DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: SY26

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00226 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) MARANATHA CARE CENTER (L1)245462 1. Initial 2. Recertification (L4) 5409 69TH AVENUE NORTH 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55429 731342000 (L2)(L5) BROOKLYN CENTER, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 8. Full Survey After Complaint (1.9)13 PTIP 01 Hospital **05 HHA** 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF 10/21/2014 (L34) 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: __ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 09/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: **X** A. In Compliance With From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) **97** (L18) _1. Acceptable POC 8. Patient Room Size __ 9. Beds/Room Life Safety Code Not in Compliance with Program **97** (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12)* Code: A* 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID (L15)1861 (e) (1) or 1861 (j) (1): 97 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date: Date: Anne Kleppe, Enforcement Specialist 10/24/2014 (L20) Sue Miller, HFE NE II 10/24/2014 (L19) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: ____ 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 04/01/1987 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (141)(L24)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (1.31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 10/21/2014 (L32) (L33)DETERMINATION APPROVAL



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,

Are Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

Email: anne.kleppe@state.mn.us



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,

Dire Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

Email: anne.kleppe@state.mn.us



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,

Are Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Email: anne.kleppe@state.mn.us

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

| (Y1) | Provider / Supplier / CLIA / Identification Number 245462 | (Y2) Multiple Construction A. Building B. Wing | | (Y3) Date of Revisit 10/21/2014 |
|------|---|--|--|------------------------------------|
| Nam | e of Facility | | Street Address, City, State, Zip Code | |
| M | ARANATHA CARE CENTER | | 5409 69TH AVENUE NORTH BROOKLYN CENTER. MN 5542 | 9 |

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 | Correction Completed 10/03/2014 | ID Prefix | F0246 | | Correction Completed 10/03/2014 | | ID Prefix | F0278 | Correction Completed 10/03/2014 |
| | 483.15(a) | | | 483.15(e)(1) | | | | | 483.20(g) - (j) | |
| | | Correction Completed | | | | Correction Completed | | | | Correction Completed |
| ID Prefix | F0282 | 10/03/2014 | ID Prefix | F0314 | | 10/03/2014 | | ID Prefix | F0322 | 10/03/2014 |
| Reg. # LSC | 483.20(k)(3)(ii) | | Reg. # LSC | 483.25(c) | | | | Reg. # LSC | 483.25(g)(2) | |
| ID Prefix | F0334 | Correction Completed 10/03/2014 | ID Prefix | F0353 | | Correction Completed 10/03/2014 | | ID Prefix | | Correction Completed |
| Reg. # | 483.25(n) | | Reg. # | 483.30(a) | | | | ъ " | | |
| ID Prefix Reg. # | | Correction Completed | ID Prefix Reg. # | | | Correction Completed | | | | |
| ID Prefix Reg. # LSC | | | Reg. # | | | Correction Completed | | | | |
| | | | | | | | | | | |
| Reviewed B | By Rev | riewed By | Date: | Signature | e of Sur | veyor: | | | Date | : |
| State Agen | • | D/AK | 10/24/20 | 14 | | | | 0302 | 23 10/21 | /2014 |
| Reviewed E | By Rev | riewed By | Date: | Signature | e of Sur | veyor: | | | Date | : |
| Followup t | to Survey Comple 9/11/201 | | | | | | | | Summary of the Facility? | S NO |

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

| (Y1) Provider / Supplier / CLIA / Identification Number 245462 | (Y2) Multiple Con A. Building B. Wing | CHEN AND CHAPEL | (Y3) Date of Revisit 10/7/2014 |
|--|---|---------------------------------------|-----------------------------------|
| Name of Facility | | Street Address, City, State, Zip Code | |
| MARANATHA CARE CENTER | | 5409 69TH AVENUE NORTH | • |
| | | BROOKLYN CENTER MN 5542 | ' 4 |

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 | C | Y5) | Date |
|----------------------------|--------------------|-------------------------|-----------|---------------------|-------------------------|------|-----------|----------|-------|-------------------------|
| | | Correction | | | Correction | | | | | Correction |
| ID Prefix | | Completed 10/03/2014 | ID Prefix | | Completed 10/03/2014 | | ID Prefix | | | Completed 10/03/2014 |
| Reg. # | NFPA 101 | | Reg. # | NFPA 101 | | | | NFPA 101 | | |
| LSC | K0050 | | LSC | K0069 | | | LSC | K0144 | | _ |
| ID Prefix | | Correction Completed | ID Prefix | | Correction Completed | | ID Prefix | | | Correction Completed |
| Reg. # | | | Reg. # | | | | Reg. # | | | |
| LSC | | | LSC | | | | LSC | | | = |
| ID Prefix Reg. # LSC | | Correction Completed | Reg. # | | Correction Completed | | ID Prefix | | | Correction Completed |
| Reg. # | | | Reg. # | | Correction Completed | | Rea.# | | | Correction Completed |
| Reg. # | | | Reg. # | | | | . | | | |
| | | | | | | | | | | |
| Reviewed E | By Review | wed By | Date: | Signature of Sur | veyor: | | | | Date: | |
| State Agen | cy PS/Al | K | 10/24/20 | _ | | | 28120 | | 10/0 | 7/2014 |
| Reviewed E | By Review | wed By | Date: | Signature of Sur | veyor: | | | | Date: | |
| Followup t | o Survey Completed | d on: | | Check for any Uncor | | | | | YES | NO |

| | State Form: Revisit Report | | | | | | | |
|------------------|--|--|--|------------------------------------|--|--|--|--|
| (Y1) | Provider / Supplier / CLIA / Identification Number 00226 | (Y2) Multiple Construction A. Building B. Wing | | (Y3) Date of Revisit 10/21/2014 | | | | |
| Name of Facility | | | Street Address, City, State, Zip Code | | | | | |
| M | ARANATHA CARE CENTER | | 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 5542 | 9 | | | | |

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 |
|--|--|--|--------------------------------|--|------|-----------|-------------------------------|---------------------------------|
| | Correction Completed 20565 10/03/2014 MN Rule 4658.0405 Subp. | _ | 20800 MN Rule 4658.0510 Sub | | | | 20900 MN Rule 4658.0525 St | |
| ID Prefix Reg. # LSC | Correction Completed 10/03/2014 MN Rule 4658.0525 Subp. | ID Prefix Reg. # LSC | | Correction Completed 10/03/2014 Sul | | ID Prefix | | Correction Completed 10/03/2014 |
| Reg. # | Correction Completed | Reg. # | | | | Reg. # | | |
| Reg. # | | Reg. # | | Correction Completed | | | | Correction Completed |
| ID Prefix Reg. # | Correction Completed | ID Prefix Reg. # | | Correction Completed | | ID Prefix | | Correction Completed |
| Reviewed E | CD/AK | Date: 10/24/202 | Signature of Sur | veyor: | | 03 | Date: 10/2 | 1/2014 |
| Reviewed E | | Date: | Signature of Sur | veyor: | | | Date: | |
| Followup to Survey Completed on: 9/11/2014 STATE FORM: REVISIT REPORT (5/99) | | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO | | | | | NO | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: SY26

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00226 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) MARANATHA CARE CENTER (L1)245462 1. Initial 2. Recertification (L4) 5409 69TH AVENUE NORTH 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55429 (L2)731342000 (L5) BROOKLYN CENTER, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (1.9)13 PTIP 01 Hospital **05 HHA** 09 ESRD 22 CLIA 6. DATE OF SURVEY 09/11/2014 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 09/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: A. In Compliance With From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) **97** (L18) _1. Acceptable POC 8. Patient Room Size __ 9. Beds/Room Life Safety Code X B. Not in Compliance with Program **97** (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12)* Code: \mathbf{R}^* 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID (L15)1861 (e) (1) or 1861 (j) (1): 97 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date: Date: 10/15/2014 (L20) 10/07/2014 Magdalene Jares, HFE NE II Anne Kleppe, Enforcement Specialist (L19)PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 04/01/1987 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (141)(L24)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (1.31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE (L32) (L33)DETERMINATION APPROVAL



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

Maranatha Care Center September 24, 2014 Page 2

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: <u>gloria.derfus@state.mn.us</u> 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.

Maranatha Care Center September 24, 2014 Page 4

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

Maranatha Care Center September 24, 2014 Page 5

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:<u>pat.sheehan@state.mn.us</u> Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Dire Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program Division of Compliance Monitoring

Minnesota Department of Health Email: anne.kleppe@state.mn.us

PRINTED: 10/03/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|---|--|-------------------------------|--|
| | | 245462 | B. WING | | 09/11/20 | 014 | |
| NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COM | (X5) IPLETION DATE | |
| F 000 | INITIAL COMMEN | ΓS | F 0 | 00 | | | |
| F 241 SS=D | as your allegation of Department's accelenrolled in ePOC, yat the bottom of the form. Your electror be used as verificated. Upon receipt of an on-site revisit of your validate that substate regulations has been your verification. 483.15(a) DIGNITY INDIVIDUALITY The facility must promanner and in an experiment of the properties of t | of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an our facility may be conducted to untial compliance with the en attained in accordance with a compliance of the entity | F 2 | 41 | 10/3 | 3/14 | |
| | full recognition of h This REQUIREMEI by: Based on observar review, the facility f (R3) was treated w continence when as the resident from father fa | is or her individuality. NT is not met as evidenced tion, interview and document ailed to ensure 1 of 1 resident ith dignity regarding bladder ssistance was requested by | | The Credible Allegation of Comhas been prepared and timely structured Submission of the Credible Allegation of the Credible Allegation of the Credible Allegation of the State Deficiencies were correctly cited also not to be construed as an adjust interest of the Facility, its Administrator, or any employees or other individuals who draft or discussed in this Credible Allegation of this Credible Allegation. | ubmitted. gation of sion that a ement of d, and is admission s s, agents, may be ation of ration and | | |
| ABORATOR' | / DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIGN | IΔTURE | TITLE | (X6) D | ATF | |

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

10/03/2014

Electronically Signed

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) MULTIPL A. BUILDING | | (X3) DATE SURVEY COMPLETED |
|---|--|---|-----------------------------|--|---|
| | | 245462 | B. WING | | 09/11/2014 |
| | PROVIDER OR SUPPLIER | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE 409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | 3571172311 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLÉTION |
| F 241 | came in to the roor reminded the staff and needed help to without attending to put the call light on "shut it off" without to be teary-eyed as happened that mor some pauses and felt sick and getting crying, I never wet pointed to one pillo at the head of the bewet all the way up to so bad." R3's electronic Admindicated R3 had dewithout behavioral failure, difficulty in muscle weakness. R3's Care Area Ass 5/6/14, indicated R activities of daily live weakness and pair and had impaired replaced balance, strength a incontinent of bowed decreased mobility bathroom fast enoughs was noted to prefer rather than prompting R3 was at risk for fine put the call live weakness. | light. R3 stated "two girls" in and told her to get up. R3 she could not get up by herself of do so, but the staff left of R3's needs. R3 stated she again, then staff came in and helping R3. R3 was observed is she talked about what ning. R3 wiped own tears, took continued to talk about having the bed wet. R3 stated, "I was the bed like that before." R3 w (without a pillow case) lying bed and described the bed was to her pillow. R3 stated, "I felt include demential disturbance, acute respiratory walking, generalized pain, and sessments (CAAs) dated 3 had deficits in performing ing (ADLs) related to a secondary to history of fall nobility, ambulation, decreased and activity tolerance; R3 was el and bladder related to R3 could not get to the ugh due to her pain, and R3 calling staff for assistance ng her to go to the bathroom; alls, was noted to be unable to | F 241 | Compliance does not constitute an admission or agreement of any kind the facility of the truth of any of the alleged or the correctness of any conclusions set forth in this allegation the survey agency. It is the practice of Maranatha Care Center to promote care for resident manner and environment that main and enhances each resident's dignizespect in full recognition of his or hindividuality. R3's concerns were reported to the appropriate state and county agency 9/9/14 with a full investigation being completed and submitted to the Off Health Facility Complaints (OHFC). facility received a disposition letter of OHFC requiring no further action of 9/23/14. Education provided to the involved on 9/18/14. Education completed for facility state 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 the QA committee with appropriate plans as indicated. | facts on by estimates in a tains ity and her dice of The from n staff ff on de de d d to |
| | was alert and able | ate without assistance, and to make needs known. ed 5/20/14, indicated R3 had | | Administrator, DON and/or designe be responsible for ongoing complia Date certain for the purposes of one | nce. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--------------------|--------------|---|-----|----------------------------|
| | | 245462 | B. WING | | | 09/ | 11/2014 |
| | PROVIDER OR SUPPLIER | | | 54 | REET ADDRESS, CITY, STATE, ZIP CODE 09 69TH AVENUE NORTH ROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 241 | encouraged to use R3's care plan dest bowel and bladder, being able to common restroom and need toileting. The care plant display urinary incomphysical mobility arrugency. The care false accusations. R3's Minimum Data depicted R3 as havin a noisy setting or voice. The MDS also speech, making he ability to comprehe A review of the faci revealed the follow At 3:59 a.m. R3's com. At 4:07 a.m. R3's common. At 4:07 a.m. R3's common. At 4:12 a.m. R3's common. Even though the cafalse accusations, sidentified the reside the early morning of the facility's undata Sheet indicated R3 | deficit and was to be call light to call for assistance. Cribed R3 as continent of the facility identified R3 as nunicate needs to use the ed assistance of one staff for clan further indicated R3 may entinence due to decreased and needed staff assistance for plan indicated R3 verbalized a Set (MDS) dated 8/1/14, ring minimal hearing loss when rewhen spoken to in a soft so identified R3 as having clear reself understood and had the end others verbal intent. Call light was turned on again. Call light was canceled in call light was canceled in the call light was canceled in the call light log clearly ent had utilized the call light on the call light log clearly ent had utilized the call light on | F 2 | 241 | compliance is 10/15/14. | | |

| , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------|---|-------------------------------|--|
| | | 245462 | B. WING _ | | 9/11/2014 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
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| F 246 SS=D | staff and R3 was bradministrator (ICA) stated, "I would explan and give her a administrator also a follow care plan and The ICA and administrator also a follow care plan and The ICA and administrator also a follow care plan and The ICA and administrator also a follow care plan and The ICA and administrator plan administrator also a follow care plan administrator plan administrator and the ICA and administrator plan administrator also a follow care plan and administrator also a follow care plan admini | a.m. when incident between rought to the interim clinical and the administrator, the ICA pect the staff to check the care assistance out of bed." The agreed staff were expected to dimeet R3's needs. istrator stated the facility did plicy for dignity, but stated din all policies of the facility. ONABLE ACCOMMODATION ERENCES | F 24 | | 10/3/14 | |
| | by: Based on observative review, the facility for (R143) had their care. Findings include: On 9/8/14, at 3:28 probservation the call laying on the floor behind the night standight stand. R143 was R143 was comine. | ion, interview, and document ailed to ensure 1 of 1 resident II light readily accessible. o.m. during R143's room I light was observed to be by the head of bed slightly and and in between the bed was observed to be in the room in ambulating down the om towards the dining room. | | 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. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | | E SURVEY IPLETED |
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| | | 245462 | B. WING _ | | 09/ | 11/2014 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 246 | Continued From page 4 | | F 24 | | | |
| | p.m. R143's call ligh | a.m. to approximately 1:15 nt was still observed to remain the night stand not accessible. | | To identify other potentially imparesidents, a full house audit for oplacement was completed. | | |
| | environmental tour, call light was on the floor from behind th what her expectatio accessibility, the ad lights have to be at resident is able to u | ministrator stated "all call reach at all times regardless if | | To assure compliance, all staff e will be completed regarding account to call lights. Weekly audits reflected to of residents on each house be completed to assure ongoing compliance. Results of the audits will be reported the facility QA committee. | essibility ective of ehold will | |
| | identified R143 was staff to remind R14 | at risk for falls and directed 3 to call for assistance and and keep call light and | | Administrator, DON and/or design be responsible for ongoing compate certain for the purposes of compliance is 10/15/14. | oliance. | |
| | 8/4/14, indicated R ² cognition. In additioused a walker for lo | nimum Data Set (MDS) dated 143 had moderately impaired n, the MDS indicated R143 comotion and had fallen in the hs in which R143 sustained a | | | | |
| | was at risk for fall re of falls and unstead directed staff, "Be s | ated 8/13/14, identified R143 elated to incontinence, history ly gait at times. The care plan cure my call light is within e to use it for assistance as | | | | |
| F 278 | | dified 10/10, directed, ht conveniently for the | F 27 | 8 | | 10/3/14 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | PROVIDER OR SUPPLIER | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE 409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | |
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| F 278 SS=D | The assessment m resident's status. A registered nurse each assessment v participation of heat assessment is come Each individual who assessment must state portion of the attention of the auxilfully and knowing false statement in a subject to a civil more resident. | RDINATION/CERTIFIED ust accurately reflect the must conduct or coordinate with the appropriate lth professionals. must sign and certify that the pleted. c completes a portion of the sign and certify the accuracy of | F 278 | | |
| | willfully and knowin to certify a material resident assessme penalty of not more assessment. Clinical disagreeme material and false s This REQUIREMENT by: Based on observative, the facility fassessments and in the Minimum Data | gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each | | It is the practice of Maranatha Care Center that resident assessments accurately reflect the resident's stat R15 will have the MDS modified to correct staging of the wound. | us. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--|--|--|-------------------------------|--|
| | | 245462 | B. WING _ | | 09/ | 11/2014 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 278 | indicated R15 had abnormal posture, a on one side) affecti cerebrovascular dis and pain in joints. T 3/18/13, revealed R pressure ulcer on the The facility conduct algorithm dated 7/5 resident was not independent was not indep | mission record dated 3/18/13, diagnoses which included anemia, hemiplegia (paralysising non-dominant side due to lease, neurogenic bladder, the admission care plan dated 15 was admitted with a ne coccyx. Med a Tissue Tolerance (Bed) /13. The algorithm noted the dependent in The algorithm was also coloration is present after in the same position for three sider to care plan to reposition However, the analysis noted, itioning every 2 hrs [hours] in ed a Tissue Tolerance (Chair) ed to determine repositioning. The algorithm noted the | F 27 | To identify other potentially im residents, all residents with w have an audit of the most recaccuracy. To assure continued compliant education will be provided to responsible for MDS coding. randomized audits of 6 compliantly will be completed for coding at the policy completion of the for reviewed and is current. Audit results will be reported to QA committee. DON and/or designee will be for ongoing compliance. Date the purposes of ongoing com 10/15/14. | ounds will ent MDS for nce, the RN's Weekly leted MDS's accuracy. MDS was to the facility responsible e certain for | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--------------------|-----|---|------|----------------------------|
| | | 245462 | B. WING | | | 09/ | 11/2014 |
| | PROVIDER OR SUPPLIER | | | 54 | TREET ADDRESS, CITY, STATE, ZIP CODE 409 69TH AVENUE NORTH ROOKLYN CENTER, MN 55429 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | X | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 278 | significant change in pressure ulcer and surfaces." Copies with when R15 developed 7/29/14, and no fur provided. A Comprehensive S (CSRDC) dated 3/7 indicated R15 had a which meant R15 with developing pressure the CSRDC that R1 ulcer to coccyx whistable. Copies of the Risk were requested developed the pressure ulcer (CAAs) dated 3/13/II pressure ulcer (prinvolving epidermis could be superficial abrasion, blister, or and was at risk for bowel incontinence decreased mobility, needed the assistated; staff would chast scheduled; and ulcer to avoid compared to avoid compared to avoid compared to a see see see see see see see see see s | or status, upon emergence of changes with pressure vere requested of the facility ed the pressure ulcer on ther documents were Skin Risk Data Collection 7/14, completed for R15 a Braden Risk score of 13, was at moderate risk for e ulcer. It was further noted in 15 also had chronic pressure ch was inherited and was e CSRDC and the Braden dof the facility when R15 sure ulcer on 7/29/14, and no were provided. The Care Area Assessments 14, indicated R15 had a stage artial thickness skin loss and presents clinically as an shallow crater) on the coccyx further skin breakdown due to use of Foley catheter and The CAAs indicated R15 nee of two staff for mobility in eck skin on shower days and care plan to address pressure olications and minimize risks. The Sheet dated 4/13/14, R15's pressure ulcer on the sment indicated the wound | F 2 | 278 | | | |
| | was completed for coccyx. The assess was 95% granulate 4/13/14, was the date of the complete of the control of | R15's pressure ulcer on the | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 245462 | B. WING | | 09/ | 11/2014 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY) | D BE | (X5) COMPLETION DATE | |
| F 278 | that subsequently of Assessment Flow Sof the facility when ulcer on 7/29/14, all provided. R15's quarterly MD to have a stage II put to have a follows: -On 7/25/14, R15's assessed by the wounded depicted con place included: who have a programmed another pressure described as, "unstage II put to have a programmed another pressure described as, "unstage II put to have a programmed another pressure described as, "unstage II put to have a programmed another pressure described as, "unstage II put to have a programmed another pressure described as, "unstage II put to have a programmed another pressure described as, "unstage II put to have a programmed another pressure described as, "unstage II put to have a programmed another pressure described as, "unstage II put to have a programmed another pressure described as, "unstage II put to have a programmed another pressure and to have a programmed another pressure another pressure and to have a programmed another pressure another pressure and to have a programmed another pressure another pressure another pressure and to have a programmed another pressure another pressure and to have a programmed another pressure another pressure another pressure and to have a programmed another pressure another pressure and to have a programmed another pressure | Sheet completed for the wound developed on 7/29/14. Wound Sheet copies were requested R15 developed the pressure and no further documents were as dated 6/9/14, identified R15 pressure ulcer with granulation ensive assistance of one staff ansfers, toileting, and personal arterly MDS also indicated R15 | F 278 | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245462 | B. WING | | 09/- | 11/2014 |
| | PROVIDER OR SUPPLIER | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE 1409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 278 | Continued From pa | age 9 | F 278 | | | |
| | are removed) area measured 1 cm in wound covered in s scar tissue and pre wound and rectum. The Wound Consuthe coccyx ulcer was | oltation dated 7/29/14, indicated as 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." | | | | | |
| | indicated R15's cod 2.6 x 0.5 cm and w identified as "MA" (available on the for | litation sheet dated 8/12/14, ccyx pressure ulcer was as superficial. The stage was (the key for MA was not rm). The wound base was at scant drainage. The edges and scarred. | | | | |
| | indicated R15's cod "non-stage [unstag loosening with sligh was 1.3 x 0.5 cm. 7 | Itation sheet dated 8/26/14, ccyx pressure ulcer was eable]" and at 100% slough, at drainage. The measurement The consult indicated R15 was epositioned every two hours. | | | | |
| | Stage 2 pressure u was there upon adi R15 as being at ris ulcers. The MDS a unstageable pressi the facility on 7/29/ ulcer developed an | 4/14, revealed R15 had one alcer and the pressure ulcer mission. The MDS did identify k for development of pressure also lacked evidence of the ure ulcer that was identified by 14, when the new pressure and again on 8/26/14, as ound Consultation sheet. In | | | | |

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| | | 245462 | B. WING _ | | 09 | /11/2014 | |
| | PROVIDER OR SUPPLIER ATHA CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | , | |
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| F 278 | addition, the MDS I turning and repositivas left blank. When interviewed overified R15's pressa "long time." LPN-(IDT) do wound rouwound measuremes she did not measure wound was at Stage On 9/11/14, at 10:1 nursing assistant casupposed to be repositioned according stated R15 should two hours per R15's On 9/11/14, at 10:2 and acknowledged ulcer to coccyx, and been tried and the better" but would on R15's care plan interesident would be rout that R15 was no given the time R15 room until that time. The facility's Skin R directed the facility Braden Scale, a ne Collection Tool, and | acked evidence R15 was on a oning program as that section on 9/10/14, at 7:48 a.m. LPN-A sure wound had been there for A stated interdisciplinary team ands every Tuesdays where nts were done. LPN-A stated the the wound but stated the e 2. 0 a.m. NA-D checked her are sheet and stated R15 was ositioned every two hours. 0 a.m. RN-E stated he would with pressure ulcer to be ding to care plan and further have been repositioned every as care plan. 9 a.m. RN-D was interviewed R15 had chronic pressure dithat different treatments had bressure ulcer would "get been up again. RN-D verified erventions indicated the epositioned every two hours, of repositioned accordingly was brought out from her | F 27 | 78 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| was not followed for ulcer was developed further directed state repositioning sched move. R15's newly area was not proper as the facility did not identify, re-assess a clinical conditions in skin integrity, and preventative measure appropriate treatment according industry and second in the services provided by the second and the secon | rividual risk factors. The policy of R15 when a new pressure and on 7/29/14. The policy of to establish individualized dule if a resident was unable to re-opened Stage 2 pressure orly re-assessed by the facility of follow the policy "to properly and monitor residents whose increase the risk for impaired pressure ulcers; to implement ures; and to provide on the modalities for ulcers standards of care." RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in an arranged by the facility or qualified persons in an arranged by the facility or qualified persons in an arranged by the care plan (R15) reviewed for pressure the facility failed to follow the resident (R143) whose call sible reviewed for | F 282 | It is the practice of Maranatha Care Center that the services provided an arranged by the facility are provided qualified persons in accordance with resident's written plan of care. R15 and R143 have had their care p reviewed and updated if applicable. All resident care plans are reviewed updated in conjunction with the RAI process. | by the lans | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER ATHA CARE CENTER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE 1409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | X | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 282 | abnormal posture, a (paralysis on one si side due to cerebro A Comprehensive S (CSRDC) dated 3/8 indicated R15 had not pressure ulcers a pressure ulcer to co A review of the Nur. 7/25/14, indicated a coccyx had resolve Nurse's Progress N developed another coccyx area which length and 0.6 cm in the wound bed as a surrounding skin with the presence of red R15's rectum. R15's care plan review importance of frequestaff to reposition R day and two times a The undated Nursin Team 2, Northern L non-ambulatory and staff for transfers, to Care Sheet directed two hours. During a continuous | diagnoses which included anemia, and hemiplegia de) affecting non-dominant vascular disease. Skin Risk Data Collection 1/14, completed for R15 moderate risk for development and R15 had a chronic occyx. Ses' Progress Notes dated chronic pressure ulcer on d. However, on 7/29/14, a lote indicated R15 had unstageable pressure ulcer to measured 1 centimeter (cm) in min width. The note described covered with slough, the scar tissue and described in ses between the wound and itsed on 7/31/14, addressed the lent repositioning and directed 15 every two hours during the lat night. Ing Assistant Care Sheet for lights Lane, indicated R15 as dineeded assistance of two colleting and repositioning. The distaff to reposition R15 every | F 2 | 282 | The policy for care plans was revie and is current. Clinical staff were educated on following the location of care plan information 10/3/14 and ongoing. Audits will be completed on following care plan and placement of resider lights on 10% of residents. Audit results will be reported to the QA committee. DON and/or designee will be responsive or ongoing compliance. Date cert the purposes of ongoing compliance 10/15/14. | owing ons and n on on on on facility onsible ain for | |
| | repositioned for two | a.m. R15 had not been hours and 55 minutes since eelchair grooming self in front | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245462 | B. WING | | | 09/ | 11/2014 |
| | PROVIDER OR SUPPLIER | | | 54 | TREET ADDRESS, CITY, STATE, ZIP CODE 409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
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| F 282 | of mirror in her roor the time as directed On 9/11/14, at 10:1 (NA)-D checked Nukept in her pocket at to be repositioned on 9/11/14, at 10:2 (RN)-E stated he expressure ulcer to be care plan. RN-E fur been repositioned of care plan. On 9/11/14, at 10:2 chronic pressure ultreatments were triebetter" then re-oper interventions in R1s repositioning every been repositioned at On 9/11/14, at 3:22 administrator (ICA) should have follower repositioning R15 et he care plan. The facility's Reside Policy and Procedu guidelines for staff are necessary to ac needs of the reside information and ass Call light: On 9/8/14, at 3:28 pt. | m. This was 55 minutes over the by the care plan. O a.m. nursing assistant ursing Assistant Care Sheet and stated R15 was supposed | F 2 | 282 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245462 | B. WING _ | | 09/ | 11/2014 |
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| F 282 | stand and in betwee was observed comin hallway from her room on 9/9/14, at 9:15 ap.m. R143's call light the floor behind the the resident. On 9/9/14, at approper on the floor from behind the what her expectation accessibility, the accessibility, the accessibility of the room of the floor from behind the floor floo | bed slightly behind the night en the bed night stand. R143 ing ambulating down the om towards the dining room. a.m. to approximately 1:15 ht was observed to remain on a night stand not accessible to eximately 3:45 p.m. during the the administrator verified the effoor and picked it off the ne night stand. When asked on was for call light diministrator stated "all call reach at all times regardless if | F 28 | 2 | | |
| F 314 SS=G | was at risk for falls of falls and unstead directed, "Be sure reach encourage meeded." Call Light policy dat directed, "Position the resident to use. 483.25(c) TREATM PREVENT/HEAL P Based on the compresident, the facility who enters the facil does not develop pindividual's clinical of the sure of the su | | F 31 | 4 | | 10/3/14 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245462 | B. WING | | 09/1 ⁻ | 1/2014 |
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| F 314 | pressure sores reconservices to promote prevent new sores | eives necessary treatment and e healing, prevent infection and | F 314 | | | |
| | by: Based on observative review, the facility for were implemented prevent further skin residents (R15) in the ski | tion, interview and document ailed to ensure interventions to promote healing and breakdown for 1 of 2 he sample reviewed for is resulted in actual harm, as | | It is the practice of Maranatha Care Center to provide necessary treatm and services to promote healing, prinfection and prevent new sores frod developing. R15 has had a comprehensive reassessment of her skin risk and surfaces on 10/2/14. | ent event m | |
| | in bed awake. Nurs licensed practical in room to help R15 g permission, the sur ulcer on R15's cocc she had "just chang coccyx. The wound was intact. LPN-A dressing to be checobserved to have in discoloration was on LPN-A identified as wound treatment. During observations a.m. to 7:25 a.m., F seated on a cushio -At 7:26 a.m. regist R15's room and was | a.m. R15 was observed lying ing assistant (NA)-C and urse (LPN)-A was in R15's et up from bed. With R15's veyor observed a pressure byx with LPN-A. LPN-A stated ged" the dressing to R15's dressing was dated 9/10 and carefully opened the adhesive bked. The wound was o drainage however, a yellow bserved on the dressing which being from Medihoney, a gel as of R15 on 9/11/14, from 7:10 R15 was observed in her room in the wheelchair. Hered nurse (RN)-D, entered is observed to give R15 some eft when R15 took all the | | All residents are assessed for poter and actual alteration in skin risk with RAI process along with the emerger a new wound. To identify other potentially impacter residents, all residents with pressur 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 reviewer is current. Education has been provided to all regarding the assessment of and interventions for residents at risk for alterations and those with current alterations. Education was provided clinical staff responsible on following care plan. | th the nce of ded and nurses r skin d to | |

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| | PROVIDER OR SUPPLIER | | | 5409 69 | T ADDRESS, CITY, STATE, ZIP CODE 9TH AVENUE NORTH IKLYN CENTER, MN 55429 | | |
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| F 314 | -From 7:27 a.m. to room alone, seated herselfAt 8:01 a.m. NA-B enter R15's room, her dentures in and pushed R15 out to to the Northern Ligh (TV) area/lounge. It was not off-loaded she repositionedFrom 8:06 a.m. to seated in wheelchal lounge. R15 remain wheelchair and did reposition herselfAt 8:35 a.m. RN-E wheelchair was par RN-E was observed then to push R15 to R15's table. R15 was repositioned and di-From 8:49 a.m. to seated in wheelchair working on breakfa -At 9:25 a.m. NA-B dining table towards R15 in front of TV arange At 9:32 a.m. NA-B wheelchair away from hallway going past and to the elevators R15 to the 3rd floor -At 9:34 a.m. R15 was not off-loaded reposition herself. | 8:00 a.m. R15 remained in her in front of a mirror grooming and NA-M were observed to NA-B approached R15 and put changed her shirt. NA-M then the hallway at 8:05 a.m., and its Lane (NLL) unit television during that observation, R15 from her wheelchair, nor was 8:35 a.m. R15 remained ir in the same spot in the TV ited in the same position in her not receive assistance, nor approached where R15's ked in the NLL TV lounge. It to speak briefly to R15, and of the dining room area towards as not off-loaded or in otreposition herself. 9:20 a.m. R15 remained ir at the dining room, slowly st with the use of right hand. Wheeled R15 away from the is the NLL TV area. NA-B left in the NLL TV area. NA-B left in the NLL TV area towards the first floor nurses' station is NA-B stated she was to take | F3 | We interest tea folkers con All A | eekly audits of skin assessmerventions to be completed bum. Audits will be completed owing the care plan on 10% idents. Audits of repositionir impleted weekly on 10% of reaudits will be forwarded to the committee. ON and/or designee will be recongoing compliance. Date of purposes of ongoing completely. | by wound I on of of og will be esidents. he facility esponsible certain for | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

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| F 314 | reader at the news -At 10:02 a.m. RN-I that R15 had been for the strict conditionAt 10:03 a.m. R15 area in Room 112 bestaff members left in the common area -At 10:05 a.m. RN-I observed to enter in the common area -At 10:05 a.m. RN-I observed to enter in the use of a gait be in the use of a | ared to be listening to the reading activity. D was notified by the surveyor seated in the wheelchair since ested that R15 be assessed was pushed to the common by NA-M and RN-E. The two R15 seated in the wheelchair alhallway. D, RN-E and NA-D, were R15's room with her lso gave permission for the kin on her buttocks. R15 was rewheelchair to her bed with lit by RN-D, RN-E and NA-D. RN-E assessed the pressure ttocks and described the open awing 90% slough and slight ounding skin up to the open the rest of the buttocks was defended the observed from the none of 11/14, a period of 2 repositioned during that time. In mission record dated 3/18/13, diagnoses which included anemia, hemiplegia (paralysis ing non-dominant side due to rease, neurogenic bladder, the admission care plan dated 15 had been admitted with a | F3 | 14 | | | |

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| | | 245462 | B. WING | | 09 | /11/2014 | |
| NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CO 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | CODE | | | |
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| F 314 | on her coccyx as of Progress Notes revices coccyx persisted the beginning 6/19/13 of ulcer had fluctuated evidenced by variethe interdisciplinary as follows: -On 6/19/13, R15's measured 1.5 centicm. -On 12/5/13, R15's measured 2.7 cm > -On 6/3/14, R15's of measured 0.3 cm > -On 7/8/14, R15's of measured 0.7 cm > -On 7/25/14, the downward team had do pressure wound waindicated continued a wheelchair cushid and routine observation of the interim clinical at R15 had a pressure described as, "unstalloss in which the basiough or an eschalof the damage can are removed) area measured 1 cm in lawound covered in sear tissue and prewound and rectum. The facility had continued and rectum. | ated R15 had a pressure ulcer of 6/19/13. The Nurses' realed R15's pressure ulcer on grough assessment dates until 7/25/14. The pressure d in its stages of healing as d measurements pulled from rowound team progress notes coccyx pressure wound meters (cm) X 0.5 cm X 0.3 coccyx pressure wound (0.9 cm X 0.4 cm. coccyx pressure wound (0.3 cm X 0.2 cm. coccyx pressure | F3 | 14 | | | |

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| | | 245462 | B. WING | | 09 | /11/2014 | |
| | MARANATHA CARE CENTER | | | STREET ADDRESS, CITY, STATE, Z 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 5 | ZIP CODE | | |
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| F 314 | used to determine rassessment docum was not independent form was also checked position for three he plan to reposition ethe analysis include every 2 hrs [hours] The facility had also Tolerance (Chair), who documentation on the was not independent was also checked frafter resident has been three hours on skin reposition every three analysis included, Repo. [repositioning when in bed." The evidence of any oth documents having the Tissue Tolerance. To be completed unwith significant characteristic and no further arecurrence of R15's and no further documents having the Tissue Tolerance. The evidence of any oth documents having the Tissue Tolerance. To be completed unwith significant characteristic and no further documents having the Tissue Tolerance. The evidence of the Tissue Tolerance of R15's and no further documents having the Tissue Tolerance of R15's and no further documents having the Tissue Tolerance of R15's and no further documents having the Tissue Tolerance of R15's and no further documents having the Tissue Tolerance of R15's and no further documents having the Tissue Tolerance of R15's and no further documents having the Tissue Tolerance of R15's and no further documents having the Tissue Tolerance of R15's and no further documents having the Tissue Tolerance of R15's and no further documents having the Tissue Tolerance of R15's and no further documents having the Tissue Tolerance of R15's and Tissue Tolerance o | repositioning schedule). The rentation indicated the resident of in mobility/positioning. The reked for "No discoloration is ent has been in the same ours on skin. Consider to care very three hours." However, ed, "Resident on repositioning in bed." To completed a Tissue which was undated. The hat form indicated the resident on the in mobility/positioning. But or "No discoloration is present een in the same position for . Consider to care plan to ee hours." However, the Resident is on every 2 hrs gl when up in w/c [wheelchair] er medical record lacked er Tissue Tolerance been completed. Directions on se document indicated it was pon, admission, annually and | F3 | 314 | | | |

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| F 314 | R15 had demonstrawith the chair. A Comprehensive S (CSRDC) had beer and indicated R15 (indicated moderated development). The had a history of chrococyx which was istable. The surveyof further assessment R15's pressure ulcodocuments were pure the control of the company of the | Skin Risk Data Collection completed for R15 on 3/7/14, had a Braden Risk score of 13 erisk for pressure ulcer CSRDC also indicated R15 ronic pressure ulcer to the dentified as inherited and or requested to review any tes following recurrence of er on 7/29/14, and no further | F 314 | | |

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| F 314 | hygiene. The progress notes geriatric nurse prace Geriatric Services of were reviewed from notes included: On 7/7/14, "Res. seen by wound nur of wound has decrein size 1.1 cm x 0.8 cm." On 8/8/14, "Nsg [I wound of 7/29/14, "I registered nurse] in "Coccyx wound: received [circle with a line dr no edema, shallow wrote a plan for the clean & dry, keep H 30 degrees, change continue with curre - On 9/5/14, the phywound was "shallow 8/8/14." Documentation from 7/8/14, indicated the (full thickness skin necrosis of subcutation for the clean the complex of the clean the clean the curre of the current of the clean the current of the cu | fers, toileting, and personal a from the physician and etitioner (GNP) entitled, of Minnesota Progress Notes in 7/7/14 through 9/11/14. The gresident] has coccyx wound see & reported as stable. Size eased [arrow downward image] acm, currently 0.4 cm x 0.2 Inursing] request to assess in cm x 0.6 cm. Wound RN envolved." Also noted was indicated the ease awn through it to depict no], alcer, no bruising." The GNP estaff to follow: "keep skin HOB [head of bed] < [less than] e position q [every] 2 [hours], and wound care orders." It wound care orders." It wound care orders and wound per GNP note woods involving damage to or an eous tissue that may extend fough, underlying fascia. The cally as a deep crater with or gof adjacent tissue). The | F 314 | , | | |
| | facility documented had slough." Accor the granulation was | l, "chronic ST II [stage 2] but rding to this documentation, s at 90% and the slough was at d measured 0.7 cm x 0.3 cm x | | | | |

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| F 314 | indicated the reside ulcer with 100% slo 1.0 cm x 0.6 cm x 0 described as rolled has resurfaced." The goal was to "proto heal but maintain A Physician's Order to treat R15's press with wound cleanse with silver nitrate 10 cauterization], zincochapped skin, or other-wound to prote [an all-in-one foam absorbs and retains keeps the wound swith Skin-Prep [a licupon application to film to help reduce tapes and films] are 8/12/14, the doctor Medihoney (used to stalled under first-lintowards healing) to of the silver nitrate ounavailable since of the product became to use the previous R15's care plan revenad a chronic pressiplan interventions of complete treatment effectiveness; follow | ion note dated 7/29/14, nt had an unstageable coccyx ugh. The measurement was 1.1 cm and the edges were The note indicated, "slough the recommendations revealed offect as goal may not be [sic] | F3 | 14 | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | FIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| F 314 | to R15 about the imrepositioning; and f two hours during th The care plan lacked load/reposition self evidence of any net to minimize/prevent recurrent unstageal coccyx. A Wound Consultatindicated R15's coccys. A Wound Consultatindicated R15's coccys. A Wound Consultatindicated R15's coccys. A Wound Consultatindicated R15's coccoys. The Wound Consultatindicated R15's coccoys were macerated and the work of | inally, reposition R15 every e day and two times at night. ed evidence that R15 could off in the wheelchair and lacked w interventions implemented t an increase in size for the ble pressure ulcer to the cion sheet dated 8/12/14, coyx pressure ulcer was 2.6 x perficial. The stage was the key for MA was not m). The wound base was at coant drainage. The edges | F3 | 14 | | |

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| F 314 | Continued From pa | age 24 | F 314 | | | |
| | evidence that there pressure ulcer ident progress note which pressure ulcer had. The facility's undate Sheet for Team 2, I described R15 as massistance of two strepositioning. The light directed staff to reput When interviewed everified R15's pressa "long time." LPN-(IDT) do wound room wound measurement. | ed Nursing Assistant Care Northern Lights Lane, non-ambulatory and requiring staff for transfers, toileting and Nursing Assistant Care Sheet position R15 every two hours. on 9/10/14, at 7:48 a.m. LPN-A sure wound had been there for A stated interdisciplinary team unds every Tuesdays where ents were done. LPN-A stated re the wound but stated the | | | | |
| | nursing assistant c | 0 a.m. NA-D checked her are sheet and stated R15 was positioned every two hours. | | | | |
| | expect a resident w repositioned accord | 20 a.m. RN-E stated he would with pressure ulcer to be ding to care plan and further have been repositioned every s care plan. | | | | |
| | and acknowledged ulcer to coccyx, and been tried and the better" but open up care plan interventi would be reposition | 29 a.m. RN-D was interviewed R15 had chronic pressure d that different treatments had pressure ulcer would "get again. RN-D verified R15's ions indicated the resident ned every two hours, but that itioned accordingly given the | | | | |

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| 245462 B. WING | 09/11/2014 |
| NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER STREET ADDRESS, CITY, STATE, Z 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 5 | ZIP CODE |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCY DEFI | TION SHOULD BE COMPLETION DATE |
| 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 322 SS=D 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 | 10/3/14 |

| - | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` , | TIPLE CONSTRUCTION | | E SURVEY PLETED |
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| | PROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CO 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | DDE | |
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| F 322 | (2) A resident who gastrostomy tube r treatment and serv pneumonia, diarrhemetabolic abnorma | age 26 use of a naso gastric tube was is fed by a naso-gastric or eceives the appropriate ices to prevent aspiration ea, vomiting, dehydration, alities, and nasal-pharyngeal re, if possible, normal eating | F3 | 22 | | |
| | by: Based on observareview, the facility of (R121) had a feeding placement prior to Findings include: R121's tube feeding dated 7/30/14, directube placement "becomedication adminis (checking for residdetermine proper placement become proper placement become determine deter | tion, interview and document failed to ensure 1 of 2 residents ing tube checked for proper administering medications. g Physician's Order sheet cted staff to check feeding efore tube feeding, flushes and stration" by aspirating residual ual stomach contents to placement of the tube feeding). Ition observation on 9/9/14, at tered nurse (RN)-H prepared to (potassium supplement) 7.5 prolol (used to treat high blood rams (mg) and Levetiracetam ures) 500 mg. RN-H crushed Levetiracetam tablets | | It is the practice of Maranath Center that a resident who refeeding via gastrostomy tube appropriate treatment and seprevent aspiration pneumonic vomiting, dehydration, metababnormalities and naso-pharand to restore, if possible, no skills. Education was provided to the notification. The policy for Gastrostomy T Placement was reviewed and All nurses have been re-educe checking placement of the gatube according to the policy. Three weekly observation aucompleted to assure ongoing | eceives a receives the ervices to a, diarrhea, colic yngeal ulcers ormal eating the nurse upon Tube d is current. cated on astrostomy dits will be | |

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| F 322 | individually and add to dissolve the med R121 the procedur with 30 ml of water medications, and fl water in between the not check the feedi medication administration administration or the RN-H explained she placement because tube feeding at 3:00 since the 4:00 p.m. was so close to the check for the same medication administration administration administration administration administration administration administration administration or to staff to, "Test for conference of the check the feedi medication administration administration or to staff to, and procedu placement check be administration or to per the Gastrostomy was expected to cheach medication administration administration or to the check the feedi medication administration or to per the Gastrostomy was expected to cheach medication administration administration or to per the Gastrostomy was expected to cheach medication administration administration or to per the Gastrostomy was expected to cheach medication administration administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication administration or to per the Gastrostomy was expected to cheach medication | ded 10 ml of water to each cup dications. RN-H explained e, flushed the feeding tube administered the ushed the tube with 30 ml of the medications. The RN-H diding tube placement prior to stration. 19/9/14, at 3:55 p.m. the RN-H check the feeding tube emedication administration. The check the feeding tube emedication administration edidn't check the feeding tube eshe just administered the p.m. RN-H further explained medication administration feeding she "didn't need to thing." RN-H stated the stration record (MAR) included Medication Administration diffied in July 2013. RN-H cure included instructions for prect placement of RN-H acknowledged she did ng tube placement before stration. 19/11/14, at 12:04 p.m. RN-B expected to follow the facility's re regarding feeding tube effore each medication the feeding. The RN-B verified by Tube Placement policy staff the diministration by checking the | F3 | Audit results will be reported QA committee. DON and/or designee will be for ongoing compliance. Dathe purposes of ongoing cor 10/15/14. | e responsible te certain for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | ` ' | E SURVEY MPLETED |
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| assure adequate pla | ube placement check was "to acement of gastrostomy tube on of medications." | F 32 | | | 10/2/14 |
| The facility must deventhat ensure that (i) Before offering the each resident, or the representative receivenefits and potential immunization; (ii) Each resident is immunization Octobe annually, unless the contraindicated or the immunized during the (iii) The resident or the representative has the immunization; and (iv) The resident's medocumentation that following: (A) That the reside representative was pure the benefits and potential immunization; and (B) That the reside influenza immunization or the facility must developed that ensure that (i) Before offering the | ves education regarding the al side effects of the offered an influenza er 1 through March 31 immunization is medically ne resident has already been his time period; the resident's legal he opportunity to refuse nedical record includes indicates, at a minimum, the ont or resident's legal provided education regarding ential side effects of influenza on the either received the ion or did not receive the ion due to medical refusal. | F 3: | 34 | | 10/3/14 |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | 245462 | B. WING | | 09/11/2014 |
| | PROVIDER OR SUPPLIER | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE 409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | |
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| F 334 | immunization; (ii) Each resident is immunization, unle medically contraind already been immu (iii) The resident or representative has immunization; and (iv) The resident's idocumentation that following: (A) That the resident representative was the benefits and popeumococcal immunication or (v) As an alternative and practitioner recogneumococcal immunization, unle immunization, unle | offered a pneumococcal so the immunization is licated or the resident has inized; the resident's legal the opportunity to refuse medical record includes indicated, at a minimum, the ent or resident's legal provided education regarding itential side effects of inunization; and ent either received the inunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second inunization may be given after 5 first pneumococcal is medically contraindicated or resident's legal representative | F 334 | | |
| | by: Based on interviev facility did not ensu | NT is not met as evidenced v and document review, the re 3 of 5 residents (R7, R103, and/or received the Influenza | | It is the practice of Maranatha Car Center that all residents are offered influenza immunization October 1-I 31 annually unless the immunization contraindicated or the resident has already been immunized during this | d the March n is |

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| | PROVIDER OR SUPPLIER | | | 54 | TREET ADDRESS, CITY, STATE, ZIP CODE 409 69TH AVENUE NORTH ROOKLYN CENTER, MN 55429 | | |
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| F 334 | R7 was admitted to remained in the fac provided to indicate influenza vaccine. R103 was admitted remained in the fac R103's representational street influenza vaccine to influenza vaccine to influenza vaccinational to the fac R36 was admitted to remained in the fac lacked documentational vaccination had every and refused. During interview on clinical coordinator/stated the influenza everybody, unless to medical record that outside of the facilitation conserwould like my family fluenza vaccine. On 9/11/14, at 12:0 not find any informatic received or were of the Influenza vaccine. | the facility on 9/10/13, and ility. No documentation was a R7 was offered the annual to the facility on 5/10/12, and ility. The record indicated ive requested the annual of be given and signed the on Consent form on 9/24/13. In the facility on 9/10/13, and ility. R36's medical record ion to indicate the Influenza er been received, or offered a 9/11/14, at 10:43 a.m. the fregistered nurse (RN)-B a vaccine was offered to here was evidence in the resident had received it y. RN-B verified R103's | F3 | 34 | period. R7, R103, R36 have been offered to influenza immunization and provide education on the risks and benefits. All residents and/or responsible participate in this year's annual influimmunization. The policy for Influenza Immunization been reviewed and is current. To assure ongoing compliance, each admission will be audited for reviewinfluenza immunization status and if needed according to the policy. Audit results will be reported to the QA committee. DON and/or designee will be responsationally for the policy of the ongoing compliance. Date certain purposes of ongoing compliance is 10/15/14. | ed trities ty to uenza ton has the vof offered facility onsible ain for | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | FIPLE CONSTRUCTION NG | ` ' | E SURVEY IPLETED |
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| F 334 | against influenza." vaccine program ru March 31st", and th encouraged to have documentation in the include the education against include the education against influence again | will be offered immunization The policy also indicated "the ins from early October through nat "residents will be the vaccine." Per the policy, ne medical record should on provided, vaccine dent refusal and education of | F 3 | 34 | | |
| F 353 SS=F | 483.30(a) SUFFICI PER CARE PLANS The facility must had provide nursing and maintain the highest and psychosocial with determined by reside individual plans of control of the facility must pronumbers of each of personnel on a 24-leare to all residents care plans: Except when waive section, licensed nupersonnel. Except when waive section, the facility nurse to serve as a duty. | ENT 24-HR NURSING STAFF ave sufficient nursing staff to d related services to attain or at practicable physical, mental, vell-being of each resident, as dent assessments and | F3 | 53 | | 10/3/14 |
| | by: | tion, interviews and document | | It is the practice of Maranatha | Care | |

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| | | 245462 | B. WING | | | 09/ | 11/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | - |
| ΜΔΡΔΝΑ | ATHA CARE CENTER | | | 5 | 409 69TH AVENUE NORTH | | |
| MANAIN | ATTIA CANE CENTER | | | Е | BROOKLYN CENTER, MN 55429 | | |
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| F 353 | Continued From pa | ge 32 | F 3 | 353 | | | |
| | review with resident failed to ensure suff was available to me observed/interviewe R208, R17, R134, F voiced concerns re- assure resident need | ts, family, and staff, the facility ficient qualified nursing staff eet the needs of residents ed (R15, R218, R3, R168, R11) as well as family member garding lack of staff persons to eds were met timely. This had ct 89 of 89 residents that | | | Center to have sufficient nursing st provide nursing and related service attain or maintain the highest pract physical, mental and psychosocial well-being of each resident, as determined by resident assessment individual plans of care. R15 has had a comprehensive reassessment of her skin risk and surfaces on 10/2/14. | es to ical ats and | |
| | 6/9/14, identified Raulcer with granulation assistance of one stransfers, toileting, quarterly MDS also cognitive impairments | | | | R3's concerns were reported to the appropriate state and county agence 9/9/14 with a full investigation being completed and submitted to the Of Health Facility Complaints (OHFC) facility received a disposition letter OHFC stating no further action was needed on 9/23/14. Education proto the staff involved on 9/18/14. | cies on g fice of . The from | |
| | Stage 2 pressure ul was there upon adr R15 as being at risk ulcers. The MDS di Stage 3 pressure ul facility on 7/8/14. The of the unstageable the facility on 7/29/1 ulcer developed and identified on the Wo addition, the MDS laturning and repositi was left blank. The that there was a presidentified on 7/25/14 | definition of the progress of the sound Consultation sheet. In acked evidence R15 was on a coning program as that section MDS also lacked evidence evious healed pressure ulcer 4, as per the progress note coccyx pressure ulcer had | | | R218's concerns were reported to appropriate state and county agency 9/2/14 with a full investigation being completed and submitted to the Of Health Facility Complaints (OHFC) facility received a disposition letter OHFC stating no further action was needed on 9/9/14. R168, R208, R17, R134 and R11 winterviewed and concerns addressed Plan was initiated and residents we educated/informed of plan in place. Maranatha Administration has reviewed and sessignments and school appropriate to the properties of the prope | cies on grand fice of . The from so were ed. ere | |

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| F 353 | in bed awake. Nurs licensed practical in room to help R15 g permission, the sur wound on R15's co stated she had "jus R15's coccyx. The 9/10 and was intact adhesive dressing the wound no drain discoloration was dwas identified by LI treatment. On 9/11/14, from 7 observed in her room wheelchairAt 7:26 a.m. regist R15's room and was medications, then I medicationsFrom 7:31 a.m. to room alone, was in grooming herselfAt 8:01 a.m. NA-B room, NA-B approadentures in R15's rishirt. NA-M pushed the Northern Lights (TV) area/lounge. It was not off-loaded repositioned from conserved in wheelchallounge and watchir | s a.m. R15 was observed lying sing assistant (NA)-C and lurse (LPN)-A was in R15's let up from bed. With R15's veyor observed a pressure ccyx with LPN-A. LPN-A t changed" the dressing to wound dressing was dated to be checked. Observation of age however, a yellow bserved on the dressing and PN-A as a Medihoney 10 a.m. to 7:25 a.m. R15 was om seated on a cushion in the lered nurse (RN)-D, entered as observed to give R15 some left when R15 took all the 7:58 a.m. R15 remained in front of mirror and continued and NA-M entered R15's leched R15 and put R15's leched R15 and put R15's leched R15 out to the hallway and to a Lane (NLL) unit television ouring that observation, R15 from wheelchair nor | F 35 | support can be added. Interviews will be conducted with residents and family members re of 10% of residents weekly to de times of greatest resident need. interviews involving three staff or household representing each shi completed weekly to assist in de times of greatest resident need. Interviews will be reviewed with t interdisciplinary team to facilitate identified changes in staffing assignments. Resident meetings, conducted weekly to discuss a patterns and adjustment plans as to gain feedback from residents effectiveness of adjustments. The call-in policy has been reviewing current. The policy has been rewith the Staffing Coordinators and direct care staff have been re-ed on the process. The call light response policy has reviewed and remains current. A have been educated on call light and meeting resident needs. We audits will be completed for call I timing on 10% of residents on each household. Interview results and feedback for resident meetings will be discuss facility QA committee. | flective termine Staff n each ft will be termining ne any eekly for staffing s well as on the wed and eviewed d all ucated s been all staff response eekly ght ch | |

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| F 353 | parked in wheelchat talked briefly to R15 R15 to the dining ro R15 was not off-load original position in reposition herselfFrom 8:49 a.m. to seated in wheelchat working on breakfar-At 9:25 a.m. NA-B dining table toward R15 in front of TV ar-At 9:32 a.m. NA-B wheelchair away from hallway going past and to the elevators R15 to the 3rd flood At 9:34 a.m. R15 are member was reading not off-loaded nor round R15 did not reposition At 9:43 a.m. R15 are was calm and apperent at the news At 9:59 a.m. RN-D been seated in the 10:05 a.m. and req for skin conditionAt 10:03 a.m. R15 are for skin conditionAt 10:05 a.m. RN-D been seated in the 1 | approached where R15 was air at the NLL TV lounge and 5. RN-E was observed to push from area towards R15's table. Indeed nor repositioned from wheelchair, nor did R15 9:20 a.m. R15 remained air at the dining room, slowly st with the use of right hand. In wheeled R15 away from the state the NLL TV area. NA-B left at the NLL TV area. In returned to push R15's from NLL TV area towards the first floor nurses' station as. NA-B stated she was to take for an activity. In was at the 3rd floor activities' sidents where a female staffing the newspaper. R15 was repositioned from wheelchair, was still seated in wheelchair, was notified that R15 had wheelchair from 7:25 a.m. to uested that R15 be assessed was pushed to common area and and RN-E. The two staffines at the NLE TV to the staffines area of the wheelchair in the seated in wheelchair in the | F 353 | Administrator, DON and/or do be responsible for compliance certain for the purposes of or compliance is 10/15/14. | ce. Date | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTII A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| F 353 | wound was from 9/pressure wound on that open area on Islight redness on sarea, skin to rest of creases from diaper R15 went two hours repositioning. Stage 1 family inter On 9/8/14, at 7:00 pasked if family merenough staff availa member get the cawithout having to wlights can be a chait can take a long tiand if they come the come back and the get on their case. " Stage 1 Resident In R218's Brief Interviassessment dated intact cognition. Meg 9/5/14, indicated Ractivities of daily live transfers, toileting a Progress Notes daindicated R218 was with cares. On 9/8/14, at 3:45 pasked if he felt ther to make sure you gneed without having staff say they are visited in the staff say | 10/14, RN-E assessed R15's buttocks and described R15's coccyx had 90% slough, urrounding skin up to the open buttocks clear dry, intact, with ar and skin was blanchable. s and 55 minutes without rview b.m. during interview when able to make sure your family are and assistance they need that a long time, F-A stated "call llenge to answer at times and are before they could answer it ey would indicate they would by don't come back. I usually | F 35 | 3 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION NG | | MPLETED |
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| F 353 | 1:15 a.m. one time sharp bedpan and on a weekend. Staft them, I told [registe and two nights later today third time, an some. [I] tried to tel said she would get in my pants a coup when bedpan was further stated now with two assist and they never hurry the R3's quarterly MDS cognition was mode extensive physical dressing, toileting, hygiene. In addition both a walker and who behaviors. On 9/9/14, at 11:28 asked if she felt the to make sure you gneed without having stated, "They alway like this morning, seenough staff." | after they put me on a plastic didn't take me off till 4:00 a.m. if flip name tags or don't wear red nurse, RN-A], one night was good, told [RN-A] again d he said he would investigate I the social worker and she back to meI have had to go le of times a little and in bed not positioned correctly. R218 she gets up to the bathroom "staff at night hurries me, but | F 35 | 53 | | |
| | without attending to put the call light on | do so, but the staff left R3's needs. R3 stated she again, then staff came in and helping R3. R3 was observed | | | | |

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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | = |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 353 | to be teary-eyed as happened that mor some pauses and of felt sick and getting crying, I never wet in pointed to one pillor at the head of the bowet all the way up to so bad." On 9/9/14, at 11:34 asked if she felt the to make sure you go need without having "They always say the some pause of the same pause." | she talked about what ning. R3 wiped own tears, took continued to talk about having the bed wet. R3 stated, "I was the bed like that before." R3 w (without a pillow case) lying red and described the bed was to her pillow. R3 stated, "I felt a.m. during interview when are was enough staff available et the care and assistance you go to wait a long time R3 stated, ney are in a hurry just like this on't know if they have enough | F 38 | 53 | | |
| | cognition was intact required physical strated in the strategy of the strategy | DS dated 6/12/14, indicated t was independent but also upervision oversight of one and personal hygiene and used y and had no behaviors. a.m. during interview when ere was enough staff available et the care and assistance you g to wait a long time R168 is I wait an hour to eat" 8/19/14, indicated cognition aired extensive physical to two staff with dressing, toilet ransfers and personal hygiene. S indicated R208 used a ility and had functional motion on one side upper and | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 245462 | B. WING | | | 09/ ⁻ | 11/2014 |
| | PROVIDER OR SUPPLIER ATHA CARE CENTER | | | 54 | TREET ADDRESS, CITY, STATE, ZIP CODE 409 69TH AVENUE NORTH ROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 353 | On 9/8/14, at 4:51 pasked if she felt the to make sure you gneed without having stated, "They need evening." R17's quarterly MD cognition was seve extensive physical dressing, toileting, and had no behavior on 9/8/14, at 4:13 pasked if he felt ther to make sure you gneed without having stated, "I don't think because they alway called-in sick and that while they do." R134's quarterly Mcognition was seve extensive physical with dressing, toilet hygiene. In addition both a walker and wno behaviors. On 9/8/14, at 6:28 pasked if he felt ther to make sure you gneed without having seed without having se | d had no behaviors. o.m. during interview when ere was enough staff available let the care and assistance you g to wait a long time R208 more staff in morning and S dated 6/17/14, indicated rely impaired and required assistance of one staff with transfers and personal hygiene | F3 | 353 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245462 | B. WING _ | | 09 | 9/11/2014 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 353 | after putting call ligh | _ | F 35 | 53 | | |
| | cognition was intac physical assistance toileting and persor limitation in ROM to | t and required extensive of one staff with dressing, nal hygiene; had a functional b both lower extremities and in elichair for mobility and had no | | | | |
| | asked if he felt ther to make sure you g need without having | o.m. during interview when e was enough staff available et the care and assistance you g to wait a long time R11 tried to cut down the help and | | | | |
| | who requested to re surveyor the bedsic changed since Sun a problem which ha resident council and resolved and the re staffing. The anony | eximately 2:30 p.m. a resident emain anonymous indicated to de water mugs had not been day 9/7/14, and this had been ad been brought up at the d the unit staff, but had not sident thought was related to mous resident further stated t council this was going to be ty attention. | | | | |
| | On 9/10/14, at 7:35 R97's room on. The and R97 was obser adaptive call light ly -At approximately 7 assistant (NA)-A wa towards R97's room medication aide (TI | bservation 3rd floor a.m. observed call light in e hallway light to room was on rved lying in bed with an ring on top of the bedding. (:40 a.m. observed nursing alking down the hallway n as she was walking trained MA)-A was overheard in a high you going to get [R97] call | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION IG | | TE SURVEY MPLETED |
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| | | 245462 | B. WING _ | | 09 | /11/2014 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 353 | light?" and NA-A re to walk into R97's rat approximately 7 was observed clear and walked away frathe call light. When interviewed a stated R97 was a sumped her call light. When interviewed a stated R97 was a sumped her call light. When interviewed a came out of R97's assistance R97 read to be a sumped the call light in the room and what ime, R97 had indicated pan. NA-A state about to get up soot then but had told N pan anyway. When light was on and if I without asking the interviewed assume, but had the call light. Staff interviews When interviewed a 2:13 p.m. the admit of the ice machine malfunctioning and environmental serving replacement. When would not get the ice | plied, "Yeah" as she continued com. 2:41 a.m. NA-A came right out using her hands at the door com the room after answering on 9/10/14, at 7:41 a.m. NA-A leep and had probably hit in her sleep. R97's call light was observed into the room briefly spoke with door after putting the light on. On 9/10/14, at 7:47 a.m. NA-A room when asked what quired, NA-A stated R97 had hit the first time she had been en she went in the second cated she needed to use the ed R97 had thought she was on and would use the bed pan A-A to still put her on the bed asked when a resident call NA-A would just turn it off resident or meeting the need, as supposed to ask and not ought resident had bumped | F 35 | 53 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION IG | | E SURVEY MPLETED |
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| | | 245462 | B. WING _ | | 09 | /11/2014 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 353 | residents who had got ice for themsel asked about the of able to get the wat got fresh water addresident council m. On 9/11/14, at 10:4 conducted with the interim clinical adn. When asked how staffing pattern SC each floor" as she the census and state. When asked who at the facility SC stup and she quit a vibeing trained in." When asked if the supplement for sic and ICA indicated. When asked who stated "they are susupervisor who would be supplemented in the facility would flexibility with acuit. When asked who was low and if the the facility would flexibility with acuit. When asked if st with incidents such others and if there stated falls were dinterdisciplinary teat to ask the five why. When asked if st identified or report "Staff have had co | the problem were those that lives from the machine. When ther residents who were not ther for themselves and never ministrator referred surveyor to inutes. 45 a.m. an interview was estaffing coordinator (SC) and ministrator (ICA). If the facility determined the context of the stated by the grid we have for showed sheets which indicated affing patterns. If the facility used pool staffing to the facility used pool staffing to the calls or other leaves both SC the facility did not use pool. If the facility did not use pool. If the facility did not use pool when the census facility flexed down ICA stated ex with census but there was the sy with census affing was tracked and trended in as falls, infections among any patterns with staffing ICA iscussed on the daily am meetings (IDT) and "we try | F 35 | 33 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | ATE SURVEY OMPLETED |
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| | | 245462 | B. WING | | | 9/11/2014 |
| | | | | STREET ADDRESS, CITY, STATE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN | , ZIP CODE | |
| PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFI TAG | PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE |
| F 353 | concerns except for requested to receive being moved to a dunit (TCU) from lonindicated falls state last quarter and any concern we have heresident with concern completed per the followed." - When asked about turnover rate, open being reported to quarter ICA increase in the turn the facility had "a standard resident with a standard resident resident with a standard resident reside | r one nurse who has e more training as she is ifferent unit transitional care g term unit." ICA also d falls had decreased in the ytime "we have had a call light ad to run the report for the rn and a grievance is facility grievances policy is at the facility employee positions, and if both were uality assurance meeting in a stated, "We have had an over rate." ICA also indicated raffing meeting on Thursday the turnover rate and the red." SC provided a list of rons for both licensed nurses ant (NA's) which showed the time NA positions on all shifts d four part time and one full has open also. A or corporate did exit ed they had not done them porate does not do them, "but if reting our standards we have oximately 12:17 a.m. both the ICA approached surveyor g for the last six months was | F3 | 353 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | | | |
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| | | 245462 | B. WING | | | 09/ ⁻ | 11/2014 |
| | PROVIDER OR SUPPLIER | | | 54 | TREET ADDRESS, CITY, STATE, ZIP CODE 109 69TH AVENUE NORTH ROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 353 | for the staff. - When asked if an stated there was not a when asked if the doing them on the floring the shift, the facility did not do the during the shift, the facility did not do the when asked since done on the floors is resident needs had stated she thought call light the resident Con 9/11/14, at 12:4 approached survey have a specified stafollowed the grind approvided earlier. When interviewed a stated her expectate answer the call light resident room they the resident need whom room. RN-B further staff to stop in the resident to answer other staff on the uncall lights. When interviewed a stated she would have a specified to answer other staff on the uncall lights. | y of those were available, she o record of it. e facility did audits of the staff floor over a period of time administrator stated the | F3 | 53 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF A. BUILDING | PLE CONSTRUCTION G | | TE SURVEY MPLETED |
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| | | 245462 | B. WING | | 09 | /11/2014 |
| | PROVIDER OR SUPPLIER | , | | STREET ADDRESS, CITY, STATE, ZIP COD 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 353 | 9/9/14, revealed the Resident/Visitor C 6/30/14, at 11:10 phad indicated he had put the call light responded so he the self-transfer as state another resident. F R105's call light had which was over nin RN-A indicated he regarding call light - Resident/Visitor C 7/21/14, at 6:50 a.r found kneeling on the Follow-up education R153 was at risk for while in bed and confurther indicated, "Hup by [6:00] due to this the Night shift of bed [due to] d/t staffing issues, tho adequately staffed, priority for AM care from happening" Although the staff of where, and what time before the fall/incidindication of the last toileted, lacked who of the reports ident bathroom floors at Secondly residents as residents had be seen as the second of the | cility dated 2/1/14, through e following: Doccurrence Report dated .m. for R105 revealed R105 and to use the bathroom and not on but staff had not hought he was able to ff was probably helping follow up call light log revealed do been put on at 10:51 p.m. eteen minutes to R105's falls. would follow-up with staff response time. Doccurrence Report dated m. indicated R153 had been the floor leaning over the bed. In facility investigation indicated or falls related to being restless onfusion. The investigation His current care plan is to be this reason. The night prior to was not able to assist him out ugh day shift was more than [R153] should have been the s this morning to prevent this | F 350 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | | TE SURVEY MPLETED |
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| | | 245462 | B. WING _ | | 09 | /11/2014 |
| | MARANATHA CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 45 assist. | | | STREET ADDRESS, CITY, STATE, ZIP COD 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| PRÉFIX | (EACH DEFICIENC) | / MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 353 | assist. Review of Resident Forms provided by 4/23/14, to 8/27/14 response time, med back after leaving to brought up to the faby alert residents a times and signed on Although the facility had been provided been reviewed, the ups completed to end been met despite the timely, as indicated A review of the Morand responses from revealed the following and resident felt like stated they would only have get her ready for been the moreon and responses from revealed the following answer, more than resident felt like stated they would only have get her ready for been the moreon and indicate would be looking at basis. A minutes on 3/26 concern was omitted addition on the new were brought up: "Staff aren't always" | t/Family/Staff-Quality Concern the facility dated between revealed concerns of call light eting the needs and coming unanswered call light had been acility and a family member multiple ff by the administrator. A had indicated staff education and the call light logs had re was no evidence of follow nsure resident needs had ne call lights being answered on the investigations. The Resident Council Minutes of 6/12/13, through 8/27/14, ang: The goal of 5 minutes. One off made her wait longer so that we to come to her room once to ed. [Household coordinator] with the resident and this the staff explained the new do reports that can be pulled to es; trends, average call light do the household coordinator | F 35 | 3 | | |

| | MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ` ' | (X3) DATE SURVEY COMPLETED | | |
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| | | 245462 | B. WING | | 09 | /11/2014 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 554 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 353 | eating. Staff telling resider minute, I have to fin may or may not constaff will come in, answer/meet the received response/action to was indicated as "S-The minutes on 4 staffing concerns who business minutes. The minutes on 5 indicated, "Call light down again. Reside medications & not response indicated "will continue to austaff education & trousiness: "Blue mushift on third floor" who took the minute household coordinated audit this." The minutes on 6 concern for call light revisited again with added to the all stare-education on the quality improvement respectively. The minutes on 7 response time was passed were brough business on the cowere both old and 15/28/14, minutes. The minutes for 8 | way before they are done at that "They'll be back in a hish up something" and they me back. Shut the call light off and not esident's need." be taken to all three concerns | F 3 | 53 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245462 | B. WING _ | | 09/ | /11/2014 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 353 | water mugs being preither of the conceprevious minutes at 7/30/14, minutes. Although the subject fresh water mugs he meetings the concept thoroughly or review staffing patterns to met in a timely man facility administrator individual call light of investigated the fact a system in place to were audited, track were meeting the reanswering the call I provide any informational provided to the staffindicated on the condidicated on the condition of the condition | cassed were brought up, but erns had been discussed in the senw business from the set of call lights and passing ad been brought up on several erns were never followed up wed by the facility to look at the ensure resident needs were ener. In addition although the rand the staff indicated concerns had been ensure all resident call lights ed and trended to ensure staff esidents needs upon ights. The facility did not atton on the re-education of regarding the concerns as uncil minutes. The facility also call light concerns, keeping in who did not attend the council were not able to report the bout call light delays. Our schedules dated 12/29/13, aled the following: iff three NA positions were CU and one NA in the TCU of the a TMA. In addition in the etwo RN's and one licensed N) scheduled on the day shift sus for this shift in the TCU. It worked a double from | F 35 | 53 | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | TIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245462 | B. WING _ | | 09 | /11/2014 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 353 | crossed off with no Mallard Manor (MM with census of twer resident acuity/nee on MM two NA's we and only one was rescheduled NA's agent PM shows reason leaving the scheduled NA's. On 5/10/14, accord Direct Care Hours of TCU was scheduled only 53.00 hours have been participated in analyzing both Withours spreadsheet pattern for staffing manipulated to reavery widely in-skilled in Wing 2 on 5/10/with 35.00 hours for TMA. On 5/10/14, accord Direct Care Hours of TCU was scheduled in | ift one of the four TCU NA was reason; another was moved to following two NA for the shift of the four unaware of the devel for the shift. In addition the ere crossed off with no reason eplaced of the five originally ain unaware of the census. If the one NA was crossed off with the woof three NA's originally ding to the census for Wing 2 sheet provided by the facility, do have 60.50 NA hours and additionally developed that day. The ster by shift was requested the rovided to review in relation to Doccurrence Report for R105 putting his call light on for efore fall and had not been | F 3: | 53 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | LE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
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| | | 245462 | B. WING | | 09/11/ | 2014 |
| | PROVIDER OR SUPPLIER ATHA CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE CO | (X5) DMPLETION DATE |
| F 353 | On 7/21/14: - daily but had not been p a Resident/Visitor (who had a fall after nineteen minutes be promptly answered In analyzing both Whours spreadsheet pattern for staffing manipulated to reavery widely in-skilleton -In Wing 2 on 5/10/with 35.00 hours for 7.50 hours for TMA total hours of 128.00 -On 5/1/14, census RN; 16.25 hours for NA per patient day of 50 -On 5/24/14, census RN; 0.0 hours for NA per patient day of 50 -On 5/24/14, census RN; 0.0 hours for NA per patient day of 50 -On 5/24/14, census RN; 16.25 hours for NA per patient day of 50 -On 5/24/14, census RN; 10.0 hours for NA per patient day of 50 -On 5/24/14, census | roster by shift was requested rovided to review in relation to Dccurrence Report for R105 putting his call light on for efore fall and had not been. Ving 1 & Wing 2 Direct Care is, there was no set skill but rather the hours were chiper patient day hours and id set. For example: 14, census was 23 residents if RN; 24.50 hours for LPN; and 61.00 hours for NA for 100 with per patient day of 5.57. was 27 with 45.00 hours for TMA and for total hours of 143.00 with 16.30. Its was 22 with 53.25 hours for PN; 0.0 hours for TMA and or total hours of 113.25 with | F 353 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION | | E SURVEY PLETED |
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| | | 245462 | B. WING | | 09/ | 11/2014 |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| F 353 | Continued From pa | _ | F 353 | 3 | | |
| | visibly displayed on audibly heard at the light went off at 3:3. R220 what he had rang his call light as afternoon snack. R comes up at 3:00 p At 3:45 p.m. R220 bring him his aftern At 3:31 p.m. observed displayed on the cat the nursing station 3:40 p.m. Writer he blanket stating R14 On 9/10/14, at 8:42 visibly displayed on audibly heard at the light went off at 8:44 At 8:53 a.m. was he requesting staff asset the bathroom. At 9:39 a.m. observed. | o.m. observed R220's call light the call light panel and enursing station. R220's call 2 p.m. When surveyor asked needed R220 stated he had she was waiting for his 220 stated "usually the snack o.m." was still waiting for the staff to soon snack. wed R144's call light visibly all light panel and audibly heard on. R144's call light went off at eard R144 ask of NA-L for a light was cold. et a.m. observed R55's call light the call light panel and enursing station. R55's call | | | | |
| | at the nursing static 9:44 a.m. Observed radio for staff assis NA-K reply over the | on. R218's call light went off at d RN-F request help over the tance for R218 and heard e radio "it will be awhile" as another resident. R218 stated | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|---------------------|---|--------|----------------------------|
| | | 245462 | B. WING _ | | 09 | /11/2014 |
| NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 51 to surveyor RN-F had come into her room, turne 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 assistant 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 hea at the nursing station. R219's call light went out | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | , 30 | |
| PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 353 | to surveyor RN-F hoff the call light and helping another reside to the toilet. At 10:00 a.m. R218 sitting in her wheeld to the bathroom. Riwith standing lift for At 9:46 a.m. observed displayed on the call the nursing static 9:52 a.m. The nursing answer R219's call On 9/10/14, at 11:0 light visibly displayed audibly heard at the light went off at 11:1 During observation coordinator (HUC) the call light panel awith the room number the call lights had be at the nursing static 11:31 a.m. While that the entrance abordisplayed flashing or requesting help. R1 nursing station with | ad come into her room, turned at told R218 NA-K was busy sident before R218 could go to a was observed in her room chair still waiting for assistance 218 needed two staff assist toileting. Yed R219's call light visibly all light panel and audibly heard on. R219's call light went out at e at the desk had gotten up to light. 8 a.m. observed R208's call ed on the call light panel and enursing station. R208's call 20 a.m. of call light the health unit was seated at the desk with alarming and visibly displayed pers and the amount of time | F 35 | 3 | | |
| | were observed to w stopping to answer | valk by R144's room without the call light including: NA-I, dietary staff, housekeeper, | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL ⁻ A. BUILDI | TIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
|--------------------------|--|---|------------------------------------|--|---------|----------------------------|
| | | 245462 | B. WING | | 09 | /11/2014 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 353 | two maintenance a a.m. observed RN-audible ringing of R observed to look at above R144's door RN-A and administ HUC seated at des call light and displa call light rang. No s R144's room while At 11:24 a.m. obserdisplayed on the cat the nursing static 11:31 a.m. At 11:30 a.m. obserdisplayed on the cat the nursing static capital letters and the ding ringing double light ended at 11:35 surveyor that R130 out of the wall. At 1:33 p.m. observed isplayed on the cat the nursing static 1:37 p.m. R144 observed isplayed on the cat the nursing static 1:37 p.m. observed isplayed on the cat the nursing static 1:37 p.m. observed isplayed on the cat the nursing static 1:37 p.m. observed isplayed on the cat the nursing static capital letters and the ding ringing double light went out at 1:44 the toilet for assistations. | Ind the administrator. At 11:27 C standing at desk with 144's call light at desk, RN-C R144's white flashing light and walked off. Observed rator standing at desk, the k with audible sound of R144's y of room number and time taff was observed going into R144's call light rang. Tived R219's call light visibly all light panel and audibly heard on. R219's call light went off at rived R130's call light went off at audible sound of the ding increase in speed. R130's call is a.m. It was verified to had pulled his call light visibly all light panel and audibly heard on. R144's call light visibly all light panel and audibly heard on. R144's call light went out at served to say to staff "had to | F3 | 53 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION NG | ` , | TE SURVEY MPLETED |
|--------------------------|--|--|---------------------|---|--------|----------------------------|
| | | 245462 | B. WING _ | | 09 | /11/2014 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 353 | at the nurse's static unattended. At 1:41 p.m. observed displayed on the case at the nursing static 1:46 p.m. On 9/11/14, at 8:08 light visibly displayed audibly heard at the light went out at 8:1 At 8:26 a.m. observed displayed on the case at the nursing static 8:35 a.m. At 9:31 a.m. observed displayed on the case at the nursing static 9:41 a.m. Staff and have walked by R1-R144's call light. The station desk during R144's call light and observation the SW the unit answering of the unit answering of the case at the nursing static capital letters and the ding ringing double light went out at 9:55 observation RN-A at the call light panel at R213's room, word | yed R221's call light visibly all light panel and audibly heard on. R221's call light went out at a.m. observed R130's call and on the call light panel and a nursing station. R130's call | F 34 | 53 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---------------------|--|-------------------------------|----------------------------|--|
| | | 245462 | B. WING _ | | 09 | /11/2014 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | .,, | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 353 | a.m. RN-F stated withe resident door allight button the pagpaged to the NAs riminutes when not a nurses' page gets that answered in 10 again get triggered then every 5 minutes been across the haresident when she nurse requesting as the facility had been system since last Nathe green lights over occasionally left on At 9:32 a.m. NA-J sigoes down the numadjusted down. Call Light policy more facility personnel mat all times. 2. Answerther or not you 3. For bedside call will appear and be resident's room. 6. prompt, calm, court light as soon as positive to the NAT of the page of | th RN-F on 9/10/14, at 9:06 when the green light is on over and the resident pushed the call er goes to HELP and gets ight away, and then after 5 canswered by the NAs the riggered and if the call light is minutes the call light will and paged to the nurses and es after. RN-F stated she had all in a room helping another theard the page from the other esistance for R55. RN-F stated in using the new call light lovember. RN-F further stated er the residents' doors are by staff. Stated when resident census in the stated when resident census in the aware of call light lights wer ALL call lights promptly are assigned to the resident. It lights, a light and/or a sound the heard over the door of the Answer all call lights in a teous manner; turn off the call is sible" | F 35 | 3 | | | |

PRINTED: 10/07/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - MAIN BULIDING B. WING 09/16/2014 245462 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5409 69TH AVENUE NORTH MARANATHA CARE CENTER **BROOKLYN CENTER, MN 55429** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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 **EPOC 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: (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | TIPLE CONSTRUCTION DING 02 - MAIN BULIDING | | COMPLETED | | |
|--|--|---|--|-----|-----------------------------------|----------------------------|--|
| | | 245462 | B. WING | | | /16/2014 | |
| | PROVIDER OR SUPPLIER | • | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| K 000 | Marian.Whitney@s THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or possible for corprevent a reoccurr Maranatha Care Coin 2013. Main Build with no basement Type II (222) constitive sprinkler protecting the kitch building has a fire detection in reside open to the corridor automatic fire department of the building is attachapel 03 building construction and so the corridors and space monitored for automatic fire alarm system corridors and space monitored for automatic for automatic fire alarm system corridors and space monitored for automatic for automatic fire alarm system corridors and space monitored for automatic for automatic for automatic fire alarm system corridors and space monitored for automatic for automatic for automatic for automatic fire alarm system corridors and space monitored for automatic for automatic for automatic fire alarm system corridors and space monitored for automatic fire alarm system corridors and space monitored for automatic fire alarm system corridors and space monitored for automatic fire alarm system corridors and space monitored for automatic fire alarm system corridors and space monitored for automatic fire alarm system corridors and space monitored for automatic fire department for automatic fire alarm system corridors and space monitored for automatic fire department for automatic fire for automatic fire department for automatic f | state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done | | 000 | | | |

| CENTER | S FUR WEDICARE | & MEDICAID SERVICES | | _ | | | |
|---|--|--|--------------------|-----|---|---|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION 12 - MAIN BULIDING | (X3) DATE SURVEY COMPLETED | |
| | | 245462 | B. WING | | | 09/1 | 6/2014 |
| | PROVIDER OR SUPPLIER | | | 54 | REET ADDRESS, CITY, STATE, ZIP CODE 109 69TH AVENUE NORTH ROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 018 SS=E | Building 02 building construction and set of the non-construction and set of the non-construction with (2) of the facility has a consus of 90 at the NFPA 101 LIFE SA Doors protecting constructed to resident of the normal provided hardware. Dutch of the non-construction of the normal provided hardware. | which is of non-conforming eparated by a 2-hour fire wall. Iforming construction, enter is surveyed as 2 and surveyed as 2 apacity of 97 beds and had a a time of the inspection. | K | 000 | | | 10/3/14 |
| | Based on observation has failed to maintaccordance with N Section 18.3.6.3. affect some reside Findings include: On facility tour betton 09/16/2014, obstave taped over all | is not met as evidenced by: tion and interview, the facility ain corridor doors in FPA 101 Life Safety Code (00) This deficient practice could nts. ween 10:00 AM and 12:00 PM servation revealed that staff nd blocked the door strikes to storage room doors. | | | The Credible Allegation of Complianas been prepared and timely subrous Submission of the Credible Allegatic Compliance is not a legal admission deficiency exists or that the Statem Deficiencies were correctly cited, a also not to be construed as an admagainst interest of the Facility, its Administrator, or any employees, a or other individuals who draft or madiscussed in this Credible Allegatic Compliance. In addition, preparations submission of this Credible Allegatics. | mitted. ion of on that a nent of ind is nissions agents, ay be on of on and | |

| STATEMENT AND PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION 02 - MAIN BULIDING | COMP | LETED |
|--------------------------|--|---|---------------------|--|---|----------------------------|
| | | 245462 | B. WING | | 09/1 | 6/2014 |
| | PROVIDER OR SUPPLIER | | 6 | STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| K 018 | This deficient pract | age 3 tice was verified by the tor at the time of the | K 018 | Compliance does not constitute ar admission or agreement of any kir the facility of the truth of any of the alleged or the correctness of any conclusions set forth in this allegate the survey agency. Tape was removed from the memostorage room doors and all other stroom doors in the facility were che compliance. The fire doors for all areas will be added to the monthly door inspection checklist in the elework order system to ensure these are working properly. In addition, will be educated on the importance maintaining the operational integrifire doors. The Environmental Se Director or his designee will be responsible for ensuring that the nother checks are completed. The safety committee will review the fire door inspection reports quarterly. | ory care storage of the cectronic e doors staff e of ty of the rvices monthly | |
| K 050 SS=F | NFPA 101 LIFE SA | AFETY CODE STANDARD | K 050 | compliance is 10/15/14. | | 10/3/14 |
| 33-1 | varying conditions, The staff is familia that drills are part of Responsibility for p assigned only to co qualified to exercis conducted between | at unexpected times under at least quarterly on each shift. It with procedures and is aware of established routine. Dianning and conducting drills is competent persons who are see leadership. Where drills are in 9 PM and 6 AM a coded by be used instead of audible at the conduction of the code | | | | |

| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | | | | | 0930-039 I |
|--------------------------|--|--|---|-----|--|--|----------------------------|
| STATEMENT AND PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BULIDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 245462 | B. WING | | | 09/1 | 6/2014 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| MARANA | THA CARE CENTER | | | | 9 69TH AVENUE NORTH OOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 050 | Continued From pa | ge 4 | ΚO |)50 | | | |
| K 069 SS=F | Based on review of interview, it was de to vary the times at in the last 12-mont practice could affect of a fire. Improper the safety of all restriction on facility tour beto 12:00 PM on 09/16 that there is no doos shift fire drills for the This deficient practice inspection. NFPA 101 LIFE SACOOKING facilities at 12:00 PM on 10:00 PM on 10 | s not met as evidenced by: If reports, records and Itermined that the facility failed and dates of numerous fire drills In period. This deficient It how staff react in the event Ireaction by staff would affect Idents. In the event Itereaction of a more and a more | K | | The facility will conduct fire drills w frequencies and timings as require NFPA 101 LSC (2000) including at once per shift per quarter at varying and conditions. These fire drills wi conducted by the Environmental Schedule will be entered into the electronic work order scheduling sy to ensure completion. The fire drill schedule will also be entered into t Campus Administrator's electronic calendar. The Campus Administrator's verify that the fire drills were condurequired. The safety committee wi review fire drill reports quarterly for accuracy and timeliness. Date certain for the purposes of or compliance is 10/15/14. | d by least g times ll be ervices drill ystem he ator will acted as | 10/3/14 |
| | Based on observation hood suppression maintained in accordance. | is not met as evidenced by: Ition and review, the kitchen system has not been ordance with The Life Safety 3. This deficient practice could | | | The UL 300 fire suppression system be tested or inspected at frequency timings as required by NFPA 101 L (2000) of at least every 6 months. Inspections will be entered into the electronic work order system and the sy | ies and SC These | |

| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | | _ | | | 0930-030 |
|--------------------------|--|---|--|---|--|--|---------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - MAIN BULIDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 245462 | B. WING | | | 09/1 | 16/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| MARANA | ATHA CARE CENTER | | | | 09 69TH AVENUE NORTH ROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETIO DATE |
| K 069 K 144 SS=F | 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 1 | | Environmental Services Director of designee will be responsible for exthese inspections take place at the timing. These inspections will also entered into the Campus Administ electronic calendar to ensure they completed as required. The safe committee will review the inspective reports bi-annually for accuracy attimeliness. Date certain for purposes of ongo compliance is October 15, 2014. | | 10/3/14 |
| | Based on observation failed to maintain the accordance with the second affer the second aff | ween 10:00 AM and 12:00 PM cord review revealed that: umentation of monthly | | | The generator will be inspected at tested as required by the NFPA 10 (2000) whereas the generator and generator systems will be inspected weekly by the Environmental Service Director or his designee. The general will be run under at least 30% load one time per month for at least 30 minutes. This testing will be arrant the Environmental Services Direct designee. The schedule for this inspection and testing will be enter | 1 LSC ed ices erator I at least ged by or or his | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BULIDING (X3) DATE SE COMPLE | | | | | |
|--|---|---|--------------------|-----|--|--|----------------------------|
| | | 245462 | B. WING | | | 09/1 | 6/2014 |
| | PROVIDER OR SUPPLIER | | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE 409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 144 | testing prior to June These deficient pra | mentation of weekly generator | K 1 | 144 | the electronic work order schedulir system to ensure completion. The schedule for inspecting and testing generator and systems will be enterthe Campus Administrator's electrocalendar. The Campus Administratority that the inspection and testing generator and generator systems of completed as required. The safety committee will review the results of inspection and testing for accuracy timeliness. Date certain for the purposes of or compliance is October 15, 2014. | the ered into onic otor will g of the was find and | |

(X2) MULTIPLE CONSTRUCTION

PRINTED: 10/07/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 03 - KITCHEN AND CHAPEL B. WING 09/16/2014 245462 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5409 69TH AVENUE NORTH MARANATHA CARE CENTER **BROOKLYN CENTER, MN 55429** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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 **EPOC** 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: (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

Facility ID: 00226

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | E CONSTRUCTION 03 - KITCHEN AND CHAPEL | | E SURVEY MPLETED |
|--------------------------|---|---|--------------------|-----|---|------|----------------------------|
| | | 245462 | B. WING | | | 09/ | 16/2014 |
| | PROVIDER OR SUPPLIER | | | 54 | TREET ADDRESS, CITY, STATE, ZIP CODE 409 69TH AVENUE NORTH ROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| K 000 | Marian.Whitney@s THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of value to correct the deficit 2. The actual, or pr 3. The name and/oresponsible for correcting the correcting the light with no basement at Type II (222) construction in resider open to the corridor automatic fire departs and the building has a fire a detection in resider open to the corridor automatic fire departs and the building is attangled to building is attangled to building with no base of Type V (111) fully fire sprinkler protecting the kitch fire alarm system was corridors and spacemonitored for automatored | tate.mn.us RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. | K | 000 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - KITCHEN AND CHAPEL | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---|-----|--|---|----------------------------|
| | | 245462 | B. WING | | | 09/1 | 16/2014 |
| | PROVIDER OR SUPPLIER | | | 54 | TREET ADDRESS, CITY, STATE, ZIP CODE 409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 050 SS=F | Building 02 building construction and seconstruction and seconstruction and seconstruction and secons of the facility has a consus of 90 at the The requirement at NOT MET as evident NFPA 101 LIFE SAFITE drills are held a varying conditions. The staff is familiar that drills are part of Responsibility for passigned only to conducted between | g which is of non-conforming eparated by a 2-hour fire wall. Informing construction, enter is surveyed as 2 cmS-2786R forms completed. Informing construction, enter is surveyed as 2 cmS-2786R forms completed. Informing construction, enter is surveyed as 2 cmS-2786R forms completed. Informing and the inspection. Informing and conduction enter at least quarterly on each shift. Informing and conducting drills is ompetent persons who are eleadership. Where drills are in 9 PM and 6 AM a coded y be used instead of audible | | 050 | | | 10/3/14 |
| | Based on review of interview, it was de to vary the times and in the last 12-mont practice could affect. | is not met as evidenced by: of reports, records and etermined that the facility failed and dates of numerous fire drills h period. This deficient out how staff react in the event reaction by staff would affect sidents. | | | The Credible Allegation of Complian has been prepared and timely submission of the Credible Allegation Compliance is not a legal admission deficiency exists or that the Statemed Deficiencies were correctly cited, an also not to be construed as an adminisary interest of the Facility, its Administrator, or any employees, agor other individuals who draft or may | nitted. on of n that a ent of nd is ission gents, | |

| TATEMENT | ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION IG 03 - KITCHEN AND CHAPEL | | E SURVEY PLETED | |
|--------------------------|---|---|--|---|--|--------------------|
| | | 245462 | B. WING _ | | 09/ | 16/2014 |
| MARANA | PROVIDER OR SUPPLIER ATHA CARE CENTER SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | STREET ADDRESS, CITY, STATE, ZIP COL 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 PROVIDER'S PLAN OF CORR | ECTION | (X5) |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE PROPRIATE | COMPLETION DATE |
| K 050 | On facility tour beto 12:00 PM on 09/16 that there is no doo shift fire drills for the This deficient prace | age 3 ween between 10:00 AM and 6/2014, record review revealed cumentation of AM or Night are first quarter of 2014. tice was verified by the tor at the time of the | K 05 | discussed in this Credible Alle Compliance. In addition, pres submission of this Credible Alle Compliance does not constitute admission or agreement of any the facility of the truth of any alleged or the correctness of conclusions set forth in this at the survey agency. The facility will conduct fire drifted frequencies and timings as really NFPA 101 LSC (2000) includity once per shift per quarter at a vand conditions. These fire drived conducted by the Environment Director or his designee. The schedule will be entered into electronic work order schedule to ensure completion. The first schedule will also be entered Campus Administrator's electical calendar. The Campus Administrator's required. The safety committed review fire drill reports quarted accuracy and timeliness. | paration and legation of legation of legation of the an my kind by of the facts any legation by fills with equired by mg at least varying times all Services of fire drill the ling system of the ronic mistrator will conducted as see will rly for | |
| K 069 SS=F | | AFETY CODE STANDARD are protected in accordance 2.6, NFPA 96 | K 06 | compliance is 10/15/14. | | 10/3/14 |
| | This STANDARD | is not met as evidenced by: | | | | |

PRINTED: 10/07/2014 FORM APPROVED OMB NO. 0938-0391

| | TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLE A. BUILDING 03 - KITCHEN AND CHAPEL | | PLETED | | | | |
|--------------------------|--|--|---------------------|----|---|---|----------------------------|
| | | 245462 | B. WING | | | 09/1 | 6/2014 |
| | PROVIDER OR SUPPLIER | , | | 54 | TREET ADDRESS, CITY, STATE, ZIP CODE 409 69TH AVENUE NORTH ROOKLYN CENTER, MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 144 SS=F | hood suppression s maintained in acco Code, Section 9.2.3 affect all residents. Findings include: On facility tour betwon 09/16/2014, rec UL300 systems we 2013. This deficient pract maintenance direct inspection. | tion and review, the kitchen system has not been rdance with The Life Safety 3. This deficient practice could ween 10:00 AM and 12:00 PM ord review revealed that all 4 are last inspected in October tice was verified by the tor at the time of the AFETY CODE STANDARD pected weekly and exercised ninutes per month in | K 0 | | The UL 300 fire suppression system be tested or inspected at frequencitimings as required by NFPA 101 L (2000) of at least every 6 months. inspections will be entered into the electronic work order system and the Environmental Services Director or designee will be responsible for enthese inspections take place at the timing. These inspections will also entered into the Campus Administry electronic calendar to ensure they completed as required. The safety committee will review the inspection reports bi-annually for accuracy and timeliness. Date certain for purposes of ongoin compliance is October 15, 2014. | es and SC These he his suring proper be eator's are | 10/3/14 |
| | Based on observa failed to maintain the accordance with the | is not met as evidenced by: tion and interview, the facility he emergency generator in e requirements of NFPA Section 6-4. This deficient ct all residents. | 82 | | The generator will be inspected ar tested as required by the NFPA 10 (2000) whereas the generator and generator systems will be inspecte weekly by the Environmental Servi Director or his designee. The generator | 1 LSC d ces | |

Event ID: SY2621

PRINTED: 10/07/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A, BUILDING 03 - KITCHEN AND CHAPEL (X3) DATES COMPLE | | | |
|---|--|---|---------------------|---|---|
| | | 245462 | B. WING | | 09/16/2014 |
| | PROVIDER OR SUPPLIER | | (| STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION |
| K 144 | Findings include: On facility tour betwon 09/16/2014, reconstruction of the construction of the constructi | veen 10:00 AM and 12:00 PM ord review revealed that: mentation of monthly rior to May 2014, mentation of weekly generator | K 144 | will be run under at least 30% load one time per month for at least 30 minutes. This testing will be arran the Environmental Services Direct designee. The schedule for this inspection and testing will be enter the electronic work order schedulir system to ensure completion. The schedule for inspecting and testing generator and systems will be enter the Campus Administrator's electric calendar. The Campus Administrator verify that the inspection and testing generator and generator systems of completed as required. The safety committee will review the results of inspection and testing for accuracy timeliness. Date certain for the purposes of or compliance is October 15, 2014. | ged by or or his red into ng the grad into onic ator will ng of the was f the y and |

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

Facility ID: 00226

Minnesota Department of Health

| - | IENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--|---|-------------------------------|----------------------|
| | | 00226 | B. WING | | 09/11/201 | 4 |
| | PROVIDER OR SUPPLIER | 5409 69TH | DRESS, CITY, S I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COM | X5) IPLETE ATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | ***** | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall light form. | Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. | | | | |
| | corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was | | | | |
| | that may result from orders provided tha the Department with | hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance. | | | | |
| | receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st | participate in the electronic nsure orders consistent with artment of Health in 14-01, available at ate.mn.us/divs/fpc/profinfo/inf e licensing orders are | | Minnesota Department of Health i documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes. | oftware. | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

10/03/14

TITLE

Electronically Signed

(X6) DATE

Minnesota Department of Health

| STATEME | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE S COMPL | |
|--------------------------|--|--|---------------------|---|--|--------------------------|
| | | 00226 | B. WING | | 09/11 | /2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MARAN | ATHA CARE CENTER | | I AVENUE N | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 000 | Department of Hearyou electronically. Is necessary for Starenter the word "corrected. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be stated to Minnesota Department be State Licensing federal software. The assigned to Minnesota Department be stated to Minnesota Department be sta | Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading edate your orders will be ectronically submitting to the ent of Health. 2/11/14, surveyors of this visited the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, ewhen they will be completed. The talth is documenting correction Orders using an numbers have been ota state statutes/rules for the state statutes/rules for the orders is listed in the order of Deficiencies" column to Comply" portion of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and rection. RD THE HEADING OF THE | 2 000 | The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Method Correction and the Time Period Following the States of Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES. | Tag." the tute/rule ies" ply" his s which after the s veyors d of or DING OF THIS O DN FOR | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 2 of 46

| Millineso | <u>ta Department of He</u> | eaith | | | _ | |
|--------------------------|--|---|---------------------|---|---|--------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| | | | AVENUE N | | | |
| MARANA | ATHA CARE CENTER | | N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 000 | Continued From pa | ge 2 | 2 000 | | | |
| | PLAN OF CORREC | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. | | | | |
| 2 565 | MN Rule 4658.0409 Plan of Care; Use | 5 Subp. 3 Comprehensive | 2 565 | | | 10/3/14 |
| | | omprehensive plan of care I personnel involved in the :. | | | | |
| | by: Based on observation review, the facility of hours repositioning for 1 of 2 residents ulcers; in addition, of care plan for 1 of 1 light was not access environmental conditions. Findings include: Pressure ulcer: R15's electronic addindicated R15 had abnormal posture, (paralysis on one side due to cerebro A Comprehensive S (CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC) dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC dated 3/8 indicated R15 had a light paralysis on the side due to cerebro CSRDC dated 3/8 indicated R15 had a light pa | mission record dated 3/18/13, diagnoses which included anemia, and hemiplegia ide) affecting non-dominant | | The Credible Allegation of Complia been prepared and timely submitted Submission of the Credible Allegation Compliance is not a legal admission deficiency exists or that the Statem Deficiencies were correctly cited, a also not to be construed as an adragainst interest of the Facility, its Administrator, or any employees, a or other individuals who draft or midiscussed in this Credible Allegation Compliance. In addition, preparat submission of this Credible Allegation Compliance does not constitute an admission or agreement of any kir facility of the truth of any of the facility of the truth of any of the facility of the correctness of any conclusions set forth in this allegation the survey agency. POC written for accompanying Federiciencies. Data certain for purposed. | ed. tion of that a nent of and is nission agents, ay be on of tion and tion of n d by the tts tion by deral | |

Minnesota Department of Health

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|---|--|-------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| | PROVIDER OR SUPPLIER ATHA CARE CENTER | 5409 69TH | DRESS, CITY, S I AVENUE N 'N CENTER | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 565 | pressure ulcer to co A review of the Nurs 7/25/14, indicated of coccyx had resolve Nurse's Progress N developed another coccyx area which is length and 0.6 cm is the wound bed as of surrounding skin with the presence of red R15's rectum. R15's care plan rev importance of freque staff to reposition R day and two times as The undated Nursir Team 2, Northern L non-ambulatory and staff for transfers, to Care Sheet directed two hours. During a continuous 7:10 a.m. to 10:05 a repositioned for two first observed in wh of mirror in her roor the time as directed On 9/11/14, at 10:10 (NA)-D checked Nu kept in her pocket a to be repositioned of | ses' Progress Notes dated hronic pressure ulcer on d. However, on 7/29/14, a ote indicated R15 had unstageable pressure ulcer to measured 1 centimeter (cm) in width. The note described overed with slough, the th scar tissue and described ness between the wound and ised on 7/31/14, addressed the ent repositioning and directed 15 every two hours during the at night. In Assistant Care Sheet for ights Lane, indicated R15 as dineeded assistance of two bileting and repositioning. The distaff to reposition R15 every as observation on 9/11/14, at a.m. R15 had not been be hours and 55 minutes since eelchair grooming self in front in. This was 55 minutes over I by the care plan. | 2 565 | ongoing compliance is 10/15/14. | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|------------------------------|---|-------------------------------|--------------------------|
| | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| MARANATHA CARE CENTER | | H AVENUE N YN CENTER, | | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| care plan. RN-E furbeen repositioned ecare plan. On 9/11/14, at 10:29 chronic pressure uld treatments were triebetter" then re-oper interventions in R15 repositioning every been repositioned at On 9/11/14, at 3:22 administrator (ICA) should have followe repositioning R15 ethe care plan. The facility's Reside Policy and Procedur guidelines for staff that are necessary to acheeds of the resider information and assign observation the call floor by the head of stand and in between was observed comin hallway from her row On 9/9/14, at 9:15 at p.m. R143's call light. | ge 4 e repositioned according to ther stated R15 should have every two hours as directed by a.m. RN-D stated R15 had a cer to coccyx and different ed and the pressure ulcer "got ned up again. RN-D verified b's care plan included two hours, but R15 had not according to the care plan. p.m. the interim clinical acknowledged facility staffed the care plan as directed on every two hours according to the care which accordinate all cares which accordinate all cares which accomplish goals in meeting the ent, and to communicate vital sign care for all disciplines. D.m. during R143's room light was observed on the bed slightly behind the night en the bed night stand. R143 ng ambulating down the om towards the dining room. a.m. to approximately 1:15 nt was observed to remain on night stand not accessible to | 2 565 | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|--|----------------------------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | | ., |
| MARANA | ATHA CARE CENTER | | AVENUE N | | | |
| | | | 'N CENTER, | | 211 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 565 | Continued From pa | ge 5 | 2 565 | | | |
| | environmental tour call light was on the floor from behind th what her expectatio accessibility, the ad lights have to be at resident is able to uncertainty. R143's care plan dawas at risk for falls of falls and unstead directed, "Be sure in | ministrator stated "all call reach at all times regardless if | | | | |
| | directed, "Position to the resident to use. SUGGESTED MET DON could schedul importance of follow residents. The qualification randomly audit residents. The DO policies and proced and provide addition designated staff course. | ed as last modified on 10/10, he call light conveniently for" "HOD OF CORRECTION: The e an in service to discuss the ving the plans of care for ity assurance committee could dents records to insure ON could review and revise ures for care delivery systens in training to involved staff. A all did monitor the system to ing delivered (monitoring). | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 800 | MN Rule 4658.0510 Staffing requirement | Subp. 1 Nursing Personnel; | 2 800 | | | 10/3/14 |
| | | requirements. A nursing a duty at all times a sufficient | | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 6 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---------------------|---|------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MARAN | MARANATHA CARE CENTER 5409 69TBROOK | | | ORTH , MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T | D BE | (X5) COMPLETE DATE |
| 2 800 | number of qualified registered nurses, I nursing assistants or residents at all nursin all buildings if moinvolved. This incluand vacation replace. This MN Requirements by: Based on observative review with resident failed to ensure suff was available to me observed/interview R208, R17, R134, I voiced concerns reassure resident neet the potential to affer resided at the facility. Findings include: Pressure ulcer: R15's quarterly Min 6/9/14, identified Rulcer with granulating assistance of one stransfers, toileting, quarterly MDS also cognitive impairments. The MDS dated 9/4 Stage 2 pressure ulcers. The MDS divided in the material was there upon adright as being at rising ulcers. The MDS divided in the material was there upon adright. | I nursing personnel, including licensed practical nurses, and to meet the needs of the ses' stations, on all floors, and one than one building is udes relief duty, weekends, cements. ent is not met as evidenced lion, interviews and document tts, family, and staff, the facility ficient qualified nursing staff set the needs of residents ed (R15, R218, R3, R168, R11) as well as family member garding lack of staff persons to leds were met timely. This had loct 89 of 89 residents that tty. simum Data Set (MDS) dated 15 to have a stage II pressure on tissue, needed extensive staff for repositioning, and personal hygiene. R15's indicated R15 had severe | 2 800 | POC written for accompanying Fe deficiencies. Date certain for purpongoing compliance is 10/15/14. | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 7 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|--|-------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| | PROVIDER OR SUPPLIER ATHA CARE CENTER | 5409 69TH | DRESS, CITY, S I AVENUE N 'N CENTER, | ****** | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | of the unstageable the facility on 7/29/1 ulcer developed and identified on the Wo addition, the MDS laturning and reposition was left blank. The that there was a presidentified on 7/25/14 which indicated the been resolved. On 9/10/14, at 7:18 in bed awake. Nursilicensed practical in room to help R15 given yound on R15's constated she had "just R15's coccyx. The syl10 and was intact adhesive dressing the wound no draind discoloration was or identification." | pressure that was identified by 14, when the new pressure d again on 8/26/14, as bund Consultation sheet. In acked evidence R15 was on a oning program as that section MDS also lacked evidence evious healed pressure ulcer 4, as per the progress note coccyx pressure ulcer had a.m. R15 was observed lying ing assistant (NA)-C and urse (LPN)-A was in R15's et up from bed. With R15's veyor observed a pressure ccyx with LPN-A. LPN-A t changed" the dressing to wound dressing was dated at LPN-A carefully opened the to be checked. Observation of age however, a yellow bserved on the dressing and PN-A as a Medihoney | 2 800 | | | |
| | observed in her roo wheelchairAt 7:26 a.m. registe R15's room and wa medications, then le medications. -From 7:31 a.m. to room alone, was in | 10 a.m. to 7:25 a.m. R15 was am seated on a cushion in the ered nurse (RN)-D, entered as observed to give R15 some eft when R15 took all the 7:58 a.m. R15 remained in front of mirror and continued | | | | |
| | room, NA-B approa | and NA-M entered R15's sched R15 and put R15's nouth, and changed R15's | | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 8 of 46

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
|--------------------------|---|--|---------------------|--|-----------|--------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
| | | | D. WILLIA | | | |
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MARANA | ATHA CARE CENTER | | I AVENUE N | | | |
| | | BROOKLY | 'N CENTER, | MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF | D BE | (X5) COMPLETE DATE |
| 2 800 | shirt. NA-M pushed the Northern Lights (TV) area/lounge. It was not off-loaded repositioned from orepositioned from 8:06 a.m. to seated in wheelchal lounge and watching in the same position reposition herself. -At 8:35 a.m. RN-E parked in wheelchal talked briefly to R15 R15 to the dining round reposition herself. -From 8:49 a.m. to seated in wheelchal working on breakfalloung and watching table towards R15 in front of TV alloung table towards R15 in front of TV alloung round reposition in watch and reposition herself. | R15 out to the hallway and to Lane (NLL) unit television during that observation, R15 from wheelchair nor riginal position. 8:35 a.m. R15 remained ir on the same spot at the TV g TV. R15 was calm and still in in wheelchair. R15 did not approached where R15 was ir at the NLL TV lounge and 5. RN-E was observed to push from area towards R15's table, ded nor repositioned from wheelchair, nor did R15 9:20 a.m. R15 remained ir at the dining room, slowly st with the use of right hand, wheeled R15 away from the sethe NLL TV area. NA-B left at the NLL TV area towards the first floor nurses' station is. NA-B stated she was to take | 2 800 | | | |
| | -At 9:34 a.m. R15 v room with other res member was readir | vas at the 3rd floor activities' idents where a female staffing the newspaper. R15 was | | | | |
| | not off-loaded nor re R15 did not repositi -At 9:43 a.m. R15 was calm and appereader at the news -At 9:59 a.m. RN-D been seated in the | epositioned from wheelchair. on herself. vas still seated in wheelchair, ared to be listening to the | | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 9 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--|---|--------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| | PROVIDER OR SUPPLIER ATHA CARE CENTER | 5409 69TH | ORESS, CITY, S I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 2 800 | -At 10:03 a.m. R15 in Room 112 by NA members left R15 s common area/hallw -At 10:05 a.m. RN-I area in R15's room check on her buttoo wheelchair to bed b RN-E and NA-D. RI wound was from 9/pressure wound on that open area on F slight redness on starea, skin to rest of creases from diape R15 went two hours repositioning. Stage 1 family inter On 9/8/14, at 7:00 p asked if family men enough staff availal member get the cal without having to willights can be a chall it can take a long tir and if they come the come back and the get on their case. " Stage 1 Resident In R218's Brief Intervit assessment dated intact cognition. Me 9/5/14, indicated R2 activities of daily livit transfers, toileting a Progress Notes dat | was pushed to common area -M and RN-E. The two staff seated in wheelchair in the ray. D and NA-D, entered common R15 gave permission for skin cks. R15 was transferred from ry use of gait belt by RN-D, N-D confirmed dressing on 10/14, RN-E assessed R15's buttocks and described R15's coccyx had 90% slough, arrounding skin up to the open buttocks clear dry, intact, with r and skin was blanchable. It is and 55 minutes without View o.m. during interview when on ber (F)-A felt there was pole to make sure your family re and assistance they need the ait a long time, F-A stated "call lenge to answer at times and the before they could answer it ey would indicate they would y don't come back. I usually | 2 800 | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--------------------------|--|-------|--------------------------|
| | | | | | | |
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| MARANA | ATHA CARE CENTER | | I AVENUE N 'N CENTER, | | | |
| (VA) ID | CLIMMA DV CTA | TEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECT | ION | ()/5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | O Continued From page 10 | | 2 800 | | | |
| | asked if he felt ther to make sure you g need without having stated, "On night sh staff say they are veback to you but dor 1:15 a.m. one time sharp bedpan and on a weekend. Stafthem, I told [registe and two nights later today third time, an some. [I] tried to tel said she would get in my pants a couple when bedpan was a further stated now s | o.m. during interview when e was enough staff available et the care and assistance you g to wait a long time R218 hift have to wait a long time, ery busy and say will come of t I called my daughter at after they put me on a plastic didn't take me off till 4:00 a.m. If flip name tags or don't wear red nurse, RN-A], one night was good, told [RN-A] again d he said he would investigate I the social worker and she back to me I have had to go le of times a little and in bed not positioned correctly. R218 she gets up to the bathroom "staff at night hurries me, but emselves." | | | | |
| | cognition was mode extensive physical a dressing, toileting, thygiene. In addition both a walker and who behaviors. On 9/9/14, at 11:28 asked if she felt the to make sure you gheed without having stated, "They always." | dated 8/1/14, indicated erately impaired and required assistance of one staff with transfers and personal the MDS indicated R3 used wheelchair for mobility and had a.m. during interview when ere was enough staff available et the care and assistance you g to wait a long time. R3 as say they are in a hurry just to I just don't know if they have | | | | |
| | R3 stated she calle | d for help "early this morning" | | | | |

6899

Minnesota Department of Health

| Minnesota Department of Health | | | | | | |
|--------------------------------|---|---|----------------|--|-----------|------------------|
| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
| | | | | | | |
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| | | 5409 69TH | I AVENUE N | ORTH | | |
| MARANA | ATHA CARE CENTER | | 'N CENTER, | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | ON | (X5) |
| PRÉFIX | | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL | | COMPLETE DATE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRO DEFICIENCY) | PRIATE | DATE |
| | 0 11 15 | | 0.000 | | | |
| 2 800 | Continued From page 11 | | 2 800 | | | |
| | and put on the call | light. R3 stated "two girls" | | | | |
| | | n and told her to get up. R3 | | | | |
| | | she could not get up by herself | | | | |
| | | do so, but the staff left | | | | |
| | | R3's needs. R3 stated she again, then staff came in and | | | | |
| | | helping R3. R3 was observed | | | | |
| | | she talked about what | | | | |
| | happened that morning. R3 wiped own tears, took | | | | | |
| | some pauses and continued to talk about having | | | | | |
| | | the bed wet. R3 stated, "I was | | | | |
| | | the bed like that before." R3 | | | | |
| | | w (without a pillow case) lying led and described the bed was | | | | |
| | | o her pillow. R3 stated, "I felt | | | | |
| | so bad." | o nor pillow. No stated, Trest | | | | |
| | 00 000. | | | | | |
| | | a.m. during interview when | | | | |
| | | ere was enough staff available | | | | |
| | | et the care and assistance you | | | | |
| | | g to wait a long time R3 stated, ney are in a hurry just like this | | | | |
| | | on't know if they have enough | | | | |
| | staff." | on t know ii they have enough | | | | |
| | | | | | | |
| | | | | | | |
| | | DS dated 6/12/14, indicated | | | | |
| | | t was independent but also | | | | |
| | | upervision oversight of one nd personal hygiene and used | | | | |
| | | y and had no behaviors. | | | | |
| | a wanter for mobility | y and had no bondviors. | | | | |
| | On 9/9/14, at 10:05 | a.m. during interview when | | | | |
| | asked if she felt the | ere was enough staff available | | | | |
| | | et the care and assistance you | | | | |
| | | g to wait a long time R168 | | | | |
| | stated, "Sometimes | s I wait an hour to eat" | | | | |
| | | | | | | |
| | R208's MDS dated | 8/19/14, indicated cognition | | | | |

6899

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | | DATE SURVEY COMPLETED | |
|---|--|--|--------------------------|--|-------|--------------------------|--|
| | | | | | | | |
| | | 00226 | B. WING | | 09/1 | 1/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | | |
| MARAN | ATHA CARE CENTER | | I AVENUE N 'N CENTER, | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE | |
| 2 800 | was intact and requassistance of one to use, bed mobility, to In addition, the MDS wheelchair for mobilimitation of range rollower extremity and On 9/8/14, at 4:51 pasked if she felt the to make sure you goneed without having stated, "They need evening." R17's quarterly MD cognition was seve extensive physical addressing, toileting, to and had no behavior on 9/8/14, at 4:13 pasked if he felt ther to make sure you goneed without having stated, "I don't think because they always called-in sick and the awhile they do." R134's quarterly MI cognition was seve extensive physical awhile they do." | dired extensive physical to two staff with dressing, toilet cansfers and personal hygiene. Sindicated R208 used a dility and had functional motion on one side upper and I had no behaviors. D.m. during interview when the ere was enough staff available et the care and assistance young to wait a long time R208 more staff in morning and S dated 6/17/14, indicated rely impaired and required assistance of one staff with transfers and personal hygiene | 2 800 | | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|---|-------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| | PROVIDER OR SUPPLIER | 5409 69TH | ORESS, CITY, S I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | asked if he felt then to make sure you go need without having stated, "Sometime after putting call light R11's quarterly MDs cognition was intact physical assistance toileting and person limitation in ROM to addition used wheel behaviors. On 9/8/14, at 6:48 pasked if he felt then to make sure you go need without having stated, "They have its very noticeable." On 9/9/14, at approwho requested to resurveyor the bedsic changed since Suna problem which have resident council and resolved and the restaffing. The anony on the next resident brought to the facility | o.m. during interview when e was enough staff available et the care and assistance you go to wait a long time R134 have to wait for a long time nt on." S dated 6/12/14, indicated a tand required extensive of one staff with dressing, hal hygiene; had a functional both lower extremities and in lichair for mobility and had no one. The was enough staff available et the care and assistance you go to wait a long time R11 tried to cut down the help and eximately 2:30 p.m. a resident emain anonymous indicated to be water mugs had not been day 9/7/14, and this had been and been brought up at the did the unit staff, but had not sident thought was related to mous resident further stated to council this was going to be the attention. | 2 800 | DEFICIENCY) | | |
| | R97's room on. The and R97 was obser adaptive call light ly | bservation 3rd floor a.m. observed call light in hallway light to room was on ved lying in bed with an ing on top of the bedding. :40 a.m. observed nursing | | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 14 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---------------------|--|------------|--------------------------|
| | | 00226 | B. WING | | 09/11/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | | DRESS CITY S | STATE, ZIP CODE | 1 03/1 | 1/2014 |
| | | | I AVENUE N | • | | |
| WARAN | ATHA CARE CENTER | BROOKLY | 'N CENTER, | MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | assistant (NA)-A wattowards R97's room medication aide (TI tone of voice, "Are light?" and NA-A reto walk into R97's real approximately 7 was observed clear and walked away from the call light. When interviewed a stated R97 was a sumped her call light. When interviewed a stated R97 was a sumped her call light. When interviewed a stated R97 was a sumped her call light. When interviewed a came out of R97's assistance R97 required bumped the call light in the room and who time, R97 had indicated pan. NA-A stated about to get up soothen but had told N pan anyway. When light was on and if N without asking the room NA-A stated she wassume, but had the call light. Staff interviewed a staff interview | alking down the hallway in as she was walking trained MA)-A was overheard in a high you going to get [R97] call plied, "Yeah" as she continued doom. ':41 a.m. NA-A came right out insing her hands at the door form the room after answering on 9/10/14, at 7:41 a.m. NA-A leep and had probably the inher sleep. R97's call light was observed into the room briefly spoke with door after putting the light on. on 9/10/14, at 7:47 a.m. NA-A room when asked what juired, NA-A stated R97 had into the first time she had been en she went in the second fated she needed to use the leed R97 had thought she was in and would use the bed pan A-A to still put her on the bed asked when a resident call NA-A would just turn it off resident or meeting the need, as supposed to ask and not ought resident had bumped on 9/9/14, at approximately instrator stated she was aware on 3rd Floor was had spoken with the | 2 800 | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|--|---|-------------------------------|--------------------------|
| | | 00226 | B. WING | | 09/ | 11/2014 |
| | PROVIDER OR SUPPLIER ATHA CARE CENTER | 5409 69TH | DRESS, CITY, S I AVENUE N IN CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 2 800 | replacement. When would not get the ice administrator stated residents who had a got ice for themselve asked about the other able to get the water got fresh water administrator stated falls were distincted with the interim clinical administration. When asked how staffing pattern SC each floor as she stated falls were distincted to the supplement for sick and ICA indicated the supplement for sick and ICA i | a asked how come the staff e from another floor, d it was challenging and the the problem were those that the problem were those that the from the machine. When the residents who were not the for themselves and never inistrator referred surveyor to the facility determined the staffing coordinator (SC) and inistrator (ICA). The facility determined the stated "by the grid we have for showed sheets which indicated fing patterns. The facility used pool staffing to the facility used pool staffing to the facility did not use pool. The facility flexed down ICA stated the sick call sheet. The popened when the census accility flexed down ICA stated the sick call sheet. The popened when the census accility flexed down ICA stated the sick call sheet. The popened when the census accility flexed down ICA stated the sick call sheet. The popened when the census accility flexed down ICA stated the sick call sheet. The popened when the census accility flexed down ICA stated the sick call sheet. The popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census accility flexed down ICA stated the popened when the census | 2 800 | | | |

Minnesota Department of Health

Minnesota Department of Health

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|-------------------|-----------------------|---|--------------|---|-----------|------------------|
| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
| | | | | | | |
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS CITY S | STATE, ZIP CODE | | |
| TO WILL OF | NOVIDEN ON CONTENEN | | HAVENUE N | | | |
| MARANA | ATHA CARE CENTER | | 'N CENTER, | | | |
| | OLIMAN DV OTA | | 1 | | | 0.50 |
| (X4) ID PREFIX | | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL | | (X5) COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRO | PRIATE | DATE |
| | | | | DEFICIENCY) | | |
| 2 800 | Continued From pa | ge 16 | 2 800 | | | |
| | due to low census a | and low acuity and this reflects | | | | |
| | | out no workload particular | | | | |
| | concerns except for | r one nurse who has | | | | |
| | | e more training as she is | | | | |
| | | ifferent unit transitional care | | | | |
| | , , | g term unit." ICA also | | | | |
| | | d falls had decreased in the | | | | |
| | | time "we have had a call light | | | | |
| | | ad to run the report for the | | | | |
| | | rn and a grievance is | | | | |
| | followed." | acility grievances policy is | | | | |
| | | ut the facility employee | | | | |
| | | positions, and if both were | | | | |
| | | uality assurance meeting in | | | | |
| | | stated, "We have had an | | | | |
| | | over rate." ICA also indicated | | | | |
| | | affing meeting on Thursday | | | | |
| | | he turnover rate and the | | | | |
| | positions being offe | red." SC provided a list of | | | | |
| | | ons for both licensed nurses | | | | |
| | _ | int (NA's) which showed the | | | | |
| | | time NA positions on all shifts | | | | |
| | - | four part time and one full | | | | |
| | time nurses position | • | | | | |
| | | A or corporate did exit ed they had not done them | | | | |
| | | orate does not do them, "but if | | | | |
| | | eting our standards we have | | | | |
| | to let them go." | cting our standards we have | | | | |
| | 3 - 1 - 3 - 1 - 3 - 1 | | | | | |
| | On 9/11/14, at appr | oximately 12:17 a.m. both the | | | | |
| | | ICA approached surveyor | | | | |
| | | g for the last six months was | | | | |
| | | iges. Administrator stated | | | | |
| | | light concern had been | | | | |
| | | ents the log was printed out | | | | |
| | | m was completed accordingly. | | | | |
| | | er indicated in the past the | | | | |
| | racility was printing | the call light logs and would | | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 17 of 46

Minnesota Department of Health

| - | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLETION (X3) DATE SUF COMPLETION (X4) DATE SUF COMPLETION (X5) MULTIPLE CONSTRUCTION (X6) DATE SUF COMPLETION (X6) DATE SUFFICIENT (X6 | | | | |
|--------------------------|---|--|--|---|--------|--------------------------|
| | | 00226 | B. WING | | 09/ | 11/2014 |
| | PROVIDER OR SUPPLIER | 5409 69TH | DRESS, CITY, S I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 2 800 | go through them and for the staff. - When asked if any stated there was not a washed if the doing them on the following them on the following the shift, the facility did not do the when asked since done on the floors to resident needs had stated she thought call light the resident needs and stated she thought call light the resident of stated and provided earlier. When interviewed to stated her expectated answer the call light resident room they the resident need we room. RN-B further staff to stop in the most resident to answer to the staff on the uncall lights. When interviewed to stated she would have answer the call light and would also expresident room if the and turned off the licoming back. | of made an interactive posting y of those were available, she of record of it. of facility did audits of the staff loor over a period of time administrator stated the | 2 800 | | | |

6899

Minnesota Department of Health

| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | SURVEY |
|--------------------------|--|--|---------------------|---|-----------|--------------------------|
| - | OF CORRECTION | IDENTIFICATION NUMBER: | ` ' | | | LETED |
| | | | | | | |
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| | TILL OADE OFNITED | 5409 69TH | I AVENUE N | ORTH | | |
| MAKANA | ATHA CARE CENTER | BROOKLY | N CENTER, | MN 55429 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 800 | Continued From pa | ge 18 | 2 800 | | | |
| | provided by the faci 9/9/14, revealed the Resident/Visitor O 6/30/14, at 11:10 p. had indicated he had had put the call light responded so he th self-transfer as staf another resident. For R105's call light had which was over nine RN-A indicated he was regarding call light in Resident/Visitor O 7/21/14, at 6:50 a.m found kneeling on the Follow-up education R153 was at risk for while in bed and confurther indicated, "Hup by [6:00] due to this the Night shift work of bed [due to] d/t staffing issues, thou adequately staffed, priority for AM cares from happening" | lity dated 2/1/14, through e following: eccurrence Report dated m. for R105 revealed R105 and to use the bathroom and to no but staff had not ought he was able to f was probably helping collow up call light log revealed do been put on at 10:51 p.m. eteen minutes to R105's falls. would follow-up with staff | | | | |
| | where, and what tin before the fall/incide indication of the las toileted, lacked whe of the reports identi bathroom and most bathroom floors at o | time resident had been seen ent, the forms lacked time resident had been ere the call light was, as most fied residents had to use the had been found on the different times of the day. | | | | |
| | as residents had be | een left in the room for an | | | | |

6899

Minnesota Department of Health STATE FORM

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | · / | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
|--|--|--|--|--|-------------------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| | PROVIDER OR SUPPLIER ATHA CARE CENTER | 5409 69TH | ORESS, CITY, S I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | Review of Resident Forms provided by 4/23/14, to 8/27/14, response time, mee back after leaving up brought up to the faby alert residents artimes and signed of Although the facility had been provided been reviewed, there ups completed to endeen met despite the timely, as indicated A review of the Morrand responses from revealed the following answer, more than resident felt like stated they would only have get her ready for be HHC will follow-up word concern" One of call light system had look at call light times, and indicated would be looking at basis. A minutes on 3/26 concern was omitted addition on the new were brought up: "Staff aren't always of time they need to | /Family/Staff-Quality Concern the facility dated between revealed concerns of call light eting the needs and coming manswered call light had been cility and a family member multiple of by the administrator. In had indicated staff education and the call light logs had re was no evidence of follow moure resident needs had ne call lights being answered on the investigations. | 2 800 | | | |

6899

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MARANATHA CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE A. BOILDING. B. WING DPROVIDER STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429 CMPLIT (EACH CORRECTIVE ACTION SHOULD BE COMPLIED TO THE APPROPRIATE DEFICIENCY) | STATEMENT | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
|--|------------|---|--|----------------|--|-----------|--------------------------|
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| CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY DATE DEFICIENCY DEFICIENCY DEFICIENCY DATE DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DATE DEFICIENCY DEFICIENCY | NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
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| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLIANCE OF THE APPROPRIATE DEFICIENCY | MAKANA | THA CARE CENTER | BROOKLY | 'N CENTER, | MN 55429 | | |
| | PREFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI | D BE | (X5) COMPLETE DATE |
| 2 800 Continued From page 20 2 800 | 2 800 | Continued From pa | ge 20 | 2 800 | | | |
| 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 | | Staff telling resident minute, I have to fin may or may not constaff will come in, so answer/meet the response/action to was indicated as "Song The minutes on 4/staffing concerns whosiness minutes. The minutes on 5/indicated, "Call light down again. Reside medications & not response indicated "will continue to audicated "will continue | t that "They'll be back in a aish up something" and they ne back. hut the call light off and not sident's need." be taken to all three concerns staff education." '30/14, call lights and/or ere omitted from the old '28/14, new business tresponse time has slowed ents will request pain eceive it in a timely manner" the household coordinators dit call light times & provide aining." In addition new gs aren't being passed twice a land the response was the staff es was to inform the lators "so they can begin to '25/14, old business both the ts and blue water mugs were the response both had been ff meeting agenda for call light expectation and at (QI) meetings for each floor '30/14, old business call light and blue water mugs being the put both were never new uncil minutes from 6/25/14, but new business from the | 2 800 | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 21 of 46

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|--------------------------|---|---|---------------------|---|-----------|--------------------------|
| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
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| | | 00226 | B. WING | | 09/1 | 1/2014 |
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| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| ΜΔΡΔΝΔ | THA CARE CENTER | 5409 69TH | AVENUE N | ORTH | | |
| MUNICINA | THA CARL CLIVIER | BROOKLY | N CENTER, | MN 55429 | | |
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| 2 800 | Continued From pa | ge 21 | 2 800 | | | |
| | 7/30/14, minutes. | | | | | |
| | 7/50/14, 111110165. | | | | | |
| | Although the subject | ct of call lights and passing | | | | |
| | | ad been brought up on several | | | | |
| | | erns were never followed up | | | | |
| | | ved by the facility to look at the | | | | |
| | | ensure resident needs were | | | | |
| | | ner. In addition although the | | | | |
| | individual call light of | r and the staff indicated | | | | |
| | | ility failed to ensure there was | | | | |
| | | ensure all resident call lights | | | | |
| | | ed and trended to ensure staff | | | | |
| | | esidents needs upon | | | | |
| | | ights. The facility did not | | | | |
| | | ation on the re-education | | | | |
| | | f regarding the concerns as | | | | |
| | | uncil minutes. The facility also | | | | |
| | | call light concerns, keeping in who did not attend the council | | | | |
| | | were not able to report the | | | | |
| | | oout call light delays. | | | | |
| | | . can cam ngun acuaya | | | | |
| | Review of the rando | om schedules dated 12/29/13, | | | | |
| | going forward revea | | | | | |
| | | ift three NA positions were | | | | |
| | | CU and one NA in the TCU | | | | |
| | | be a TMA. In addition in the | | | | |
| | | e two RN's and one licensed | | | | |
| | | N) scheduled on the day shift sus for this shift in the TCU. | | | | |
| | | lay shift worked a double from | | | | |
| | day to evening shift | • | | | | |
| | that was penciled in | had the name crossed off | | | | |
| | | ware of what the census was | | | | |
| | that shift. | | | | | |
| | 0.54044 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 | 70 CO C TO TO | | | | |
| | | ift one of the four TCU NA was | | | | |
| | | reason; another was moved to l) leaving two NA for the shift | | | | |

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 22 of 46 SY2611

Minnesota Department of Health

| | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
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| | | 00226 | B. WING | | 09/1 | 1/2014 |
| | PROVIDER OR SUPPLIER ATHA CARE CENTER | 5409 69TH | DRESS, CITY, S I AVENUE N 'N CENTER, | | | |
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| 2 800 | with census of twen resident acuity/need on MM two NA's we and only one was rescheduled NA's aga - PM shi no reason leaving to scheduled NA's. On 5/10/14, accord Direct Care Hours on TCU was scheduled only 53.00 hours had a fall after nineteen minutes be promptly answered. In analyzing both WHours spreadsheets pattern for staffing to manipulated to read very widely in-skilled-In Wing 2 on 5/10/with 35.00 hours for 7.50 hours for TMA On 5/10/14, accord Direct Care Hours of TCU was scheduled only 53.00 hours had a fall after thad not been promptly and promp | aty four unaware of the delevel for the shift. In addition are crossed off with no reason eplaced of the five originally ain unaware of the census. If tone NA was crossed off with wo of three NA's originally aing to the census for Wing 2 sheet provided by the facility, do to have 60.50 NA hours and ad been worked that day. Inster by shift was requested evided to review in relation to occurrence Report for R105 putting his call light on for effore fall and had not been worked that the context of | 2 800 | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 23 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| MARANA | ATHA CARE CENTER | | I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 800 | Hours spreadsheet pattern for staffing I manipulated to read very widely in-skille -In Wing 2 on 5/10/with 35.00 hours for 7.50 hours for TMA total hours of 128.00 -On 5/1/14, census RN; 16.25 hours for NA per patient day of 5 -On 5/24/14, census RN; 0.0 hours for NA for patient day of 5 When ICA and SC staffing pattern plar TMA's and NA's) w surveyor was referr did not indicate a selevels. In addition w brought up to qualit stated staffing was during staffing mee evidence staffing we effectiveness and p | /ing 1 & Wing 2 Direct Care s, there was no set skill but rather the hours were ch per patient day hours and d set. For example: '14, census was 23 residents r RN; 24.50 hours for LPN; and 61.00 hours for NA for to with per patient day of 5.57. was 27 with 45.00 hours for TLPN; 7.50 hours for TLPN; 7.50 hours for TMA and for total hours of 143.00 with 30. s was 22 with 53.25 hours for PN; 0.0 hours for TMA and or total hours of 113.25 with 3.15. were asked about the facility in (how many RN's, LPN's, the ed to the staffing grind which the et pattern for staffing skilled when asked if staffing had been by improvement meeting ICA discussed every Thursday things but did not provide as analyzed for efficacy, the pattern safety but rather facility I staff regularly as evidenced | 2 800 | | | |
| | TCU call light obse On 9/9/14, at 3:24 p | rvations o.m. observed R220's call light | | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | E SURVEY PLETED |
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| | | 00226 | B. WING | | 09/ | 11/2014 |
| | PROVIDER OR SUPPLIER ATHA CARE CENTER | 5409 69T | DRESS, CITY, S H AVENUE NO YN CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| 2 800 | visibly displayed on audibly heard at the light went off at 3:32 R220 what he had rang his call light as afternoon snack. R2 comes up at 3:00 p At 3:45 p.m. R220 v bring him his aftern At 3:31 p.m. observed displayed on the cath the nursing station 3:40 p.m. Writer he blanket stating R14 On 9/10/14, at 8:42 visibly displayed on audibly heard at the light went off at 8:48 At 8:53 a.m. was herequesting staff assist he bathroom. At 9:39 a.m. observed isplayed on the cath the nursing station 9:44 a.m. Observed radio for staff assist NA-K reply over the NA-K was helping at to surveyor RN-F had for the call light and helping another rest the toilet. At 10:00 a.m. R218 | the call light panel and a nursing station. R220's call 2 p.m. When surveyor asked needed R220 stated he had a he was waiting for his 220 stated "usually the snack.m." was still waiting for the staff to oon snack. red R144's call light visibly light panel and audibly heard on. R144's call light went off at ard R144 ask of NA-L for a 4 was cold. a.m. observed R55's call light the call light panel and enursing station. R55's call | | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 25 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED |
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| | | 00226 | B. WING | | 09/ | 11/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| MARANA | ATHA CARE CENTER | | H AVENUE N | | | |
| | | | YN CENTER, | | | |
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| 2 800 | Continued From pa | ge 25 | 2 800 | | | |
| | to the bathroom. R2 with standing lift for | 218 needed two staff assist toileting. | | | | |
| | displayed on the ca at the nursing static | red R219's call light visibly Il light panel and audibly heard on. R219's call light went out at the desk had gotten up to light. | | | | |
| | light visibly displaye | 8 a.m. observed R208's call don the call light panel and nursing station. R208's call 20 a.m. | | | | |
| | coordinator (HUC) the call light panel a | of call light the health unit was seated at the desk with alarming and visibly displayed pers and the amount of time een on. | | | | |
| | displayed on the ca at the nursing static 11:31 a.m. While th at the entrance abo displayed flashing v requesting help. R1 nursing station with open. While R144's were observed to w stopping to answer three therapy staff, two maintenance ar a.m. observed RN-0 audible ringing of R observed to look at above R144's door RN-A and administr HUC seated at desi | ved R144's call light visibly II light panel and audibly heard on. R144's call light went off at e call light was on, the lights we the door of R144's room white indicating R144 was 44's room was visible to the the door to R144's room call light rang several staff alk by R144's room without the call light including: NA-I, dietary staff, housekeeper, and the administrator. At 11:27 C standing at desk with 144's call light at desk, RN-C R144's white flashing light and walked off. Observed rator standing at desk, the k with audible sound of R144's y of room number and time | | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 26 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE COMP | SURVEY LETED | |
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| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| MARANA | ATHA CARE CENTER | | I AVENUE N 'N CENTER, | | | |
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| 2 800 | Continued From pa | ge 26 | 2 800 | | | |
| | | taff was observed going into R144's call light rang. | | | | |
| | displayed on the ca | rved R219's call light visibly Il light panel and audibly heard on. R219's call light went off at | | | | |
| | displayed on the ca at the nursing static capital letters and the ding ringing double | rved R130's call light visibly II light panel and audibly heard on display the word CORD in he audible sound of the ding increase in speed. R130's call a.m. It was verified to had pull | | | | |
| | The Administrator a | THOD OF CORRECTION: and Director of Nursing could patterns and develop ways to t needed staff. | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 900 | MN Rule 4658.0525 Ulcers | 5 Subp. 3 Rehab - Pressure | 2 900 | | | 10/3/14 |
| | comprehensive resident of nursing services | sores. Based on the ident assessment, the director must coordinate the ursing care plan which | | | | |
| | without pressure so pressure sores unle condition demonstra | o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and | | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 27 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
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| 2 900 | B. a resident w receives necessary promote healing, pr new sores from dev | ho has pressure sores y treatment and services to event infection, and prevent yeloping. | 2 900 | | | |
| | by: Based on observati review, the facility for were implemented prevent further skin residents (R15) in t | on, interview and document ailed to ensure interventions to promote healing and breakdown for 1 of 2 he sample reviewed for is resulted in actual harm, as t pressure ulcer. | | POC written for accompanying Fedeficiencies. Date certain for purpongoing compliance is 10/15/14. | | |
| | in bed awake. Nurs licensed practical n room to help R15 g permission, the sur ulcer on R15's cocc she had "just chang coccyx. The wound was intact. LPN-A dressing to be checobserved to have n discoloration was o LPN-A identified as wound treatment. During observations a.m. to 7:25 a.m., F seated on a cushior -At 7:26 a.m. regist R15's room and was | a.m. R15 was observed lying ing assistant (NA)-C and urse (LPN)-A was in R15's et up from bed. With R15's veyor observed a pressure cyx with LPN-A. LPN-A stated ged" the dressing to R15's dressing was dated 9/10 and carefully opened the adhesive sked. The wound was o drainage however, a yellow bserved on the dressing which being from Medihoney, a gel of R15 on 9/11/14, from 7:10 as observed in her room in the wheelchair. | | | | |

6899

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------|--|-------|-------------------------------|--|
| | | | | | | | |
| | | 00226 | B. WING | | 09/1 | 1/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, S | STATE, ZIP CODE | | | |
| MARANA | ATHA CARE CENTER | 5409 69TH | I AVENUE N | ORTH | | | |
| 10741474147 | WITH OAKE OLIVIER | BROOKLY | 'N CENTER, | MN 55429 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE | |
| 2 900 | -From 7:27 a.m. to room alone, seated herselfAt 8:01 a.m. NA-B enter R15's room, Ner dentures in and pushed R15 out to to the Northern Ligh (TV) area/lounge. Description of the West of the Northern Ligh (TV) area/lounge. Description of the Northern Ligh (TV) area/lounge. Description of the Northern Ligh (TV) area/lounge. Description of the Northern B:06 a.m. to seated in wheelchair and did reposition herselfAt 8:35 a.m. RN-E wheelchair was par RN-E was observed then to push R15 to R15's table. R15 was repositioned and did-From 8:49 a.m. to seated in wheelchair working on breakfar-At 9:25 a.m. NA-B dining table towards R15 in front of TV arange of the NA-B wheelchair away from the N | 8:00 a.m. R15 remained in her in front of a mirror grooming and NA-M were observed to NA-B approached R15 and put changed her shirt. NA-M then the hallway at 8:05 a.m., and its Lane (NLL) unit television ouring that observation, R15 from her wheelchair, nor was 8:35 a.m. R15 remained ir in the same spot in the TV ited in the same position in her not receive assistance, nor approached where R15's ked in the NLL TV lounge. It to speak briefly to R15, and of the dining room area towards as not off-loaded or in the dining room, slowly st with the use of right hand. Wheeled R15 away from the state the NLL TV area. NA-B left in the NLL TV area. NA-B left in the NLL TV area towards the first floor nurses' station is NA-B stated she was to take | 2 900 | DEFICIENCY) | | | |
| | activity room with or staff member was r was not off-loaded reposition herself. -At 9:43 a.m. R15 w | vas observed in the 3rd floor ther residents where a female eading the newspaper. R15 nor repositioned and did not vas still seated in wheelchair, ared to be listening to the | | | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 29 of 46

Minnesota Department of Health

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| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
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| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS CITY S | STATE, ZIP CODE | | |
| TO WILL OF | THO VIDEN ON OUT FEILIN | | I AVENUE N | • | | |
| MARANATHA CARE CENTER | | | 'N CENTER, | | | |
| 0.0.15 | CLIMMA DV CTA | | | | DNI . | ()(=) |
| (X4) ID PREFIX | | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL | | (X5) COMPLETE |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRO | | DATE |
| | | | | DEFICIENCY) | | |
| 2 900 | Continued From pa | ge 29 | 2 900 | | | |
| | reader at the news | reading activity. | | | | |
| | | D was notified by the surveyor | | | | |
| | | seated in the wheelchair since | | | | |
| | 7:25 a.m., and requ | ested that R15 be assessed | | | | |
| | for skin condition. | | | | | |
| | | was pushed to the common | | | | |
| | | by NA-M and RN-E. The two | | | | |
| | | R15 seated in the wheelchair | | | | |
| | in the common area | | | | | |
| | -At 10:05 a.m. RN-D, RN-E and NA-D, were observed to enter R15's room with her | | | | | |
| | | Ilso gave permission for the | | | | |
| | | kin on her buttocks. R15 was | | | | |
| | | r wheelchair to her bed with | | | | |
| | | It by RN-D, RN-E and NA-D. | | | | |
| | | e dressing on R15's wound | | | | |
| | | RN-E assessed the pressure | | | | |
| | wound on R15's bu | ttocks and described the open | | | | |
| | | aving 90% slough and slight | | | | |
| | | ounding skin up to the open | | | | |
| | | the rest of the buttocks was | | | | |
| | | nd the skin was blanchable. | | | | |
| | | nt had been observed from n. on 9/11/14, a period of 2 | | | | |
| | | es, she was not offered, or | | | | |
| | | repositioned during that time. | | | | |
| | onocaragoa, to so . | openioned daming that times | | | | |
| | R15's electronic ad | mission record dated 3/18/13, | | | | |
| | | diagnoses which included | | | | |
| | | anemia, hemiplegia (paralysis | | | | |
| | | ng non-dominant side due to | | | | |
| | | sease, neurogenic bladder, | | | | |
| | | he admission care plan dated | | | | |
| | | 115 had been admitted with a | | | | |
| | pressure ulcer to th | е соссух. | | | | |
| | A review of the Nur | ses' Progress Notes from the | | | | |
| | | fication survey exited in June | | | | |
| | | ated R15 had a pressure ulcer | | | | |
| | | 6/19/13. The Nurses' | | | | |

6899

Minnesota Department of Health

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | | (3) DATE SURVEY COMPLETED | |
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| | | | | | | | |
| | | 00226 | B. WING | | 09/1 | 1/2014 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, S | STATE, ZIP CODE | | | |
| ΜΔΡΔΝΑ | ATHA CARE CENTER | 5409 69TH | I AVENUE N | ORTH | | | |
| WALL | ATTIA GAILE GENTER | BROOKLY | 'N CENTER, | MN 55429 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| 2 900 | Continued From pa | ge 30 | 2 900 | | | | |
| 2 300 | Progress Notes rev coccyx persisted the beginning 6/19/13 culcer had fluctuated evidenced by varied the interdisciplinary as follows: -On 6/19/13, R15's measured 1.5 centicm. -On 12/5/13, R15's measured 2.7 cm X-On 6/3/14, R15's comeasured 0.3 cm X-On 7/8/14, R15's comeasured 0.7 cm X-On 7/25/14, the dowound team had depressure wound was indicated continued a wheelchair cushic and routine observation of 7/29/14, a Nurthe interim clinical at R15 had a pressure described as, "unstaloss in which the basiough or an eschalof the damage can are removed) area measured 1 cm in lowound covered in secretized and preserved and preser | ealed R15's pressure ulcer on rough assessment dates until 7/25/14. The pressure in its stages of healing as dimeasurements pulled from wound team progress notes coccyx pressure wound meters (cm) X 0.5 cm X 0.3 coccyx pressure wound 0.9 cm X 0.4 cm. occyx pressure wound 0.3 cm X 0.2 cm. occyx pressure wound 0.3 cm X 0.3 cm X 0.3 cm. occyx pressure wound 0.3 cm X 0.2 cm. occyx pressure wound 0.3 cm X 0.3 cm | 2 300 | | | | |
| | used to determine rassessment docum | repositioning schedule). The rentation indicated the resident in mobility/positioning. The | | | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 31 of 46

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|-------------------------|---|-------------------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MARANA | ATHA CARE CENTER | | HAVENUE N YN CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 900 | present after reside position for three ho plan to reposition et the analysis include every 2 hrs [hours] The facility had also Tolerance (Chair), yellow documentation on the was not independent was also checked from a side of after resident has be three hours on skin reposition every three hours on skin reposition every three hours included, "Repo. [repositioning & when in bed." The evidence of any oth documents having the Tissue Tolerand "To be completed unwith significant chair emergence of pressure surfaces." review any further a recurrence of R15's and no further documents having the Daily Flow Sheet day had trial use of a Brositioning chair) for repositioning and proceeding to record been formally assig R15 had demonstrativity the chair. | ked for "No discoloration is inthas been in the same ours on skin. Consider to care very three hours." However, ed, "Resident on repositioning in bed." o completed a Tissue which was undated. The hat form indicated the resident on the inmobility/positioning. But or "No discoloration is present een in the same position for . Consider to care plan to ee hours." However, the Resident is on every 2 hrs g] when up in w/c [wheelchair] ee medical record lacked the resident is on every 2 hrs ge medical record lacked the resident is on every 2 hrs ge medical record lacked the resident indicated it was pon, admission, annually and | 2 900 | | | |

6899

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE \$409 93TH AVENUE NORTH BROOKLYN CENTER, MN. 55429 SUMMARY STATEMENT OF DEFICIENCIES TAG CONTINUED TO SUMMARY STATEMENT OF DEFICIENCY TAG CONTINUED TO SUMMARY STATEMENT OF TAG CONTINUED TO SUMMARY STATEMENT OF TAG CONTINUED TO SUMMARY STATEMENT OF TAG CONTINUED TO SUMARY STATE | - | AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--------|---|--|----------|---|-------------------------------|----------|
| MARANATHA CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDENS PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE COMPLETE AT TAG TAG COMPLETE ACTION SHOULD BE CANSA-REPERRICED TO THAT APPROPRIATE COMPLETE DEFICIENCY) 2 900 Continued From page 32 2 900 (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, bilster, 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 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. | | | 00226 | B. WING | | 09/1 | 1/2014 |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 development in 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, bilster, 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, tolleting, and personal hygiene. | | | 5409 69Ti | AVENUE N | ORTH | | |
| (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. | PRÉFIX | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO | LD BE | COMPLETE |
| The progress notes from the physician and geriatric purse practioner (GNP) entitled. Geriatric | 2 900 | (CSRDC) had been and indicated R15 h (indicated moderate development). The had a history of chrucoccyx which was is stable. The surveyor further assessment R15's pressure ulce documents were produced to the stable of the stable of the surveyor further assessment R15's pressure ulce documents were produced R15 had a (partial thickness skillow crater) on the stable of the stable | completed for R15 on 3/7/14, and a Braden Risk score of 13 erisk for pressure ulcer CSRDC also indicated R15 onic pressure ulcer to the dentified as inherited and or requested to review any so following recurrence of er on 7/29/14, and no further ovided. Sement (CAA) dated 3/13/14, as stage II pressure ulcer cin loss involving epidermis, er ulcer could be superficial ally as an abrasion, blister, or the coccyx, and that the for further skin breakdown inence, use of Foley catheter oility. The CAA indicated R15 the coft two staff for mobility in each skin on shower days and care plan to address pressure ulcer had be cated R15's pressure ulcer had be the er was no Wound sheet completed for the wound endeveloped on 7/29/14. Simum Data Set (MDS) dated 15 as having a Stage 2 granulation tissue, which ssistance of one staff for fers, toileting, and personal | 2 900 | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--------------------------|---|-------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MARANA | ATHA CARE CENTER | | I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 900 | Services of Minnes reviewed from 7/7/included: On 7/7/14, "Res. [seen by wound nur of wound has decre in size 1.1 cm x 0.8 cm." On 8/8/14, "Nsg [rwound of 7/29/14, fregistered nurse] in "Coccyx wound: rec [circle with a line dr no edema, shallow wrote a plan for the clean & dry, keep H 30 degrees, change continue with curre On 9/5/14, the phywound was "shallow 8/8/14." Documentation from 7/8/14, indicated the (full thickness skin necrosis of subcutate down to, but not three ulcer presents clinic without undermining facility documented. | ota Progress Notes were 14-9/11/14. The notes resident] has coccyx wound se & reported as stable. Size eased [arrow downward image] cm, currently 0.4 cm x 0.2 mursing] request to assess I cm x 0.6 cm. Wound RN holoved." Also noted was d, blanchable, no drainage awn through it to depict no], ulcer, no bruising." The GNP estaff to follow: "keep skin IOB [head of bed] < [less than] esposition q [every] 2 [hours], in wound care orders." ysician notes indicated the woccyx wound per GNP note in a Wound Consultation dated be coccyx ulcer was a Stage 3 loss involving damage to or aneous tissue that may extend ough, underlying fascia. The cally as a deep crater with or g of adjacent tissue). The proposition of this documentation, in the cally as the coccy wound per global part of this documentation, | 2 900 | | | |
| | the granulation was 10%, and the woun 0.2 cm. A Wound Consultatindicated the reside ulcer with 100% slc 1.0 cm x 0.6 cm | at 90% and the slough was at d measured 0.7 cm x 0.3 cm x dion note dated 7/29/14, ent had an unstageable coccyx ough. The measurement was 0.1 cm and the edges were at the note indicated, "slough". | | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 34 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 00226 | B. WING | | 09/1 | 1/2014 |
| | PROVIDER OR SUPPLIER | 5409 69TI | DRESS, CITY, S H AVENUE NO YN CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 900 | has resurfaced." The the goal was to "proto heal but maintain A Physician's Order to treat R15's press with wound cleanse with silver nitrate 10 cauterization], zinc chapped skin, or ot peri-wound to prote [an all-in-one foam absorbs and retains keeps the wound swith Skin-Prep [a lid upon application to film to help reduce tapes and films] are 8/12/14, the doctor Medihoney (used to stalled under first-lint towards healing) to of the silver nitrate unavailable since of the product became to use the previous R15's care plan revended a chronic pressiplan interventions of complete treatment effectiveness; follow orders for skin care to R15 about the imrepositioning; and fit two hours during the The care plan lacked load/reposition self evidence of any new | ne recommendations revealed obtect as goal may not be [sic] | 2 900 | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 35 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| 71112 1 2711 01 0011 | REOTION | IDENTIFICATION NOMBER. | A. BUILDING: | | CONI | |
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF PROVIDE | R OR SUPPLIER | | , , | STATE, ZIP CODE | | |
| MARANATHA C | ARE CENTER | | I AVENUE N (N CENTER, | | | |
| | EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| recurred cocy. A Wo indicated o.5 critical availated av | aund Consultate ated R15's coor and was sulfied as "MA" (fable on the formation solved R15's coordinated R15's coordinated R15's coordinated R15's coordinated R15's coordinated R15 was at two hours. MDS dated 9/4 at 2 pressure under two hours. MDS dated 9/4 at 2 pressure under two hours. MDS dated 9/4 at 2 pressure under two hours. MDS dated 9/4 at 2 pressure under two hours. MDS dated 9/4 at 2 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. MDS dated 9/4 at 3 pressure under two hours. | ble pressure ulcer to the tion sheet dated 8/12/14, ccyx pressure ulcer was 2.6 x perficial. The stage was the key for MA was not m). The wound base was at scant drainage. The edges | 2 900 | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | |
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| | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | - | |
| MARANATHA CARE CENTER | | I AVENUE N 'N CENTER, | | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| assistance of two strepositioning. The N directed staff to repositioning. The N directed staff to repositioning. The N directed staff to reposition of N directed staff to repositioned according stated R15 should have hours per R15's On 9/11/14, at 10:20 expect a resident wirepositioned according stated R15 should have hours per R15's On 9/11/14, at 10:20 and acknowledged Nulcer to coccyx, and been tried and the positioned according to the number of N directions of N directi | on-ambulatory and requiring aff for transfers, toileting and lursing Assistant Care Sheet osition R15 every two hours. In 9/10/14, at 7:48 a.m. LPN-A ure wound had been there for a stated interdisciplinary team ands every Tuesdays where ents were done. LPN-A stated the wound but stated the e.2. In a.m. NA-D checked her are sheet and stated R15 was ositioned every two hours. In a.m. RN-E stated he would the pressure ulcer to be ing to care plan and further have been repositioned every | 2 900 | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 37 of 46

Minnesota Department of Health

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 00226 | B. WING | | 09/1 | 1/2014 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MARANA | ATHA CARE CENTER | | I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 900 | directed the facility: Braden Scale, a new Collection Tool, and algorithm with the orand care plan interviresident and/or individual was not followed for ulcer was developed further directed staff repositioning sched move. R15's newly area was not proper as the facility did not identify, assess and clinical conditions in skin integrity, and preventative measure appropriate treatment according industry streceive repositionin. SUGGESTED MET director of nursing, policies and proced implemented, and in staff reassess, and pressure ulcers. | staff to complete a new w Comprehensive Data danew tissue Tolerance onset of a new pressure ulcer, ventions according to the vidual risk factors. The policy r R15 when a new pressure don 7/29/14. The policy f to establish individualized fule if a resident was unable to re-opened Stage 2 pressure rly re-assessed by the facility of follow the policy "to properly dimonitor residents whose increase the risk for impaired ressure ulcers; to implement ures; and to provide ent modalities for ulcers standards of care" nor did R15 g in a timely manner. | 2 900 | | | |
| 2 930 | Nasogastric, Gastro Subp. 7. Nasogastr and feeding | ric tubes, gastrostomy tubes, | 2 930 | | | 10/3/14 |
| | | n the comprehensive resident sing home must ensure that: | | | | |

6899

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| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---|---|-------------------------------|--------------------------|
| | | 00226 | B. WING | | 09/11/2014 | |
| NAME OF I | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 1 307. | ., |
| MARANA | ATHA CARE CENTER | | I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 930 | B. a resident was gastrostomy tube of appropriate treatment aspiration pneumor dehydration, metabolic nasal-pharyngeal upossible, normal features. This MN Requirement | who is fed by a nasogastric or reeding syringe receives the ent and services to prevent nia, diarrhea, vomiting, olic abnormalities, and lcers and to restore, if | 2 930 | | | |
| | 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: | | | POC written for accompanying Fe deficiencies. Date certain for purp ongoing compliance is 10/15/14. | | |
| | dated 7/30/14, directube placement "be medication adminis | g Physician's Order sheet cted staff to check feeding fore tube feeding, flushes and tration" by aspirating residual. | | | | |
| | 3:39 p.m. the regist Potassium Chloride milliliter (ml), Metop pressure) 25 milligr (used to treat seizu the Metoprolol and individually and add to dissolve the med R121 the procedure with 30 ml of water, medications, and fluwater in between the | ushed the tube with 30 ml of the medications. The RN-H did ang tube placement prior to | | | | |

6899

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|--|-------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| MARANATHA CARE CENTER 5409 69TH | | | DRESS, CITY, S I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 930 | During interview on verified she did not placement prior the The RN-H explaine tube placement bed the tube feeding at explained since the administration was didn't "need to check RN-H stated the me included the "Gastro Administration" poli 2013, and verified to instructions for staff of gastrostomy tube did not check the feedication administration or tuper the Gastrostom was expected to cheach medication adresidual with a syring the facility's Gastro dated last modified the purpose of the transure adequate ple prior to administration via golicies and proced administration via golicies and procedure procedur | 9/9/14, at 3:55 p.m. the RN-H check the feeding tube medication administration. d she didn't check the feeding tause she just administered 3:00 p.m. The RN-H further 4:00 p.m. medication so close to the feeding she k for the same thing." The edication administration record ostomy Medication cy dated modified in July he procedure included to "Test for correct placement eding tube placement before tration. 9/11/14, at 12:04 p.m. RN-B sected to follow the facility's re regarding feeding tube effore each medication be feeding. The RN-H verified by Tube Placement policy staff eck the tube placement before liministration by checking the rige. 1. Stomy Tube Placement policy in November 2010, indicated ube placement check was "to accement of gastrostomy tube on of medications." | 2 930 | | | |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--|--|-------------------------------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| MARANATHA CARE CENTER 5409 69TH | | | DRESS, CITY, S H AVENUE N (N CENTER, | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 930 | medication adminis delegate nursing stareport to the Quality | ge 40 tration. The DON could aff to monitor compliance and Assurance Committee. R CORRECTION: Twenty-one | 2 930 | | | |
| 21805 | Residents of HC Fa Subd. 5. Courteouresidents have the courtesy and respe | 651 Subd. 5 Patients & ac.Bill of Rights us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a | 21805 | | | 10/3/14 |
| | by: Based on observatireview, the facility facil | ent is not met as evidenced on, interview and document ailed to ensure 1 of 1 resident th dignity regarding bladder assistance was requested by icility staff. | | POC written for accompanying Fe deficiencies. Date certain for purp ongoing compliance is 10/15/14. | | |
| | during interview if s respect and dignity, question spontaned stated about calling and put on the call licame in to the room reminded the staff s and needed help to without attending to put the call light on | a.m. when R3 was asked he was being treated with R3 did not answer the busly, R3 shook head and for help "early this morning" light. R3 stated "two girls" in and told her to get up. R3 she could not get up by herself do so, but the staff left R3's needs. R3 stated she again, then staff came in and helping R3. R3 was observed | | | | |

6899

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--|---|--------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 11/2014 |
| MARANATHA CARE CENTER 5409 69TH | | | ORESS, CITY, S I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 21805 | to be teary-eyed as happened that more some pauses and of felt sick and getting crying, I never wet to pointed to one pillow at the head of the bewet all the way up to so bad." R3's electronic Admindicated R3 had di without behavioral of failure, difficulty in womuscle weakness. R3's Care Area Ass 5/6/14, indicated R3 activities of daily living weakness and pain and had impaired mobalance, strength a incontinent of bowed decreased mobility, bathroom fast enough was noted to prefer rather than prompting R3 was at risk for fatransfer and ambulations was alert and able to R3's care plan date ADL performance of encouraged to use R3's care plan described bowel and bladder, being able to comming restroom and needs toileting. The care parts of the parts of the promote of the parts of the promote of the preference of | she talked about what ning. R3 wiped own tears, took continued to talk about having the bed wet. R3 stated, "I was he bed like that before." R3 w (without a pillow case) lying ed and described the bed was other pillow. R3 stated, "I felt hission Record dated 4/29/14, agnoses to include demential disturbance, acute respiratory walking, generalized pain, and essments (CAAs) dated a had deficits in performing ing (ADLs) related to secondary to history of fall nobility, ambulation, decreased and activity tolerance; R3 was I and bladder related to R3 could not get to the gh due to her pain, and R3 calling staff for assistance ing her to go to the bathroom; alls, was noted to be unable to ate without assistance, and o make needs known. | 21805 | | | |

Minnesota Department of Health

STATE FORM SY2611 If continuation sheet 42 of 46

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--------------------------|---|-------------------------------|--------------------------|
| | 00226 | | B. WING | | 09/1 | 1/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MARAN | ATHA CARE CENTER | | I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (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. | | | | | |
| | depicted R3 as hav in a noisy setting or voice. The MDS als speech, making he | a Set (MDS) dated 8/1/14, ing minimal hearing loss when when spoken to in a soft to identified R3 as having clear rself understood and had the and 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 onAt 4:06 a.m. R3's call light was canceled in roomAt 4:07 a.m. R3's call light was turned on againAt 4:11 a.m. R3's call light cord was pulled out | | | | | |
| | from wallAt 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. | | | | | |
| | Sheet indicated R3 | ed Nursing Assistant Care needed assist of one staff for ed staff to assist R3 with | | | | |
| | staff and R3 was br administrator (ICA) stated, "I would exp plan and give her a administrator also a follow care plan and | a.m. when incident between rought to the interim clinical and the administrator, the ICA bect the staff to check the care ssistance out of bed." The agreed staff were expected to d meet R3's needs. | | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY IPLETED | |
|---|--|---|--------------------------|---|--|---------------------|--|
| | | 00226 | B. WING | | 09/11/2014 | | |
| NAME OF I | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 1 03/1 | 1/2014 | |
| MARANA | ATHA CARE CENTER | | I AVENUE N 'N CENTER, | | | | |
| (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 SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T | CTION SHOULD BE COI O THE APPROPRIATE | | |
| 21805 | SUGGESTED MET The Director of Nur could develop, revie procedures to ensur maintained. The Director of Nur could educate all ap and procedures. The or designee could of ensure ongoing cor TIME PERIOD FOR Twenty-One (21) D | olicy for dignity, but stated d in all policies of the facility. THOD OF CORRECTION: sing Services or designee ew, and/or revise policies and re all residents' dignity is sing Services or designee expropriate staff on the policies are Director of Nursing Services develop monitoring systems to impliance. R CORRECTION: ays. | 21805 | | | 10/3/14 | |
| 21010 | 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: | | 21010 | POC written for accompanying Fe deficiencies. Date certain for purp ongoing compliance is 10/15/14. | | 10/3/14 | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--|--|-------|--------------------------|
| | | 00226 | B. WING | | 09/1 | 1/2014 |
| MARANATHA CARE CENTER 5409 69TH | | | ORESS, CITY, S I AVENUE N 'N CENTER, | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21810 | On 9/8/14, at 3:28 probservation the call floor by the head of stand and in between On 9/9/14, at 9:15 at p.m. R143's call light on the floor behind. On 9/9/14, at approper environmental tour call light was on the floor from behind the what her expectation accessibility she state at reach at all times to use it or not." The falls Care Area identified R143 was staff to remind R14; use her wheelchair commonly used articles at the state of the state of falls and unstead free of minor injury staff "Be sure my call for the state of the | John. during R143's room light was observed on the bed slightly behind the night en the bed night stand. Jam. to approximately 1:15 at was still observed to remain the night stand not accessible. Eximately 3:45 p.m. during the the administrator verified the enight stand and when asked on was for call light ated "all call lights have to be regardless if resident is able. Assessment dated 2/21/14, at risk for falls and directed at the call for assistance and and keep call light and icles within reach. Inimum Data Set (MDS) dated 143's Brief Interview for Mental sed to measure cognition) dicating moderately impaired the MDS indicated R143 used | 21810 | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|---|--------|------------------------------|--|
| | | 00226 | B. WING | | 09/1 | 11/2014 | |
| | MARANATHA CARE CENTER 5409 69TH | | | STATE, ZIP CODE ORTH MN 55429 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE | |
| 21810 | Call Light policy mo "Position the call lig resident to use" SUGGESTED MET The administrator o review, and/or revis ensure resident call residents. The adm educate all appropr procedures. The ad develop monitoring compliance. | ge 45 dified 10/10, directed, ht conveniently for the THOD OF CORRECTION: r designee could develop, e policies and procedures to lights were accessible to inistrator or designee could iate staff on the policies and ministrator or designee could systems to ensure ongoing R CORRECTION: Twenty-one | 21810 | | | | |

6899