



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2024

Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

RE: CCN: 245462
Cycle Start Date: December 10, 2024

Dear Administrator:

On December 10, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

Maranatha Care Center

December 18, 2024

Page 2

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor

Fergus Falls District Office

Health Regulation Division

Minnesota Department of Health

2312 College Way

Fergus Falls, 56537

Email: leann.huseth@state.mn.us

Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 March 10, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by June 10, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

Maranatha Care Center

December 18, 2024

Page 4

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a loop at the end of the last name.

Kamala Fiske-Downing

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2024

Administrator
Maranatha Care Center
5409 69th Avenue North
Brooklyn Center, MN 55429

Re: State Nursing Home Licensing Orders
Event ID: VO6H11

Dear Administrator:

The above facility was surveyed on December 5, 2024 through December 10, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Maranatha Care Center

December 18, 2024

Page 2

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

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

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

LeAnn Huseth, RN, Regional Operations Supervisor

Fergus Falls District Office

Health Regulation Division

Minnesota Department of Health

2312 College Way

Fergus Falls, 56537

Email: leann.huseth@state.mn.us

Office: (218) 332-5140 Mobile: (218) 403-1100

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 12/31/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2024
--	---	--	---

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

(X4) ID PREFIX TAG	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	<p>INITIAL COMMENTS</p> <p>On 12/5/24, 12/6/24, and 12/10/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed.</p> <p>H54622044C (MN00108781 and MN00108755).</p> <p>As a result of the investigation, deficiencies were cited at F578, F684.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000		
F 578 SS=D	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or</p>	F 578		1/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 12/27/2024
---	-------	--------------------------------

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.

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

PRINTED: 12/31/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2024
NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	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 578	<p>Continued From page 1 inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure the Physician Orders for Life Sustaining Treatment (POLST) was reviewed and/or revised following a change in condition comprehensive assessment for 1 of 1 residents (R1) reviewed.</p>	F 578	<p>The identified residents with Change of condition were reviewed and addressed their POLST immediately with the family members and their providers House wide audit was completed on all resident POLSTs, and reviewed with the residents, families, and provider to ensure</p>	

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

PRINTED: 12/31/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2024
NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	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 578	<p>Continued From page 2</p> <p>Findings include:</p> <p>R1's significant change Minimal Data Set (MDS) dated 11/1/24, indicated R1 had diagnoses of chronic kidney disease, dementia, and malignant neoplasm of sigmoid colon. Further, R1's cognition was noted to be moderately impaired.</p> <p>R1's POLST dated 9/13/24, which was signed by R1's health care agent and family member (FM)-A, indicated R1's wishes were to be do not attempt resuscitation (DNR), allow natural death, in the event R1 had no pulse and was not breathing, as well as comfort-focused treatment (allow natural death) to relieve pain and suffering through the use of any medications by any route, positioning, wound care, and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.</p> <p>R1's care conference summary printed 12/5/24, indicated a care conference was held on 11/21/24, with FM-A present. Further, the document revealed information shared included code status of DNR and comfort-focused treatment and to see R1's POLST for details. In addition, the questions: advanced directives reviewed with the resident/resident representative and does the POLST match the code status order were left blank and not completed by staff. The summary lacked evidence the POLST was reviewed with resident/resident representative. However, on 12/6/24, summary revealed revisions had been made by social services (SS)-A indicating advanced directives were reviewed with the resident/resident</p>	F 578	<p>they are current.</p> <p>The interdisciplinary team reviewed the policy. The Household coordinator or designee will notify the resident and family members about the resident change of condition, review and confirm the current POLST with them and ask if they wish to change and set up a care conference to discuss further, and nursing will update the provider. All licensed staff and IDT were reeducated about POLST Policy and process to ensure accuracy and timely POLST implementation with change in condition, admissions, quarterly, annually and as needed for each resident. The DON and the interdisciplinary team will complete an audit for all new admissions and residents with change in condition to verify that the code status is reflected accurately in the EMR banner, orders, and the signed POLST and reviewed with family as appropriate daily for 2 weeks and then weekly for 4 weeks. 5 random resident audits weekly for 4 weeks to ensure resident choices are being honored. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate. The facility will continue to review code status with the family on admission, quarterly, annually and with significant changes.</p>	

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

PRINTED: 12/31/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2024
NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	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 578	<p>Continued From page 3 representative.</p> <p>On 12/5/24 at 12:03 p.m., FM-A indicated when R1 was admitted to the facility with hospice services and a POLST was completed for R1 by FM-A, which indicated R1 wished to be DNR and comfort focused treatment. FM-A stated R1's health improved and no longer qualified for hospice services. FM-A stated the facility initiated a care conference following R1 discharging from hospice services, however the facility staff did not review R1's POLST with FM-A at the meeting and R1 remained DNR and comfort focused treatment. FM-A stated had she been given the option to review the POLST at that time, she would have revised the POLST to not include comfort focused treatment due to R1 "wanting to live" and hospice was no longer involved in R1's care. FM-A stated she was R1's power of attorney and health care agent.</p> <p>On 12/6/24 at 12:17 p.m., registered nurse (RN)-A stated during each resident's care conference the POLST was expected to be reviewed. RN-A stated social services (SS) would review the POLST with the resident and the resident representative. Further, RN-A stated on the day of R1's care conference, RN-A was not present when the POLST would have been reviewed so she was unsure if SS-A reviewed the POLST. RN-A was not aware of any revisions to R1's POLST either.</p> <p>On 12/10/24 at 11:58 a.m., SS-A stated on 11/21/24, R1 had a significant change care conference related to ending hospice services. SS-A stated she checked R1's POLST order in the computer and offered the option to make changes, which no changes were requested.</p>	F 578		

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

PRINTED: 12/31/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2024
NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	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 578	Continued From page 4 SS-A stated the discussion could be confirmed by RN-A. SS-A stated she did not lock the care conference summary following the meeting as expected, no revisions were made but confirmed she did not check the boxes related to code status prior. On 12/10/24 at 12:45 p.m., director of nursing (DON) stated staff were expected to review the resident's POLST during care conferences and change in condition or when a family requested. Review of facility policy titled Code Status: Physician's Order for Life Sustaining Treatment Policy dated 6/11, indicated advanced directors/other treatment options may be discussed in a care conference and at any time the form can be updated to reflect any changes requested and with any significant change in status.	F 578		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor and evaluate response to interventions for 1 of 1 resident (R1) identified to have been taking antibiotics for a urinary tract	F 684	The affected resident completed his antibiotic therapy and was discharged. All residents receiving antibiotic therapy have been/were identified, and infection	1/17/25

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

PRINTED: 12/31/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2024
NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	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 684	<p>Continued From page 5 infection (UTI).</p> <p>Findings include:</p> <p>R1's significant change Minimal Data Set (MDS) dated 11/1/24, indicated R1 had diagnoses of chronic kidney disease, dementia, and malignant neoplasm of sigmoid colon. Further, R1's cognition was noted to be moderately impaired.</p> <p>R1's medication administration record (MAR) and treatment administration record (TAR) for the month of November 2024, indicated Keflex 500 milligram (mg) twice daily for UTI until 11/15/24, ordered on 11/13/24 and Macrobid 100 mg twice daily for retention of urine for 5 days begin on 11/8/24 discontinued on 11/12/24. Further on 11/8/24, refer to infection progress note template for assessment and documentation requirements. Document at least with the start and the end of an antibiotic regimen and during the course of treatment with clinical change or vital signs/assessment that was not within normal limits one time a day for clinical monitoring for seven days.</p> <p>Review of R1's progress notes revealed the following:</p> <ul style="list-style-type: none"> -On 11/8/24, resident had a new foley catheter inserted, urine sample was collected to rule out infection. Resident was started on Macrobid, and first dose had been given at the hospital. -On 11/8/24, R1 returned at 1:00 p.m. with a new catheter inserted and a five-day prescription for Nitrofurantoin 100 mg, twice a day with breakfast and dinner. -On 11/10/24, Infection Note included type of infection was urine retention, vital signs were obtained, treatment was Macrobid 100 mg twice a 	F 684	<p>monitoring has been/were initiated and audited to ensure antibiotic therapy was monitored per the policy.</p> <p>The Director of Nursing, Infection Prevention and Control, and clinical coordinators reviewed the antibiotic therapy policy and provided education to all nursing staff. The education focused on initiating antibiotic monitoring batch orders, including vital signs, completing assessments while residents are on antibiotic therapy, and reporting to providers for abnormal Vital Signs and assessments.</p> <p>The DON, IPC, and clinical coordinators will conduct daily audits for residents with infections to ensure proper documentation, monitoring, and time outs are completed for 4 weeks. Results will be reported to the QA committee and the need for ongoing audits and action plans initiated as appropriate.</p>	

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

PRINTED: 12/31/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2024
NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	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 684	<p>Continued From page 6</p> <p>day for 3 days, response to treatment was ongoing, no notification to provider was needed, date resolved was ongoing.</p> <p>-On 11/14/24, Infection Note included type of infection urinary tract, vitals obtained, treatment included Keflex 500 mg by mouth twice daily until 11/15/24, response to treatment was ongoing, and date resolved was ongoing.</p> <p>R1's progress notes lacked consistent monitoring and evaluation for effectiveness of treatment through the antibiotic course.</p> <p>On 12/5/24 at 4:38 p.m., licensed practical nurse (LPN)-A stated if a resident was ordered antibiotics staff were expected to implement infection monitoring which would include obtaining vital signs every shift as well as documenting the medication and the reasoning for the medication.</p> <p>On 12/5/24 at 4:54 p.m., registered nurse (RN)-C stated she recalled R1 being prescribed an antibiotic for urinary infection. RN-C stated staff were expected to monitor a resident on antibiotics for at least seven days to ensure the treatment was effective and there were no adverse reactions, and the monitoring included obtaining vitals signs every shift.</p> <p>On 12/6/24 at 9:37 a.m., LPN-B stated staff were expected to monitor the resident for symptoms of the infection, obtain vital signs, and effectiveness of treatment for the duration of the antibiotic. The treatment for monitoring was typically added as a treatment order in the resident's record and would be expected to be completed every shift.</p> <p>On 12/6/24 at 12:17 p.m., RN-A stated at the start</p>	F 684		

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

PRINTED: 12/31/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2024
NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	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 684	<p>Continued From page 7</p> <p>of the resident's antibiotic staff were expected to document a progress note related to the resident's status and condition as well as at the end of the antibiotic course. Further, RN-A stated staff would be expected to obtain vital signs with each administration of the antibiotic, or at least once a shift, due to resident having a change in condition requiring an antibiotic. RN-A stated monitoring a resident would be important during the antibiotic course to ensure the treatment was effective and no adverse reactions. RN-A stated R1 was started on an antibiotic for a urinary tract infection (UTI) and completed the antibiotic on 11/15/24. RN-A stated nurses were expected to be monitoring R1's urine for any signs or symptoms of a UTI and monitoring vital signs every shift because R1 was on treatment and staff should have been keeping "a close eye on him for anything abnormal". Further, RN-A confirmed staff were not consistent with obtaining vital signs and there were "very poor notes" related to monitoring R1 during his antibiotic course.</p> <p>On 12/10/24 at 10:35 a.m., nurse practitioner (NP) stated the facility's goal was good stewardship of antibiotic use and would expect staff to obtain vital signs every shift for at minimum three days to ensure the resident was stable because the antibiotic should have kicked in and be effective. NP would also expect staff to update her with the effectiveness of the antibiotic.</p> <p>On 12/10/24 at 12:45 a.m., director of nursing (DON) stated there was a standard practice for monitoring infections that staff were expected to implement "right away" which included staff documenting a progress note in the resident's record with type of infection, symptoms, all vital</p>	F 684		

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

PRINTED: 12/31/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2024
NAME OF PROVIDER OR SUPPLIER MARANATHA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5409 69TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
(X4) ID PREFIX TAG	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 684	<p>Continued From page 8</p> <p>signs, change in condition, isolation precautions, response to treatment, and notifications to the provider (if needed). Further, DON stated he would expect the clinical coordinator on the unit to initiate the monitoring and would expect the monitoring to be completed every shift as once daily would not reveal accurate information due to over a few hours the resident could have a change in condition. Further, DON confirmed R1 was on antibiotic treatment from 11/8 through 11/15/24 and there was only monitoring on 11/10/24 and 11/14/24. DON stated there was a problem with documentation and it was a learning opportunity. In addition, DON stated monitoring an antibiotic was important to ensure the treatment was effective and no further infection concerns were noted.</p> <p>Review of facility policy titled Infection Control-Antibiotic Stewardship Procedure dated 8/17, directed the nursing to complete progress note and documentation at the start and end of an antibiotic regimen, with any change in condition, and monitor/review response to antibiotics, and laboratory results when available, to determine if the antibiotics was still indicated or adjustments should be made. However, the policy lacked identification how often staff were required to monitor or evaluate the response to antibiotics or obtain vitals.</p>	F 684		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2024
--	--	---	---

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

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

2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: On 12/5/24, 12/6/24 and 12/10/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you</p>	2 000		
-------	---	-------	--	--

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 12/27/24
---	-------	------------------------------

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2024
--	--	---	---

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

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

2 000	<p>Continued From page 1</p> <p>have reviewed these orders and identify the date when they will be completed.</p> <p>The following complaint was reviewed.</p> <p>H54622044C (MN00108781 and MN0010755).</p> <p>As a result of the investigation, a licensing order was issued at 1830.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will</p>	2 000		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2024
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment	21830		1/17/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2024
--	--	---	---

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

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

21830	<p>Continued From page 3</p> <p>planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the resident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:</p> <p>(1) examining the personal effects of the resident;</p> <p>(2) examining the medical records of the resident in the possession of the facility;</p> <p>(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and</p> <p>(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.</p> <p>(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by</p>	21830		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2024
--	--	---	---

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

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

21830	<p>Continued From page 4</p> <p>examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Physician Orders for Life Sustaining Treatment (POLST) was reviewed and/or revised following a change in condition comprehensive assessment for 1 of 1 residents (R1) reviewed.</p> <p>Findings include:</p> <p>R1's significant change Minimal Data Set (MDS) dated 11/1/24, indicated R1 had diagnoses of chronic kidney disease, dementia, and malignant neoplasm of sigmoid colon. Further, R1's cognition was noted to be moderately impaired.</p>	21830	Corrected	
-------	--	-------	-----------	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2024
--	--	---	---

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

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

21830	<p>Continued From page 5</p> <p>R1's POLST dated 9/13/24, which was signed by R1's health care agent and family member (FM)-A, indicated R1's wishes were to be do not attempt resuscitation (DNR), allow natural death, in the event R1 had no pulse and was not breathing, as well as comfort-focused treatment (allow natural death) to relieve pain and suffering through the use of any medications by any route, positioning, wound care, and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.</p> <p>R1's care conference summary printed 12/5/24, indicated a care conference was held on 11/21/24, with FM-A present. Further, the document revealed information shared included code status of DNR and comfort-focused treatment and to see R1's POLST for details. In addition, the questions: advanced directives reviewed with the resident/resident representative and does the POLST match the code status order were left blank and not completed by staff. The summary lacked evidence the POLST was reviewed with resident/resident representative. However, on 12/6/24, summary revealed revisions had been made by social services (SS)-A indicating advanced directives were reviewed with the resident/resident representative.</p> <p>On 12/5/24 at 12:03 p.m., FM-A indicated when R1 was admitted to the facility with hospice services and a POLST was completed for R1 by FM-A, which indicated R1 wished to be DNR and comfort focused treatment. FM-A stated R1's health improved and no longer qualified for</p>	21830		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2024
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	<p>Continued From page 6</p> <p>hospice services. FM-A stated the facility initiated a care conference following R1 discharging from hospice services, however the facility staff did not review R1's POLST with FM-A at the meeting and R1 remained DNR and comfort focused treatment. FM-A stated had she been given the option to review the POLST at that time, she would have revised the POLST to not include comfort focused treatment due to R1 "wanting to live" and hospice was no longer involved in R1's care. FM-A stated she was R1's power of attorney and health care agent.</p> <p>On 12/6/24 at 12:17 p.m., registered nurse (RN)-A stated during each resident's care conference the POLST was expected to be reviewed. RN-A stated social services (SS) would review the POLST with the resident and the resident representative. Further, RN-A stated on the day of R1's care conference, RN-A was not present when the POLST would have been reviewed so she was unsure if SS-A reviewed the POLST. RN-A was not aware of any revisions to R1's POLST either.</p> <p>On 12/10/24 at 11:58 a.m., SS-A stated on 11/21/24, R1 had a significant change care conference related to ending hospice services. SS-A stated she checked R1's POLST order in the computer and offered the option to make changes, which no changes were requested. SS-A stated the discussion could be confirmed by RN-A. SS-A stated she did not lock the care conference summary following the meeting as expected, no revisions were made but confirmed she did not check the boxes related to code status prior.</p> <p>On 12/10/24 at 12:45 p.m., director of nursing (DON) stated staff were expected to review the</p>	21830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2024
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	<p>Continued From page 7</p> <p>resident's POLST during care conferences and change in condition or when a family requested.</p> <p>Review of facility policy titled Code Status: Physician's Order for Life Sustaining Treatment Policy dated 6/11, indicated advanced directors/other treatment options may be discussed in a care conference and at any time the form can be updated to reflect any changes requested and with any significant change in status.</p> <p>SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices related to offering to review/revise POLST and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then audit to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21830		