DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 15, 2019

Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

Re: Reinspection Results - Complaint Numbers H5409056C, H5409052C, H5409055C

Dear Administrator:

On February 28, 2019 an investigator from the Minnesota Department of Health completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on February 20, 2019. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

February 22, 2019

Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

RE: Projects Numbers S5409030, H5409056C, H5409052C, H5409055C and H5409054C, H5409053C, H5409057C.

Dear Administrator:

On December 28, 2018, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 25, 2019.

This was based on the deficiencies cited by this Department for a standard survey completed on December 7, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 25, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 22, 2019. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard survey, completed on December 7, 2018. As a result of the revisit findings, we notified you that the following would remain in effect:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 25, 2019.

- Civil Money Penalty (42 CFR 488.430 through 488.444)

On February 20, 2019, the Minnesota Department of Health completed an abbreviated standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the PCR, completed on January 25, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 22, 2019. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on January 25, 2019.

In addition, at the time of this revisit, we identified additional deficiencies:

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

As a result of the revisit findings, the following actions related to the imposed remedies:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 25, 2019.

- Civil Money Penalty (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of December 28, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), If you have not achieved substantial compliance by February 25, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Maple Manor Nursing And Rehab, LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 25, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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.

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 electronic plan of correction should be directed to:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast

Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

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 June 7, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure(s)

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 _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	**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 An abbreviated survey was conducted 1/23/19, 1/24/19 and 2/20/19 to investigate the following complaints: H5409056C, H5409054C, H5409057C, H5409052C, H5409053C, and H5409055C. The complaints found to be substantiated were H5409056C at F689, H5409052C at F760 and H5409055C at 609. H5409057C, H5409053C and H5409054C, were found to be non-substantiated. Maple Manor was not in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility is enrolled in the electronic Plan of Correction (ePOC) and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	F 000		
F 609 SS=D	. Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		2/22/19

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

Electronically Signed | 02/25/2019

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F 609	Continued From page 1 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to report an allegation of resident-to-resident verbal abuse, immediately to the administrator and to the designated state agency (SA) within two hours for 1 of 1 resident (R39). Findings include: R39's Admission Record printed 1/25/19, indicated R39's diagnoses down syndrome and dementia with behavioral disturbance. R39's quarterly Minimum Data Set (MDS) dated 11-12-18, indicated R39 had severe cognitive impairment, did not have indicators of delirium, had no mood symptoms or behaviors. The MDS indicated R39 required limited assist of 1 staff for	F 609	It is the policy of Edenbrook Rochester to immediately report all alleged violations to the appropriate persons and within the designated timeframes. Education has been provided to staff on reporting requirements and timeframes. Progress notes and incident reports will be reviewed during morning clinical meeting to determine if timely notification to the Administrator has been made and reporting has been completed within the specified timeframes for events needing to be reported. Negative findings will be reported and follow up education will be completed immediately. All findings will be reviewed at monthly QAPI. Administrator will be responsible. Completion date: 2/22/19	

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F 609	Continued From page 2	F 609		

ambulation.

R39 was observed to independently ambulate throughout the unit without any supportive devices during the survey.

R252's quarterly Minimum Data Set (MDS) dated 11-120-18, indicated R252 had no cognitive impairment, did not have indicators of delirium, had no behaviors and reported mood symptoms of feeling tired and having little energy. The MDS indicated R252 did not ambulate, required extensive assist two staff for transfers. R252 required supervison for locomation on the unit.

R252 was observed to indepedently use a scooter throughout the unit during the survey.

R39's initial vulnerable report submitted to the SA on 1/8/19, at 5:22 p.m. identified an incident ocurred on 1/6/19 at 1:30 p.m. of a "Verbal confrontation between residents. Verbal threats between residents." Review of the initial report made to the SA lacked documentation of how and when the facility director of nursing (DON) became aware of the abuse allegation that occurred on 1/6/18, which was reported by the DON on 1/8/19. The DON became aware of the abuse allegation when reviewing progress notes the morning of 1/8/19 per the facility administrator.

R39's investigative summary submitted to the SA on 1/10/19, at 12:04 p.m. included, "R259 was a long standing resident at Eden Brook of Rochester he has been a resident since [11/--/2017] he resides sown [sic] the West hallway in room 3B. He has diagnoses of left leg amputee, CHF (congestive heart failure), major

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depressive disorder. He ambulates with a power scooter and has a BIMs (brief interview for mental score) of 15. R39 had been a resident of Eden Brooks since 10/11/2018 he also resides down the West hallway in room 12A. He has diagnosis of Downs Syndrome with respiratory failure. He has a BIMs (brief interview for mental score) of 2. Last Sunday 1/6/19 approximately 14:00 hours. R39 and R259 were in the main common area there was an argument between the 2 that staff attended to. From history R39 likes to sit in the main common area to color he sits at a table that is labeled specifically for R39. On this particular Sunday R39 was sitting in the main common area sitting at a table that was not labeled for R39 but at the longer table that is for everyone use. Per Interview with R259 he states that he was upset that R39 was not using the table that was intended just for him and R259 states he wanted to use the common table and 2 other residents wanted to use it also. R259 states that he asked R39 to move his things and that R39 would not move his things. R259 stated R39 stood up and told R259 to shut up. R259 states that he personally did nothing wrong and did not raise his voice to R39, R259 states he doesn't understand why writer is asking him questions about this situation because R39 was the one that wasn't sharing the table. R259 does have in his care plan that he does have behaviors of targeting residents in the past. R39 is unable to account for this episode. R39 does not remember, and changes that subject to his birthday when being interviewed. R39 does not feel scared, or threatened when asked. Interview with staff: Activities (A)-A stated that she was visiting with another resident when she walked into an argument between R259 and R39. R259 was telling R39 to shut up and his tone was

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threatening. R39 then stood up and told R259 to shut up. A-A stated that a nurse then came over and tried to calm them both down, and to be quiet. A few more words were spoken between R39 and R259. Licensed practical nurse (LPN)-A states that all she heard was R39 going on and on stating shut up to R259. That there was nothing physical that happened. Registered Nurse (RN)-A states that she overheard R259 calling R39 a retard, and a pathetic little thing. RN-A told R259 this was inappropriate and then R259 left the room. RN-A then went in with R39 and walked him back to his room. The investigative summary indicted the vulnerable adult policy was followed. Actions taken to prevent reoccurrence to subjected resident: Nurse had walked R39 out of the common area to his personal room. Action taken to prevent reoccurrence to other resident: Staff education on the Vulnerable Adult Policy.

On 1/25/19, at 3:00 p.m. licensed practical nurse (LPN)-A stated if we overhear anything (between R39 and R259) we separate them. R39 was moved to different wing. LPN-A stated we try to keep them separated. LPN-A stated the facility had twenty-four hours to report abuse to state, but we would report it to the director of nursing and administrator right away. LPN-A stated R259 seemed to ignore R39 and we try to keep them separated.

On 1/25/19, at 3:06 p.m. registered nurse (RN)-A stated the facility had twenty-four hours to report to the designated state agency if it was abuse. RN-A stated we report to the administrator and director of nursing right away. RN-A stated I have never seen physical abuse between R39 and R259. RN-A stated the one time, it got a little

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louder, R39 was at a little table and R39 was pointing and raising his voice to R259, not really yelling. RN-A stated I separated them and R39 was a harder one to get too separate. RN-A stated I redirected R39 to his room. RN-A stated I was charting and I did not hear any verbal abuse or name-calling.

On 1/25/19, at 5:06 p.m. the administrator stated there was a verbal exchange of shut up, nothing physical on 1/6/19. The administrator stated I should have been made aware immediately and stated I would have wanted this to be reported within two hours to ensure we were complaint. The administrator verified the initial report was made to the SA on 1/8/19, which was two days later then the alleged incident. The administrator stated on 1/8/19, the DON read a progress note from 1/7/19, which eluded to the incident that allegedly occurred on 1/6/19, which was not reported to the administrator or the DON. The DON found the progress noted dated 1/7/19 and brought it to morning meeting at 9:30 a.m. on 1/8/19 and that was when we discussed it. The administrator stated I would have expected A-A would have reported to her supervisor or myself on 1/6/19. The administrator stated allegations of abuse get reported as soon as residents are assured that they are safe. The administrator stated the notification process begins per our policy to determine if it is abuse, what type of abuse and then what necessary steps needs to take place, are we sending to the emergency room, are we calling the police, then determine how soon we are reporting. The administrator stated the alleged incident was reported to the SA on 1/8/19, at 5:22 p.m. The administrator stated I would have wanted this reported as immediate as possible. The administrator stated she would

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F 609	Continued From page 6 have expected the DON to report immediately within the two hours, that is what I would have expected. The administrator verified the DON did not report the alleged resident-to-resident abuse within two of hours. The administrator stated if any staff are aware of an allegation of abuse, they are aware they are responsible to report it and to keep residents safe. On 1/25/19, at 6:19 p.m. activity aide (A)-A stated abuse was to be reported immediately. A-A stated I can get ahold of the administrator, we have her number here, or I could report to my supervisor. A-A stated I do not remember what happened in the incident (on 1-6-19), I just remember the tone, they were upset with each other. The tone of voices was angry for both residents. A-A stated I was watching it (the resident to resident interaction) and I guess I was wrongly thinking the nurse was going to take care of it. A-A stated that is not what I should have done. I should have taken care of it. A-A stated I should have intervened and separated them. A-A stated I had had been thinking I needed to do something, but then nurse came over. A-A stated we both should have reported and I know better. A-A stated I was retrained on vulnerable adult reporting very quickly after that however, did not recall the date she was retrained.	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		2/25/19

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MAPLE MANOR NURSING AND REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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F 689	Continued From page 7 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 ensure residents were free from accident hazards for 1 of 1 residents (R27) who slipped out of a transfer sling while being transfered by staff and a mechanical lift. Finding include: R27's face sheet, R27 was originally admitted to the facility on 11/1/12 with a diagnosis of vascular dementia without behavioral disturbance, osteoarthritis in the upper extremities and an abnormality of gait and mobility. According to R27's care plan, a focus problem area stated R27 has an "alteration in mobility: potential for injury r/t [related to]fall risk: dementia, impaired mobility." Focus area was initiated 6/15/15 and revised 12/14/18. An intervention for transferring R27 was initiated 9/24/15 and revised on 1/15/19, instructing nursing staff as follows: Pivot disc standing transfers with trained staff. Hoyer if staff is not trained. According to incident report dated, 12/18/18 the nursing home incident reporting web site for the Minnesota Department of Health (MDH) indicated R27 was being transferred with a "mechanical stand machine with one assist." According to the report, nursing assistant (NA)-P positioned R27 into the mechanical lift, placed a lift harness around R27 but failed to tighten the abdominal strap after buckling it. NA-P also failed to apply a safety strap around R27's lower legs. NA-P had	F 689	-R27 has had a Transfer and Mobility Evaluation completed and is currently utilizing the full body lift for transfers. Care plan and NA Kardex have been updated with type of lift required and sling size. -Transfer and Mobility Evaluations have been completed on residents using mechanical lifts to transfer. Care plans and NA Kardex have been updated with type of lift required and sling size to be used. -New hires will complete Lift Competency prior to operating lifts. Current clinical staff education/competency completed and continuing for employee files. -Residents needing assistance with transfers have the potential to be affected if proper transfer method is not assessed. -Audits will be completed on weekly x 4 weeks on proper transfer of residents utilizing mechanical lifts. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI for need to continue. -DON will be responsible. -Completion date: 2/25/19	

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	245409	A. BUILDING _____ B. WING _____	C 02/20/2019

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F 689	Continued From page 8	F 689		

not properly positioned the bed at the correct level and was unable to move R27 directly to the bed. NA-P left R27 standing in the lift while attempting to lower the bed, but NA-P let go of the lift, slipped through the sling and onto the floor. R27 suffered 2 skin tears on her left forearm near her elbow. The mechanical lift was found to be missing a buckle on the leg strap which would have prevented it from being used.

According to a document dated, 12/18/18 and written by NA-P included with the report noted above, NA-P said she had been attempting to put R27 to bed using the mechanical lift and had buckled the straps but had not tightened them. NA-P also wrote that when she discovered the bed was too high she left the stand to lower the bed. At that time, R27 let go and slid off the bed using her left elbow to break her fall.

According to the mechanical lift manufacturer's (EZ Way, Inc.) guidelines, the EZ Way Smart Stand is used for patient transfer. The instructions included the following: "for the safety of the patient, securely fasten the safety strap [of the harness] around the patient's torso ...secure the buckle and pull the strap to tighten ...stand beside the patient. As the patient is being raised, simultaneously tighten the safety strap buckled around their torso." The guidelines indicated that a shin strap can be used for additional safety when needed to keep the patients feet or shins on the lift plate. The guidelines also indicated a variety of types and sizes of harnesses are available because patients vary in "size, shape and weight." The following guideline stated, "For safe operation of the EZ Way Smart Stand, operators should watch the training video, read through this manual, complete the competency

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F 689	Continued From page 9	F 689		

checklist, and practice on fellow staff members before use with patients."

Evidence of NA-P having received training and competency testing upon hire was requested. A document titled Orientation Checklist was provided by the facility.The checklist did not include the EZ Way competency checklist as recommended by the manufacturer nor did it include a facility written step by step competency exam. The Orientation Checklist only included the initials of a trained medication aid/NA (TMA)-A and a statement that mechanical lift training had been completed on 12/9/18.

During observaiton and interview on 1/24/19 at 10:42 a.m. NA-B was assisting R27 to transfer out of bed using a gait belt and standing her on a disc, pivoting her into a wheelchair. NA-B reported he was trained by another NA who had started before him. NA-B said only persons who had been trained could use the disc and others had to use the Hoyer mechanical lift. He reported that those who did not use the disc used to use the EZ Way stand. He was unsure of why they were no longer using it, but said, "I think there was some sort of accident or something." During an interview 1/24/19, 2:30 p.m. NA-D confirmed that R27 was no longer being transferred using the EZ Way stand. NA-D said they were to use a mechanical Hoyer lift and 2 assist unless they had been trained to use the pivot disc. In the past they had been using the EZ Way stand. NA-D confirmed that she had been taught they should always use the appropriate size harness and the shin strap. NA-D said she wasn't sure where to find the information on what size of harness to use for any given resident.

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F 689	Continued From page 10 According to an interview on 1/24/19, at 4:33 p.m. the assistant director of nursing (ADON) confirmed that NA-P was trained to use the EZ Way stand by a preceptor peer and the only competency document at that time was the facility orientation checklist. ADON was unable to relate what size of harness was used. According to a progress note dated on 12/13/18, at 7:44 p.m. R27 sustained 2 skin tears on her left forearm near the elbow as a result of sliding out of the harness during the attempted transfer. One skin tear was 1cm in size and the other was 2cm by 0.6cm and both required cleansing and dressing of the wounds. A request was made for a policy related to the use of mechanical lifts. The facility provided a policy and procedure titled Using a Mechanical Lift and dated 8/1/15. The policy was related to the use of a Hoyer lift and not an EZ Way Stand lift.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure physician orders were implemented as directed to prevent a significant medication error and concurrent administration of 3 anticoagulants (blood thinners), for 1 of 1 resident (R204) reviewed for medication errors.	F 760	-R204 is receiving her anticoagulant medication and associated lab monitoring as ordered. -Residents receiving Coumadin were reviewed for current orders and lab monitoring. No discrepancies were noted. -Residents receiving Coumadin have the potential to be negatively affected if	2/22/19

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F 760	Continued From page 11 Findings include: R204's Admission Record, identified an admit date of 11/27/18, with a diagnosis of abnormal coagulation profile, long term use of anticoagulants, and pulmonary embolism. R204's care plan dated 12/12/18, identified a focus: takes anticoagulant medication related to DVT/CAD (deep vein thrombosis/coronary artery disease). Goal: will have no signs and symptoms of abnormal bleeding or other adverse effects related to the use of anticoagulant medication through next review. Approach: administer medication as ordered and INR as ordered. R204's medication administration record (MAR), dated January, 2019, identified R204's 4 mg Coumadin doses were not administered on 1/3/19, 1/4/19, and 1/5/19. R204's medication error report dated 1/7/19, at 12:54 p.m. identified nursing description: R204 went without Coumadin on 1/3/19, 1/4/19, and 1/5/19. Resident description: R204 was unaware. Immediate action taken: 2 milligrams (mg) given 1/6/19. INR drawn and results were 1.1. Provider notified. VA report submitted and investigation pending. No injuries observed. Mental status: alert and oriented to person, place, time and situation. No predisposing situational factors identified. No witnesses identified. Physician was notified on 1/7/19 at 12:56 pm. R204's progress note dated 1/7/19, at 12:57 p.m. identified, resident went without Coumadin 1/3 to 1/5. Vulnerable adult (VA) report filed and investigation started, INR results today 1.1. Provider aware. Nursing held accountable.	F 760	Coumadin dosing is missed and lab monitoring is not completed. -Anticoagulant Therapy policy has been reviewed and nursing staff responsible for medication administration have been educated on Anticoagulant Therapy policy. Anticoagulant flow sheet has been implemented to track Coumadin dosing and lab monitoring. Flow sheet is updated with each INR completed and includes ordered dosing and next scheduled lab monitoring. -Anticoagulant flow sheet will be reviewed twice weekly to insure Coumadin dosing and lab monitoring are complete. Discrepancies will be investigated immediately. Medication errors will be reviewed at monthly QAPI. -DON will be responsible. -Completion date: 2/22/19	

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F 760	Continued From page 12	F 760		

Additional progress note dated 1/25/19, ay 5:05 p.m. identified R204 was alert and oriented.

R204's signed physician orders dated 1/24/19, identified R204 receives Coumadin (blood thinner medication) for pulmonary embolus and the goal international normalized ratio (INR) (INR is a blood test used to monitor how well the blood-thinning medication-an anticoagulant, is working to prevent blood clots), is 2.0 - 3.0. INR on 1/3/19 was 1.9 and R204 was ordered to receive 4 mg of Coumadin daily. INR was rechecked on 1/7/19 and the results were 1.1.

During observation and interview on 1/24/19, at 11:51 a.m. R204 was sitting in her wheelchair wearing a peach outfit and was well groomed, propelling self-down the hallway. R204 stated, they let my Coumadin lapse for 3 days, thank god for [RN-C], he caught the missed doses. I have been on Coumadin for 5-6 years, they said my clots will come back in my lungs If I don't take it. R204 denies pain or difficulty with her breathing. R204 further stated, the lowest my INR has been since I have been here was 1.1. I have been getting a little over 1 mg of Coumadin, it's a little concerning to me, they checked my INR this morning it was 1.3, and it was at 2.0 before I came here. I would feel more secure if I was getting 2.5 mg of Coumadin. When I was on that dose my INR levels were better.

During interview on 1/24/19, at 2:43 p.m. registered nurse (RN)-C stated, I am the one who noticed the Coumadin error, I was doing the med pass on 1/6/19 in the evening and I was getting R204's medications ready and there was nothing for Coumadin in her MAR, that was a huge thing when she first came here. I remembered her

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F 760	Continued From page 13	F 760		

being on that, so I checked her last INR date which was 1/3/19, and this was the 6th now, so she had missed 3 days. I found it, I called the on call provider and he said to continue last known order for Coumadin that she was on. R204 was on 2.5 mg and we gave it to her that night. The INR was gotten in the morning and it was like 1.1, her last INR was this morning and it was 1.3, so they are going to bump her dose of Coumadin up. I think the error happened because if the INR isn't done, it drops off the MAR. To prevent this from happening again, now at 4 pm you have to sign out to check Coumadin dose and also the treatment sheet says, the resident is on Coumadin and to monitor for bleeding. The night shift does the INR's in the morning. I reported this to the director of nursing (DON) right away and they filed a VA report and she filled out the med error report. We are directed to report the medication error to the DON right away so she can follow up with an investigation. Verified family was not notified. She is now on 5 mg daily.

During interview on 1/25/19, at 5:01 p.m. regional clinical nurse (RCN) and corporate clinical nurse (CCC), verified that R204 missed her Coumadin dose for 3 days and that would be a significant med error. RCN stated, "I would have expected the nurses that were responsible to administer the Coumadin, to have given it. I would also expect there to be a progress note that the MD was notified."

Facility policy, Coumadin Monitoring, revised 9/11/2018, identified a purpose to provide a consistent therapeutic INR range between 2.0 and 3.0 for residents on Coumadin.

Facility policy, Medication Error and Drug

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F 760	Continued From page 14 Interactions, issued 8/1/15, identified, all medication errors and drug reactions will be reported immediately to the director of nursing, the attending physician, and will be documented according to established procedures. Medication error is identified as the preparation or administration of medications or biological that is not in accordance with the prescriber's orders, manufacturer specifications regarding the preparation and administration of medication or biological and/or accepted practice standards for medication or biological administration. 2. A detailed account of the error will be recorder in the resident's medical record. Such documentation must include, but is not limited to: a. Time and date of the incident b. Name, strength, and dosage of medication administered. c. Residents reaction to the medication d. Condition of the resident e. Any treatment administered f. Date and time the physician was notified and what instructions were given.	F 760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 22, 2019

Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

Re: State Nursing Home Licensing Orders - Complaint Numbers H5409056C, H5409052C, H5409055C and H5409054C, H5409053C, H5409057C.

Dear Administrator:

A complaint investigation was completed on February 20, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The Surveyor from the Minnesota Department of Health, noted one or more violations of these rules.

These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all licensing orders are corrected, the form should be signed and returned electronically to:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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

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

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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	00916	A. BUILDING: _____ B. WING _____	C 02/20/2019

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint invesigation was conducted 1/23 to 2/20/19, to investigate the following complaints: H5409056C, H5409052C, H5409055C, H5409054C, H5409057C, and H5409053C. The following complaints were substantiated H5409056C, H5409052C and H5409055C. In addition,the complaint related to H5409054C,	2 000		

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2 000	Continued From page 1 H5409053Cand H5409057C were not substantiated.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were free from accident hazards for 1 of 1 residents (R27) who slipped out of a transfer sling while being transfered by staff and a mechanical lift. Finding include: R27's face sheet, R27 was originally admitted to the facility on 11/1/12 with a diagnosis of vascular dementia without behavioral disturbance, osteoarthritis in the upper extremities and an abnormality of gait and mobility. According to R27's care plan, a focus problem area stated R27 has an "alteration in mobility:	2 830	Corrected.	2/25/19

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2 830	Continued From page 2 potential for injury r/t [related to]fall risk: dementia, impaired mobility." Focus area was initiated 6/15/15 and revised 12/14/18. An intervention for transferring R27 was initiated 9/24/15 and revised on 1/15/19, instructing nursing staff as follows: Pivot disc standing transfers with trained staff. Hoyer if staff is not trained. According to incident report dated, 12/18/18 the nursing home incident reporting web site for the Minnesota Department of Health (MDH) indicated R27 was being transferred with a "mechanical stand machine with one assist." According to the report, nursing assistant (NA)-P positioned R27 into the mechanical lift, placed a lift harness around R27 but failed to tighten the abdominal strap after buckling it. NA-P also failed to apply a safety strap around R27's lower legs. NA-P had not properly positioned the bed at the correct level and was unable to move R27 directly to the bed. NA-P left R27 standing in the lift while attempting to lower the bed, but NA-P let go of the lift, slipped through the sling and onto the floor. R27 suffered 2 skin tears on her left forearm near her elbow. The mechanical lift was found to be missing a buckle on the leg strap which would have prevented it from being used. According to a document dated, 12/18/18 and written by NA-P included with the report noted above, NA-P said she had been attempting to put R27 to bed using the mechanical lift and had buckled the straps but had not tightened them. NA-P also wrote that when she discovered the bed was too high she left the stand to lower the bed. At that time, R27 let go and slid off the bed using her left elbow to break her fall.	2 830		

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2 830	Continued From page 3 According to the mechanical lift manufacturer's (EZ Way, Inc.) guidelines, the EZ Way Smart Stand is used for patient transfer. The instructions included the following: "for the safety of the patient, securely fasten the safety strap [of the harness] around the patient's torso ...secure the buckle and pull the strap to tighten ...stand beside the patient. As the patient is being raised, simultaneously tighten the safety strap buckled around their torso." The guidelines indicated that a shin strap can be used for additional safety when needed to keep the patients feet or shins on the lift plate. The guidelines also indicated a variety of types and sizes of harnesses are available because patients vary in "size, shape and weight." The following guideline stated, "For safe operation of the EZ Way Smart Stand, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients." Evidence of NA-P having received training and competency testing upon hire was requested. A document titled Orientation Checklist was provided by the facility.The checklist did not include the EZ Way competency checklist as recommended by the manufacturer nor did it include a facility written step by step competency exam. The Orientation Checklist only included the initials of a trained medication aid/NA (TMA)-A and a statement that mechanical lift training had been completed on 12/9/18. During observaiton and interview on 1/24/19 at 10:42 a.m. NA-B was assisting R27 to transfer out of bed using a gait belt and standing her on a disc, pivoting her into a wheelchair. NA-B reported he was trained by another NA who had	2 830		

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2 830	Continued From page 4 started before him. NA-B said only persons who had been trained could use the disc and others had to use the Hoyer mechanical lift. He reported that those who did not use the disc used to use the EZ Way stand. He was unsure of why they were no longer using it, but said, "I think there was some sort of accident or something." During an interview 1/24/19, 2:30 p.m. NA-D confirmed that R27 was no longer being transferred using the EZ Way stand. NA-D said they were to use a mechanical Hoyer lift and 2 assist unless they had been trained to use the pivot disc. In the past they had been using the EZ Way stand. NA-D confirmed that she had been taught they should always use the appropriate size harness and the shin strap. NA-D said she wasn't sure where to find the information on what size of harness to use for any given resident. According to an interview on 1/24/19, at 4:33 p.m. the assistant director of nursing (ADON) confirmed that NA-P was trained to use the EZ Way stand by a preceptor peer and the only competency document at that time was the facility orientation checklist. ADON was unable to relate what size of harness was used. According to a progress note dated on 12/13/18, at 7:44 p.m. R27 sustained 2 skin tears on her left forearm near the elbow as a result of sliding out of the harness during the attempted transfer. One skin tear was 1cm in size and the other was 2cm by 0.6cm and both required cleansing and dressing of the wounds. A request was made for a policy related to the use of mechanical lifts. The facility provided a policy and procedure titled Using a Mechanical Lift and dated 8/1/15. The policy was related to	2 830		

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2 830	Continued From page 5 the use of a Hoyer lift and not an EZ Way Stand lift. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could assure all newly hired staff complete comprehensive competency training that matches manufacturer recommendations for all mechanical lifts in the facility; additionally, DON or designee could audit training records to be sure that all current staff have completed a comprehensive competency training for the equipment. Audits monitoring the correct techniques when using the equipment could be initiated. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident	21545		2/22/19

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21545	Continued From page 6 discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure physician orders were implemented as directed to prevent a significant medication error and concurrent administration of 3 anticoagulants (blood thinners), for 1 of 1 resident (R204) reviewed for medication errors. Findings include:	21545	Corrected.	

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21545	Continued From page 7 R204's Admission Record, identified an admit date of 11/27/18, with a diagnosis of abnormal coagulation profile, long term use of anticoagulants, and pulmonary embolism. R204's care plan dated 12/12/18, identified a focus: takes anticoagulant medication related to DVT/CAD (deep vein thrombosis/coronary artery disease). Goal: will have no signs and symptoms of abnormal bleeding or other adverse effects related to the use of anticoagulant medication through next review. Approach: administer medication as ordered and INR as ordered. R204's medication administration record (MAR), dated January, 2019, identified R204's 4 mg Coumadin doses were not administered on 1/3/19, 1/4/19, and 1/5/19. R204's medication error report dated 1/7/19, at 12:54 p.m. identified nursing description: R204 went without Coumadin on 1/3/19, 1/4/19, and 1/5/19. Resident description: R204 was unaware. Immediate action taken: 2 milligrams (mg) given 1/6/19. INR drawn and results were 1.1. Provider notified. VA report submitted and investigation pending. No injuries observed. Mental status: alert and oriented to person, place, time and situation. No predisposing situational factors identified. No witnesses identified. Physician was notified on 1/7/19 at 12:56 pm. R204's progress note dated 1/7/19, at 12:57 p.m. identified, resident went without Coumadin 1/3 to 1/5. Vulnerable adult (VA) report filed and investigation started, INR results today 1.1. Provider aware. Nursing held accountable.	21545		

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21545	Continued From page 8 Additional progress note dated 1/25/19, ay 5:05 p.m. identified R204 was alert and oriented. R204's signed physician orders dated 1/24/19, identified R204 receives Coumadin (blood thinner medication) for pulmonary embolus and the goal international normalized ratio (INR) (INR is a blood test used to monitor how well the blood-thinning medication-an anticoagulant, is working to prevent blood clots), is 2.0 - 3.0. INR on 1/3/19 was 1.9 and R204 was ordered to receive 4 mg of Coumadin daily. INR was rechecked on 1/7/19 and the results were 1.1. During observation and interview on 1/24/19, at 11:51 a.m. R204 was sitting in her wheelchair wearing a peach outfit and was well groomed, propelling self-down the hallway. R204 stated, they let my Coumadin lapse for 3 days, thank god for [RN-C], he caught the missed doses. I have been on Coumadin for 5-6 years, they said my clots will come back in my lungs If I don't take it. R204 denies pain or difficulty with her breathing. R204 further stated, the lowest my INR has been since I have been here was 1.1. I have been getting a little over 1 mg of Coumadin, it's a little concerning to me, they checked my INR this morning it was 1.3, and it was at 2.0 before I came here. I would feel more secure if I was getting 2.5 mg of Coumadin. When I was on that dose my INR levels were better. During interview on 1/24/19, at 2:43 p.m. registered nurse (RN)-C stated, I am the one who noticed the Coumadin error, I was doing the med pass on 1/6/19 in the evening and I was getting R204's medications ready and there was nothing for Coumadin in her MAR, that was a huge thing when she first came here. I remembered her	21545		

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21545	Continued From page 9 being on that, so I checked her last INR date which was 1/3/19, and this was the 6th now, so she had missed 3 days. I found it, I called the on call provider and he said to continue last known order for Coumadin that she was on. R204 was on 2.5 mg and we gave it to her that night. The INR was gotten in the morning and it was like 1.1, her last INR was this morning and it was 1.3, so they are going to bump her dose of Coumadin up. I think the error happened because if the INR isn't done, it drops off the MAR. To prevent this from happening again, now at 4 pm you have to sign out to check Coumadin dose and also the treatment sheet says, the resident is on Coumadin and to monitor for bleeding. The night shift does the INR's in the morning. I reported this to the director of nursing (DON) right away and they filed a VA report and she filled out the med error report. We are directed to report the medication error to the DON right away so she can follow up with an investigation. Verified family was not notified. She is now on 5 mg daily. During interview on 1/25/19, at 5:01 p.m. regional clinical nurse (RCN) and corporate clinical nurse (CCC), verified that R204 missed her Coumadin dose for 3 days and that would be a significant med error. RCN stated, "I would have expected the nurses that were responsible to administer the Coumadin, to have given it. I would also expect there to be a progress note that the MD was notified." Facility policy, Coumadin Monitoring, revised 9/11/2018, identified a purpose to provide a consistent therapeutic INR range between 2.0 and 3.0 for residents on Coumadin.	21545		

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21545	Continued From page 10 Facility policy, Medication Error and Drug Interactions, issued 8/1/15, identified, all medication errors and drug reactions will be reported immediately to the director of nursing, the attending physician, and will be documented according to established procedures. Medication error is identified as the preparation or administration of medications or biological that is not in accordance with the prescriber's orders, manufacturer specifications regarding the preparation and administration of medication or biological and/or accepted practice standards for medication or biological administration. 2. A detailed account of the error will be recorder in the resident's medical record. Such documentation must include, but is not limited to: a. Time and date of the incident b. Name, strength, and dosage of medication administered. c. Residents reaction to the medication d. Condition of the resident e. Any treatment administered f. Date and time the physician was notified and what instructions were given. SUGGESTED METHOD OF CORRECTION: The administrator, DON, and consulting pharmacist could review and revise policies and procedures for appropriate medication administration and educate staff. The DON or designee, could audit medication administration and take those results to the Quality Assurance Performance Improvement (QAPI) committee for a set amount of time to determine compliance and the need for further monitoring. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21545		

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21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to report an allegation of resident-to-resident verbal abuse, immediately to the administrator and to the designated state agency (SA) within two hours for 1 of 1 resident (R39). Findings include: R39's Admission Record printed 1/25/19, indicated R39's diagnoses down syndrome and dementia with behavioral disturbance. R39's quarterly Minimum Data Set (MDS) dated 11-12-18, indicated R39 had severe cognitive impairment, did not have indicators of delirium, had no mood symptoms or behaviors. The MDS indicated R39 required limited assist of 1 staff for ambulation. R39 was observed to independently ambulate throughout the unit without any supportive devices during the survey.	21995	Corrected.	2/22/19

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21995	Continued From page 12 R252's quarterly Minimum Data Set (MDS) dated 11-120-18, indicated R252 had no cognitive impairment, did not have indicators of delirium, had no behaviors and reported mood symptoms of feeling tired and having little energy. The MDS indicated R252 did not ambulate, required extensive assist two staff for transfers. R252 required supervison for locomation on the unit. R252 was observed to indepedently use a scooter throughout the unit during the survey. R39's initial vulnerable report submitted to the SA on 1/8/19, at 5:22 p.m. identified an incident ocurred on 1/6/19 at 1:30 p.m. of a "Verbal confrontation between residents. Verbal threats between residents." Review of the initial report made to the SA lacked documentation of how and when the facility director of nursing (DON) became aware of the abuse allegation that occurred on 1/6/18, which was reported by the DON on 1/8/19. The DON became aware of the abuse allegation when reviewing progress notes the morning of 1/8/19 per the facility administrator. R39's investigative summary submitted to the SA on 1/10/19, at 12:04 p.m. included, "R259 was a long standing resident at Eden Brook of Rochester he has been a resident since [11/--/2017] he resides sown [sic] the West hallway in room 3B. He has diagnoses of left leg amputee, CHF (congestive heart failure), major depressive disorder. He ambulates with a power scooter and has a BIMs (brief interview for mental score) of 15. R39 had been a resident of Eden Brooks since 10/11/2018 he also resides down the West hallway in room 12A. He has	21995		

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21995	Continued From page 13 diagnosis of Downs Syndrome with respiratory failure. He has a BIMs (brief interview for mental score) of 2. Last Sunday 1/6/19 approximately 14:00 hours. R39 and R259 were in the main common area there was an argument between the 2 that staff attended to. From history R39 likes to sit in the main common area to color he sits at a table that is labeled specifically for R39. On this particular Sunday R39 was sitting in the main common area sitting at a table that was not labeled for R39 but at the longer table that is for everyone use. Per Interview with R259 he states that he was upset that R39 was not using the table that was intended just for him and R259 states he wanted to use the common table and 2 other residents wanted to use it also. R259 states that he asked R39 to move his things and that R39 would not move his things. R259 stated R39 stood up and told R259 to shut up. R259 states that he personally did nothing wrong and did not raise his voice to R39, R259 states he doesn't understand why writer is asking him questions about this situation because R39 was the one that wasn't sharing the table. R259 does have in his care plan that he does have behaviors of targeting residents in the past. R39 is unable to account for this episode. R39 does not remember, and changes that subject to his birthday when being interviewed. R39 does not feel scared, or threatened when asked. Interview with staff: Activities (A)-A stated that she was visiting with another resident when she walked into an argument between R259 and R39. R259 was telling R39 to shut up and his tone was threatening. R39 then stood up and told R259 to shut up. A-A stated that a nurse then came over and tried to calm them both down, and to be quiet. A few more words were spoken between R39 and R259. Licensed practical nurse (LPN)-A	21995		

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21995	Continued From page 14 states that all she heard was R39 going on and on stating shut up to R259. That there was nothing physical that happened. Registered Nurse (RN)-A states that she overheard R259 calling R39 a retard, and a pathetic little thing. RN-A told R259 this was inappropriate and then R259 left the room. RN-A then went in with R39 and walked him back to his room. The investigative summary indicted the vulnerable adult policy was followed. Actions taken to prevent reoccurrence to subjected resident: Nurse had walked R39 out of the common area to his personal room. Action taken to prevent reoccurrence to other resident: Staff education on the Vulnerable Adult Policy. On 1/25/19, at 3:00 p.m. licensed practical nurse (LPN)-A stated if we overhear anything (between R39 and R259) we separate them. R39 was moved to different wing. LPN-A stated we try to keep them separated. LPN-A stated the facility had twenty-four hours to report abuse to state, but we would report it to the director of nursing and administrator right away. LPN-A stated R259 seemed to ignore R39 and we try to keep them separated. On 1/25/19, at 3:06 p.m. registered nurse (RN)-A stated the facility had twenty-four hours to report to the designated state agency if it was abuse. RN-A stated we report to the administrator and director of nursing right away. RN-A stated I have never seen physical abuse between R39 and R259. RN-A stated the one time, it got a little louder, R39 was at a little table and R39 was pointing and raising his voice to R259, not really yelling. RN-A stated I separated them and R39 was a harder one to get too separate. RN-A stated I redirected R39 to his room. RN-A stated I	21995		

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21995	Continued From page 15 was charting and I did not hear any verbal abuse or name-calling. On 1/25/19, at 5:06 p.m. the administrator stated there was a verbal exchange of shut up, nothing physical on 1/6/19. The administrator stated I should have been made aware immediately and stated I would have wanted this to be reported within two hours to ensure we were complaint. The administrator verified the initial report was made to the SA on 1/8/19, which was two days later then the alleged incident. The administrator stated on 1/8/19, the DON read a progress note from 1/7/19, which eluded to the incident that allegedly occurred on 1/6/19, which was not reported to the administrator or the DON. The DON found the progress noted dated 1/7/19 and brought it to morning meeting at 9:30 a.m. on 1/8/19 and that was when we discussed it. The administrator stated I would have expected A-A would have reported to her supervisor or myself on 1/6/19. The administrator stated allegations of abuse get reported as soon as residents are assured that they are safe. The administrator stated the notification process begins per our policy to determine if it is abuse, what type of abuse and then what necessary steps needs to take place, are we sending to the emergency room, are we calling the police, then determine how soon we are reporting. The administrator stated the alleged incident was reported to the SA on 1/8/19, at 5:22 p.m. The administrator stated I would have wanted this reported as immediate as possible. The administrator stated she would have expected the DON to report immediately within the two hours, that is what I would have expected. The administrator verified the DON did not report the alleged resident-to-resident abuse within two of hours.	21995		

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	00916	A. BUILDING: _____ B. WING _____	C 02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENBROOK OF ROCHESTER	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) COMPLETE DATE
21995	Continued From page 16 The administrator stated if any staff are aware of an allegation of abuse, they are aware they are responsible to report it and to keep residents safe. On 1/25/19, at 6:19 p.m. activity aide (A)-A stated abuse was to be reported immediately. A-A stated I can get ahold of the administrator, we have her number here, or I could report to my supervisor. A-A stated I do not remember what happened in the incident (on 1-6-19), I just remember the tone, they were upset with each other. The tone of voices was angry for both residents. A-A stated I was watching it (the resident to resident interaction) and I guess I was wrongly thinking the nurse was going to take care of it. A-A stated that is not what I should have done. I should have taken care of it. A-A stated I should have intervened and separated them. A-A stated I had had been thinking I needed to do something, but then nurse came over. A-A stated we both should have reported and I know better. A-A stated I was retrained on vulnerable adult reporting very quickly after that however, did not recall the date she was retrained. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to immediately report suspected abuse to the administrator and to the designated state agency within two hours. The director of nurses' could monitor incident reports for implementation of this requirement. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21995		