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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YVBD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00916

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245409**
2.STATE VENDOR OR MEDICAID NO.
(L2) **843242200**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLE MANOR HEALTHCARE & REHAB**
(L4) **1875 19TH STREET NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 03/13/14 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **81** (L18)

13.Total Certified Beds **81** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(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):
Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective February 22, 2014, the facility is certified for 81 beds.

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NEII 03/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/24/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5409 April 25, 2014

Mr. Patrick Blum, Administrator
Maple Manor Healthcare & Rehab
1875 19th Street Northwest
Rochester, Minnesota 55901

Dear Mr. Blum:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 22, 2014 the above facility is certified for:

81 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 81 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit
Licensing and Certification Program

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 18, 2014

Mr. Patrick Blum, Administrator
Maple Manor Healthcare & Rehab
1875 19th Street Northwest
Rochester, Minnesota 55901

RE: Project Number S5409024

Dear Mr. Blum:

On January 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 13, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 21, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 22, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 13, 2014, effective February 22, 2014 and therefore remedies outlined in our letter to you dated January 28, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program, Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245409	A. Building B. Wing	~~3/12/2014~~ 03/13/2014

Name of Facility	Street Address, City, State, Zip Code
MAPLE MANOR HEALTHCARE & REHAB	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **02/22/2014**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **02/22/2014**	ID Prefix **F0252** Reg. # **483.15(h)(1)** LSC	Correction Completed **02/22/2014**
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **02/22/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **02/22/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/22/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **02/22/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **02/22/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/22/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **02/22/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/kfd	03/18/2014	31221	03/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/13/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245409	A. Building 01 - MAIN BUILDING 01 B. Wing	2/21/2014

Name of Facility	Street Address, City, State, Zip Code
MAPLE MANOR HEALTHCARE & REHAB	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0071	Correction Completed 02/16/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/kfd	**Date:** 03/18/2014	**Signature of Surveyor:** 03049	**Date:** 02/21/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 1/10/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YVBD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00916

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245409**
2.STATE VENDOR OR MEDICAID NO.
(L2) **843242200**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLE MANOR HEALTHCARE & REHAB**
(L4) **1875 19TH STREET NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

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 **01/13/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **81** (L18)

13.Total Certified Beds **81** (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: (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 02/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/24/2014 CO.
YVBD

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5409

At the time of the Standard survey, on January 13, 2014 the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8330

January 28, 2014

Mr. Patrick Blum, Administrator
Maple Manor Healthcare & Rehab
1875 19th Street Northwest
Rochester, Minnesota 55901

RE: Project Number S5409024

Dear Mr. Blum:

On January 13, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-2711

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 February 22, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 22, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 April 13, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 13, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

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
	245409	A. BUILDING _____ B. WING _____ FEB 11 2014 MN Dept of Health Rochester	01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR HEALTHCARE & REHAB	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form 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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	See Attachment #1 2/12/14 GPN	2/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/7/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	01/13/2014

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MN Dept of Health
Rochester

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156		

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MN Dept of Health Regulatory

(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 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the liability and appeal rights notices upon termination of all Medicare skilled services for 2 of 3 residents (R87, R11) reviewed for liability notices. Findings include: R87 was admitted to the facility on 9/14/13 and discharged on 10/30/13. R87 did not receive the proper liability and appeal rights notices 48 hours prior to the end of skilled services. R11 was admitted to the facility on 8/26/13 and discharged on 9/14/13. R11 did not receive the proper liability and appeal rights notices 48 hour notice prior to the end of skilled services. When interviewed on 1/8/14 at 3:50 p.m., Business office assistant (BOA)-E stated that she did not give R11 a liability and appeal rights notices because he was a veteran and she did not realize that he needed to receive one. BOA-E stated that R87 did receive one and was looking	F 156		

Attachment 1

Regulation 483.10(b)(5) Tag F156
Notice of Rights and Services

Maple Manor Healthcare and Rehabilitation routinely informs the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Such notification is made prior to or upon admission and during the resident's stay. Receipt of such information and any amendments to it are acknowledged in writing.

The goal of Maple Manor Healthcare and Rehabilitation is to assure that each resident knows his or her rights and responsibilities and that the facility communicates this information in a timely manner. The facility routinely notifies the resident/family before Medicare benefits are discontinued and provides the resident/legal representative with a timely notice of the right of expedited appeal of the facility's decision to deny benefits.

The policies/procedures for notifying residents of discontinuation/ineligibility of Medicare benefits were reviewed and found appropriate. Residents/legal representatives will continue to be provided with and requested to sign 1) an Advanced Beneficiary Notice explaining the reduction or discontinuation of Medicare benefits, payment liability, and the right to a demand bill submitted and 2) the Notice of Medicare Provider Non-Coverage which informs them of the right to an expedited appeal by the Quality Improvement Organization of the decision to discontinue Medicare benefits. To verify that the liability and appeal notices have been provided, copies of the signed forms are kept on file at the facility.

The regulations and facility policies/procedures addressing resident notification of the discontinuation of Medicare benefits were reviewed with the responsible staff. They were instructed 1) that notices regarding discontinuation of Medicare benefits are to be provided to residents whose stay is covered by the facility's contract with the Veteran's Administration and 2) duplicate copies of signed notices are to be retained.

Resident number 11 – The resident was receiving short-term respite care under a contract with the Veteran's Administration (VA). Because the veteran was not personally responsible for the cost of care provided by the facility and because Medicare benefits were not impacted by his stay, a notice of Medicare noncoverage was not provided to the resident. The staff has been educated on the requirement/policy to provide Medicare notices to residents receiving care under the VA contract.

Resident number 87 – Upon investigation it was found that the appropriate notices had been provided to the resident. Emails and discussions with the staff and the resident verified that an explanation of Liability Notices and Beneficiary Appeals Rights Review were provided in a timely manner before Medicare A coverage was discontinued. However, copies of the notices were not retained at the facility. The staff responsible for issuing notices related to reduction or denial of Medicare benefits have been educated on the documentation/filing procedures.

The Office Manager will be responsible for monitoring compliance. Resident records will be audited for two months to verify completion of required Medicare notification and documentation. Random audits will be ongoing.

Completion Date: February 22, 2014

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	245409	A. BUILDING _____ B. WING _____ FEB 11 2014	01/13/2014

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F 156	Continued From page 3 for the documentation. During an interview on 1/1014 at 8:30 a.m., BOA-E stated that they had still not found documentation for R87's liability and appeal rights notice. A facility policy titled Medicare Notice of Denial and Expedited Decision Notice, revised on 9/16/10, indicated that the office manager or office manager assistant would complete the appropriate denial notice and that all original notices would be filed in the resident's financial folder in the business office. All letters should be given or mailed at least 48 hours (a required notice period) before being taken off a skilled level of care.	F 156		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to fully investigate and promptly resolve a grievance related to missing personal property for 1 of 2 residents (R14) reviewed for missing personal property. Findings include: R14 had informed the staff that they were missing an electric wheelchair. However, the facility had not fully investigated and inform their findings to R14 about their findings.	F 166	See Attachment #2	2/22/14

Attachment 2

Regulation 483.10(f)(2) Tag F166
Resolution of Grievances

Maple Manor Healthcare and Rehabilitation staff respects the residents' right to autonomy and choice and protects and promotes the residents' legal rights as well as their rights to privacy and a dignified existence. The facility encourages the residents to voice grievances about concerns in care and/or services and respects their right to have prompt efforts and follow up to resolve grievances and concerns.

After receiving a complaint/grievance, the facility strives to seek a resolution in a timely manner and keeps the resident appropriately apprised of its progress toward resolution. The residents/families are encouraged to voice concerns during the interdisciplinary care planning conferences.

The policies and procedures for responding to residents' grievances were reviewed and found appropriate. Resident/family grievances and the staff response to the concern will continue to be tracked by the Social Worker. Residents' grievances and concerns are routinely reviewed during the shift-to-shift reports, quarterly care conferences, and the quarterly Quality Assurance Committee meetings. Residents will be asked about their satisfaction with follow up to reports of missing items during the resident council meetings. To ensure timely follow up to resident concerns, the Social Worker will be tracking grievances and monitoring facility interventions.

During the mandatory meetings January 21, 22 and February 12, 13, 2014, the staff were/will be reinstructed on the facility's policies and procedures for handling resident grievances/concerns and the responsibility of all staff to appropriately report resident grievances/concerns including missing items.

Resident number 14 – The resident's allegation that the power wheelchair she is currently using does not belong to her was thoroughly investigated by the administrator and social worker. The resident has had four admissions to the facility with the most recent being August 4, 2008. The resident originally had two power wheelchairs–one gray and one red. Several years ago during the process of downsizing from an apartment to the long-term care facility, the resident sold the red chair and the facility offered to store the gray chair which was marked with her name. As she requested, two years later the power wheelchair was removed from storage for her use. After seeing the chair, she expressed no concerns about ownership and willingly paid for a repair to the chair. Several staff members distinctly remember the circumstances of the selling and storage of the power wheelchairs and were able to verify that the gray chair belongs to her.

During the December 5, 2013 discussion with the Social Worker, the resident questioned whether the gray chair was hers. Without prompting, she related that she had sold her red chair. After the social worker reviewed the circumstances and showed her that the gray chair was marked with her name, she agreed it must be hers. Since the resident confirmed that the chair was hers, the facility did not pursue the grievance procedure or missing item protocol. If the resident expresses further concern regarding the ownership of the wheelchair, the social worker and/or the administrator will counsel with and reassure her that the gray wheelchair is hers.

The Social Worker will monitor for compliance by routinely asking members of the Resident Council for feedback on their satisfaction with the handling of grievances/concerns. The residents/families will continue to be asked about their satisfaction with follow up to grievances/concerns during the quarterly care conferences. Compliance will be reviewed during the April 2014 Quality Assurance Committee meeting and ongoing.

Date of Completion: February 22, 2014

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	245409	A. BUILDING _____ B. WING _____ FEB 11 2014	01/13/2014

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F 166	Continued From page 4 During interview on 1/7/14, at 4:43 p.m., R14 reported she had a missing power wheelchair and informed staff of it being lost. Review of R14's quarterly progress note dated 11/25/13, indicated R14 was alert and oriented, able to voice needs and make her own decisions. The quarterly Minimum Data Set (MDS) dated 11/27/13, indicated R14 had a Brief Interview for Mental Status (BIMS, a tool used to determine cognitive loss) score of 15 out of 15, which indicated no cognitive impairment. The MDS further indicated R14 had no communication barriers, and had no episodes of hallucinations, delusions or acute onset of mental problems. Licensed social worker (LSW) progress notes were reviewed and revealed a LSW note dated 12/5/13, had identified R14 had reported the power wheelchair (WC) that was brought to her to use had not belonged to her. The note indicated the WC had R14's name on it in two different places, and had been in storage for two years during which time R14 had not seen it. The note indicated R14 had voiced concern that her WC had been switched with another chair. During interview on 1/9/14, at 1:00 p.m. R14 reported the facility had been storing her electric WC, and when she had requested it be taken out of storage for use the facility brought her a different WC. R14 stated, "They keep telling me the chair has my name on it so I guess I should just agree with them. This chair is gray; my chair was red with tan." During observation on 1/9/14, at 6:42 a.m. a gray electric WC was noted in R14's room. The WC had two large stickers with R14's name printed on	F 166		

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F 166	Continued From page 5 the sticker. On asking the facility for information on resolving R14's grievance, none was provided. During interview on 1/10/14, at 11:47 a.m. LSW stated R14 had talked about the power WC on 12/5/13. LSW indicated the gray WC in the residents room belonged to R14 because it had her name on it in two different places. LSW stated the facility had made no attempts to look for a red and tan WC and verified the grievance had not been documented, a complaint form had not been filed and an investigation had not been completed. LSW stated, "Because it was her wheel chair so I didn't think a form needed to be filled out." LSW was unable to report what the facility is doing to resolve R14 ' s grievance. During interview on 1/10/14, at 12:40 p.m. environmental service director (ESD) reported he first became aware of R14's complaint "four or five weeks ago" and the complaint had been "on-going." ESD verified the facility had not looked for a red and tan chair because the staff felt the gray chair belonged to R14. On 1/10/14, at 12:46 p.m. the administrator verified the facility had not followed the missing personal belongings policy and procedure when R14 reported her WC missing. During review of missing resident personal belongings policy dated 10/20/06, directed social service to search for the missing item in an appropriate area, fill out a resident complaint form upon notification of missing item and the complaint form and conclusion to be sent to family within 10 business days.	F 166		

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F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a homelike dining experience for 6 of 57 residents (R70, R35, R58, R39, R57 and R3) during the dining experience. Findings include: R70, R35, R58, R39, R57 and R3 had been observed to have the plastic food tray left under the food items during the time they ate the food. This practice was observed in both the main and north dining rooms which was an institutional type dining experience for residents and not homelike. During meal observation in the main dining room on 1/8/14, at 8:31 a.m., R70, R35 and R58 were sitting at the table with food on the plastic trays setting on the table in front of them while eating. During meal observation in the north dining room on 1/8/14, at 9:05 a.m., R39 had been observed to have a plastic food tray setting on table in front of the resident while eating independently. During meal observation in the main dining room on 1/9/14, at 7:17 a.m., R57, R3, R70, R40, R35 sitting at the assisted table had been observed to have the plastic food trays setting on the table in front of them while eating. During interview on 1/10/14, at 1:00 p.m., administrator stated no residents should have trays unless they ask for them. During interview on 1/10/14, at 1:10 p.m., dietary	F 252	See Attachment #3	2/22/14

Attachment 3

Regulation 483.15(h) 483.10(l) Tag F252
Homelike Environment

Maple Manor Health Care and Rehabilitation provides residents with a safe, clean, comfortable and homelike environment. Resident rooms and common areas are designed to optimize nursing care delivery, comfort, cleanliness, privacy and dignity of the residents.

The facility allows the resident to use personal belongings and encourage practices that support a homelike environment. The individuality and autonomy of the resident are recognized and respected, an opportunity for self-expression is provided, and links with the past and family members are encouraged. The staff is committed to provide an environment that enhances quality of life for residents, in accordance with resident preferences and strives to provide person-centered care that emphasizes individualization, relationships and a psychosocial environment that welcomes each resident and makes her/him comfortable.

During the mandatory training meetings, the importance of a dignified and homelike dining experience was reinforced. The dietary and nursing staff were instructed to remove all food and eating utensils from the transport trays when serving residents. If the resident requests, that food/utensils may be left on the tray–this preference will be respected and included in the resident's plan of care.

Compliance will be monitored by the dietary manager through dining room observations three times per week for one month with ongoing random monitoring. If noncompliance is noted, additional auditing and staff education will be done.

Completion date: February 22, 2014

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	245409	A. BUILDING _____ B. WING _____	01/13/2014

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F 252	Continued From page 7 manager stated only two residents are care planned for use of trays. Dietary manager stated main dining room not to have trays except if the resident asked for them since they started to dish food from steam table the tray is removed when food is set on table, the north dining room has trays and the food had not been removed from trays because they are set up and delivered to the unit on trays.	F 252		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272	See Attachment #4	2/22/14

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	245409	A. BUILDING _____ B. WING _____	01/13/2014

FEB 11 2014
MN Dept of Health
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F 272	Continued From page 8 Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess a resident's fall risk at the time of admission for 1 of 3 residents (R91) reviewed for falls. Findings include: R91 was admitted with a history of falls, but was not comprehensively assessed for risk of falls. R91 was admitted 9/13/13 as noted on the face page. On a physician's note dated 9/13/13, R91 had diagnoses listed that included Parkinson's disease with Lewy Body dementia, progressive lower extremity weakness with recurrent falls. The physician's admission exam was faxed to the facility on 9/13/13 at 11:00 a.m. The physician had indicated R91 had fallen 2 to 3 times a day. The physical therapy evaluation dated 9/13/13 indicated R91 was a fall risk. The Tinetti Assessment Tool (used to evaluate gait and balance) dated 9/16/13 indicated that based on balance and gait evaluation scores R91 was at a high risk for falls.	F 272		

Attachment 4

Regulation 483.20 (b) Tag F272
Comprehensive Assessments

The interdisciplinary care planning team at Maple Manor Healthcare and Rehabilitation conducts a comprehensive assessment of each resident's needs. The assessment (1) is based on a uniform data set specified by the Secretary of Health and Human Services and approved by the State and (2) describes the resident's capability to perform daily life functions and significant impairments in functional capacity. The staff will continue to routinely assess the residents' condition upon admission, if a significant change occurs, and no less than every three months, and more often as needed, to assure necessary follow up and timely revisions of the plan of care.

The policies and procedures for assessing the residents' fall risks were reviewed and found appropriate. At the time of admission, during the interdisciplinary team care plan reviews, and whenever there is a change in condition, the residents' fall risks are reassessed. Referrals are made to the physician and/or physical/occupational therapist when there is an increase in safety risk or a decline or a potential for improvement in mobility/safety. The resident's care plan is modified as necessary to assure maximum safety and function as well as minimal risk of injury and adverse clinical outcomes.

During the mandatory staff meetings January 22 and February 12, 2014, the licensed nurses were reinstructed on the 1) facility policy requiring specified assessments at the time of admission and 2) procedures for completing the fall risk assessments.

Resident number 91 - On January 2, 2014 the resident's fall risk was comprehensively reassessed by the interdisciplinary team including the resident's fall history, medications, cognitive/mental status, mobility impairments and predisposing diseases. The causal factors of the falls have been investigated and the type and effectiveness of safety interventions evaluated. The circumstances of any future falls will be reviewed by the care team and the effectiveness of current safety interventions and the need for additional interventions will be assessed. The care plan has been updated and will be revised as necessary to reflect changes in safety interventions.

The MDS Coordinator will monitor compliance by conducting chart audits to assure completion of admission fall assessments for one month. If noncompliance is noted additional auditing and staff education will be done. Compliance will be reviewed during the April Quality Assurance and Assessment committee meeting and ongoing.

Completion date: February 22, 2014

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F 272	Continued From page 9 Review of the admission Minimum Data Set (MDS) dated 9/19/13 indicated R91 had not fallen the six months prior to admission. Further review of the medical record did not reveal a comprehensive fall risk assessment had been completed during the fourteen day assessment period in completing the admission MDS. During an interview on 1/9/14 at 10:00 a.m. the registered nurse (RN)-A a clinical manager indicated he was unaware R91 had a history of falling prior to admission to the facility. At 10:20 a.m. on 1/9/14 the RN-C a MDS coordinator stated she did not know the resident had fallen prior to admission and had not found an admission fall risk assessment. On 1/9/14 at 11:10 a.m. RN-C stated a comprehensive fall risk assessment had not been completed at the time of admission.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280	See Attachment #5	2/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____ FEB 11 2014	01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR HEALTHCARE & REHAB	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

MN Dept of Health Rochester

(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 280	Continued From page 10 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to revise care plans when a change in health status for 1 of 3 residents (R91) reviewed for falls, for 1 of 3 residents (R65) reviewed for pain and for 1 of 2 residents (R1) reviewed for pressure ulcers. Findings include: R91 did not have care plan revisions that included identified fall risk interventions. R91 was admitted 9/13/13. On a physician ' s note of 9/13/13, R91 had diagnoses listed that included Parkinson ' s Disease with Lewy Body dementia, progressive lower extremity weakness with recurrent falls. The care plan dated 1/9/2014 identified R91 at risk for falls due to lower extremity weakness, dementia, and Parkinson's disease. Interventions directed staff to: 1. assist with front wheeled walker for transfers, ambulation, toileting, etc.; 2. call light within reach; 3. Anticipate needs; 4. low bed; 5. Urinal at bedside; 6. perimeter mattress. The nursing assistant worksheet provided 1/9/14 noted R91 was a "fall risk: call light within reach. Anticipate needs. Low bed. 11/12/13 perimeter air mattress." The nursing assistant worksheet also directed under the heading transfer/mobility to 10/1/13 transfer with assist of front wheeled	F 280		

Attachment 5

Regulation 483.20 (d)(3) 483.10(k)(2) Tag F280
Comprehensive Care Plans

Maple Manor Healthcare and Rehab staff develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents' functional abilities and quality of life. The residents and their families/legal representative are encouraged to participate in the care planning process and the quarterly care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary.

During mandatory meetings January 22 and February 12, 2014, the nursing staff were/will be 1) informed of the regulatory requirement that the residents' care plans be current at all times 2) reinstructed on the facility policies for care plan reviews and updates and 3) reminded of the importance of facilitating accurate care plans by communicating the resident's care/condition changes to the clinical manager in a timely manner.

Resident number 91 – The resident's fall risk has been reassessed and the care plan updated to reflect safety interventions to reduce the risk of falls and injury. The resident's fall risk will be reassessed at least quarterly and the care plan updated as appropriate.

Resident number 65 - The resident's care plan has been updated to address arm pain as well as interventions to minimize discomfort. The resident's pain will be monitored on an ongoing basis and the plan of care updated as necessary.

Resident number 1 – The resident's skin condition had shown improvement; the tissue tolerance evaluation indicates that the repositioning interval could be changed to from every hour to every two hours. The care plan and resident care guides have been updated accordingly.

To monitor compliance the Director of Nursing/Designee will conduct random audits of care plans weekly for two months. If care plan omissions or inaccuracies are identified, additional care plan audits and staff training will be done. As part of the quarterly care plan review process, the interdisciplinary team and MDS Coordinator will continue to review the plans of care for completeness, accuracy, and relevancy quarterly and with a significant change in condition. Compliance will be reviewed during the April 2014 Assessment and Assurance Committee meeting.

Completion date: February 22, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	01/13/2014

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MAPLE MANOR HEALTHCARE & REHAB	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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F 280	Continued From page 11 walker to and from bed and use wheelchair to toilet and ambulation with therapies only. Also the nursing assistant worksheet under continence heading included to: prompt/assist to toilet every 1 hour and as needed and urinal at bedside. The clinical manager's fall incident notes were reviewed. · Clinical notes of 9/30/13 documented tested for urinary tract infections (UTIs) but staff not instructed on care plan to observe for UTIs. Clinical note also noted the fitting of a foot/leg brace that was not identified on the care plan or nursing assistant worksheet. On 10/2/13 the IDT discussion noted apply socks and shoes. This intervention was not identified on the care plan or nursing assistant worksheet. · Clinical note of 12/16/13 documented pain assessed and use of pain medications added. Bladder scans reviewed and increased. Neither intervention was added to the care plan or nursing assistant worksheet. · Clinical notes of 12/31/13 documented applied strip of dicem to prevent slipping from wheelchair. The intervention was not added to the care plan or nursing assistant worksheet. During a telephone interview on 1/13/14 at 8:10 a.m. registered nurse (RN)-A a clinical nurse manager stated that interventions noted in his clinical notes were to be added to the care plan and the nursing assistant work sheet. R65's comprehensive care plan had not been revised to include diagnosis of left distal radius (bone located from elbow to the thumb) fracture and use of Royce splint.	F 280		

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F 280	Continued From page 12 During interview on 1/7/14, at 7:01 p.m., resident stated arm hurts and had been broken. During observation on 1/9/14, at 3:00 p.m., R65 rested in bed and had splint on left arm. R65's primary care internal med nursing home physician progress note dated 12/5/13, identified diagnoses pain management status post left distal radius fracture. R65's physician orders dated 12/23/13 identified an order for Royce splint and to wean out over the next ten to fourteen days, recheck with x-rays at three months and activities as tolerated. R65's quarterly pain assessment dated 12/5/13, identified resident experienced a fall on 11/7/13 in which resident fractured left distal radius, pain daily, interferes with sleeping at times, relieved by med, elevate, body actions protecting area, vocalizations cursing. R65's care plan dated 10/15/13, identified at risk for pain related to Lumbago (lower back pain which is often chronic) and approaches of offer pain medication, medications per orders, report verbal or facial signs of pain to nurse, nurse to report to physician of any unresolved pain as soon as possible, offer non-pharmacological interventions quiet room, repositioning, soft music, etc. However, R65's care plan did not include information about the left distal fracture nor interventions (which included the use of the splint) to promote healing and prevent further injury. During interview on 1/10/14, at 2:30 p.m., director	F 280		

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F 280	Continued From page 13 of nursing stated she would expect the care plan to be updated at the time an assessment is completed. R1's comprehensive care plan had not been revised to include appropriate repositioning schedule following comprehensive skin assessment. During continuous observation on 1/9/14, R1 had been observed to be sitting in wheelchair from 10:42 a.m. until 12:47 p.m. R1 had been admitted on 9/11/13. R1's quarterly Minimum Data Set (MDS) dated 12/17/13, identified diagnosis of diabetes mellitus, aphasia, dementia, paraplegia, risk of pressure ulcer, pressure reducing device in chair and bed. R1's Tissue Tolerance Evaluation dated 12/6/13, identified assist to reposition sitting and lying every two hours and as needed. R1's certified nursing assistant (CNA) pocket care plan sheet identified assist to reposition every one hour and as needed. R1' s care plan dated 9/23/13, identified at risk for skin breakdown related to needing assist with bed mobility, incontinence and approach of offload every hour and as needed. During interview on 1/9/14, at 12:49 P.M., CNA-D stated R1 is to be repositioned every two hours. CNA-D showed CNA pocket care plan to surveyor and verified CNA pocket care plan read assist to reposition R1 every one hour and as needed. However, the CAN pocket care plan had not been updated to read every two hours for repositioning	F 280		

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F 280	Continued From page 14 based on the skin assessment done on 12/6/13. During interview on 1/9/14, at 12:52 p.m., registered nurse (RN)-A verified Tissue Tolerance Evaluation dated 12/6/13 read reposition R1 sitting and lying every two hours and as needed, R1's care plan read offload every hour and as needed. RN-A verified R1 ' s care plan had not been updated to reflect assessment. During interview on 1/10/14, at 2:30 p.m., director of nursing stated she would expect the care plan to be updated at the time an assessment is completed. Document review of the facility CARE PLAN dated 1/19/12, read "Care Plan Updates: 1. The Social Services Director shall notify other departments of care plan reviews. The nursing department shall formerly update care plans every 90 days and PRN [as needed] of care residents. It is important to note that care plans should always be updated when the patient's condition warrants. These care plan changes may be done by nursing administration and charge nurses. This approach is consistent with the facilities goal of providing its staff with a comprehensive working tool which reflects the patient's current needs and problems."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	See Attachment #6	2/22/14

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F 282	Continued From page 15 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 (R91) reviewed for restorative nursing program. Findings include: R91 did not receive restorative nursing services in accordance with the plan of care. R91 was admitted to the facility in September 2013. On a physician's note of 9/13/13, R91 had diagnoses listed that included Parkinson's disease with Lewy Body dementia, progressive lower extremity weakness with recurrent falls. R91 was observed on 1/8/14 at 2:30 p.m. sitting in a lift recliner chair with the lift control on lap. Nursing staff entered the room to replace pitcher of water, but did not offer to provide restorative nursing exercises. During an interview on 1/9/14 at 10:30 a.m. R91 stated that no one assisted with exercises but would like to have that happen. The nursing assistant work sheet provides 1/8/14 had a note dated 11/21/13 that directed "provide seated LE [lower extremity] exercise " and to have R91 "stand w [with]/staff at rail for 1 min [minute]. All exercises 1 x daily." The care plan dated 1/9/14 identified a problem of "requires assistance with ADLs [activities of daily living] " and had interventions dated 11/21/13 directing staff to provided seated lower extremity exercise and to have R91 stand by the rail once a day. Physical therapy notes dated 11/20/13 documented nursing to provide seated exercises for lower extremity strengthening, 20 repetitions	F 282		

Attachment 6

Regulation 483.20(k)(3)(ii) Tag F282
Services by Qualified Personnel per Care Plan

Maple Manor Healthcare and Rehabilitation assures that services are provided that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each resident's written plan of care. The interdisciplinary care planning team 1) uses an assessment process to develop an individualized care plan for each resident that supports the highest practicable level of function and well-being 2) implements procedures and practices as outlined in the plan 3) reviews the plan at least quarterly and with significant changes in condition and 4) makes modifications as necessary.

Policies and procedures for providing nursing restorative/functional maintenance services were drafted. Based on the comprehensive resident assessment and recommendations from the therapists, a plan of care will be developed with the goal to improve/maintain the resident's functional status. The interdisciplinary care team will review the residents' restorative/maintenance plan of care at least quarterly and with significant changes in condition; revisions to the plan will be made as necessary.

During the mandatory training meetings, January 21, 22 and February 12, 13, 2014, the nursing staff were/will be reminded/instructed that the plans of care must be followed and that job performance expectations include being aware of and following the resident's plan of care. The policies and procedures for providing restorative/functional maintenance services and documenting the provision of cares were reviewed.

Resident number 91 – On January 3, 2014, the nurse practitioner ordered the physical therapist to evaluate and treat the resident. At the conclusion of the physical therapy rehabilitative treatments, the resident will be reassessed by the interdisciplinary team. Based on the assessment and the recommendations of the physical therapist, a nursing restorative/functional maintenance plan of care will be developed. The licensed nurses and direct care staff will be notified and the resident's care plan and nursing assistant care guides will be updated accordingly.

During the weekly interdisciplinary team meeting, residents with therapy recommendations for nursing restorative/maintenance services and residents with changes in functional status will be assessed and restorative/maintenance nursing services will be initiated as appropriate. The interdisciplinary care team will continue to assess the need for and the appropriateness of restorative/maintenance nursing services during the quarterly care reviews. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed at the 2014 April quarterly Quality Assurance Committee meeting.

Completion date: February 22, 2014

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F 282	Continued From page 16 daily. Resident to stand at hall rails with wheelchair behind the resident for 1 minute daily. The occupational therapist (OTR) was interviewed on 1/9/14 at 7:30 a.m. and noted that OTR had developed a nursing restorative program for upper body strengthening when R91 was discharged from OT. PT and OTR were interviewed on 1/9/14 at 11:00 a.m. and both stated they would except that nursing would do the specific exercise program and that the exercise program was to be done as written-daily Licensed practical nurse (LPN)-C was interviewed on 1/9/14 at 8:00 a.m. and stated that when restorative nursing was completed for the resident it would be documented in the treatment book. Nursing assistants complete the restorative program and document in the treatment book. The treatment sheets for November December 2013, and January 2014 were reviewed and identified a restorative nursing program plan for R91 dated 11/21/13 and to provide lower extremity strengthening. However, no documentation was found that the program plan had been completed. Nursing Assistant (NA)-A was interviewed on 1/9/14 at 12:30 p.m. and stated she did care for R91. NA-A stated she did not always assist R91 with the exercises, but if NA-A did help with the exercises it would be document in the NA charting binder. The restorative nursing treatment sheet for November, December 2013, and January 2014 were provided and did not indicate the restorative exercises had been provided for R91. During an interview on 1/10/14 at 8:30 a.m. registered nurse (RN)-C the Minimum Data Set coordinator indicated the restorative nursing treatment sheet actually indicated the restorative	F 282		

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F 282	Continued From page 17 services had not been provided. During an interview on 1/9/14 at 8:10 a.m. registered nurse (RN)-A a clinical manager also verified that a restorative nursing program had not been charted as having been completed and would look for other documentation. During an interview on 1/9/14 at 10:50 a.m. RN-A stated the facility had no functioning restorative nursing program at this time. Also RN-A was unable to provide information that R91 had not received physical therapy per nursing for the past three months nor could a policy for nursing rehabilitation services be provided. On 1/10/14 at 10:00 a.m. the director of nursing verified the facility did not have a functioning restorative nursing program.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 observations, interview, and record review, the facility failed to provide grooming assistance for a resident that was unable to provide personal hygiene cares of shaving for 1 of 3 residents (R26) reviewed for grooming and cleanliness. Findings include: R26 did not receive assistance	F 312	See Attachment #7	2/22/14

Attachment 7

Regulation 483.25(a)(3) Tag F312
Activities of Daily Living Care

Maple Manor Healthcare and Rehabilitation provides the necessary services to maintain good nutrition, grooming, personal care and oral hygiene for residents who are unable to carry out activities of daily living independently. Based on the comprehensive resident assessment, the staff provides cares which assist the resident to maintain and enhance his/her self-esteem and self-worth including assistance with removal of facial hair according to resident preferences and as outlined in the plan of care. The residents' need for assistance with personal hygiene is reassessed quarterly and with significant changes in condition. The plan of care is revised as necessary.

During the mandatory meetings January 21, 22 and February 12, 13, 2014, the nursing staff were/will be 1) reinstructed on the facility's policies for providing personal hygiene to the residents 2) reminded that their job description requires knowledge of and responsibility for following the residents' plans of care and 3) instructed on the importance of shaving female residents with excessive facial hair unless the resident/legal representative prefers otherwise. The need to provide cares as necessary to improve/enhance the residents' appearance, comfort, and dignity including shaving of female residents was emphasized.

The grooming plan of care for resident number 26 was reviewed and revised to include routine shaving of the resident's chin hairs. The nursing assistant care guide has been updated accordingly.

The Clinical Manager will be responsible for monitoring compliance by randomly checking face hygiene for two weeks. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed at the April 2014 quarterly Quality Assurance Committee meeting.

Completion Date: February 22, 2014

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F 312	Continued From page 18 with removing facial hair. R26 ' s care plan dated 1/9/2014 indicated R26 was admitted 12/8/10 and had diagnoses that included debility, dementia, and osteoporosis. Also R26 ' s Care plan dated 1/9/14 directed staff to observe skin with cares, keep clean and dry, lotion with cares. The nursing assistant work sheet provided 1/9/14 noted R26 was to have a bath every Wednesday morning, to assist with oral care twice a day, and use Vanicream to skin at bedtime. R26 was observed on 1/7/14 at 4:34 p.m. sitting at the wheelchair at the dining room table and was noted to have visible chin hair. Again R26 was observed on 1/7/14 at 6:40 p.m. and noted to have visible chin hairs. On Wednesday 1/8/14 at 3:30 p.m. R26 was sitting in bedroom in wheelchair in front of the TV and again had visible chin hair that had not been removed for the past two days. On 1/9/14 at 7:45 a.m. R26 was sitting in the wheelchair in the dining room and had visible facial hair that had not been removed for the past three days. The skin audit sheet dated 1/8/14 (Wednesday) indicated R26 had received a bath on that date. The skin audit sheet did not indicate R26 had been removed. Nursing assistant (NA)-B was interviewed on 1/9/14 at 7:45 a.m. and stated R26 was assisted to get up in the morning by the overnight staff and verified the resident had facial hair and needed to be shave. The annual Minimum Data Set (MDS) dated 11/24/13 indicated R26 required extensive	F 312		

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F 312	Continued From page 19 assistance of staff to complete personal hygiene. During an interview on 1/9/14 at 8:20 a.m. registered nurse (RN)-A clinical manager was interviewed and stated female shaving was by individual preference or family request if the resident was not able to request self. Licensed practical nurse (LPN)-B was interviewed on 1/9/14 at 8:25 a.m. and stated she would expect the nursing assistants to shave the female residents.	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess a resident's fall risk at the time of admission for 1 of 3 residents (R91) reviewed for history of frequent falls. In addition the facility failed to ensure hazardous chemicals were secured from several cognitively impaired resident access who had free access to the chemical located in the bathing area. Finding include: R91 was admitted 9/13/13. On a physician's note of 9/13/13, R91 had diagnoses	F 323	See Attachment #8	2/22/14

Attachment 8

483.25 (h)(1) Tag F323
Accidents and Supervision

Maple Manor Healthcare and Rehabilitation ensures that the residents' environment remains safe and as free of accident hazards as possible. The facility identifies each resident at risk for accidents and develops a plan of care addressing safety issues and implements procedures to prevent accidents and incidents. Hazardous materials are secured and stored in a manner that prevents resident access/exposure.

FALL RISK ASSESSMENTS

The use of and need for safety devices for all residents are assessed at admission and reassessed during the interdisciplinary care planning conferences and whenever there is a change in the resident's behavior, physical condition, and/or mental function. The resident's care plan is modified as necessary to assure maximum safety and minimal risk of injury. The policies and procedures related to assessing the resident's risk of falls was reviewed and found appropriate. An assessment of fall risk will continue to be done at the time of admission.

During the mandatory meetings January 21, 22 and February 12, 13, 2014, the licensed nurses and direct care staff were/will be reinstructed on 1) the importance of providing a safe environment for residents 2) the facility's policy requiring specified assessments at the time of admission 3) the procedures for completing the fall risk assessments and 4) the need to assess the resident's need for safety interventions/devices and routinely evaluate their effectiveness.

Resident number 91 - On January 2, 2014 the resident's fall risk was comprehensively reassessed by the interdisciplinary team including the resident's fall history, medications, cognitive/mental status, mobility impairments and predisposing diseases. The causal factors of the falls have been investigated and the type and effectiveness of safety interventions evaluated. The circumstances of any future falls will be reviewed by the care team and the effectiveness of current safety interventions and the need for additional interventions will be assessed. The care plan has been updated and will be revised as necessary to reflect changes in safety interventions.

The use of the resident's personal lift recliner chair was assessed. The resident infrequently uses the recliner. Due to safety concerns related to the resident's cognitive decline, the chair will be unplugged to disable the electric reclining feature and the staff will discuss with the family whether the lift recliner should be removed from the room.

SECURING HAZARDOUS CHEMICALS

The north hallway shower room has a secure locked cupboard to store hygiene items and hazardous materials such as cleaners and disinfectants. During the mandatory meetings January 21, 22 and February 12, 13, 2014, the staff were/will be reinstructed on the facility's policies for securing substances that could be harmful to the residents. Instruction on the appropriate storage of hazardous materials is included in the new employee orientation and is addressed during the required annual safety training.

The MDS Coordinator will monitor compliance with the required assessments by conducting chart audits to assure completion of admission fall assessments for one month. The Director of Nurses/designee will monitor the tub rooms to assure safe storage of cleansers/chemicals three times per week for two weeks. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the April 2014 quarterly Quality Assurance and Assessment committee meeting.

Completion date: February 22, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR HEALTHCARE & REHAB	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 323	Continued From page 20 listed that included Parkinson's disease with Lewy Body dementia, progressive lower extremity weakness with recurrent falls. R91 was observed and interviewed on 1/8/14 at 2:30 p.m. R91 was observed sitting in a lift recline chair. The lift control resting on lap along with the call light. R91 stated they had fallen a couple of time by sliding off wheelchair or out of bed. R91 stated legs and feet were numb and that R91 did not have very good control. R91 also said that he forgets to use call light for help when doing stuff. R91 stated the bed was not always level and sometimes lower and sometimes higher than currently. R91 stated needed to be able to grab something sturdy to come to a standing position. R91 stated when they had slipped off bed at night there was a space between the bed and the wall. R91 has a lip mattress but is ok with it. The admission Minimum Data Set (MDS) dated 9/19/13 indicated R91 had a BIMS (Brief Interview of Mental Status) score of 15/15 or no cognitive impairment. During the quarterly MDS dated 12/15/13 R91 had a BIMS score of 12/15 or mild cognitive impairment. The admission MDS noted that R91 required limited assist with bed mobility, transfer and activities of daily living, but the quarterly MDS noted R91 required extensive assistance with bed mobility and transfer mobility. The admission MDS lacked a comprehensive falls risk assessment even though R91 had a history of frequent falls at home and admission was due to frequent falls and safety concerns. On 1/9/14 at 11:10 a.m. registered nurse (RN)-A clinical manager stated a comprehensive fall risk assessment had not been completed at the time	F 323		

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F 323	Continued From page 21 of admission. RN-A was interviewed by telephone on 1/13/14 at 8:00 am. He stated the resident was admitted with multiple falls. RN/CM stated R91 had not fallen out of lift recliner, but that the recliner had not been assessed for safe use. HAZARDOUS CHEMICALS: The Classic Whirlpool Disinfectant Cleaner was not secured safely from cognitively impaired resident access which had the potential to cause harm to the resident if swallowed. On 1/7/14 at 4:40 p.m. the north hallway shower room door was open and the light in the room was on. The whirlpool cleanser was sitting on top of the garbage can beside a similar bottle of shampoo. The whirlpool cleanser was within reach of any resident walking or in a wheelchair. On 1/7/14 at 6:46 p.m. the whirlpool cleanser remained within reach on top of the garbage can with the soap bottle beside it. Residents with dementia were noted to be wheeling independently within the hallway and going by the shower room door. On 1/8/14 at 7:30 a.m. the whirlpool cleaners remained on the garbage can beside the soap container. At 3:45 p.m. on 1/8/14 the whirlpool cleaner was again located on the garbage can and in reach by residents. Nursing Assistant (NA)-F stated the shower room was used as a bathing area for the north hall residents. NA-F stated the whirlpool cleanser was also used to clean the shower. NA-F stated the cleaner and shampoo was to be kept in the cupboard beside the whirlpool. On 1/8/14 at 4:15 p.m. the director of nursing	F 323		

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F 323	Continued From page 22 indicated the whirlpool cleaner was not being out and accessible to residents. The material safety data sheet (MSDS) dated 7/9/10 was provided. MSDS indicated the classic whirlpool disinfectant cleaner would cause eye irritation, skin irritation and would be harmful if swallowed or if a spray mist was inhaled.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sanitary conditions were maintained related to food storage, food preparation area cleanliness and failed to maintain equipment in a clean and sanitary manner to prevent food borne illness. This had the potential to affect 55 of 57 residents residing in the facility. Findings include: On 1/7/14, at 2:30 p.m. an initial tour of the kitchen was conducted with dietary manager (DM) present. The following was observed during	F 371	See Attachment #9	2/22/14

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F 371	Continued From page 23 the tour: The ice machine observed to have a small ice scoop stored inside the ice bin sitting in the ice. DM indicated the ice machine was used for resident ' s ice water during meal time, and also for filling ice water glasses for residents. DM stated two boxes are located in the cupboard below the ice machine that the scoops are to be stored in. DM verified the ice scoop was not to be kept within the ice. A large stainless steel mixer was noted to be covered with a plastic cover. The plastic cover was removed and DM verified the mixer had dried yellow substance around the agitator shaft (feature on a mixer that attaches the mixing paddles/blades) which had the potential to flack off into the mixing bowl when food is mixed. DM stated the mixer should have been cleaned after each use. One stainless steel preparation counter had multiple splatters of dried yellow substances on the top of the counter and on the outside of the cabinet drawers and doors as this was noted after the noon meal preparation had been completed and the kitchen had been cleaned for the supper meal preparation service. DM verified the concern and stated the surfaces should have been cleaned after each use. The walk in refrigerator had seven bowels of prunes and three bowels of pureed fruit that were not covered or dated and a five pound bag of lettuce that had not been resealed. DM verified the concern and stated food should be covered and dated.	F 371		

Attachment 9

Regulation 483.35(l) Tag F371
Sanitary Food Preparation

Maple Manor Healthcare and Rehab stores, prepares, distributes, and serves food under sanitary conditions with the goal to provide the residents tasty, wholesome food in a homelike, dignified dining experience.

The kitchen and dining policies were reviewed. New policies were drafted addressing dining room hospitality and cleaning of small appliances. The policies and procedures addressing cold food storage were revised.

During the mandatory meetings January 27 and February 3 and 17, 2014, policies addressing the following were reviewed with the dietary staff: 1) food storage 2) labeling and dating of food 3) tray delivery 4) table/equipment cleaning 5) ice machine use/cleaning and 6) dish machine operation/cleaning. The procedures for storing of the ice scoop, labeling and covering food in the refrigerator/freezer, and cleaning of food preparation equipment/surfaces were emphasized. The dietary staff were instructed to follow the cleaning task schedules and complete the cleaning check sheet after tasks are completed.

Compliance with facility cleaning policies will be monitored by the dietary manager through direct observation of kitchen equipment and food preparation areas four times weekly for the next month and then randomly thereafter. Staff signatures verifying completion of cleaning tasks will be audited at least weekly. If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the April 2014 quarterly Quality Assurance Committee meeting.

Completion date: February 22, 2014

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F 371	Continued From page 24 The dietary Cleaning Schedule form listed daily tasks which included clean cupboards below coffee machine and ice machine, wipe coffee machine and ice machine down on Tuesdays. The walls to be wiped down and all counters cleaned on Fridays. During interview on 1/10/14, at 10:36 a.m. the DM verified the concerns and stated the kitchen cleaning schedule outlined daily tasks kitchen staff. A policy titled Labeling and dating of food items in refrigerators and freezers dated 10/19/89 read, "When there is a need to place food in the refrigerator or freezer it must be covered tightly. You should always label and date that particular item." A policy titled Dietary Cleaning Schedules dated 10/1/08 was reviewed and did not address specific cleaning tasks.	F 371		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a clean, sanitary and comfortable environment for residents, staff, and public in community area, dining rooms, shower rooms, kitchen, and resident rooms. This had the potential to affect 57 of 57 residents.	F 465	See Attachment #10	2/22/14

Attachment 10

Regulation 483.70(h) Tag F465
Safe, Sanitary, Comfortable Environment

It is the policy of Maple Manor Healthcare and Rehabilitation to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.

As part of an ongoing process to provide a pleasant, homelike environment, Maple Manor Healthcare and Rehabilitation has a schedule for routine cleaning, repairs, and maintenance of the facility. All staff members are expected to report environmental concerns to the appropriate administrative/supervisory staff.

During the mandatory meetings February 12 and 13, 2014, staff will be reminded to observe for equipment/furnishings/structures that need to be repaired, cleaned, or replaced. The procedures for reporting work items to the Environmental Services Director will be reviewed. The housekeepers and maintenance staff have been educated on the new cleaning/inspection polices and procedures.

RESIDENT CARE AREAS

An inspection of the cleanliness and condition of the walls, floors, furnishings and equipment in the lobby, dining rooms, hallways, tub rooms, therapy treatment areas, and utility rooms will be added to the list of monthly cleaning tasks. The staff member conducting the inspection will sign to verify completeness. The Environmental Services Director will provide monthly reports to the administrator which summarize maintenance requests, completed tasks, and the progress of ongoing projects.

The ceiling air vents in the north dining room and the wall exhaust vent in the north shower stall have been cleaned; vent cleaning has been added to the weekly preventive maintenance schedule. The staff member responsible for the task is now required to sign verifying its completion.

The cracked and missing tiles in shower rooms on the north, west and east hallways have been replaced. Corner guards will be installed to help prevent further damage. The wall on the right side of the sink and the darkened tiles/grout in the north shower stall have been cleaned.

The screws protruding from the wall in room 19 (vacant at time of survey tour) were from a previous resident's wall hangings. The screws were removed.

The hall way doors have had the chips repaired and have been painted and/or cleaned as necessary. The resident rooms are in the process of being deep cleaned and painted. This

process is expected to be completed by March 15, 2014. Inspection of the walls, ceilings, floors, and doors will be done during the monthly scheduled deep cleaning process. The staff will sign to verify completion of the inspection. Repairs/maintenance will be made as necessary.

KITCHEN

The lime buildup on the counter under the coffee maker and ice machine has been removed. Cleaning the counter has been added to the list of duties to be done after each meal.

The kitchen floors are mopped daily and will be deep cleaned every six months and more often if necessary. A deep cleaning is scheduled for February 12, 2014.

The soap residue has been cleaned from the wall behind the three compartment sink. The soap dispenser has been repaired the hose placement modified to reduce leakage. The grease collector tub has been cleaned and is scheduled to be repainted by February 13, 2014.

The cleaning schedules were revised to reflect more frequent cleaning of the counters and floors. During the mandatory meetings January 27 and February 3 and 17, 2014, the dietary staff were/will be instructed to follow the cleaning task schedules and complete the cleaning check sheet after tasks are completed.

MONITORING COMPLIANCE

The Environmental Services Director will monitor compliance by direct observation of the cleanliness and condition of the staff work areas, resident care areas and common areas of the facility weekly for one month. The environmental task completion checklists will be audited for completeness weekly for one month. After that random audits will be done.

Compliance with kitchen cleaning policies will be monitored by the dietary manager through direct observation of kitchen floors, walls, and equipment four times weekly for the next month and then randomly thereafter. Staff signatures verifying completion of cleaning tasks will be audited at least weekly.

If noncompliance is noted, additional auditing and staff education will be done. Compliance will be reviewed during the April 2014 quarterly Quality Assurance Committee meeting.

Completion date: February 22, 2014

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	245409	A. BUILDING _____ B. WING _____	01/13/2014

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F 465	Continued From page 25 Findings include: The north dining room was observed on 1/7/14 at 4:36 p.m. It was noted that the air vents located over a dining room table where residents ate their meal had a coat of debris/dust. This table was observed during the supper meal on 1/7/14 to seat four residents around the table and under the four dirty vents. During a tour with environmental services director (ESD) on 1/9/14 at 10:30 a.m. he stated these were air conditioning vents and currently not in operation. ESD stated the vents were usually cleaned in the spring time of the year, but he was not able to say when last cleaned. On 1/7/14 at 4:40 p.m. there were several tiles missing from the wall in the north shower stall. The remaining tiles were noted to be soiled and grout was blackened/browned in color. The wall exhaust vent was covered with dust and the wall to the right side of the sink was soiled and had multiple areas of soap on it. During the tour with the ESD on 1/9/14 at 10:30 a.m., the shower rooms located on the west and east hallways were also noted to have cracked and chipped tile in the shower stalls. ESD verified the tiles were cracked and that the north hallway shower stall needed repair. Also ESD verified that the shower could not be fully sanitized due to the missing and cracked tiles. During the tour with ESD on 1/9/14 at 10:30 a.m., room 19 was noted to have 8 screws protruding from the wall beside the resident's bed. EDS stated he was unaware of the screws and that they needed to be removed. During the tour with ESD on 1/9/14 at 10:30 a.m. hallway walls, doors ,resident room walls and doors, and mop boards were noted to be soiled, marred, and chipped. ESD stated that he would annually do a walk through to determine	F 465		

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F 465	Continued From page 26 preventative maintenance needed. EDS stated that he did the walk through in September 2013 in one hallway, but had not yet done the needed maintenance found during that tour nor had he looked at the other two hallways. During the interview on 1/914 at 10:30 a.m. ESD stated the facility had a system in place for general maintenance. He stated daily housekeeping would be done. The preventative program was outlined in policy/procedures, but EDS stated he did not maintain records when the work was completed. A maintenance request book was kept on each unit to notify maintenance of needed repairs. On 1/7/14, at 2:30 p.m. an initial tour of the kitchen was conducted with dietary manager (DM) present. The following was observed during the tour: The stainless steel counter which held a coffee maker and an ice machine had white marks which appeared as a fluid stain covering the top of the counter. DM verified the white marks were lime buildup stains. The flooring in the entire kitchen which included the dish washing area and hallway to the walk-in-cooler had heavy build-up of dark debris around the entire kitchen wall between the floor surface and base cove and grout. DM verified the concern and reported the floors are mopped daily, and thoroughly cleaned annually. The three compartment sink was observed to have multiple pots and pans with food debris sitting in the sink. The white tiled wall above the sink had an approximate 12 inch dried blue substance splattered on the wall and the	F 465		

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F 465	Continued From page 27 substance was dripping down into the stainless steel sink. DM verified and stated the blue substance was from a hand soap dispenser located on this wall. DM stated the soap dispenser leaked and stated the wall should be cleaned. A large tub used for grease noted sitting on floor under the three compartment sink. The tub had dark brownish raised debris on top and appeared greasy. DM verified the tub was soiled and reported the brown debris was chipped paint. DM stated, "When they painted it last they painted over the whole thing and when we lift the cover it pulls it off the paint seal." The dietary Cleaning Schedule form listed daily tasks which included cleaning cupboards below coffee machine and ice machine, wiping coffee machine and ice machine down on Tuesdays. The walls to be wiped down and all counters cleaned on Fridays. During interview on 1/10/14, at 10:36 a.m. the DM verified the concerns and stated the kitchen cleaning schedule outlined daily tasks for kitchen staff. A policy titled Dietary Cleaning Schedules dated 10/1/08 was reviewed and did not address specific cleaning tasks.	F 465		

STATEMENT OF COMPLIANCE

Maple Manor Health Care and Rehabilitation has been providing high quality services to the community for the past 50 years. The facility's policies and procedures have been developed over the years in accordance with State and Federal Regulations and community practice standards.

Maple Manor Health Care and Rehabilitation objects to and disagrees with both the findings of noncompliance and the level of deficiencies cited.

Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agent or other individuals who draft or may be discussed in the Credible Allegation of Compliance.

In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by this Facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegation by the survey agency.

Accordingly, this Credible Allegation of Compliance is being submitted solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare and Medical Assistance programs.

The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegation of noncompliance or admissions by the Facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Maple Manor Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POCok JB 2-11-14 RECEIVED FEB 10 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 2-22-14
EXIT: 1-13-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 2/7/14

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

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(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
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Maple Manor Nursing Home is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction, with a partial basement. In 1974, addition was constructed and was determined to be of Type II(111) construction, with a full basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 81 beds and had a census of 58 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/10/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR HEALTHCARE & REHAB	**1875 19TH STREET NORTHWEST** **ROCHESTER, MN 55901**

(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
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 071 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has a laundry chute that does not meet the requirements of Sections 19.5.4, 9.5 and 8.4 and 1999 NFPA 82 Section 3-2.5.. This deficient practice could affect 25 out of 56 residents. Finding include:	K 071		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 071	Continued From page 3 On facility tour between 10:00 AM and 12 Noon on 01/10/2014, observation revealed, that the soiled linen chute has a domestic sprinkler head at top of chute and the water supply is shut off. There is no NFPA 13 fire sprinkler head with-in the chute This deficient practice was confirmed by the Facility Maintenance Director (JT) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 071	On February 16, 2014, the Summit Fire Protection Company installed a sprinkler in the soiled linen chute in accordance with Chapter 19 of the Life Safety Code.	02/16/14