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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: T7G9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00520

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245276**

2.STATE VENDOR OR MEDICAID NO.
(L2) **010343800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLEWOOD CARE CENTER**
(L4) **1900 SHERREN AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55109**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/01/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **130** (L18)

13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

On 2/26, 2/27, 2/28 and 3/1/18, a standard survey and complaint investigations were also completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. At the time of the survey, investigation of complaints
H5276093 and H5276097. The were completed and found to be unsubstantiated.

17. SURVEYOR SIGNATURE — Date :
Momodou Fatty, HFE NE II — 04/04/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Amy Johnson, Enforcement Specialist — 04/17/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 19, 2018

Ms. Sara Sterling, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: Project Numbers S5276028, H5276093, H5276097

Dear Ms. Sterling:

On March 1, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567 whereby corrections are required. In addition, at the time of the March 1, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5276093 and H5276097 that were found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

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 April 10, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 1, 2018 (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 September 1, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE MAPLEWOOD, MN 55109**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 2/26/18 through 3/1/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 2/26, 2/27, 2/28 and 3/1/18, a standard survey and complaint investigations were also completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. At the time of the survey, investigation of complaints H5276093 and H5276097. The were completed and found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must	F 561		4/10/18

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

Electronically Signed | 03/28/2018

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F 561	Continued From page 1 promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to comprehensively assess bathing preferences, and implement a care plan based upon resident preference for 1 of 1 resident (R99) reviewed for choices. Findings include: During interview on 2/26/18, at 1:39 p.m. when asked about bathing preferences, R99 said facility staff seemed to have firm rules about	F 561	F000 It is the policy of Maplewood Care Center to follow all Federal, State, and local guidelines, laws, regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of	

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F 561	Continued From page 2 residents receiving one shower a week. R99 also added that sometimes staff allowed his shower to be pushed back a couple days due to his pain. R99 said he understood the importance of cleanliness, but described having constant pain that made showering uncomfortable. When asked whether staff had offered other bathing options, such as a bed bath, R99 said he was not aware that was an option. R99 further explained he had received bed baths during a recent hospital stay, and acknowledged his pain was not as bad during a bed bath as it was during a shower. During the interview, R99 was observed to wince in pain multiple times, stopping mid-sentence with squinted eyes. R99 appeared to hold his breath until the pain was gone, before being able to open his eyes and speak again. R99 described his pain as spasms that shot through his body with any body movement. Review of the electronic medical record revealed R99 had diagnoses including spinal enthesopathy (inflammation of a tendon, ligament, or cartilage at its insertion into the spine) at multiple sites, ankylosing spondylitis (inflammatory disease that can cause vertebrae in the spine to fuse) at multiple sites, cramps and spasms. R99's care plan indicated he required assistance of one staff for bathing. The care plan included a section specific to pain, which confirmed chronic pain related to the spinal conditions, and R99's need for pain medication 30 minutes before showering. During interview on 3/1/18, at 11:59 a.m. when asked about how the facility assessed residents for bathing preferences, registered nurse (RN)-G said staff asked residents about their personal	F 561	deficiencies does not constitute agreement with citations. The preparation, submission and implementation of this plan of correction will serve as our credible allegation of compliance. F561 The bathing preferences for resident R99 were noted on his Kardex and the unit bath list specifying his preference for a bed bath in the evening. All residents have the potential to be affected by this practice. Nurse Managers will audit admission/readmission assessments to assure that bathing preferences for day, time and type of bath are accommodated. Audits will be conducted weekly for four weeks, then monthly for 2 months and as needed based on the recommendation of the QAPI committee. Policy and Procedure was reviewed for Self Determination and Resident Preference. Staff education will be provided by 4/10/18 on bathing preference and documenting refusals. Responsible: Director of Nursing or designee Date of Correction: 4/10/18	

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F 561	Continued From page 3 bathing preferences during an initial admission assessment. RN-G reviewed the most recent Admission/Readmission assessment form for R99, dated 2/19/18, and referred to the section about bathing preferences. This section began with the following bolded text, "REQUIRED QUESTION: Ask the resident their preferences for bathing and past routine, mark answers here for their plan of care." Staff also had an option to check a box to identify interventions assessed to be appropriate for the resident. Options included, but were not limited to, "I do not have specific bathing/showering preferences, I prefer a bed bath, I prefer baths, and I prefer showering." None of the boxes had been checked to specify R99's bathing preferences. RN-G sated she was unsure whether staff had asked R99 about his bathing preferences because no boxes indicating preference had been checked. RN-G said she could not say for certain whether R99 was asked specifically about bathing, since she was not the nurse who'd completed the assessment. RN-G said she would follow-up with R99 about bathing options and preferences, and ensure current preferences were accommodated. On 3/1/18, at 4:08 p.m. the administrator was asked about whether the facility had a policy regarding resident choice and bathing preferences. The administrator stated the facility did not have a written policy about assessing residents for bathing preference, but stated preferences were suppose to be assessed using the Admission/Readmission assessment forms.	F 561		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		4/10/18

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F 641	Continued From page 4 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurate for 1 of 1 residents (R26) identified on the MDS as having a mental health diagnosis. Findings include: No assessment of R26's mental health was found in the medical record to indicate the 12/13/17, annual MDS, which indicated R26 had a bipolar disorder, was accurate. R26's annual MDS dated 12/13/17, indicated R26 had major depression and manic depression of bipolar disorder. The 12/17 annual MDS was the first time a bipolar diagnosis appeared on an MDS. An admission MDS dated 12/15/16, and quarterly MDS' dated 3/15, 6/14, and 9/13/17, did not indicate R26 had a bipolar disorder. The admission history and physical dated 12/8/16, did not address a bipolar disorder diagnosis. Record review indicated R26 returned to the hospital shortly after admission and the hospital discharge summary dated 1/11/17, indicated R26 had received the antipsychotic medications of Zyprexa and Seroquel for delusions and hallucinations, related to diagnosis of sepsis. However, the discharge summary did not indicate R26 had a bipolar disorder, and R26 was not discharged on the antipsychotic medications. Care plan reviewed 12/28/17, did not address a	F 641	F641 The bipolar diagnosis was removed from R26□s diagnosis list. All resident□s diagnosis lists will be reviewed by 4/10/18 to ensure correct diagnoses. Staff education will be provided by 4/10/18. The MDS coordinators will review the diagnosis list each time they complete an MDS for accuracy and update as needed. The Interdisciplinary team will review the accuracy of diagnoses when conducting their Psychoactive medication review to assure they are current as required. Audits will be conducted weekly for four weeks, monthly for 2 months and as needed based on recommendation of the QAPI committee. Responsible: Director of Nursing or designee Date of Correction: 4/10/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 5	F 641		

Bipolar Disorder; and the first physician visit after admission and dated 1/5/17, did not list a diagnosis of Bipolar Disorder.

Although physician visit notes dated 3/13, 4/17, 7/21 and 10/12/17; and nurse practitioner visits dated 2/16, 4/3, 5/4, 8/14, 9/7, 11/8/17 and 1/10/18, indicated R26 had a Bipolar Disorder, the medical record lacked evidence to indicate the diagnosis had an impact on the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nurse monitoring, or risk of death during the 7 day look back period.

On 2/28/18, at 11:45 a.m. registered nurse (RN)-H, an MDS coordinator reviewed R26's medical record to determine where the bipolar diagnosis had originated. RN-H identified a psychology note dated 1/2/17, where R26 had given a history of a "near" bipolar episode approximately 40 years ago however, visit documentation did not indicate a current bipolar disorder diagnosis. RN-H verified the first time the bipolar diagnosis had shown up on an MDS was at the time of the annual dated 12/13/17. RN-H confirmed there may be discrepancy related to the bipolar diagnosis and the medical record and stated she would speak with the primary physician to determine whether the bipolar diagnosis for R26 was appropriate. During a subsequent interview with RN-H at 1:54 p.m. 2/28/18, RN-H provided a hospital History and Physical (H&P) dated 1/16/17 which listed bipolar disorder, however there was no indication whether this was a current or past diagnosis.

On 3/1/18 at 10:08 a.m., RN-H stated she had spoken with R26's primary physician. RN-H

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE MAPLEWOOD, MN 55109**

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F 641	Continued From page 6 stated the physician said if there had been no formal psychiatric visit, with a diagnosis listed, then bipolar disorder should be removed from R26's diagnosis list.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		4/10/18

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	245276	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 656	Continued From page 7 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the plan of care for 1 of 1 resident (R42) reviewed for transferring between surfaces. Findings include: On 2/27/18 at 9:41 a.m., nursing assistant (NA)-G placed a transfer belt on R42 prior to assisting the resident with a transfer. R42 was observed to be sitting in her wheelchair and began calling out. R42 stiffened up and NA-G was observed to physically pull R42 to a standing position to help her hold on to her walker. NA-G had to hold on to R42 and guided R42 to sit on the toilet. NA-G then placed the walker in front of R42 who was calling out. When R42 was done on the toilet, NA-G again held on to R42 to physically guide her back to the wheelchair. During this process, the wheelchair was observed to tip back slightly. NA-G then grabbed the wheelchair and applied the breaks. NA-G stated it was "scary" to help R42 with transferring with just one person because of R42's "behaviors." NA-G also stated she had helped R42 without additional staff assistance because there was no one else available to assist at that time and R42 needed to use the toilet.	F 656	F656 Resident R42□s care plan, accountability sheets and Kardex have been reviewed to assure they continue to be accurate. All care plans, accountability sheets and Kardex will be reviewed to ensure they match by 4/10/18. Nursing staff have received re-education regarding the necessity to follow the care plan, Kardex and task list to provide care. Nursing staff have received re-education regarding the importance of informing the manager of discrepancies between the Care Plan and the actual care provided so that the care is consistent. Managers will confer with NARs prior to IDT to assure the Care Plan matches the care being provided. Policy and Procedure was reviewed for Care Plans. Audits of weekly Care Plans will be conducted for consistent interventions for 3 months and as needed based on recommendation of the QAPI committee. Responsible: Director of Nursing or designee	

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F 656	Continued From page 8 On 2/27/18 at 10:01 a.m., registered nurse (RN)-E, the nurse manager of the unit, was interviewed and stated R42's care plan had been auto-populated from completed assessments, and that she believed R42 was appropriate to transfer with one or two staff assistance. However, RN-E acknowledged she could not recall the last time she'd actually observed R42 transfer. RN-E stated staff should read the entire care plan to determine whether they could transfer R42 with one or two staff assistance. R42's care plan last revised 7/28/17, included: "Resident has a self care deficit r/t [related to] cognitive impairment and impaired mobility r/t [related to] Dementia dx [diagnosis]. I use two persons for transfers." There was no indication in the care plan that staff could interpret when to use one or two staff for transfers. R42's Accountability Sheets dated 2/26/18, indicated: "Transfer: A2 [assist of two]" .	F 656	Date of Correction: 4/10/18	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene to 2 of 4 residents (R19 and R41) dependent on staff for activities of daily living (ADL's).	F 677	F677 Residents R19 and R41 have had their facial hair shaved. Nursing staff have received re-education re: shaving all	4/10/18

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	245276	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 9 Findings include: R19 was observed to have several long facial hairs the evening of 2/26/18, and during subsequent days of the survey on 2/27/18, and 2/28/18. On 2/26/18 at 5:23 p.m., R19 was observed sitting on the edge of the bed. R19 was observed to have matter around her right eye and on her eyelashes. In addition, she had several long facial hairs around the chin area approximately 1 inch long. The hairs were gray, white and black. When asked whether staff helped her with shaving, or how she felt about having the facial hair, R19 stated, "Staff do not help to shave or wash my face and I get short of breathe when I try to shave myself. No body helps me when I need help right away." On 2/27/18 at 8:30 a.m., R19 was observed lying in bed. The resident still had numerous long gray, white and black facial hairs to her upper lip and chin area. At 11:57 a.m., R19 was observed sitting up at the edge of the bed with oxygen administered by nasal cannula. She had not been shaved. On 2/28/18 at 7:57 a.m., R19 was observed lying in bed with the oxygen on. R19 still had the long gray, white and black facial hair. At that time, R19 stated she did not like having the whiskers. R19's admission record identified R19 had been admitted to the facility on 3/15/14, with diagnoses including: paranoid schizophrenia, dementia, anxiety disorder, extrapyramidal movement disorder, and psychosis.	F 677	residents and the importance of reporting and documenting refusals by 4/10/18. Policy and Procedure was reviewed for Shaving Residents. Daily observations of shaving will be conducted for 2 weeks, weekly for 4 weeks, monthly for 1 month then as needed based on recommendations of the QAPI committee. Responsible: Director of Nursing or designee Date of Correction: 4/10/18	

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	245276	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 677	Continued From page 10	F 677		

R19's quarterly Minimum Data Set (MDS) dated 12/6/17, identified R19 required extensive assist of one staff with personal hygiene needs, including shaving.

Review of R19's medical record lacked any documentation related to refusal of cares. The care plan dated 8/1/14, directed staff to assist R19 with grooming. An undated Nursing Assistant Assignment Sheet included: "Grooming-A-1 [grooming assist of one]".

During an observation of R19 with licensed practical nurse (LPN)-B on 2/28/18 at 11:28 a.m., LPN-B verified R19 had long facial hairs. LPN-B stated she would shave R19 or would ask the nursing assistant (NA) to shave her. LPN-B asked R19 if wished to be shaven and R19 replied, "The nursing assistant combed my hair but did not shave me and I would like to be shaved daily."

R41 was observed to have several long facial hairs the evening of 2/26/18, and during subsequent days of the survey on 2/27/18, and 2/28/18.

On 2/26/18 at 1:49 p.m., R41 was observed sitting in her wheelchair. She had numerous gray and white facial hairs on her chin area. When asked whether staff assisted her with shaving, or how she felt about having facial hair, R41 stated, "I do not like it."

On 2/27/18 at 11:54 a.m., R41 was observed sitting in her wheelchair again. She still had numerous gray and white facial hairs noted on her upper lip and chin area. R41 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 677	Continued From page 11	F 677		

would like staff to shave her daily.

On 2/28/18 at 9:12 a.m., R41 was observed lying in bed in her room. She had still not been shaved, and had the long gray and white facial hairs. R41 again stated she would prefer if staff would shave her daily. At 9:45 a.m., NA-A assisted R41 with her morning cares, including grooming. However, NA-A did not offer or assist R41 with shaving even though the resident had obvious gray and white facial hairs. At 11:05 a.m., NA-A assisted R41 to get up to use the toilet. NA-A still did not offer to shave R41. At 11:19 a.m., R41 was observed in the dining room. She stated, "They did not shave me." The resident still had the long gray and white facial hairs.

R41's admission record noted R41 had been admitted to the facility on 11/8/16, with diagnoses including: type two diabetes mellitus, major depression, restlessness and agitation, shortness of breath and mixed anxiety disorders.

R41's quarterly MDS dated 12/27/17, indicated R41 required extensive assist of one staff with personal hygiene needs including shaving.

On 2/28/18 at 11:33 a.m., review of R41's medical record was reviewed, and lacked any evidence the resident refused cares. R41's undated Nursing Assistant Assignment Sheet indicated, "Grooming-A-1".

During an observation and interview with LPN-A on 2/28/18 at 11:42 a.m., LPN-A verified R41's facial hair. LPN-A told the surveyor NA-A had reported R41 had refused to be shaven.

The policy and procedure titled SHAVING THE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 12 RESIDENT dated 2006, included: "To remove facial hair and improve the resident's appearance and morale."	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 1 of 1 residents (R26) identified with limited range of motion of the lower extremities. Findings included: On 2/26/18, at 6:16 p.m. R26 was observed in bed with the right foot and ankle uncovered. A noticeable foot drop/flexion was observed on the right foot. At that time, R26 stated ROM to both	F 688	F688 Resident R26□s care plan, Kardex and POC documentation have been reviewed and revised to reflect the current order for AROM and appropriate documentation. Nursing staff has received re-education regarding the necessity of documenting care when completed. Audits of ROM physician orders have been completed to assure they are included on the Kardex, POC and treatment sheets for	4/10/18

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	245276	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 688	Continued From page 13 ankles and feet was suppose to be done on a daily basis, but did not always happen. During observation of morning cares on 3/1/18, at 8:20 a.m. nursing assistant (NA)-B was observed to lotion R26's right lower leg, feet and ankle. Range of motion was not provided. At that time, a slight foot drop/flexion was noted to the left foot/ankle. On 3/1/18, at 8:25 a.m. NA-B and NA-C were asked about ROM to R26's bilateral feet/ankles. NA-B stated ROM was done when R26 got up in the Hoyer sling, but R26 never got out of bed. NA-C stated ROM was not listed on the NA assignment sheet. NA-B stated R26's ROM was very limited and R26 could hardly flex the right foot/ankle. R26 then stated the ROM was "sometimes" done while R26 was in bed. At 8:30 a.m. NA-B lotioned R26's left lower extremity, but did not provide ROM. On 3/1/18, at 9:38 a.m. registered nurse (RN)-A stated R26's ROM should be done every shift. RN-A stated completion of ROM for residents was monitored when RN-A was giving medications. RN-A said she would see staff giving the ROM. RN-A stated although R26's ROM was identified on the care plan, it should also be on the NA assignment sheet. At that time, RN-A showed the surveyor the NA assignment sheet for R26. ROM was not identified on the assignment sheet and RN-A stated, "It's not on there." At 9:42 a.m. on 3/1/18, the "Task" section of the computerized point of care documentation pertaining to R26's ROM was reviewed with RN-A. The documentation indicated ROM was to	F 688	documentation of completion. Policy and Procedure was reviewed for ROM. Audits will be conducted weekly for 4 weeks, monthly for 2 months and as needed as recommended by the QAPI committee. Person responsible: Director of Nursing or designee Date of Correction: 4/10/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 688	Continued From page 14 be completed as follows: "Restorative active range of motion to ankles before and after getting in EZ lift (mechanical lift device) and after getting back to bed. 15 reps twice a day." The documentation reviewed with RN-A had a date range of 2/1 to 2/28/18. The review with RN-A revealed R26 was not consistently receiving ROM twice a day. A physician's order dated 9/5/17, revealed ROM exercises to R26's ankles was to be completed before and after placing R26 in a lift; and after lifted back to bed. The physician's order indicated ROM was to be done "two times a day." A review of the care plan revised on 2/12/18, verified R26's need for active ROM, with a frequency of 15 reps twice a day to the right and left lower extremities, feet and ankles.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oxygen therapy was administered according to physician orders for 3 of 4 residents (R154, R156, R206) observed receiving oxygen therapy.	F 695	F695 Residents R154 and R206 have discharged. R156 had their med and treatment sheets reviewed and revised to	4/10/18

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	245276	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 695	Continued From page 15 Findings include: On 2/26/18, at 1:21 p.m. R154 was observed in bed, the head of the bed was elevated, a nasal cannula was in R154's nares and oxygen tubing was attached to a portable oxygen tank. R154 (who had diagnoses including pneumonia, pulmonary hypertension and ascites) told the surveyor at that time, there was no oxygen in the portable tank. The portable tank was observed to be set at 3 liters (L) per minute (PM). R154 stated she was "surprised" the larger oxygen tank had not been brought back to the room. R154 turned the call light on and nursing assistant (NA)-D responded promptly and verified R154's portable oxygen tank was empty. On 3/1/18, at 11:10 a.m. R154 stated she had also run out of oxygen from the portable tank over the weekend. R154 stated therapy services always check the portable tank to ensure there is enough oxygen, but R156 said she "always" has to ask nursing staff to check the portable tank to be sure there is enough oxygen to last the day. A review of physician orders dated 2/19/18, revealed R154 was to receive 4 LPM of oxygen continuously. On 2/26/18, at 1:41 p.m. R156's spouse was heard to ask staff to fill R156's portable oxygen tank because it was empty. At that time, the spouse was asked by the surveyor if R156 had run out of oxygen in the past. The spouse stated R156 had been at the facility for about 7-10 days and R156's portable oxygen tank frequently ran out of oxygen.	F 695	include licensed staff documenting portable tanks are filled at least once per shift and more often if indicated by ordered liter flow. NARs have been re-educated on the correct technique for filling portable tanks, filling prior to the end of shift and responding promptly to requests to fill portable tanks. Policy Observation audits of residents portable 02 will be conducted daily for 2 weeks, weekly for four weeks and monthly for one month. Further audits will be conducted on an as needed basis recommended by the QAPI committee. Person responsible: Director of Nursing or designee Date of Correction: 4/10/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 16	F 695		

On 2/27/18, at 9:20 a.m. R156 asked the spouse if the oxygen in the portable tank was working and the spouse stated it was. R156 stated she felt she was not getting enough oxygen. R156 was not observed to have any cyanosis (discoloration due to lack of oxygen) noted at that time. At 9:23 a.m. the call light was turned on and answered by NA-D who verified the portable oxygen tank was set at 3 LPM, but the tank was empty. At 10:03 a.m. NA-E stated the portable oxygen tank had been filled that morning around 7:45 a.m. NA-E questioned if the portable tank was leaking and stated she would inform the nurse.

A physician's order dated 2/20/18, revealed R156 was to receive 2-6 LPM of oxygen continuously. A review of progress notes for R156 did not reveal documentation of R156 having run out of oxygen on 2/26 or 2/27/18. Oxygen saturation levels were recorded as follows: 2/12/17-94%; 2/13/17-94%; and 2/13/18- 90%.

On 3/1/18, at 7:44 a.m. the oxygen supplier's service technician stated a portable oxygen tank set at 2 LPM should last about six (6) hours; if set at 3 LPM the portable oxygen should last about four (4) hours. The service technician stated there was a customer handbook which gave estimated duration of portable oxygen tanks based on the LPM the tank was set at. The service technician provided the surveyor the Customer Handbook. A review of the handbook revealed portable oxygen for a resident on 3 LPM, such as what R156 was on, should last about 5.3 hours; if set at 4 LPM the tank would last about 4.1 hours. The service technician stated a portable oxygen tank would most likely leak in the summer because of humidity and the

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	245276	A. BUILDING _____ B. WING _____	C 03/01/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 17	F 695		

service technician questioned if staff were filling the tanks correctly if the oxygen was running out faster than anticipated.

On 3/1/18, at 7:49 a.m. NA-F stated nursing assistants were responsible for checking the portable oxygen tanks periodically on the shift to ensure there was enough oxygen in the portable tank.

On 3/1/18, at 9:44 a.m. registered nurse (RN)-A stated nursing assistants were to fill the portable oxygen tanks every morning and RN-A would check the tanks on her unit during the noon meal. RN-A verified residents will complain of not being able to breath if the oxygen tank ran empty.

A review of the facility's Oxygen Administration policy dated 2010, indicated portable oxygen tanks were to be filled according to manufacturer's instructions and checked at regular intervals to ensure adequate supply. The policy also indicated resident's respirations and oxygen saturation levels were to be completed at regular intervals to assess need for further oxygen therapy when necessary, as well as after oxygen has been discontinued.

During observation on 2/26/18 at 7:10 p.m., R206 was in his room and had oxygen applied from a large tank via nasal cannula at 2 liters/minute. A small, portable oxygen tank was hanging on the back of his wheelchair. At this time, R206 stated his small oxygen tank had run out of oxygen more than once since he had been in the facility. He stated the small tank is filled by staff once every shift. He couldn't remember if there was a particular time of day that he ran out of oxygen.

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	245276	A. BUILDING _____ B. WING _____	C 03/01/2018

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F 695	Continued From page 18	F 695		

When interviewed on 2/27/18 at 10:29 a.m. and on 2/28/18 at 11:00 a.m., R206 stated he'd had no problems with his oxygen tank running out of oxygen the previous night or current day.

When interviewed on 3/1/18 at 10:30 a.m., registered nurse (RN)-A, unit manager for R206, stated she was unaware of any concerns with oxygen tanks on her unit. The surveyor informed RN-A about the concern R206 had described. RN-A stated she would call the oxygen supplier immediately and ask for a new tank for R206. She went on to explain that nursing staff does not have a specific schedule for checking oxygen tank function, but checks it periodically throughout the day.

During interview on 3/1/18 at 11:32 a.m., licensed practical nurse (LPN)-C was asked if she was aware of any oxygen concerns with residents on her unit. She stated that she remembered that approximately a couple weeks ago, R206 was in the first floor dining room and his lips appeared a bit cyanotic (bluish discoloration). LPN-C said when she'd checked his portable oxygen tank, set to 2 liters/minute, the flow "didn't felt like 2 liters/minute." LPN-C stated she'd checked R206's oxygen saturation level at that time and it had registered in the 80s, so she'd refilled the small oxygen tank that R206 was using and then the flow of the oxygen seemed appropriate. LPN-C stated after having switched to the large tank in his room, his oxygen saturation level had immediately come up to the 90s. LPN-C stated she'd reported this to staff during shift report that day and assumed R206 would receive a new small oxygen tank. LPN-C was unable to verify the date when this had happened and stated she

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F 695	Continued From page 19 has not heard anything about oxygen tanks not working properly on that unit since.	F 695		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 755		4/10/18

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F 755	Continued From page 20 Based on observation, interview and document review, the facility failed to ensure expired/outdated medications were not available for use for 10 of 66 residents whose medication storage was reviewed (R13, R53, R56, R78, R86, R103, R159, R160, R161, R162), and failed to ensure stock medications were not discarded when expired which had the potential to affect any residents who may use those medications. Findings include: During observation of a medication pass on 3/1/18, at 12:33 p.m. on the three (3) south unit, licensed practical nurse (LPN)-D was observed to place two tablets of acetaminophen into a medication cup for R78 from a bottle of stock acetaminophen. When observed at that time, the stock bottle of acetaminophen had an expiration date of 6/17. LPN-D was stopped before administering the medication and the expiration date was pointed out to LPN-D, who verified the medication label indicated it had expired on 6/17. Stock medications in the three (3) south medication cart were reviewed on 3/1/18 at 12:35 p.m. The following outdated medications were identified: a bottle of stock vitamin B12 labeled with an expiration date of 1/17, and oyster shell calcium with an expiration date of 1/17. LPN-D stated none of the current eight (8) residents residing on the 3 south unit were currently taking these stock medications. An inhalation asthma medication (Advair) for R13 was not dated when opened; two bottles of olapatadine eye drops for R56 were not dated when opened, and a bottle of the laxative polyethylene glycol prescribed to R56 was labeled with an expiration date of 12/17. LPN-D stated R13 was no longer using the	F 755	F755 All med carts have been reviewed and outdated and discontinued medications have been removed. Nursing staff have received re-education on dating medications when opened, expiration dates and removal of discontinued medication from the carts promptly. Night staff will clean medication carts and remove outdated, expired medications no less than weekly. Medications will be removed from the cart when discontinued. The Policy and Procedure for Expired Medications was reviewed. Audits will be conducted weekly for one month, monthly for 2 months and as needed based on the recommendation of the QAPI committee. Person responsible: Director of Nursing or designee Date of Correction: 4/10/18	

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F 755	Continued From page 21	F 755		

Advair, and verified the polyethylene glycol expiration date was 12/17, but stated R56 also no longer used that medication. LPN-D verified the eye drops should have been dated when opened and confirmed R56 was currently receiving the eye drops. Also in the 3 south medication cart there was a bottle of atropine mouth drops which were not dated when opened for R103; and a bottle of latanosprost eye drops which were dated as having been opened on 1/17/18, for R53 and which according to LPN-D were still in use. There were also two bottles of gatifloxacin eye drops for R86 which were open, but had not been dated when opened; and a bottle of Latanoprost eye drops for R86 which were dated as having been opened on 1/17/18. LPN-D verified the Latanoprost drops were still in use.

On 3/1/18 at 1:00 p.m., the two north medication cart was reviewed and observed to contain the following stock medications that had expired: a bottle of Naproxen (for pain) expired on 1/18; and a bottle of vitamin C 500 milligrams (mg) which had been opened on 10/16, and had expired on 1/18. Registered nurse (RN)-C stated no residents on the 2 north unit were currently receiving these stock medications.

At 1:10 p.m. on 3/1/18, the three (3) north medication and treatment carts were reviewed. In the 3 north medication cart the following expired stock medications were observed: vitamin D 400 mg expired 4/17, magnesium 250 mg expired 11/17, glucosamine sulfate 500 mg expired 10/17, Naproxen expired 1/18, vitamin B6 expired 12/17, and vitamin B complex expired on 1/18. At that time, LPN-E stated none of the current 38 residents on the 3 north unit received these stock medications. There was also a bottle of allergy

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F 755	Continued From page 22	F 755		

medication (loratidine10 mg) observed in the 3 north medication cart which had an expiration date of 8/17. LPN-E stated there were "lots" of residents on the 3 north unit who frequently used this stock medication. LPN-E stated there was no specific routine for nurses to follow regarding checking medication carts for expired medications, and stated there was not a specific assignment for a nurse or shift to check medications for expiration dates. LPN-E stated she tried to check the medication carts on weekends when she worked to identify any expired medications.

At 1:25 p.m. on 3/1/18, 6 of 6 bottles of insulin stored in the first floor TCU (transitional care unit)-1 medication cart were identified to have not been dated when opened. This included bottles of Novolog and Lantus for R162; a bottle of Novolog and Levemir for R161; a bottle of Novolog, which RN D stated came from the emergency kit; and another bottle of Novolog which was not labeled or dated when opened. RN-D verified none of the insulins in the medication cart had been dated when opened. RN-D stated she had gone through the medication cart about a month ago and took it upon herself to check the medications in her medication cart for expiration dates and to ensure medications had been dated when opened. RN-D stated there was otherwise no specific system for looking at the medication carts for expired medications.

Manufacturer guidance for Lantus, Humalog and Novolog insulin indicated vials should be discarded 28 days after opening. The Basaglar insulin pen was to be discarded after 28 days according manufacturer guidance. Manufacturer guidance for Levemir insulin indicated vials

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F 755	Continued From page 23	F 755		

should be discarded 42 days after opening.

On 3/1/18 at 1:34 p.m., the first floor TCU-2 medication cart was noted to contain one of seven bottles of insulin (Humalog for R159) which was not dated when opened. There was also one Basaglar insulin pen in the medication cart for R160, which was not dated when opened. RN-B stated insulins were to be dated when opened, and verified the bottle of Humalog and the Basaglar insulin pen had not been dated when opened.

On 3/1/18 at 1:40 p.m. the first floor TCU-3 medication cart was noted to contain a bottle of stock acidophilus which had expired on 6/17. LPN-C stated no one on her unit was currently taking the acidophilus.

On 3/1/18, at 2:59 p.m. the director of nursing (DON) stated the facility had no system in place for checking medication carts for expired medications. The DON stated the facility also did not have a specific policy to follow regarding checking medications for expiration dates or for labeling medications when opened. The DON stated the facility followed the contracted pharmacy's policy and procedures regarding expired medications and dating when opened.

The DON provided a copy of the pharmacy's 2013 policy titled Storage and Expiration of Medications, Biologicals, Syringes and Needles. The policy indicated that once a medication or biological package was opened the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. The DON said facility staff should record the date opened on the medication

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F 755	Continued From page 24 container for any medications with a shortened expiration. The pharmacy policy also indicated that medications should be destroyed and reordered when there was a missing label, and indicated outdated/expired medications should be destroyed by the facility or returned to the pharmacy. The policy did not address how frequently staff were to check medications for expiration.	F 755		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		4/10/18

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F 883	Continued From page 25 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure pneumonia vaccines were offered to 1 of 5 residents reviewed (R26) for compliance with recommended vaccinations. Findings include: R26's most recent minimum data set assessment dated 12/13/17, identified R26 had been admitted	F 883	F883 Resident R26 has been offered and received a PCV 13 vaccination. All residents were reviewed and any missing vaccinations were given by 4/10/18. The facility Infection Preventionist will monitor all new and readmissions to the facility for compliance	

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F 883	Continued From page 26 to the facility on 1/20/17 and was over the age of 65 years old. Review of R26's immunization record revealed R26 had received a PPSV23 (pneumococcal polysaccharide vaccine) on 4/1/15, after R26 had turned 65 years of age. However, there was no record of a PCV13 vaccination. On 3/1/18 at 9:39 a.m., the facility's infection preventionist and registered nurse (RN)-F stated staff should have offered R26 a PCV13 vaccination at the time of admission since R26 was eligible and there was no record of her having received one previously. The facility's Pneumococcal Vaccine protocol dated 2017, included: "Adults > [older than] 65 years who have already received a dose of PPSV23, should also receive a dose of PCV13 a year or more later."	F 883	with recommended vaccinations. The Policy and Procedure for Pneumococcal Immunization has been reviewed. Audits will be conducted monthly for 3 months and as needed based on the recommendations of the QAPI committee. Person responsible: Director of Nursing or designee Date of Correction: 4/10/18	

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	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2018**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Facility name) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 3-story building was constructed in 1964 and was determined to be of Type II(222) construction. It has a full basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 149 beds and had a census of 116 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

Electronically delivered
March 19, 2018

Ms. Sara Sterling, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

Re: State Nursing Home Licensing Orders - Project Numbers S5276028, H5276093, H5276097

Dear Ms. Sterling:

The above facility was surveyed on February 26, 2018 through March 1, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5276093 and H5276097 that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susie Haben, Unit Supervisor at (651) 201-2731 or at susie.haben@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/26/18 - 3/1/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. At the time of the survey, investigation of complaints Investigation of complaint H5276093 and H5276097 were completed and found to be	2 000		

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	00520	A. BUILDING: _____ B. WING _____	C 03/01/2018

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2 000	Continued From page 1 unsubstantiated You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 270	MN Rule 4658.0090 Use of Oxygen A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oxygen therapy was administered according to physician orders for 3 of 4 residents (R154, R156, R206) observed receiving oxygen therapy. Findings include: On 2/26/18, at 1:21 p.m. R154 was observed in bed, the head of the bed was elevated, a nasal cannula was in R154's nares and oxygen tubing was attached to a portable oxygen tank. R154 (who had diagnoses including pneumonia, pulmonary hypertension and ascites) told the surveyor at that time, there was no oxygen in the portable tank. The portable tank was observed to be set at 3 liters (L) per minute (PM). R154 stated she was "surprised" the larger oxygen tank had not been brought back to the room. R154 turned the call light on and nursing assistant (NA)-D responded promptly and verified R154's portable oxygen tank was empty.	2 270	Corrected	4/10/18

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2 270	Continued From page 3 On 3/1/18, at 11:10 a.m. R154 stated she had also run out of oxygen from the portable tank over the weekend. R154 stated therapy services always check the portable tank to ensure there is enough oxygen, but R156 said she "always" has to ask nursing staff to check the portable tank to be sure there is enough oxygen to last the day. A review of physician orders dated 2/19/18, revealed R154 was to receive 4 LPM of oxygen continuously. On 2/26/18, at 1:41 p.m. R156's spouse was heard to ask staff to fill R156's portable oxygen tank because it was empty. At that time, the spouse was asked by the surveyor if R156 had run out of oxygen in the past. The spouse stated R156 had been at the facility for about 7-10 days and R156's portable oxygen tank frequently ran out of oxygen. On 2/27/18, at 9:20 a.m. R156 asked the spouse if the oxygen in the portable tank was working and the spouse stated it was. R156 stated she felt she was not getting enough oxygen. R156 was not observed to have any cyanosis (discoloration due to lack of oxygen) noted at that time. At 9:23 a.m. the call light was turned on and answered by NA-D who verified the portable oxygen tank was set at 3 LPM, but the tank was empty. At 10:03 a.m. NA-E stated the portable oxygen tank had been filled that morning around 7:45 a.m. NA-E questioned if the portable tank was leaking and stated she would inform the nurse. A physician's order dated 2/20/18, revealed R156 was to receive 2-6 LPM of oxygen continuously. A review of progress notes for R156 did not reveal documentation of R156 having run out of oxygen	2 270		

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2 270	Continued From page 4 on 2/26 or 2/27/18. Oxygen saturation levels were recorded as follows: 2/12/17-94%; 2/13/17-94%; and 2/13/18- 90%. On 3/1/18, at 7:44 a.m. the oxygen supplier's service technician stated a portable oxygen tank set at 2 LPM should last about six (6) hours; if set at 3 LPM the portable oxygen should last about four (4) hours. The service technician stated there was a customer handbook which gave estimated duration of portable oxygen tanks based on the LPM the tank was set at. The service technician provided the surveyor the Customer Handbook. A review of the handbook revealed portable oxygen for a resident on 3 LPM, such as what R156 was on, should last about 5.3 hours; if set at 4 LPM the tank would last about 4.1 hours. The service technician stated a portable oxygen tank would most likely leak in the summer because of humidity and the service technician questioned if staff were filling the tanks correctly if the oxygen was running out faster than anticipated. On 3/1/18, at 7:49 a.m. NA-F stated nursing assistants were responsible for checking the portable oxygen tanks periodically on the shift to ensure there was enough oxygen in the portable tank. On 3/1/18, at 9:44 a.m. registered nurse (RN)-A stated nursing assistants were to fill the portable oxygen tanks every morning and RN-A would check the tanks on her unit during the noon meal. RN-A verified residents will complain of not being able to breath if the oxygen tank ran empty. A review of the facility's Oxygen Administration policy dated 2010, indicated portable oxygen tanks were to be filled according to	2 270		

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2 270	Continued From page 5	2 270		

manufacturer's instructions and checked at regular intervals to ensure adequate supply. The policy also indicated resident's respirations and oxygen saturation levels were to be completed at regular intervals to assess need for further oxygen therapy when necessary, as well as after oxygen has been discontinued.

During observation on 2/26/18 at 7:10 p.m., R206 was in his room and had oxygen applied from a large tank via nasal cannula at 2 liters/minute. A small, portable oxygen tank was hanging on the back of his wheelchair. At this time, R206 stated his small oxygen tank had run out of oxygen more than once since he had been in the facility. He stated the small tank is filled by staff once every shift. He couldn't remember if there was a particular time of day that he ran out of oxygen.

When interviewed on 2/27/18 at 10:29 a.m. and on 2/28/18 at 11:00 a.m., R206 stated he'd had no problems with his oxygen tank running out of oxygen the previous night or current day.

When interviewed on 3/1/18 at 10:30 a.m., registered nurse (RN)-A, unit manager for R206, stated she was unaware of any concerns with oxygen tanks on her unit. The surveyor informed RN-A about the concern R206 had described. RN-A stated she would call the oxygen supplier immediately and ask for a new tank for R206. She went on to explain that nursing staff does not have a specific schedule for checking oxygen tank function, but checks it periodically throughout the day.

During interview on 3/1/18 at 11:32 a.m., licensed practical nurse (LPN)-C was asked if she was aware of any oxygen concerns with residents on

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2 270	Continued From page 6 her unit. She stated that she remembered that approximately a couple weeks ago, R206 was in the first floor dining room and his lips appeared a bit cyanotic (bluish discoloration). LPN-C said when she'd checked his portable oxygen tank, set to 2 liters/minute, the flow "didn't felt like 2 liters/minute." LPN-C stated she'd checked R206's oxygen saturation level at that time and it had registered in the 80s, so she'd refilled the small oxygen tank that R206 was using and then the flow of the oxygen seemed appropriate. LPN-C stated after having switched to the large tank in his room, his oxygen saturation level had immediately come up to the 90s. LPN-C stated she'd reported this to staff during shift report that day and assumed R206 would receive a new small oxygen tank. LPN-C was unable to verify the date when this had happened and stated she has not heard anything about oxygen tanks not working properly on that unit since. SUGGESTED METHOD OF CORRECTION: The director of nurses (or designee) could observe nursing assistants filling portable oxygen tanks to ensure a complete filling is achieved. If a complete filling is not achieved additional teaching could be conducted to ensure compliance with the facility's policy regarding filling of portable oxygen tanks. A member of the nursing staff could randomly audit residents on oxygen to ensure portable oxygen tanks were full and have the tanks filled if necessary at the time of the audit. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 270		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use	2 565		4/10/18

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2 565	Continued From page 7 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the plan of care for 1 of 1 resident (R42) reviewed for transferring between surfaces. Findings include: On 2/27/18 at 9:41 a.m., nursing assistant (NA)-G placed a transfer belt on R42 prior to assisting the resident with a transfer. R42 was observed to be sitting in her wheelchair and began calling out. R42 stiffened up and NA-G was observed to physically pull R42 to a standing position to help her hold on to her walker. NA-G had to hold on to R42 and guided R42 to sit on the toilet. NA-G then placed the walker in front of R42 who was calling out. When R42 was done on the toilet, NA-G again held on to R42 to physically guide her back to the wheelchair. During this process, the wheelchair was observed to tip back slightly. NA-G then grabbed the wheelchair and applied the breaks. NA-G stated it was "scary" to help R42 with transferring with just one person because of R42's "behaviors." NA-G also stated she had helped R42 without additional staff assistance because there was no one else available to assist at that time and R42 needed to use the toilet. On 2/27/18 at 10:01 a.m., registered nurse	2 565	Corrected.	

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2 565	Continued From page 8 (RN)-E, the nurse manager of the unit, was interviewed and stated R42's care plan had been auto-populated from completed assessments, and that she believed R42 was appropriate to transfer with one or two staff assistance. However, RN-E acknowledged she could not recall the last time she'd actually observed R42 transfer. RN-E stated staff should read the entire care plan to determine whether they could transfer R42 with one or two staff assistance. R42's care plan last revised 7/28/17, included: "Resident has a self care deficit r/t [related to] cognitive impairment and impaired mobility r/t [related to] Dementia dx [diagnosis]. I use two persons for transfers." There was no indication in the care plan that staff could interpret when to use one or two staff for transfers. R42's Accountability Sheets dated 2/26/18, indicated: "Transfer: A2 [assist of two]" SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee could develop and implement a plan of care by the interdisciplinary team to accurately reflect the individual needs and preferences of each resident. The facility could update policies and procedures to ensure resident preferences are assessed, educate staff on these changes, and audit periodically to ensure the needs and preferences of resident(s) are respected. Random audits could be conducted to ensure compliance and reported back to the QAPI committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 830	Continued From page 9	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review, the facility failed to comprehensively assess bathing preferences, and implement a care plan based upon resident preference for 1 of 1 resident (R99) reviewed for choices. Findings include: During interview on 2/26/18, at 1:39 p.m. when asked about bathing preferences, R99 said facility staff seemed to have firm rules about residents receiving one shower a week. R99 also added that sometimes staff allowed his shower to be pushed back a couple days due to his pain. R99 said he understood the importance of cleanliness, but described having constant pain that made showering uncomfortable. When asked whether staff had offered other bathing options, such as a bed bath, R99 said he was not aware that was an option. R99 further explained	2 830	Corrected.	4/10/18

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2 830	Continued From page 10	2 830		

he had received bed baths during a recent hospital stay, and acknowledged his pain was not as bad during a bed bath as it was during a shower. During the interview, R99 was observed to wince in pain multiple times, stopping mid-sentence with squinted eyes. R99 appeared to hold his breath until the pain was gone, before being able to open his eyes and speak again. R99 described his pain as spasms that shot through his body with any body movement.

Review of the electronic medical record revealed R99 had diagnoses including spinal enthesopathy (inflammation of a tendon, ligament, or cartilage at its insertion into the spine) at multiple sites, ankylosing spondylitis (inflammatory disease that can cause vertebrae in the spine to fuse) at multiple sites, cramps and spasms.

R99's care plan indicated he required assistance of one staff for bathing. The care plan included a section specific to pain, which confirmed chronic pain related to the spinal conditions, and R99's need for pain medication 30 minutes before showering.

During interview on 3/1/18, at 11:59 a.m. when asked about how the facility assessed residents for bathing preferences, registered nurse (RN)-G said staff asked residents about their personal bathing preferences during an initial admission assessment. RN-G reviewed the most recent Admission/Readmission assessment form for R99, dated 2/19/18, and referred to the section about bathing preferences. This section began with the following bolded text, "REQUIRED QUESTION: Ask the resident their preferences for bathing and past routine, mark answers here for their plan of care." Staff also had an option to check a box to identify interventions assessed to

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2 830	Continued From page 11 be appropriate for the resident. Options included, but were not limited to, "I do not have specific bathing/showering preferences, I prefer a bed bath, I prefer baths, and I prefer showering." None of the boxes had been checked to specify R99's bathing preferences. RN-G sated she was unsure whether staff had asked R99 about his bathing preferences because no boxes indicating preference had been checked. RN-G said she could not say for certain whether R99 was asked specifically about bathing, since she was not the nurse who'd completed the assessment. RN-G said she would follow-up with R99 about bathing options and preferences, and ensure current preferences were accommodated. On 3/1/18, at 4:08 p.m. the administrator was asked about whether the facility had a policy regarding resident choice and bathing preferences. The administrator stated the facility did not have a written policy about assessing residents for bathing preference, but stated preferences were suppose to be assessed using the Admission/Readmission assessment forms. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee could develop and implement a plan of care by the interdisciplinary team to accurately reflect the individual needs and preferences of each resident. The facility could update policies and procedures to ensure resident preferences are assessed, educate staff on these changes, and audit periodically to ensure the needs and preferences of resident(s) are respected. Random audits could be conducted to ensure compliance and reported back to the QAPI committee.	2 830		

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2 830	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services for 1 of 1 residents (R26) identified with limited range of motion of the lower extremities. Findings included: On 2/26/18, at 6:16 p.m. R26 was observed in bed with the right foot and ankle uncovered. A noticeable foot drop/flexion was observed on the right foot. At that time, R26 stated ROM to both ankles and feet was suppose to be done on a daily basis, but did not always happen.	2 890	Corrected.	4/10/18

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2 890	Continued From page 13 During observation of morning cares on 3/1/18, at 8:20 a.m. nursing assistant (NA)-B was observed to lotion R26's right lower leg, feet and ankle. Range of motion was not provided. At that time, a slight foot drop/flexion was noted to the left foot/ankle. On 3/1/18, at 8:25 a.m. NA-B and NA-C were asked about ROM to R26's bilateral feet/ankles. NA-B stated ROM was done when R26 got up in the Hoyer sling, but R26 never got out of bed. NA-C stated ROM was not listed on the NA assignment sheet. NA-B stated R26's ROM was very limited and R26 could hardly flex the right foot/ankle. R26 then stated the ROM was "sometimes" done while R26 was in bed. At 8:30 a.m. NA-B lotioned R26's left lower extremity, but did not provide ROM. On 3/1/18, at 9:38 a.m. registered nurse (RN)-A stated R26's ROM should be done every shift. RN-A stated completion of ROM for residents was monitored when RN-A was giving medications. RN-A said she would see staff giving the ROM. RN-A stated although R26's ROM was identified on the care plan, it should also be on the NA assignment sheet. At that time, RN-A showed the surveyor the NA assignment sheet for R26. ROM was not identified on the assignment sheet and RN-A stated, "It's not on there." At 9:42 a.m. on 3/1/18, the "Task" section of the computerized point of care documentation pertaining to R26's ROM was reviewed with RN-A. The documentation indicated ROM was to be completed as follows: "Restorative active range of motion to ankles before and after getting in EZ lift (mechanical lift device) and after getting	2 890		

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2 890	Continued From page 14 back to bed. 15 reps twice a day." The documentation reviewed with RN-A had a date range of 2/1 to 2/28/18. The review with RN-A revealed R26 was not consistently receiving ROM twice a day. A physician's order dated 9/5/17, revealed ROM exercises to R26's ankles was to be completed before and after placing R26 in a lift; and after lifted back to bed. The physician's order indicated ROM was to be done "two times a day." A review of the care plan revised on 2/12/18, verified R26's need for active ROM, with a frequency of 15 reps twice a day to the right and left lower extremities, feet and ankles. SUGGESTED METHOD OF CORRECTION: The therapy department staff could reassess the resident's specific range of motion needs and instruct staff on how to do the range of motion, as well as the frequency. The information should then be added to the nursing assistant assignment sheet. A member of the nursing staff could be assigned the responsibility to monitor staff to ensure range of motion was being completed as care planned and ordered. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary	2 920		4/10/18

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2 920	Continued From page 15 services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene to 2 of 4 residents (R19 and R41) dependent on staff for activities of daily living (ADL's). Findings include: R19 was observed to have several long facial hairs the evening of 2/26/18, and during subsequent days of the survey on 2/27/18, and 2/28/18. On 2/26/18 at 5:23 p.m., R19 was observed sitting on the edge of the bed. R19 was observed to have matter around her right eye and on her eyelashes. In addition, she had several long facial hairs around the chin area approximately 1 inch long. The hairs were gray, white and black. When asked whether staff helped her with shaving, or how she felt about having the facial hair, R19 stated, "Staff do not help to shave or wash my face and I get short of breathe when I try to shave myself. No body helps me when I need help right away." On 2/27/18 at 8:30 a.m., R19 was observed lying in bed. The resident still had numerous long gray, white and black facial hairs to her upper lip and chin area. At 11:57 a.m., R19 was observed sitting up at the edge of the bed with oxygen administered by nasal cannula. She had not been shaved.	2 920	Corrected.	

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2 920	Continued From page 16 On 2/28/18 at 7:57 a.m., R19 was observed lying in bed with the oxygen on. R19 still had the long gray, white and black facial hair. At that time, R19 stated she did not like having the whiskers. R19's admission record identified R19 had been admitted to the facility on 3/15/14, with diagnoses including: paranoid schizophrenia, dementia, anxiety disorder, extrapyramidal movement disorder, and psychosis. R19's quarterly Minimum Data Set (MDS) dated 12/6/17, identified R19 required extensive assist of one staff with personal hygiene needs, including shaving. Review of R19's medical record lacked any documentation related to refusal of cares. The care plan dated 8/1/14, directed staff to assist R19 with grooming. An undated Nursing Assistant Assignment Sheet included: "Grooming-A-1 [grooming assist of one]". During an observation of R19 with licensed practical nurse (LPN)-B on 2/28/18 at 11:28 a.m., LPN-B verified R19 had long facial hairs. LPN-B stated she would shave R19 or would ask the nursing assistant (NA) to shave her. LPN-B asked R19 if wished to be shaven and R19 replied, "The nursing assistant combed my hair but did not shave me and I would like to be shaved daily." R41 was observed to have several long facial hairs the evening of 2/26/18, and during subsequent days of the survey on 2/27/18, and 2/28/18. On 2/26/18 at 1:49 p.m., R41 was observed sitting in her wheelchair. She had numerous gray	2 920		

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2 920	Continued From page 17	2 920		

and white facial hairs on her chin area. When asked whether staff assisted her with shaving, or how she felt about having facial hair, R41 stated, "I do not like it."

On 2/27/18 at 11:54 a.m., R41 was observed sitting in her wheelchair again. She still had numerous gray and white facial hairs noted on her upper lip and chin area. R41 stated she would like staff to shave her daily.

On 2/28/18 at 9:12 a.m., R41 was observed lying in bed in her room. She had still not been shaved, and had the long gray and white facial hairs. R41 again stated she would prefer if staff would shave her daily. At 9:45 a.m., NA-A assisted R41 with her morning cares, including grooming. However, NA-A did not offer or assist R41 with shaving even though the resident had obvious gray and white facial hairs. At 11:05 a.m., NA-A assisted R41 to get up to use the toilet. NA-A still did not offer to shave R41. At 11:19 a.m., R41 was observed in the dining room. She stated, "They did not shave me." The resident still had the long gray and white facial hairs.

R41's admission record noted R41 had been admitted to the facility on 11/8/16, with diagnoses including: type two diabetes mellitus, major depression, restlessness and agitation, shortness of breath and mixed anxiety disorders.

R41's quarterly MDS dated 12/27/17, indicated R41 required extensive assist of one staff with personal hygiene needs including shaving.

On 2/28/18 at 11:33 a.m., review of R41's medical record was reviewed, and lacked any evidence the resident refused cares. R41's undated Nursing Assistant Assignment Sheet

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2 920	Continued From page 18 indicated, "Grooming-A-1". During an observation and interview with LPN-A on 2/28/18 at 11:42 a.m., LPN-A verified R41's facial hair. LPN-A told the surveyor NA-A had reported R41 had refused to be shaven. The policy and procedure titled SHAVING THE RESIDENT dated 2006, included: "To remove facial hair and improve the resident's appearance and morale." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students,	21426		4/10/18

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21426	Continued From page 19 residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 newly hired employees (E)-A, was screened for tuberculosis (TB). Findings include A review of E-A's employee TB screening tool, dated 11/28/17, revealed no tuberculin skin test (TST), TB blood test or chest x-ray. The screening tool revealed E-A's date of hire was 12/12/17 and was hired to work directly with patients. A clinic TST result was attached, however it was dated 7/26/17, more than 90 days prior to E-A's hire date. The Infection Prevention and Control Manual, dated 2017, directed staff "Employees who will be receiving the two-step Tuberculin Skin Test (TST) may begin work after the first step results are negative." and "It is the policy of this facility that all healthcare workers will be tested for tuberculosis upon hire and yearly thereafter unless contraindicated. Initial testing will be a two-step procedure with the first dose given before beginning work and the second "booster"	21426	Corrected.	

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21426	Continued From page 20 dose given 7-21 days after the first if the first dose is negative along with an employee risk screening tool." On 3/1/18 at 1:55 p.m. the human resource worker confirmed findings. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and procedures. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired/outdated medications were not available for use for 10 of 66 residents whose medication storage was reviewed (R13, R53, R56, R78, R86, R103, R159, R160, R161, R162), and failed to ensure stock medications were not discarded when expired which had the potential to affect any residents who may use those medications. Findings include:	21620	corrected.	4/10/18

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21620	Continued From page 21 During observation of a medication pass on 3/1/18, at 12:33 p.m. on the three (3) south unit, licensed practical nurse (LPN)-D was observed to place two tablets of acetaminophen into a medication cup for R78 from a bottle of stock acetaminophen. When observed at that time, the stock bottle of acetaminophen had an expiration date of 6/17. LPN-D was stopped before administering the medication and the expiration date was pointed out to LPN-D, who verified the medication label indicated it had expired on 6/17. Stock medications in the three (3) south medication cart were reviewed on 3/1/18 at 12:35 p.m. The following outdated medications were identified: a bottle of stock vitamin B12 labeled with an expiration date of 1/17, and oyster shell calcium with an expiration date of 1/17. LPN-D stated none of the current eight (8) residents residing on the 3 south unit were currently taking these stock medications. An inhalation asthma medication (Advair) for R13 was not dated when opened; two bottles of olapatadine eye drops for R56 were not dated when opened, and a bottle of the laxative polyethylene glycol prescribed to R56 was labeled with an expiration date of 12/17. LPN-D stated R13 was no longer using the Advair, and verified the polyethylene glycol expiration date was 12/17, but stated R56 also no longer used that medication. LPN-D verified the eye drops should have been dated when opened and confirmed R56 was currently receiving the eye drops. Also in the 3 south medication cart there was a bottle of atropine mouth drops which were not dated when opened for R103; and a bottle of latanosprost eye drops which were dated as having been opened on 1/17/18, for R53 and which according to LPN-D were still in use. There were also two bottles of gatifloxacin eye drops for	21620		

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21620	Continued From page 22 R86 which were open, but had not been dated when opened; and a bottle of Latanoprost eye drops for R86 which were dated as having been opened on 1/17/18. LPN-D verified the Latanoprost drops were still in use. On 3/1/18 at 1:00 p.m., the two north medication cart was reviewed and observed to contain the following stock medications that had expired: a bottle of Naproxen (for pain) expired on 1/18; and a bottle of vitamin C 500 milligrams (mg) which had been opened on 10/16, and had expired on 1/18. Registered nurse (RN)-C stated no residents on the 2 north unit were currently receiving these stock medications. At 1:10 p.m. on 3/1/18, the three (3) north medication and treatment carts were reviewed. In the 3 north medication cart the following expired stock medications were observed: vitamin D 400 mg expired 4/17, magnesium 250 mg expired 11/17, glucosamine sulfate 500 mg expired 10/17, Naproxen expired 1/18, vitamin B6 expired 12/17, and vitamin B complex expired on 1/18. At that time, LPN-E stated none of the current 38 residents on the 3 north unit received these stock medications. There was also a bottle of allergy medication (loratidine10 mg) observed in the 3 north medication cart which had an expiration date of 8/17. LPN-E stated there were "lots" of residents on the 3 north unit who frequently used this stock medication. LPN-E stated there was no specific routine for nurses to follow regarding checking medication carts for expired medications, and stated there was not a specific assignment for a nurse or shift to check medications for expiration dates. LPN-E stated she tried to check the medication carts on weekends when she worked to identify any expired medications.	21620		

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21620	Continued From page 23 At 1:25 p.m. on 3/1/18, 6 of 6 bottles of insulin stored in the first floor TCU (transitional care unit)-1 medication cart were identified to have not been dated when opened. This included bottles of Novolog and Lantus for R162; a bottle of Novolog and Levemir for R161; a bottle of Novolog, which RN D stated came from the emergency kit; and another bottle of Novolog which was not labeled or dated when opened. RN-D verified none of the insulins in the medication cart had been dated when opened. RN-D stated she had gone through the medication cart about a month ago and took it upon herself to check the medications in her medication cart for expiration dates and to ensure medications had been dated when opened. RN-D stated there was otherwise no specific system for looking at the medication carts for expired medications. Manufacturer guidance for Lantus, Humalog and Novolog insulin indicated vials should be discarded 28 days after opening. The Basaglar insulin pen was to be discarded after 28 days according manufacturer guidance. Manufacturer guidance for Levemir insulin indicated vials should be discarded 42 days after opening. On 3/1/18 at 1:34 p.m., the first floor TCU-2 medication cart was noted to contain one of seven bottles of insulin (Humalog for R159) which was not dated when opened. There was also one Basaglar insulin pen in the medication cart for R160, which was not dated when opened. RN-B stated insulins were to be dated when opened, and verified the bottle of Humalog and the Basaglar insulin pen had not been dated when opened. On 3/1/18 at 1:40 p.m. the first floor TCU-3	21620		

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21620	Continued From page 24	21620		

medication cart was noted to contain a bottle of stock acidophilus which had expired on 6/17. LPN-C stated no one on her unit was currently taking the acidophilus.

On 3/1/18, at 2:59 p.m. the director of nursing (DON) stated the facility had no system in place for checking medication carts for expired medications. The DON stated the facility also did not have a specific policy to follow regarding checking medications for expiration dates or for labeling medications when opened. The DON stated the facility followed the contracted pharmacy's policy and procedures regarding expired medications and dating when opened.

The DON provided a copy of the pharmacy's 2013 policy titled Storage and Expiration of Medications, Biologicals, Syringes and Needles. The policy indicated that once a medication or biological package was opened the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. The DON said facility staff should record the date opened on the medication container for any medications with a shortened expiration.

The pharmacy policy also indicated that medications should be destroyed and reordered when there was a missing label, and indicated outdated/expired medications should be destroyed by the facility or returned to the pharmacy. The policy did not address how frequently staff were to check medications for expiration/outdates.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise

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21620	Continued From page 25 policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		