water mugs being passed were brought up, but neither of the concerns had been discussed in the previous minutes as new business from the 7/30/14, minutes. Although the subject of call lights and passing fresh water mugs had been brought up on several meetings the concerns were never followed up thoroughly or reviewed by the facility to look at the staffing patterns to ensure resident needs were met in a timely manner. In addition although the facility administrator and the staff indicated individual call light concerns had been investigated the facility failed to ensure there was a system in place to ensure all resident call lights were audited, tracked and trended to ensure staff were meeting the residents needs upon answering the call lights. The facility did not provide any information on the re-education provided to the staff regarding the concerns as indicated on the council minutes. The facility also did not look at the call light concerns, keeping in mind the residents who did not attend the council meetings, and that were not able to report the concerns to staff about call light delays. Review of the random schedules dated 12/29/13, going forward revealed the following: On 3/7/14: - AM Shift three NA positions were hand penciled on TCU and one NA in the TCU unit was changed to be a TMA. In addition in the TCU unit there were two RN's and one licensed practical nurse (LPN) scheduled on the day shift unaware of the census for this shift in the TCU. Also one NA from day shift worked a double from day to evening shift. -Night Shift TMA in TCU that was penciled in had the name crossed off with no reason unaware of what the census was that shift.	F 353		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 48 On 5/10/14: AM Shift one of the four TCU NA was crossed off with no reason; another was moved to Mallard Manor (MM) leaving two NA for the shift with census of twenty four unaware of the resident acuity/need level for the shift. In addition on MM two NA's were crossed off with no reason and only one was replaced of the five originally scheduled NA's again unaware of the census. - PM shift one NA was crossed off with no reason leaving two of three NA ' s originally scheduled NA's. On 5/10/14, according to the census for Wing 2 Direct Care Hours sheet provided by the facility, TCU was scheduled to have 60.50 NA hours and only 53.00 hours had been worked that day. On 7/21/14: daily roster by shift was requested but had not been provided to review in relation to a Resident/Visitor Occurrence Report for R105 who had a fall after putting his call light on for nineteen minutes before fall and had not been promptly answered. In analyzing both Wing 1 & Wing 2 Direct Care Hours spreadsheets, there was no set skill pattern for staffing but rather the hours were manipulated to reach per patient day hours and very widely in-skilled set. For example: -In Wing 2 on 5/10/14, census was 23 residents with 35.00 hours for RN; 24.50 hours for LPN; 7.50 hours for TMA and 61.00 hours for NA-F On 5/10/14, according to the census for Wing 2 Direct Care Hours sheet provided by the facility, TCU was scheduled to have 60.50 NA hours and only 53.00 hours had been worked that day.	F 353		

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	245462	A. BUILDING _____ B. WING _____	09/11/2014

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F 353	Continued From page 49 On 7/21/14: - daily roster by shift was requested but had not been provided to review in relation to a Resident/Visitor Occurrence Report for R105 who had a fall after putting his call light on for nineteen minutes before fall and had not been promptly answered. In analyzing both Wing 1 & Wing 2 Direct Care Hours spreadsheets, there was no set skill pattern for staffing but rather the hours were manipulated to reach per patient day hours and very widely in-skilled set. For example: -In Wing 2 on 5/10/14, census was 23 residents with 35.00 hours for RN; 24.50 hours for LPN; 7.50 hours for TMA and 61.00 hours for NA for total hours of 128.00 with per patient day of 5.57. -On 5/1/14, census was 27 with 45.00 hours for RN; 16.25 hours for LPN; 7.50 hours for TMA and 74.25 hours for NA for total hours of 143.00 with per patient day of 5.30. -On 5/24/14, census was 22 with 53.25 hours for RN; 0.0 hours for LPN; 0.0 hours for TMA and 60.0 hours for NA for total hours of 113.25 with per patient day of 5.15. When ICA and SC were asked about the facility staffing pattern plan (how many RN's, LPN's, TMA's and NA's) were planned for each unit the surveyor was referred to the staffing grind which did not indicate a set pattern for staffing skilled levels. In addition when asked if staffing had been brought up to quality improvement meeting ICA stated staffing was discussed every Thursday during staffing meetings but did not provide evidence staffing was analyzed for efficacy, effectiveness and patient safety but rather facility continued to cancel staff regularly as evidenced	F 353		

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F 353	Continued From page 50 by reviewing the daily shift rosters. TCU call light observations On 9/9/14, at 3:24 p.m. observed R220's call light visibly displayed on the call light panel and audibly heard at the nursing station. R220's call light went off at 3:32 p.m. When surveyor asked R220 what he had needed R220 stated he had rang his call light as he was waiting for his afternoon snack. R220 stated "usually the snack comes up at 3:00 p.m." At 3:45 p.m. R220 was still waiting for the staff to bring him his afternoon snack. At 3:31 p.m. observed R144's call light visibly displayed on the call light panel and audibly heard at the nursing station. R144's call light went off at 3:40 p.m. Writer heard R144 ask of NA-L for a blanket stating R144 was cold. On 9/10/14, at 8:42 a.m. observed R55's call light visibly displayed on the call light panel and audibly heard at the nursing station. R55's call light went off at 8:48 a.m. At 8:53 a.m. was heard over the radio call requesting staff assistance for R55 help to go to the bathroom. At 9:39 a.m. observed R218's call light visibly displayed on the call light panel and audibly heard at the nursing station. R218's call light went off at 9:44 a.m. Observed RN-F request help over the radio for staff assistance for R218 and heard NA-K reply over the radio "it will be awhile" as NA-K was helping another resident. R218 stated	F 353		

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F 353	Continued From page 51	F 353		

to surveyor RN-F had come into her room, turned off the call light and told R218 NA-K was busy helping another resident before R218 could go to the toilet.

At 10:00 a.m. R218 was observed in her room sitting in her wheelchair still waiting for assistance to the bathroom. R218 needed two staff assist with standing lift for toileting.

At 9:46 a.m. observed R219's call light visibly displayed on the call light panel and audibly heard at the nursing station. R219's call light went out at 9:52 a.m. The nurse at the desk had gotten up to answer R219's call light.

On 9/10/14, at 11:08 a.m. observed R208's call light visibly displayed on the call light panel and audibly heard at the nursing station. R208's call light went off at 11:20 a.m.

During observation of call light the health unit coordinator (HUC) was seated at the desk with the call light panel alarming and visibly displayed with the room numbers and the amount of time the call lights had been on.

At 11:14 a.m. observed R144's call light visibly displayed on the call light panel and audibly heard at the nursing station. R144's call light went off at 11:31 a.m. While the call light was on, the lights at the entrance above the door of R144's room displayed flashing white indicating R144 was requesting help. R144's room was visible to the nursing station with the door to R144's room open. While R144's call light rang several staff were observed to walk by R144's room without stopping to answer the call light including: NA-I, three therapy staff, dietary staff, housekeeper,

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F 353	Continued From page 52 two maintenance and the administrator. At 11:27 a.m. observed RN-C standing at desk with audible ringing of R144's call light at desk, RN-C observed to look at R144's white flashing light above R144's door and walked off. Observed RN-A and administrator standing at desk, the HUC seated at desk with audible sound of R144's call light and display of room number and time call light rang. No staff was observed going into R144's room while R144's call light rang. At 11:24 a.m. observed R219's call light visibly displayed on the call light panel and audibly heard at the nursing station. R219's call light went off at 11:31 a.m. At 11:30 a.m. observed R130's call light visibly displayed on the call light panel and audibly heard at the nursing station display the word CORD in capital letters and the audible sound of the ding ding ringing double increase in speed. R130's call light ended at 11:35 a.m. It was verified to surveyor that R130 had pulled his call light cord out of the wall. At 1:33 p.m. observed R144'scall light visibly displayed on the call light panel and audibly heard at the nursing station. R144's call light went out at 1:37 p.m. R144 observed to say to staff "had to go to the bathroom." At 1:37 p.m. observed R213's call light visibly displayed on the call light panel and audibly heard at the nursing station display the word TOILET in capital letters and the audible sound of the ding ding ringing double increase in speed. R213's call light went out at 1:44 p.m. While R213 waited on the toilet for assistance off RN-A, RN-F, HUC, the administrator and the social worker (SW) were up	F 353		

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F 353	Continued From page 53 at the nurse's station while the call light rang unattended. At 1:41 p.m. observed R221's call light visibly displayed on the call light panel and audibly heard at the nursing station. R221's call light went out at 1:46 p.m. On 9/11/14, at 8:08 a.m. observed R130's call light visibly displayed on the call light panel and audibly heard at the nursing station. R130's call light went out at 8:14 a.m. At 8:26 a.m. observed R220's call light visibly displayed on the call light panel and audibly heard at the nursing station. R220's call light went out at 8:35 a.m. At 9:31 a.m. observed R144's call light visibly displayed on the call light panel and audibly heard at the nursing station. R144's call light went out at 9:41 a.m. Staff and therapy were observed to have walked by R144's room without answering R144's call light. The HUC was seated at nursing station desk during observation. Observed R144's call light answered by SW. At time of observation the SW was observed going around the unit answering call lights, room after room. At 9:55 a.m. observed R213's call light visibly displayed on the call light panel and audibly heard at the nursing station display the word TOILET in capital letters and the audible sound of the ding ding ringing double increase in speed. R213's call light went out at 9:59 a.m. At time of the observation RN-A and the HUC were at desk with the call light panel alarming and visibly displayed R213's room, word TOILET in capital letters and the amount of time R213's call light had been on.	F 353		

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F 353	Continued From page 54 During interview with RN-F on 9/10/14, at 9:06 a.m. RN-F stated when the green light is on over the resident door and the resident pushed the call light button the pager goes to HELP and gets paged to the NAs right away, and then after 5 minutes when not answered by the NAs the nurses' page gets triggered and if the call light is not answered in 10 minutes the call light will again get triggered and paged to the nurses and then every 5 minutes after. RN-F stated she had been across the hall in a room helping another resident when she heard the page from the other nurse requesting assistance for R55. RN-F stated the facility had been using the new call light system since last November. RN-F further stated the green lights over the residents' doors are occasionally left on by staff. At 9:32 a.m. NA-J stated when resident census goes down the number of NAs workings are adjusted down. Call Light policy modified 10/10, directed, "1. All facility personnel must be aware of call light lights at all times. 2. Answer ALL call lights promptly whether or not you are assigned to the resident. 3. For bedside call lights, a light and/or a sound will appear and be heard over the door of the resident's room. 6. Answer all call lights in a prompt, calm, courteous manner; turn off the call light as soon as possible..." On 9/11/14, the staffing policy was requested and administrator indicated the facility did not have a staffing specific policy.	F 353		

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	245462	A. BUILDING **02 - MAIN BULIDING** B. WING _____	**09/16/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Maranatha Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/03/2014

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Maranatha Care Center is 2 buildings constructed in 2013. Main Building 02 is a 3-story building with no basement and was determined to be of Type II (222) construction. The building is fully fire sprinkler protected with UL 300 systems protecting the kitchen hoods on each floor. The building has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. There is a 16-bed locked memory care unit on the first floor. The building is attached to the Kitchen and Chapel 03 building which is of non-conforming construction and separated by a 2-hour fire wall. The Kitchen and Chapel 03 building is a 1-story building with no basement and was determined to be of Type V (111) construction. The building is fully fire sprinkler protected with a UL 300 system protecting the kitchen hood. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to the Main	K 000		

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K 000	Continued From page 2 Building 02 building which is of non-conforming construction and separated by a 2-hour fire wall. Due to the non-conforming construction, Maranatha Care Center is surveyed as 2 buildings with (2) CMS-2786R forms completed. The facility has a capacity of 97 beds and had a census of 90 at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain corridor doors in accordance with NFPA 101 Life Safety Code (00) Section 18.3.6.3. This deficient practice could affect some residents. Findings include: On facility tour between 10:00 AM and 12:00 PM on 09/16/2014, observation revealed that staff have taped over and blocked the door strikes to the memory care storage room doors.	K 018	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admissions against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of	10/3/14

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K 018	Continued From page 3 This deficient practice was verified by the maintenance director at the time of the inspection.	K 018	Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Tape was removed from the memory care storage room doors and all other storage room doors in the facility were checked for compliance. The fire doors for all storage areas will be added to the monthly fire door inspection checklist in the electronic work order system to ensure these doors are working properly. In addition, staff will be educated on the importance of maintaining the operational integrity of the fire doors. The Environmental Services Director or his designee will be responsible for ensuring that the monthly checks are completed. The safety committee will review the fire door inspection reports quarterly. Date certain for the purposes of ongoing compliance is 10/15/14.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2	K 050		10/3/14

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K 050	Continued From page 4 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to vary the times and dates of numerous fire drills in the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between between 10:00 AM and 12:00 PM on 09/16/2014, record review revealed that there is no documentation of AM or Night shift fire drills for the first quarter of 2014. This deficient practice was verified by the maintenance director at the time of the inspection.	K 050	The facility will conduct fire drills with frequencies and timings as required by NFPA 101 LSC (2000) including at least once per shift per quarter at varying times and conditions. These fire drills will be conducted by the Environmental Services Director or his designee. The fire drill schedule will be entered into the electronic work order scheduling system to ensure completion. The fire drill schedule will also be entered into the Campus Administrator's electronic calendar. The Campus Administrator will verify that the fire drills were conducted as required. The safety committee will review fire drill reports quarterly for accuracy and timeliness. Date certain for the purposes of ongoing compliance is 10/15/14.	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and review, the kitchen hood suppression system has not been maintained in accordance with The Life Safety Code, Section 9.2.3. This deficient practice could affect all residents.	K 069	The UL 300 fire suppression systems will be tested or inspected at frequencies and timings as required by NFPA 101 LSC (2000) of at least every 6 months. These inspections will be entered into the electronic work order system and the	10/3/14

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K 069	Continued From page 5 Findings include: On facility tour between 10:00 AM and 12:00 PM on 09/16/2014, record review revealed that all 4 UL300 systems were last inspected in October 2013. This deficient practice was verified by the maintenance director at the time of the inspection.	K 069	Environmental Services Director or his designee will be responsible for ensuring these inspections take place at the proper timing. These inspections will also be entered into the Campus Administrator's electronic calendar to ensure they are completed as required. The safety committee will review the inspection reports bi-annually for accuracy and timeliness. Date certain for purposes of ongoing compliance is October 15, 2014.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all residents. Findings include: On facility tour between 10:00 AM and 12:00 PM on 09/16/2014, record review revealed that: 1. There is no documentation of monthly generator testing prior to May 2014,	K 144	The generator will be inspected and tested as required by the NFPA 101 LSC (2000) whereas the generator and generator systems will be inspected weekly by the Environmental Services Director or his designee. The generator will be run under at least 30% load at least one time per month for at least 30 minutes. This testing will be arranged by the Environmental Services Director or his designee. The schedule for this inspection and testing will be entered into	10/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **02 - MAIN BULIDING** B. WING _____	**09/16/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

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K 144	Continued From page 6 2. There is no documentation of weekly generator testing prior to June 2014. These deficient practices were verified by the maintenance director at the time of the inspection.	K 144	the electronic work order scheduling system to ensure completion. The schedule for inspecting and testing the generator and systems will be entered into the Campus Administrator's electronic calendar. The Campus Administrator will verify that the inspection and testing of the generator and generator systems was completed as required. The safety committee will review the results of the inspection and testing for accuracy and timeliness. Date certain for the purposes of ongoing compliance is October 15, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **03 - KITCHEN AND CHAPEL** B. WING _____	**09/16/2014**

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MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Maranatha Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/03/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. BUILDING **03 - KITCHEN AND CHAPEL** B. WING _____	**09/16/2014**

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MARANATHA CARE CENTER	**5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Maranatha Care Center is 2 buildings constructed in 2013. Main Building 02 is a 3-story building with no basement and was determined to be of Type II (222) construction. The building is fully fire sprinkler protected with UL 300 systems protecting the kitchen hoods on each floor. The building has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. There is a 16-bed locked memory care unit on the first floor. The building is attached to the Kitchen and Chapel 03 building which is of non-conforming construction and separated by a 2-hour fire wall. The Kitchen and Chapel 03 building is a 1-story building with no basement and was determined to be of Type V (111) construction. The building is fully fire sprinkler protected with a UL 300 system protecting the kitchen hood. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The building is attached to the Main	K 000		

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	245462	A. BUILDING **03 - KITCHEN AND CHAPEL** B. WING _____	**09/16/2014**

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K 000	Continued From page 2 Building 02 building which is of non-conforming construction and separated by a 2-hour fire wall. Due to the non-conforming construction, Maranatha Care Center is surveyed as 2 buildings with (2) CMS-2786R forms completed. The facility has a capacity of 97 beds and had a census of 90 at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to vary the times and dates of numerous fire drills in the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include:	K 050	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be	10/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 050	Continued From page 3 On facility tour between between 10:00 AM and 12:00 PM on 09/16/2014, record review revealed that there is no documentation of AM or Night shift fire drills for the first quarter of 2014. This deficient practice was verified by the maintenance director at the time of the inspection.	K 050	discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. The facility will conduct fire drills with frequencies and timings as required by NFPA 101 LSC (2000) including at least once per shift per quarter at varying times and conditions. These fire drills will be conducted by the Environmental Services Director or his designee. The fire drill schedule will be entered into the electronic work order scheduling system to ensure completion. The fire drill schedule will also be entered into the Campus Administrator's electronic calendar. The Campus Administrator will verify that the fire drills were conducted as required. The safety committee will review fire drill reports quarterly for accuracy and timeliness. Date certain for the purposes of ongoing compliance is 10/15/14.	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 This STANDARD is not met as evidenced by:	K 069		10/3/14

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K 069	Continued From page 4 Based on observation and review, the kitchen hood suppression system has not been maintained in accordance with The Life Safety Code, Section 9.2.3. This deficient practice could affect all residents. Findings include: On facility tour between 10:00 AM and 12:00 PM on 09/16/2014, record review revealed that all 4 UL300 systems were last inspected in October 2013. This deficient practice was verified by the maintenance director at the time of the inspection.	K 069	The UL 300 fire suppression systems will be tested or inspected at frequencies and timings as required by NFPA 101 LSC (2000) of at least every 6 months. These inspections will be entered into the electronic work order system and the Environmental Services Director or his designee will be responsible for ensuring these inspections take place at the proper timing. These inspections will also be entered into the Campus Administrator's electronic calendar to ensure they are completed as required. The safety committee will review the inspection reports bi-annually for accuracy and timeliness. Date certain for purposes of ongoing compliance is October 15, 2014.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all residents.	K 144	The generator will be inspected and tested as required by the NFPA 101 LSC (2000) whereas the generator and generator systems will be inspected weekly by the Environmental Services Director or his designee. The generator	10/3/14

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K 144	Continued From page 5 Findings include: On facility tour between 10:00 AM and 12:00 PM on 09/16/2014, record review revealed that: 1. There is no documentation of monthly generator testing prior to May 2014, 2. There is no documentation of weekly generator testing prior to June 2014. These deficient practices were verified by the maintenance director at the time of the inspection.	K 144	will be run under at least 30% load at least one time per month for at least 30 minutes. This testing will be arranged by the Environmental Services Director or his designee. The schedule for this inspection and testing will be entered into the electronic work order scheduling system to ensure completion. The schedule for inspecting and testing the generator and systems will be entered into the Campus Administrator's electronic calendar. The Campus Administrator will verify that the inspection and testing of the generator and generator systems was completed as required. The safety committee will review the results of the inspection and testing for accuracy and timeliness. Date certain for the purposes of ongoing compliance is October 15, 2014.	

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	00226	A. BUILDING: _____ B. WING _____	09/11/2014

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 9/8/14 through 9/11/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule 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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide every two hours repositioning as directed by the care plan for 1 of 2 residents (R15) reviewed for pressure ulcers; in addition, the facility failed to follow the care plan for 1 of 1 resident (R143) whose call light was not accessible reviewed for environmental concerns. Findings include: Pressure ulcer: R15's electronic admission record dated 3/18/13, indicated R15 had diagnoses which included abnormal posture, anemia, and hemiplegia (paralysis on one side) affecting non-dominant side due to cerebrovascular disease. A Comprehensive Skin Risk Data Collection (CSRDC) dated 3/8/14, completed for R15 indicated R15 had moderate risk for development of pressure ulcers and R15 had a chronic	2 565	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. POC written for accompanying Federal deficiencies. Date certain for purposes of	10/3/14

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2 565	Continued From page 3 pressure ulcer to coccyx. A review of the Nurses' Progress Notes dated 7/25/14, indicated chronic pressure ulcer on coccyx had resolved. However, on 7/29/14, a Nurse's Progress Note indicated R15 had developed another unstageable pressure ulcer to coccyx area which measured 1 centimeter (cm) in length and 0.6 cm in width. The note described the wound bed as covered with slough, the surrounding skin with scar tissue and described the presence of redness between the wound and R15's rectum. R15's care plan revised on 7/31/14,addressed the importance of frequent repositioning and directed staff to reposition R15 every two hours during the day and two times at night. The undated Nursing Assistant Care Sheet for Team 2, Northern Lights Lane, indicated R15 as non-ambulatory and needed assistance of two staff for transfers, toileting and repositioning. The Care Sheet directed staff to reposition R15 every two hours. During a continuous observation on 9/11/14, at 7:10 a.m. to 10:05 a.m. R15 had not been repositioned for two hours and 55 minutes since first observed in wheelchair grooming self in front of mirror in her room. This was 55 minutes over the time as directed by the care plan. On 9/11/14, at 10:10 a.m. nursing assistant (NA)-D checked Nursing Assistant Care Sheet kept in her pocket and stated R15 was supposed to be repositioned every two hours. On 9/11/14, at 10:20 a.m. registered nurse (RN)-E stated he expected a resident with	2 565	ongoing compliance is 10/15/14.	

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2 565	Continued From page 4 pressure ulcer to be repositioned according to care plan. RN-E further stated R15 should have been repositioned every two hours as directed by care plan. On 9/11/14, at 10:29 a.m. RN-D stated R15 had a chronic pressure ulcer to coccyx and different treatments were tried and the pressure ulcer "got better" then re-opened up again. RN-D verified interventions in R15's care plan included repositioning every two hours, but R15 had not been repositioned according to the care plan. On 9/11/14, at 3:22 p.m. the interim clinical administrator (ICA) acknowledged facility staff should have followed the care plan as directed on repositioning R15 every two hours according to the care plan. The facility's Resident Care Plan/"I" Care Plan Policy and Procedure modified on 6/14, provided guidelines for staff to coordinate all cares which are necessary to accomplish goals in meeting the needs of the resident, and to communicate vital information and assign care for all disciplines. Call light: On 9/8/14, at 3:28 p.m. during R143's room observation the call light was observed on the floor by the head of bed slightly behind the night stand and in between the bed night stand. R143 was observed coming ambulating down the hallway from her room towards the dining room. On 9/9/14, at 9:15 a.m. to approximately 1:15 p.m. R143's call light was observed to remain on the floor behind the night stand not accessible to the resident.	2 565		

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2 565	Continued From page 5 On 9/9/14, at approximately 3:45 p.m. during the environmental tour the administrator verified the call light was on the floor and picked it off the floor from behind the night stand. When asked what her expectation was for call light accessibility, the administrator stated "all call lights have to be at reach at all times regardless if resident is able to use it or not." R143's care plan dated 8/13/14, identified R143 was at risk for falls related to incontinence, history of falls and unsteady gait at times. The care plan directed, "Be sure my [R143's] call light is within reach encourage me to use it for assistance as needed." Call Light policy dated as last modified on 10/10, directed, "Position the call light conveniently for the resident to use..." SUGGESTED METHOD OF CORRECTION: The DON could schedule an in service to discuss the importance of following the plans of care for residents. The quality assurance committee could randomly audit residents records to insure compliance. The DON could review and revise policies and procedures for care delivery systens and provide addition training to involved staff. A designated staff could monitor the system to insure cares are being delivered (monitoring). TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient	2 800		10/3/14

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2 800	Continued From page 6 number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interviews and document review with residents, family, and staff, the facility failed to ensure sufficient qualified nursing staff was available to meet the needs of residents observed/interviewed (R15, R218, R3, R168, R208, R17, R134, R11) as well as family member voiced concerns regarding lack of staff persons to assure resident needs were met timely. This had the potential to affect 89 of 89 residents that resided at the facility. Findings include: Pressure ulcer: R15's quarterly Minimum Data Set (MDS) dated 6/9/14, identified R15 to have a stage II pressure ulcer with granulation tissue, needed extensive assistance of one staff for repositioning, transfers, toileting, and personal hygiene. R15's quarterly MDS also indicated R15 had severe cognitive impairment. The MDS dated 9/4/14, revealed R15 had one Stage 2 pressure ulcer and the pressure ulcer was there upon admission. The MDS did identify R15 as being at risk for development of pressure ulcers. The MDS did not indicate R15 had a Stage 3 pressure ulcer that was identified by the facility on 7/8/14. The MDS also lacked evidence	2 800	POC written for accompanying Federal deficiencies. Date certain for purposes of ongoing compliance is 10/15/14.	

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2 800	Continued From page 7 of the unstageable pressure that was identified by the facility on 7/29/14, when the new pressure ulcer developed and again on 8/26/14, as identified on the Wound Consultation sheet. In addition, the MDS lacked evidence R15 was on a turning and repositioning program as that section was left blank. The MDS also lacked evidence that there was a previous healed pressure ulcer identified on 7/25/14, as per the progress note which indicated the coccyx pressure ulcer had been resolved. On 9/10/14, at 7:18 a.m. R15 was observed lying in bed awake. Nursing assistant (NA)-C and licensed practical nurse (LPN)-A was in R15's room to help R15 get up from bed. With R15's permission, the surveyor observed a pressure wound on R15's coccyx with LPN-A. LPN-A stated she had "just changed" the dressing to R15's coccyx. The wound dressing was dated 9/10 and was intact. LPN-A carefully opened the adhesive dressing to be checked. Observation of the wound no drainage however, a yellow discoloration was observed on the dressing and was identified by LPN-A as a Medihoney treatment. On 9/11/14, from 7:10 a.m. to 7:25 a.m. R15 was observed in her room seated on a cushion in the wheelchair. -At 7:26 a.m. registered nurse (RN)-D, entered R15's room and was observed to give R15 some medications, then left when R15 took all the medications. -From 7:31 a.m. to 7:58 a.m. R15 remained in room alone, was in front of mirror and continued grooming herself. -At 8:01 a.m. NA-B and NA-M entered R15's room, NA-B approached R15 and put R15's dentures in R15's mouth, and changed R15's	2 800		

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2 800	Continued From page 8 shirt. NA-M pushed R15 out to the hallway and to the Northern Lights Lane (NLL) unit television (TV) area/lounge. During that observation, R15 was not off-loaded from wheelchair nor repositioned from original position. -From 8:06 a.m. to 8:35 a.m. R15 remained seated in wheelchair on the same spot at the TV lounge and watching TV. R15 was calm and still in the same position in wheelchair. R15 did not reposition herself. -At 8:35 a.m. RN-E approached where R15 was parked in wheelchair at the NLL TV lounge and talked briefly to R15. RN-E was observed to push R15 to the dining room area towards R15's table. R15 was not off-loaded nor repositioned from original position in wheelchair, nor did R15 reposition herself. -From 8:49 a.m. to 9:20 a.m. R15 remained seated in wheelchair at the dining room, slowly working on breakfast with the use of right hand. -At 9:25 a.m. NA-B wheeled R15 away from the dining table towards the NLL TV area. NA-B left R15 in front of TV at the NLL TV area. -At 9:32 a.m. NA-B returned to push R15's wheelchair away from NLL TV area towards hallway going past the first floor nurses' station and to the elevators. NA-B stated she was to take R15 to the 3rd floor for an activity. -At 9:34 a.m. R15 was at the 3rd floor activities' room with other residents where a female staff member was reading the newspaper. R15 was not off-loaded nor repositioned from wheelchair. R15 did not reposition herself. -At 9:43 a.m. R15 was still seated in wheelchair, was calm and appeared to be listening to the reader at the news reading activity. -At 9:59 a.m. RN-D was notified that R15 had been seated in the wheelchair from 7:25 a.m. to 10:05 a.m. and requested that R15 be assessed for skin condition.	2 800		

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2 800	Continued From page 9 -At 10:03 a.m. R15 was pushed to common area in Room 112 by NA-M and RN-E. The two staff members left R15 seated in wheelchair in the common area/hallway. -At 10:05 a.m. RN-D and NA-D, entered common area in R15's room. R15 gave permission for skin check on her buttocks. R15 was transferred from wheelchair to bed by use of gait belt by RN-D, RN-E and NA-D. RN-D confirmed dressing on wound was from 9/10/14, RN-E assessed pressure wound on R15's buttocks and described that open area on R15's coccyx had 90% slough, slight redness on surrounding skin up to the open area, skin to rest of buttocks clear dry, intact, with creases from diaper and skin was blanchable. R15 went two hours and 55 minutes without repositioning. Stage 1 family interview On 9/8/14, at 7:00 p.m. during interview when asked if family member (F)-A felt there was enough staff available to make sure your family member get the care and assistance they need without having to wait a long time, F-A stated "call lights can be a challenge to answer at times and it can take a long time before they could answer it and if they come they would indicate they would come back and they don't come back. I usually get on their case. " Stage 1 Resident Interviews R218's Brief Interview for Mental Status (BIMS) assessment dated 8/28/14, indicated R218 had intact cognition. Medicare/Skilled Note dated 9/5/14, indicated R218 required assist of one activities of daily living and two assist with transfers, toileting and bed mobility. In addition Progress Notes dated 8/25/14, through 9/11/14, indicated R218 was pleasant and cooperative with cares.	2 800		

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2 800	Continued From page 10 On 9/8/14, at 3:45 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R218 stated, "On night shift have to wait a long time, staff say they are very busy and say will come back to you but don't ... I called my daughter at 1:15 a.m. one time after they put me on a plastic sharp bedpan and didn't take me off till 4:00 a.m. on a weekend. Staff flip name tags or don't wear them, I told [registered nurse, RN-A], one night and two nights later was good, told [RN-A] again today third time, and he said he would investigate some. [I] tried to tell the social worker and she said she would get back to me ...I have had to go in my pants a couple of times a little and in bed when bedpan was not positioned correctly. R218 further stated now she gets up to the bathroom with two assist and "staff at night hurries me, but they never hurry themselves." R3's quarterly MDS dated 8/1/14, indicated cognition was moderately impaired and required extensive physical assistance of one staff with dressing, toileting, transfers and personal hygiene. In addition the MDS indicated R3 used both a walker and wheelchair for mobility and had no behaviors. On 9/9/14, at 11:28 a.m. during interview when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time. R3 stated, "They always say they are in a hurry just like this morning, so I just don't know if they have enough staff." R3 stated she called for help "early this morning"	2 800		

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2 800	Continued From page 11 and put on the call light. R3 stated "two girls" came in to the room and told her to get up. R3 reminded the staff she could not get up by herself and needed help to do so, but the staff left without attending to R3's needs. R3 stated she put the call light on again, then staff came in and "shut it off" without helping R3. R3 was observed to be teary-eyed as she talked about what happened that morning. R3 wiped own tears, took some pauses and continued to talk about having felt sick and getting the bed wet. R3 stated, "I was crying, I never wet the bed like that before." R3 pointed to one pillow (without a pillow case) lying at the head of the bed and described the bed was wet all the way up to her pillow. R3 stated, "I felt so bad." On 9/9/14, at 11:34 a.m. during interview when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R3 stated, "They always say they are in a hurry just like this morning, so I just don't know if they have enough staff." R168's quarterly MDS dated 6/12/14, indicated cognition was intact was independent but also required physical supervision oversight of one staff with toileting and personal hygiene and used a walker for mobility and had no behaviors. On 9/9/14, at 10:05 a.m. during interview when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R168 stated, "Sometimes I wait an hour to eat..." R208's MDS dated 8/19/14, indicated cognition	2 800		

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2 800	Continued From page 12 was intact and required extensive physical assistance of one to two staff with dressing, toilet use, bed mobility, transfers and personal hygiene. In addition, the MDS indicated R208 used a wheelchair for mobility and had functional limitation of range motion on one side upper and lower extremity and had no behaviors. On 9/8/14, at 4:51 p.m. during interview when asked if she felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R208 stated, "They need more staff in morning and evening." R17's quarterly MDS dated 6/17/14, indicated cognition was severely impaired and required extensive physical assistance of one staff with dressing, toileting, transfers and personal hygiene and had no behaviors. On 9/8/14, at 4:13 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R17 stated, "I don't think they got enough staff because they always say that somebody has called-in sick and they don't replace them once in awhile they do." R134's quarterly MDS dated 8/4/14, indicated cognition was severely impaired and required extensive physical assistance of one to two staff with dressing, toileting, transfers and personal hygiene. In addition the MDS indicated R3 used both a walker and wheelchair for mobility and had no behaviors.	2 800		

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2 800	Continued From page 13 On 9/8/14, at 6:28 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R134 stated, "Sometime have to wait for a long time after putting call light on." R11's quarterly MDS dated 6/12/14, indicated cognition was intact and required extensive physical assistance of one staff with dressing, toileting and personal hygiene; had a functional limitation in ROM to both lower extremities and in addition used wheelchair for mobility and had no behaviors. On 9/8/14, at 6:48 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time R11 stated, "They have tried to cut down the help and its very noticeable." On 9/9/14, at approximately 2:30 p.m. a resident who requested to remain anonymous indicated to surveyor the bedside water mugs had not been changed since Sunday 9/7/14, and this had been a problem which had been brought up at the resident council and the unit staff, but had not resolved and the resident thought was related to staffing. The anonymous resident further stated on the next resident council this was going to be brought to the facility attention. Random call light observation 3rd floor On 9/10/14, at 7:35 a.m. observed call light in R97's room on. The hallway light to room was on and R97 was observed lying in bed with an adaptive call light lying on top of the bedding. -At approximately 7:40 a.m. observed nursing	2 800		

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2 800	Continued From page 14 assistant (NA)-A walking down the hallway towards R97's room as she was walking trained medication aide (TMA)-A was overheard in a high tone of voice, "Are you going to get [R97] call light?" and NA-A replied, "Yeah" as she continued to walk into R97's room. -At approximately 7:41 a.m. NA-A came right out was observed cleansing her hands at the door and walked away from the room after answering the call light. When interviewed on 9/10/14, at 7:41 a.m. NA-A stated R97 was a sleep and had probably bumped her call light in her sleep. -At 7:42 a.m. again R97's call light was observed on and NA-A went into the room briefly spoke with R97 then shut the door after putting the light on. When interviewed on 9/10/14, at 7:47 a.m. NA-A came out of R97's room when asked what assistance R97 required, NA-A stated R97 had bumped the call light the first time she had been in the room and when she went in the second time, R97 had indicated she needed to use the bed pan. NA-A stated R97 had thought she was about to get up soon and would use the bed pan then but had told NA-A to still put her on the bed pan anyway. When asked when a resident call light was on and if NA-A would just turn it off without asking the resident or meeting the need, NA-A stated she was supposed to ask and not assume, but had thought resident had bumped the call light. Staff interviews When interviewed on 9/9/14, at approximately 2:13 p.m. the administrator stated she was aware of the ice machine on 3rd Floor was malfunctioning and had spoken with the environmental service director to get a	2 800		

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2 800	Continued From page 15 replacement. When asked how come the staff would not get the ice from another floor, administrator stated it was challenging and the residents who had the problem were those that got ice for themselves from the machine. When asked about the other residents who were not able to get the water for themselves and never got fresh water administrator referred surveyor to resident council minutes. On 9/11/14, at 10:45 a.m. an interview was conducted with the staffing coordinator (SC) and interim clinical administrator (ICA). - When asked how the facility determined the staffing pattern SC stated "by the grid we have for each floor" as she showed sheets which indicated the census and staffing patterns. - When asked who did staffing when SC was not at the facility SC stated, "We had a girl for back up and she quit a week ago and someone else is being trained in." - When asked if the facility used pool staffing to supplement for sick calls or other leaves both SC and ICA indicated the facility did not use pool. - When asked who handled the sick calls SC stated "they are supposed to call me or their supervisor who would fill the sick call sheet. - When asked what happened when the census was low and if the facility flexed down ICA stated the facility would flex with census but there was flexibility with acuity with census. - When asked if staffing was tracked and trended with incidents such as falls, infections among others and if there any patterns with staffing ICA stated falls were discussed on the daily interdisciplinary team meetings (IDT) and "we try to ask the five whys." - When asked if staffing concerns had been identified or reported to management ICA stated "Staff have had concerns for being sent home	2 800		

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2 800	Continued From page 16	2 800		

due to low census and low acuity and this reflects on their pay check but no workload particular concerns except for one nurse who has requested to receive more training as she is being moved to a different unit transitional care unit (TCU) from long term unit." ICA also indicated falls stated falls had decreased in the last quarter and anytime "we have had a call light concern we have had to run the report for the resident with concern and a grievance is completed per the facility grievances policy is followed."
- When asked about the facility employee turnover rate, open positions, and if both were being reported to quality assurance meeting in the last quarter ICA stated, "We have had an increase in the turnover rate." ICA also indicated the facility had "a staffing meeting on Thursday where we discuss the turnover rate and the positions being offered." SC provided a list of open nursing positions for both licensed nurses and nursing assistant (NA's) which showed the facility had five part time NA positions on all shifts combined open and four part time and one full time nurses positions open also.
- When asked if ICA or corporate did exit interviews, ICA stated they had not done them personally and corporate does not do them, "but if the staff are not meeting our standards we have to let them go."

On 9/11/14, at approximately 12:17 a.m. both the administration and ICA approached surveyor indicated the call log for the last six months was eleven thousand pages. Administrator stated usually when a call light concern had been brought up by residents the log was printed out and a grievance form was completed accordingly. Administrator further indicated in the past the facility was printing the call light logs and would

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2 800	Continued From page 17 go through them and made an interactive posting for the staff. - When asked if any of those were available, she stated there was no record of it. - When asked if the facility did audits of the staff doing them on the floor over a period of time during the shift, the administrator stated the facility did not do that. - When asked since the audits were not being done on the floors by the staff, if she knew if the resident needs had been met, the administrator stated she thought when the staff answered the call light the resident need had been met. On 9/11/14, at 12:47 p.m. the administrator approached surveyors stated the facility did not have a specified staffing policy, but rather followed the grind and acuity guide that SC had provided earlier. When interviewed on 9/11/14, at 2:18 p.m. RN-B stated her expectation was that all staff was to answer the call lights and when they went to the resident room they were supposed to make sure the resident need was met before leaving the room. RN-B further stated she did not expect a staff to stop in the middle when assisting another resident to answer the call light, but she expected other staff on the unit not occupied to answer the call lights. When interviewed on 9/11/14, at 3:53 p.m. ICA stated she would have expected the staff to answer the call lights promptly and meet the need and would also expect them to come back to the resident room if the staff had been in the room and turned off the light and indicated they were coming back. Review of Resident/Visitor Occurrence Reports	2 800		

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2 800	Continued From page 18 provided by the facility dated 2/1/14, through 9/9/14, revealed the following: - Resident/Visitor Occurrence Report dated 6/30/14, at 11:10 p.m. for R105 revealed R105 had indicated he had to use the bathroom and had put the call light on but staff had not responded so he thought he was able to self-transfer as staff was probably helping another resident. Follow up call light log revealed R105's call light had been put on at 10:51 p.m. which was over nineteen minutes to R105's falls. RN-A indicated he would follow-up with staff regarding call light response time. - Resident/Visitor Occurrence Report dated 7/21/14, at 6:50 a.m. indicated R153 had been found kneeling on the floor leaning over the bed. Follow-up education facility investigation indicated R153 was at risk for falls related to being restless while in bed and confusion. The investigation further indicated, "His current care plan is to be up by [6:00] due to this reason. The night prior to this the Night shift was not able to assist him out of bed [due to] d/t staffing issues, though day shift was more than adequately staffed, [R153] should have been the priority for AM cares this morning to prevent this from happening ..." Although the staff were filling a report of when, where, and what time last resident had been seen before the fall/incident, the forms lacked indication of the last time resident had been toileted, lacked where the call light was, as most of the reports identified residents had to use the bathroom and most had been found on the bathroom floors at different times of the day. Secondly resident supervision had been identified as residents had been left in the room for an extended period of time before staff returned to assist.	2 800		

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2 800	Continued From page 19 Review of Resident/Family/Staff-Quality Concern Forms provided by the facility dated between 4/23/14, to 8/27/14, revealed concerns of call light response time, meeting the needs and coming back after leaving unanswered call light had been brought up to the facility by alert residents and a family member multiple times and signed off by the administrator. Although the facility had indicated staff education had been provided and the call light logs had been reviewed, there was no evidence of follow ups completed to ensure resident needs had been met despite the call lights being answered timely, as indicated on the investigations. A review of the Monthly Resident Council Minutes and responses from 6/12/13, through 8/27/14, revealed the following: - On 2/26/14, the minute's new business concerns: "Call lights can take a long time to answer, more than the goal of 5 minutes. One resident felt like staff made her wait longer so that they would only have to come to her room once to get her ready for bed. [Household coordinator] HHC will follow-up with the resident and this concern ..." One of the staff explained the new call light system had reports that can be pulled to look at call light times; trends, average call light times, and indicated the household coordinator would be looking at these reports on a regular basis. - A minutes on 3/26/14, the subject of call lights concern was omitted from the old business. In addition on the new business several concerns were brought up: "Staff aren't always giving residents the amount of time they need to finish their meals and are taking their plate away before they are done eating.	2 800		

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2 800	Continued From page 20 Staff telling resident that "They'll be back in a minute, I have to finish up something" and they may or may not come back. Staff will come in, shut the call light off and not answer/meet the resident's need." Response/action to be taken to all three concerns was indicated as "Staff education." - The minutes on 4/30/14, call lights and/or staffing concerns were omitted from the old business minutes. - The minutes on 5/28/14, new business indicated, "Call light response time has slowed down again. Residents will request pain medications & not receive it in a timely manner" response indicated the household coordinators "will continue to audit call light times & provide staff education & training." In addition new business: "Blue mugs aren't being passed twice a shift on third floor" and the response was the staff who took the minutes was to inform the household coordinators "so they can begin to audit this." - The minutes on 6/25/14, old business both the concern for call lights and blue water mugs were revisited again with the response both had been added to the all staff meeting agenda for re-education on the call light expectation and quality improvement (QI) meetings for each floor respectively. - The minutes on 7/30/14, old business call light response time was and blue water mugs being passed were brought up but both were never new business on the council minutes from 6/25/14, but were both old and new business from the 5/28/14, minutes. - The minutes for 8/27/14, old business concern of call lights timely answering and the blue fresh water mugs being passed were brought up, but neither of the concerns had been discussed in the previous minutes as new business from the	2 800		

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2 800	Continued From page 21 7/30/14, minutes. Although the subject of call lights and passing fresh water mugs had been brought up on several meetings the concerns were never followed up thoroughly or reviewed by the facility to look at the staffing patterns to ensure resident needs were met in a timely manner. In addition although the facility administrator and the staff indicated individual call light concerns had been investigated the facility failed to ensure there was a system in place to ensure all resident call lights were audited, tracked and trended to ensure staff were meeting the residents needs upon answering the call lights. The facility did not provide any information on the re-education provided to the staff regarding the concerns as indicated on the council minutes. The facility also did not look at the call light concerns, keeping in mind the residents who did not attend the council meetings, and that were not able to report the concerns to staff about call light delays. Review of the random schedules dated 12/29/13, going forward revealed the following: On 3/7/14: - AM Shift three NA positions were hand penciled on TCU and one NA in the TCU unit was changed to be a TMA. In addition in the TCU unit there were two RN's and one licensed practical nurse (LPN) scheduled on the day shift unaware of the census for this shift in the TCU. Also one NA from day shift worked a double from day to evening shift. -Night Shift TMA in TCU that was penciled in had the name crossed off with no reason unaware of what the census was that shift. On 5/10/14: AM Shift one of the four TCU NA was crossed off with no reason; another was moved to Mallard Manor (MM) leaving two NA for the shift	2 800		

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2 800	Continued From page 22 with census of twenty four unaware of the resident acuity/need level for the shift. In addition on MM two NA's were crossed off with no reason and only one was replaced of the five originally scheduled NA's again unaware of the census. - PM shift one NA was crossed off with no reason leaving two of three NA ' s originally scheduled NA's. On 5/10/14, according to the census for Wing 2 Direct Care Hours sheet provided by the facility, TCU was scheduled to have 60.50 NA hours and only 53.00 hours had been worked that day. On 7/21/14: daily roster by shift was requested but had not been provided to review in relation to a Resident/Visitor Occurrence Report for R105 who had a fall after putting his call light on for nineteen minutes before fall and had not been promptly answered. In analyzing both Wing 1 & Wing 2 Direct Care Hours spreadsheets, there was no set skill pattern for staffing but rather the hours were manipulated to reach per patient day hours and very widely in-skilled set. For example: -In Wing 2 on 5/10/14, census was 23 residents with 35.00 hours for RN; 24.50 hours for LPN; 7.50 hours for TMA and 61.00 hours for NA-F On 5/10/14, according to the census for Wing 2 Direct Care Hours sheet provided by the facility, TCU was scheduled to have 60.50 NA hours and only 53.00 hours had been worked that day. On 7/21/14: - daily roster by shift was requested but had not been provided to review in relation to a Resident/Visitor Occurrence Report for R105 who had a fall after putting his call light on for nineteen minutes before fall and had not been	2 800		

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2 800	Continued From page 23 promptly answered. In analyzing both Wing 1 & Wing 2 Direct Care Hours spreadsheets, there was no set skill pattern for staffing but rather the hours were manipulated to reach per patient day hours and very widely in-skilled set. For example: -In Wing 2 on 5/10/14, census was 23 residents with 35.00 hours for RN; 24.50 hours for LPN; 7.50 hours for TMA and 61.00 hours for NA for total hours of 128.00 with per patient day of 5.57. -On 5/1/14, census was 27 with 45.00 hours for RN; 16.25 hours for LPN; 7.50 hours for TMA and 74.25 hours for NA for total hours of 143.00 with per patient day of 5.30. -On 5/24/14, census was 22 with 53.25 hours for RN; 0.0 hours for LPN; 0.0 hours for TMA and 60.0 hours for NA for total hours of 113.25 with per patient day of 5.15. When ICA and SC were asked about the facility staffing pattern plan (how many RN's, LPN's, TMA's and NA's) were planned for each unit the surveyor was referred to the staffing grind which did not indicate a set pattern for staffing skilled levels. In addition when asked if staffing had been brought up to quality improvement meeting ICA stated staffing was discussed every Thursday during staffing meetings but did not provide evidence staffing was analyzed for efficacy, effectiveness and patient safety but rather facility continued to cancel staff regularly as evidenced by reviewing the daily shift rosters. TCU call light observations On 9/9/14, at 3:24 p.m. observed R220's call light	2 800		

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2 800	Continued From page 24 visibly displayed on the call light panel and audibly heard at the nursing station. R220's call light went off at 3:32 p.m. When surveyor asked R220 what he had needed R220 stated he had rang his call light as he was waiting for his afternoon snack. R220 stated "usually the snack comes up at 3:00 p.m." At 3:45 p.m. R220 was still waiting for the staff to bring him his afternoon snack. At 3:31 p.m. observed R144's call light visibly displayed on the call light panel and audibly heard at the nursing station. R144's call light went off at 3:40 p.m. Writer heard R144 ask of NA-L for a blanket stating R144 was cold. On 9/10/14, at 8:42 a.m. observed R55's call light visibly displayed on the call light panel and audibly heard at the nursing station. R55's call light went off at 8:48 a.m. At 8:53 a.m. was heard over the radio call requesting staff assistance for R55 help to go to the bathroom. At 9:39 a.m. observed R218's call light visibly displayed on the call light panel and audibly heard at the nursing station. R218's call light went off at 9:44 a.m. Observed RN-F request help over the radio for staff assistance for R218 and heard NA-K reply over the radio "it will be awhile" as NA-K was helping another resident. R218 stated to surveyor RN-F had come into her room, turned off the call light and told R218 NA-K was busy helping another resident before R218 could go to the toilet. At 10:00 a.m. R218 was observed in her room sitting in her wheelchair still waiting for assistance	2 800		

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2 800	Continued From page 25 to the bathroom. R218 needed two staff assist with standing lift for toileting. At 9:46 a.m. observed R219's call light visibly displayed on the call light panel and audibly heard at the nursing station. R219's call light went out at 9:52 a.m. The nurse at the desk had gotten up to answer R219's call light. On 9/10/14, at 11:08 a.m. observed R208's call light visibly displayed on the call light panel and audibly heard at the nursing station. R208's call light went off at 11:20 a.m. During observation of call light the health unit coordinator (HUC) was seated at the desk with the call light panel alarming and visibly displayed with the room numbers and the amount of time the call lights had been on. At 11:14 a.m. observed R144's call light visibly displayed on the call light panel and audibly heard at the nursing station. R144's call light went off at 11:31 a.m. While the call light was on, the lights at the entrance above the door of R144's room displayed flashing white indicating R144 was requesting help. R144's room was visible to the nursing station with the door to R144's room open. While R144's call light rang several staff were observed to walk by R144's room without stopping to answer the call light including: NA-I, three therapy staff, dietary staff, housekeeper, two maintenance and the administrator. At 11:27 a.m. observed RN-C standing at desk with audible ringing of R144's call light at desk, RN-C observed to look at R144's white flashing light above R144's door and walked off. Observed RN-A and administrator standing at desk, the HUC seated at desk with audible sound of R144's call light and display of room number and time	2 800		

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2 800	Continued From page 26 call light rang. No staff was observed going into R144's room while R144's call light rang. At 11:24 a.m. observed R219's call light visibly displayed on the call light panel and audibly heard at the nursing station. R219's call light went off at 11:31 a.m. At 11:30 a.m. observed R130's call light visibly displayed on the call light panel and audibly heard at the nursing station display the word CORD in capital letters and the audible sound of the ding ding ringing double increase in speed. R130's call light ended at 11:35 a.m. It was verified to surveyor that R130 had pull SUGGESTED METHOD OF CORRECTION: The Administrator and Director of Nursing could review their staffing patterns and develop ways to promote and recruit needed staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		10/3/14

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2 900	Continued From page 27 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to promote healing and prevent further skin breakdown for 1 of 2 residents (R15) in the sample reviewed for pressure ulcers. This resulted in actual harm, as R15 had a recurrent pressure ulcer. Findings include: On 9/10/14, at 7:18 a.m. R15 was observed lying in bed awake. Nursing assistant (NA)-C and licensed practical nurse (LPN)-A was in R15's room to help R15 get up from bed. With R15's permission, the surveyor observed a pressure ulcer on R15's coccyx with LPN-A. LPN-A stated she had "just changed" the dressing to R15's coccyx. The wound dressing was dated 9/10 and was intact. LPN-A carefully opened the adhesive dressing to be checked. The wound was observed to have no drainage however, a yellow discoloration was observed on the dressing which LPN-A identified as being from Medihoney, a gel wound treatment. During observations of R15 on 9/11/14, from 7:10 a.m. to 7:25 a.m., R15 was observed in her room seated on a cushion in the wheelchair. -At 7:26 a.m. registered nurse (RN)-D, entered R15's room and was observed to give R15 some medications, then left when R15 took all the medications.	2 900	POC written for accompanying Federal deficiencies. Date certain for purposes of ongoing compliance is 10/15/14.	

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2 900	Continued From page 28 -From 7:27 a.m. to 8:00 a.m. R15 remained in her room alone, seated in front of a mirror grooming herself. -At 8:01 a.m. NA-B and NA-M were observed to enter R15's room, NA-B approached R15 and put her dentures in and changed her shirt. NA-M then pushed R15 out to the hallway at 8:05 a.m., and to the Northern Lights Lane (NLL) unit television (TV) area/lounge. During that observation, R15 was not off-loaded from her wheelchair, nor was she repositioned. -From 8:06 a.m. to 8:35 a.m. R15 remained seated in wheelchair in the same spot in the TV lounge. R15 remained in the same position in her wheelchair and did not receive assistance, nor reposition herself. -At 8:35 a.m. RN-E approached where R15's wheelchair was parked in the NLL TV lounge. RN-E was observed to speak briefly to R15, and then to push R15 to the dining room area towards R15's table. R15 was not off-loaded or repositioned and did not reposition herself. -From 8:49 a.m. to 9:20 a.m. R15 remained seated in wheelchair at the dining room, slowly working on breakfast with the use of right hand. -At 9:25 a.m. NA-B wheeled R15 away from the dining table towards the NLL TV area. NA-B left R15 in front of TV at the NLL TV area. -At 9:32 a.m. NA-B returned to push R15's wheelchair away from NLL TV area towards hallway going past the first floor nurses' station and to the elevators. NA-B stated she was to take R15 to the 3rd floor for an activity. -At 9:34 a.m. R15 was observed in the 3rd floor activity room with other residents where a female staff member was reading the newspaper. R15 was not off-loaded nor repositioned and did not reposition herself. -At 9:43 a.m. R15 was still seated in wheelchair, was calm and appeared to be listening to the	2 900		

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2 900	Continued From page 29	2 900		

reader at the news reading activity.
-At 10:02 a.m. RN-D was notified by the surveyor that R15 had been seated in the wheelchair since 7:25 a.m., and requested that R15 be assessed for skin condition.
-At 10:03 a.m. R15 was pushed to the common area in Room 112 by NA-M and RN-E. The two staff members left R15 seated in the wheelchair in the common area/hallway.
-At 10:05 a.m. RN-D, RN-E and NA-D, were observed to enter R15's room with her permission. R15 also gave permission for the staff to check the skin on her buttocks. R15 was transferred from her wheelchair to her bed with the use of a gait belt by RN-D, RN-E and NA-D. RN-D confirmed the dressing on R15's wound was from 9/10/14. RN-E assessed the pressure wound on R15's buttocks and described the open area on R15's as having 90% slough and slight redness on the surrounding skin up to the open area. The skin over the rest of the buttocks was clear, dry, intact, and the skin was blanchable. Although the resident had been observed from 7:10 a.m.-10:05 a.m. on 9/11/14, a period of 2 hours and 55 minutes, she was not offered, or encouraged, to be repositioned during that time.

R15's electronic admission record dated 3/18/13, indicated R15 had diagnoses which included abnormal posture, anemia, hemiplegia (paralysis on one side) affecting non-dominant side due to cerebrovascular disease, neurogenic bladder, and pain in joints. The admission care plan dated 3/18/13, revealed R15 had been admitted with a pressure ulcer to the coccyx.

A review of the Nurses' Progress Notes from the facility's last recertification survey exited in June 2013 forward, indicated R15 had a pressure ulcer on her coccyx as of 6/19/13. The Nurses'

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2 900	Continued From page 30 Progress Notes revealed R15's pressure ulcer on coccyx persisted through assessment dates beginning 6/19/13 until 7/25/14. The pressure ulcer had fluctuated in its stages of healing as evidenced by varied measurements pulled from the interdisciplinary/wound team progress notes as follows: -On 6/19/13, R15's coccyx pressure wound measured 1.5 centimeters (cm) X 0.5 cm X 0.3 cm. -On 12/5/13, R15's coccyx pressure wound measured 2.7 cm X 0.9 cm X 0.4 cm. -On 6/3/14, R15's coccyx pressure wound measured 0.3 cm X 0.3 cm X 0.2 cm. -On 7/8/14, R15's coccyx pressure wound measured 0.7 cm X 0.3 cm X 0.2 cm. -On 7/25/14, the documentation indicated the wound team had determined R15's coccyx pressure wound was resolved. The notes indicated continued interventions were to include: a wheelchair cushion, repositioning, air mattress and routine observations of the area. - On 7/29/14, a Nurses' Progress Note written by the interim clinical administrator (ICA) indicated R15 had a pressure ulcer on the coccyx described as, "unstageable" (full-tissue thickness loss in which the base of the ulcer is covered by slough or an eschar and, therefore, the true depth of the damage cannot be estimated until these are removed) area present on coccyx that measured 1 cm in length and 0.6 cm, bed of wound covered in slough, surrounding skin with scar tissue and presence of redness between wound and rectum. The facility had conducted an assessment 7/5/13 on a form entitled, Tissue Tolerance (Bed) (a tool used to determine repositioning schedule). The assessment documentation indicated the resident was not independent in mobility/positioning. The	2 900		

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2 900	Continued From page 31 form was also checked for "No discoloration is present after resident has been in the same position for three hours on skin. Consider to care plan to reposition every three hours." However, the analysis included, "Resident on repositioning every 2 hrs [hours] in bed." The facility had also completed a Tissue Tolerance (Chair), which was undated. The documentation on that form indicated the resident was not independent in mobility/positioning. But was also checked for "No discoloration is present after resident has been in the same position for three hours on skin. Consider to care plan to reposition every three hours." However, the analysis included, "Resident is on every 2 hrs Repo. [repositioning] when up in w/c [wheelchair] & when in bed." The medical record lacked evidence of any other Tissue Tolerance documents having been completed. Directions on the Tissue Tolerance document indicated it was "To be completed upon, admission, annually and with significant change in status, upon emergence of pressure ulcer and changes with pressure surfaces." The surveyor requested to review any further assessments following recurrence of R15's pressure ulcer on 7/29/14, and no further documents were provided. An occupational therapy flow sheet, Rehabilitation Daily Flow Sheet dated 12/13/13, indicated R15 had trial use of a Broda chair (a tilt and recline positioning chair) for improved resident repositioning and protection of skin integrity. According to record documentation, the chair had been formally assigned to R15 on 12/16/13, after R15 had demonstrated improved repositioning with the chair. A Comprehensive Skin Risk Data Collection	2 900		

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2 900	Continued From page 32 (CSRDC) had been completed for R15 on 3/7/14, and indicated R15 had a Braden Risk score of 13 (indicated moderate risk for pressure ulcer development). The CSRDC also indicated R15 had a history of chronic pressure ulcer to the coccyx which was identified as inherited and stable. The surveyor requested to review any further assessments following recurrence of R15's pressure ulcer on 7/29/14, and no further documents were provided. A Care Area Assessment (CAA) dated 3/13/14, indicated R15 had a stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer could be superficial and presents clinically as an abrasion, blister, or shallow crater) on the coccyx, and that the resident was at risk for further skin breakdown due to bowel incontinence, use of Foley catheter and decreased mobility. The CAA indicated R15 needed the assistance of two staff for mobility in bed; staff would check skin on shower days and as scheduled; and care plan to address pressure ulcer to avoid complications and minimize risks. A Wound Assessment Flow Sheet was completed 7/25/14, which indicated R15's pressure ulcer had healed. However, there was no Wound Assessment Flow Sheet completed for the wound that subsequently re-developed on 7/29/14. R15's quarterly Minimum Data Set (MDS) dated 6/9/14, identified R15 as having a Stage 2 pressure ulcer with granulation tissue, which needed extensive assistance of one staff for repositioning, transfers, toileting, and personal hygiene. The progress notes from the physician and geriatric nurse practioner (GNP) entitled, Geriatric	2 900		

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2 900	Continued From page 33 Services of Minnesota Progress Notes were reviewed from 7/7/14-9/11/14. The notes included: - On 7/7/14, "Res. [resident] has coccyx wound seen by wound nurse & reported as stable. Size of wound has decreased [arrow downward image] in size 1.1 cm x 0.8 cm, currently 0.4 cm x 0.2 cm." - On 8/8/14, "Nsg [nursing] request to assess wound of 7/29/14, 1 cm x 0.6 cm. Wound RN [registered nurse] involved." Also noted was "Coccyx wound: red, blanchable, no drainage [circle with a line drawn through it to depict no], no edema, shallow ulcer, no bruising." The GNP wrote a plan for the staff to follow: "keep skin clean & dry, keep HOB [head of bed] < [less than] 30 degrees, change position q [every] 2 [hours], continue with current wound care orders." - On 9/5/14, the physician notes indicated the wound was "shallow coccyx wound per GNP note 8/8/14." Documentation from a Wound Consultation dated 7/8/14, indicated the coccyx ulcer was a Stage 3 (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue). The facility documented, "chronic ST II [stage 2] but had slough." According to this documentation, the granulation was at 90% and the slough was at 10%, and the wound measured 0.7 cm x 0.3 cm x 0.2 cm. A Wound Consultation note dated 7/29/14, indicated the resident had an unstageable coccyx ulcer with 100% slough. The measurement was 1.0 cm x 0.6 cm x 0.1 cm and the edges were described as rolled. The note indicated, "slough	2 900		

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2 900	Continued From page 34 has resurfaced." The recommendations revealed the goal was to "protect as goal may not be [sic] to heal but maintain current status." A Physician's Order dated 7/31/14, directed staff to treat R15's pressure ulcer on coccyx "cleanse with wound cleanser, pat dry, paint wound base with silver nitrate 10% ointment [antiseptic wound cauterization], zinc oxide [used to severely chapped skin, or other minor skin irritations] to peri-wound to protect, cover with Mepilex Sacrum [an all-in-one foam dressing that effectively absorbs and retains wound fluid (exudate) but keeps the wound sufficiently moist], seal dressing with Skin-Prep [a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films] around edges of dressing." On 8/12/14, the doctor ordered the application of Medihoney (used to help wounds that have stalled under first-line treatment to progress towards healing) to R15's coccyx wound instead of the silver nitrate ointment, which had been unavailable since ordered on 7/31/14. Until then the product became available, staff was directed to use the previous wound treatment orders. R15's care plan revised on 7/31/14, indicated R15 had a chronic pressure ulcer to coccyx. The care plan interventions directed facility staff to: complete treatments as ordered and monitor for effectiveness; follow facility policies and doctor's orders for skin care regime; provide information to R15 about the importance of frequent repositioning; and finally, reposition R15 every two hours during the day and two times at night. The care plan lacked evidence that R15 could off load/reposition self in the wheelchair and lacked evidence of any new interventions implemented to minimize/prevent an increase in size for the	2 900		

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2 900	Continued From page 35 recurrent unstageable pressure ulcer to the coccyx. A Wound Consultation sheet dated 8/12/14, indicated R15's coccyx pressure ulcer was 2.6 x 0.5 cm and was superficial. The stage was identified as "MA" (the key for MA was not available on the form). The wound base was at 100% slough with scant drainage. The edges were macerated and scarred. The Wound Consultation sheet dated 8/26/14, indicated R15's coccyx pressure ulcer was "non-stage [unstageable]" and at 100% slough, loosening with slight drainage. The measurement was 1.3 x 0.5 cm. The consult documentation indicated R15 was to be turned and repositioned every two hours. The MDS dated 9/4/14, revealed R15 had one Stage 2 pressure ulcer and that the pressure ulcer was there upon admission. The MDS did identify R15 as being at risk for development of pressure ulcers. The MDS did not identify that R15 had a Stage 3 pressure ulcer that was identified by the facility on 7/8/14. The MDS also lacked evidence of the unstageable pressure that was identified by the facility on 7/29/14, when the new pressure ulcer developed, and again on 8/26/14, as identified on the Wound Consultation sheet. In addition, the MDS lacked evidence R15 was on a turning and repositioning program as that section was left blank. The MDS also lacked evidence that there was a previous healed pressure ulcer identified on 7/25/14, as per the progress note which indicated the coccyx pressure ulcer had been resolved. The facility's undated Nursing Assistant Care Sheet for Team 2, Northern Lights Lane,	2 900		

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2 900	Continued From page 36 described R15 as non-ambulatory and requiring assistance of two staff for transfers, toileting and repositioning. The Nursing Assistant Care Sheet directed staff to reposition R15 every two hours. When interviewed on 9/10/14, at 7:48 a.m. LPN-A verified R15's pressure wound had been there for a "long time." LPN-A stated interdisciplinary team (IDT) do wound rounds every Tuesdays where wound measurements were done. LPN-A stated she did not measure the wound but stated the wound was at Stage 2. On 9/11/14, at 10:10 a.m. NA-D checked her nursing assistant care sheet and stated R15 was supposed to be repositioned every two hours. On 9/11/14, at 10:20 a.m. RN-E stated he would expect a resident with pressure ulcer to be repositioned according to care plan and further stated R15 should have been repositioned every two hours per R15's care plan. On 9/11/14, at 10:29 a.m. RN-D was interviewed and acknowledged R15 had chronic pressure ulcer to coccyx, and that different treatments had been tried and the pressure ulcer would "get better" but open up again. RN-D verified R15's care plan interventions indicated the resident would be repositioned every two hours, but that R15 was not repositioned accordingly given the time R15 was brought out from her room until that time today. On 9/11/14, at 3:22 p.m. the ICA acknowledged that facility staff should follow the intervention to reposition R15 every two hours according to R15's care plan. The facility's Skin Risk Policy modified on 8/13,	2 900		

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2 900	Continued From page 37 directed the facility staff to complete a new Braden Scale, a new Comprehensive Data Collection Tool, and a new tissue Tolerance algorithm with the onset of a new pressure ulcer, and care plan interventions according to the resident and/or individual risk factors. The policy was not followed for R15 when a new pressure ulcer was developed on 7/29/14. The policy further directed staff to establish individualized repositioning schedule if a resident was unable to move. R15's newly re-opened Stage 2 pressure area was not properly re-assessed by the facility as the facility did not follow the policy "to properly identify, assess and monitor residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for ulcers according industry standards of care" nor did R15 receive repositioning in a timely manner. SUGGESTED METHOD OF CORRECTION: The director of nursing, and/or designee could assure policies and procedures are current, implemented, and monitored to assure nursing staff reassess, and adequently monitor for pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 900		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that:	2 930		10/3/14

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2 930	Continued From page 38 B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R121) had a feeding tube checked for proper placement prior to administering medications. Findings include: R121's tube feeding Physician's Order sheet dated 7/30/14, directed staff to check feeding tube placement "before tube feeding, flushes and medication administration" by aspirating residual. During the medication observation on 9/9/14, at 3:39 p.m. the registered nurse (RN)-H prepared Potassium Chloride (potassium supplement) 7.5 milliliter (ml), Metoprolol (used to treat high blood pressure) 25 milligrams (mg) and Levetiracetam (used to treat seizures) 500 mg. RN-H crushed the Metoprolol and Levetiracetam tablets individually and added 10 ml of water to each cup to dissolve the medications. RN-H explained R121 the procedure, flushed the feeding tube with 30 ml of water, administered the medications, and flushed the tube with 30 ml of water in between the medications. The RN-H did not check the feeding tube placement prior to medication administration.	2 930	POC written for accompanying Federal deficiencies. Date certain for purposes of ongoing compliance is 10/15/14.	

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2 930	Continued From page 39 During interview on 9/9/14, at 3:55 p.m. the RN-H verified she did not check the feeding tube placement prior the medication administration. The RN-H explained she didn't check the feeding tube placement because she just administered the tube feeding at 3:00 p.m. The RN-H further explained since the 4:00 p.m. medication administration was so close to the feeding she didn't "need to check for the same thing." The RN-H stated the medication administration record included the "Gastrostomy Medication Administration" policy dated modified in July 2013, and verified the procedure included instructions for staff to "Test for correct placement of gastrostomy tube." RN-H acknowledged she did not check the feeding tube placement before medication administration. During interview on 9/11/14, at 12:04 p.m. RN-B stated staff was expected to follow the facility's policy and procedure regarding feeding tube placement check before each medication administration or tube feeding. The RN-H verified per the Gastrostomy Tube Placement policy staff was expected to check the tube placement before each medication administration by checking the residual with a syringe. The facility's Gastrostomy Tube Placement policy dated last modified in November 2010, indicated the purpose of the tube placement check was "to assure adequate placement of gastrostomy tube prior to administration of medications." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise policies and procedures for medication administration via gastrostomy tube (G-tube) and could schedule an in-service for staff regarding	2 930		

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2 930	Continued From page 40 medication administration. The DON could delegate nursing staff to monitor compliance and report to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R3) was treated with dignity regarding bladder continence when assistance was requested by the resident from facility staff. Findings include: On 9/9/14, at 11:28 a.m. when R3 was asked during interview if she was being treated with respect and dignity, R3 did not answer the question spontaneously, R3 shook head and stated about calling for help "early this morning" and put on the call light. R3 stated "two girls" came in to the room and told her to get up. R3 reminded the staff she could not get up by herself and needed help to do so, but the staff left without attending to R3's needs. R3 stated she put the call light on again, then staff came in and "shut it off" without helping R3. R3 was observed	21805	POC written for accompanying Federal deficiencies. Date certain for purposes of ongoing compliance is 10/15/14.	10/3/14

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21805	Continued From page 41 to be teary-eyed as she talked about what happened that morning. R3 wiped own tears, took some pauses and continued to talk about having felt sick and getting the bed wet. R3 stated, "I was crying, I never wet the bed like that before." R3 pointed to one pillow (without a pillow case) lying at the head of the bed and described the bed was wet all the way up to her pillow. R3 stated, "I felt so bad." R3's electronic Admission Record dated 4/29/14, indicated R3 had diagnoses to include dementia without behavioral disturbance, acute respiratory failure, difficulty in walking, generalized pain, and muscle weakness. R3's Care Area Assessments (CAAs) dated 5/6/14, indicated R3 had deficits in performing activities of daily living (ADLs) related to weakness and pain secondary to history of fall and had impaired mobility, ambulation, decreased balance, strength and activity tolerance; R3 was incontinent of bowel and bladder related to decreased mobility, R3 could not get to the bathroom fast enough due to her pain, and R3 was noted to prefer calling staff for assistance rather than prompting her to go to the bathroom; R3 was at risk for falls, was noted to be unable to transfer and ambulate without assistance, and was alert and able to make needs known. R3's care plan dated 5/20/14, indicated R3 had ADL performance deficit and was to be encouraged to use call light to call for assistance. R3's care plan described R3 as continent of bowel and bladder, the facility identified R3 as being able to communicate needs to use the restroom and needed assistance of one staff for toileting. The care plan further indicated R3 may display urinary incontinence due to decreased	21805		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 42	21805		

physical mobility and needed staff assistance for urgency. The care plan indicated R3 verbalized false accusations.

R3's Minimum Data Set (MDS) dated 8/1/14, depicted R3 as having minimal hearing loss when in a noisy setting or when spoken to in a soft voice. The MDS also identified R3 as having clear speech, making herself understood and had the ability to comprehend others verbal intent.

A review of the facility's call light log for 9/9/14, revealed the following:
-At 3:59 a.m. R3's call light was turned on.
-At 4:06 a.m. R3's call light was canceled in room.
-At 4:07 a.m. R3's call light was turned on again.
-At 4:11 a.m. R3's call light cord was pulled out from wall.
-At 4:12 a.m. R3's call light was canceled in room.
Even though the care plan depicted R3 as stating false accusations, the call light log clearly identified the resident had utilized the call light on the early morning of 9/9/14.

The facility's undated Nursing Assistant Care Sheet indicated R3 needed assist of one staff for toileting and directed staff to assist R3 with morning cares.

On 9/11/14, at 1:46 a.m. when incident between staff and R3 was brought to the interim clinical administrator (ICA) and the administrator, the ICA stated, "I would expect the staff to check the care plan and give her assistance out of bed." The administrator also agreed staff were expected to follow care plan and meet R3's needs.

The ICA and administrator stated the facility did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00226	A. BUILDING: _____ B. WING _____	09/11/2014

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21805	Continued From page 43 not have specific policy for dignity, but stated dignity was reflected in all policies of the facility. SUGGESTED METHOD OF CORRECTION: The Director of Nursing Services or designee could develop, review, and/or revise policies and procedures to ensure all residents' dignity is maintained. The Director of Nursing Services or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R143) had their call light readily accessible reviewed for environmental concerns. Findings include:	21810	POC written for accompanying Federal deficiencies. Date certain for purposes of ongoing compliance is 10/15/14.	10/3/14

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21810	Continued From page 44 On 9/8/14, at 3:28 p.m. during R143's room observation the call light was observed on the floor by the head of bed slightly behind the night stand and in between the bed night stand. On 9/9/14, at 9:15 a.m. to approximately 1:15 p.m. R143's call light was still observed to remain on the floor behind the night stand not accessible. On 9/9/14, at approximately 3:45 p.m. during the environmental tour the administrator verified the call light was on the floor and picked it off the floor from behind the night stand and when asked what her expectation was for call light accessibility she stated "all call lights have to be at reach at all times regardless if resident is able to use it or not." The falls Care Area Assessment dated 2/21/14, identified R143 was at risk for falls and directed staff to remind R143 to call for assistance and use her wheelchair and keep call light and commonly used articles within reach. R143's quarterly Minimum Data Set (MDS) dated 8/4/14, indicated R143's Brief Interview for Mental Status (BIMS-tool used to measure cognition) score was eight, indicating moderately impaired intact. In addition, the MDS indicated R143 used a walker for locomotion. R143's care plan dated 8/13/14, identified R143 was at risk for fall related to incontinence, history of falls and unsteady gait at times. Goal "Will be free of minor injury ..." The care plan directed staff "Be sure my call light is within reach encourage me to use it for assistance as needed."	21810		

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21810	Continued From page 45 Call Light policy modified 10/10, directed, "Position the call light conveniently for the resident to use..." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident call lights were accessible to residents. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21810		