STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355050	A. BUILDING _____ B. WING _____	03/08/2012

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MAPLE MANOR CARE CENTER	1116 9TH AVE LANGDON, ND 58249

(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 For the standard Medicare/Medicaid recertification survey started on March 5, 2012 and completed on March 8, 2012 the sample included three (3) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete a significant change in status assessment [SCSA] for 1 of 1 sampled resident (Resident #6) who experienced a significant change (decline) in functional status and behavioral symptoms. Findings include:	F 274	1) A significant change was completed on Resident #6 on 3-8-2012 2) A significant change will be completed on all residents with said number of declines or improvements within the time frame as indicated in the RAI Manual 2-20 through 2-23. 3) The MDS Team reviewed and was reeducated on SCSA on 3-8-2012. This area of the RAI Manual will be reviewed quarterly by the MDS team to keep all members apprised of reasons for significant change.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Connie McPherson	Administrator	04-03-12

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

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F 274	Continued From page 1 The Centers for Medicare and Medicaid Services Long-Term Care Facility RAI User's Manual, Version 3.0, October 2011, page 2-20 through 2-23 states, "Significant Change in Status Assessment . . . When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met. . . . A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments; and the resident's condition is not expected to return to baseline within two weeks. . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia, right hip fracture on, 01/25/12, anxiety, and depression. An admission Minimum Data Set (MDS), dated 12/27/11, identified Resident #6 as independent with bed mobility, required set up assistance with eating and walking in room, and required limited assistance with transfers, walking in corridor and locomotion on and off the unit. This MDS identified the behaviors of rejection of care, which occurred 1 to 3 days, and wandering, which occurred 4 to 6 days. A quarterly MDS, dated 02/07/12, indicated Resident #6 needed extensive assistance for the following ADLs: bed mobility, transfer, locomotion	F 274	4) The MDS Team will document their review of SCSA quarterly and present to QA Coordinator a list of significant changes that have been completed in each quarter. This will happen quarterly for the first four quarters and then yearly unless changes occur then a review will be as soon as changes are recognized. 5)	3-8-12 to 03-09-12 per phone conversation w Connie Hakanson Administrator on 04/10/12 at 0940 Cheryl, RN

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F 274	Continued From page 2 on and off the unit, and eating. Walking in room and in the corridor did not occur. This MDS identified the behaviors of physical and verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others, which occurred 1 to 3 days. Rejection of care occurred 1 to 3 days, and wandering occurred 4 to 6 days. Observations of care provided during March 5-8, 2012, showed Resident #6 continued to require extensive assistance for eating, transfers, locomotion on and off the unit, and the resident did not walk in the corridor. Observation on 03/07/12 at 4:35 p.m. showed the resident hitting out at staff while in his wheel chair. The record lacked a completed SCSA for the resident's decline in the following: bed mobility, transfer ability, walking in room and in the corridor, locomotion, and eating; and for increased behavioral symptoms for physical and verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others. Failure to complete a comprehensive assessment in response to Resident #6's physical and behavioral decline increased the resident's risk for further decline and the potential lack of appropriate interventions to restore or maintain physical and mental function.	F 274		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		

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F 278	Continued From page 3 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff and resident interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 4 of 12 sampled residents regarding a toileting program (Resident #1, #8, #10 and #12) and 2 of 3 sampled residents (#2 and #7) with a urinary catheter. Failure to accurately code the MDSs for	F 278	1) A correction was done and transmitted on 3-12-12 for Resident #1, 2, 7, 8, 10 & 12. 2) All residents MDS Section H0200C was reviewed. Modifications were made if indicated on current MDS's. Corrections were transmitted to CMS and State on 3-12-12. 3) The MDS team has been reeducated on the interpretation of H0200. Residents who are continent of urine with or without assistance or who use a permanent catheter or ostomy, as well as residents who prefer not to participate will not be coded as a 1 on the MDS. 4) QA will be done by the DON which will include a review of the B&B assessments on each resident at the time of their quarterly MDS and will review the MDS input prior to closing and submitting the MDS. 5)	4-2-12

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F 278	Continued From page 4 these residents limited the facility's ability to develop and implement individualized care plans consistent with their needs and functional status. Findings include: The Long-Term Care Facility RAI User's Manual stated on: * Page H-6, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated . . . A toileting program does not refer to: - simple tracking continence status, - changing pads or wet garments, and - random assistance with toileting or hygiene." - Review of Resident #1's medical record occurred on all days of survey. The resident's current MDS, dated 01/27/12, identified moderately impaired cognition, frequently incontinent of bowel and bladder, and on a urinary toileting program. Resident #1's current "Quarterly Continence Assessment," dated 01/30/12, stated, ". . . She toilets self and is encouraged to call for help . . . she is able to make needs and wants know. She refuses toileting program. . . ." Resident #1's current plan of care stated, ". . . PROBLEM: Alteration in elimination r/t [related to] occ [occasional] urinary incontinence - dribbling. . . APPROACHES: . . . Allow resident to toilet self during the day [with] FWW [front wheeled walker] as she desires. . . ." An observation on 03/06/12 at 2:25 p.m., showed	F 278		

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F 278	Continued From page 5 Resident #1 returning from the bathroom in her room, unassisted by staff, verifying the resident's ability to toilet herself. - Review of Resident #12's medical record occurred on March 7-8, 2012. A quarterly MDS, dated 10/11/11, identified the resident as cognitively intact, continent of bowel and bladder, and on a toileting plan. Review of a "Quarterly Continence Assessment," dated 11/03/11, stated, "He has been continent of B&B [bowel and bladder]. He toilets self. Resident #12's current plan of care stated, "PROBLEM; Self care deficit . . . Resident is non compliant with letting staff assist with cares at times and with toileting. . . APPROACHES: Resident can toilet self, help pRN [sic][as needed] . . ." During an interview on 03/08/12 at 10:45 a.m., a nursing staff member (#1) indicated that both Resident #1 and #12 take themselves to the bathroom, indicating the residents' MDSs inaccurately coded for a toileting program. - Review of Resident #10's medical record occurred on March 7-8, 2012. A quarterly MDS, dated 12/14/11, identified the resident as cognitively intact, continent of bowel and bladder, and on a toileting plan. The resident's admission MDS, dated 07/07/11, identified the resident as cognitively intact, on a urinary toileting trial with being dry as the response, and currently on a bladder toileting plan. Review of "Bowel and bladder flow sheets,"	F 278		

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F 278	Continued From page 6 dated 12/04/11 through 12/17/11 identified the resident as dry and continent of urine. Resident #10's current plan of care stated, ". . . She has been toileting self. She is encouraged to call for help as needed . . . " The facility identified Resident #10 as interviewable. During a resident interview, on 03/07/12 at 5:30 p.m., the resident stated she takes herself to the bathroom verifying the resident's MDS inaccurately coded her for a toileting program. - Review of Resident #8's medical record occurred on all days of survey. The resident's current MDS, dated 02/24/12, identified severely impaired cognition, occasionally incontinent of bladder, and on a urinary toileting program. Resident #8's current "Quarterly Continence Assessment," dated 02/27/12, stated, ". . . inc. [incontinent] of urine [one time] in reference period. . . . She toilets self and is reminded to call for help as needed when seen toileting self one staff will help her as she allows. . . ." Resident #8's current plan of care stated, ". . . PROBLEM: Alteration in elimination r/t [related to] overactive bladder. . . APPROACHES: . . . Toilets self . . . Does peri [perineal] care per self. Help prn per [one] staff . . . help as she allows. . . ." During an interview on 03/08/12 at 8:30 a.m., a nursing staff member (#1) indicated that both Resident #8 and #10 toilet themselves and a trial is done every quarter during the assessment	F 278		

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F 278	Continued From page 7 reference date for the MDS. This staff member confirmed that staff will ask and prompt residents to void during this trial even when a resident is continent. The MDS incorrectly coded Resident #8 for use of a urinary toileting program. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included prostate cancer. The resident's quarterly MDS, dated 12/20/11, identified the resident as cognitively intact and indicated the resident had an indwelling catheter and on a urinary toileting plan. During an interview on 03/07/12 at 2:45 p.m., a nursing staff member (#1) stated that coding "yes" to a toileting plan or trial was an error for Resident #7 since the indwelling catheter was in place and urinary continence was not rated. - Review of Resident #2's medical record occurred on all days of survey. An admission MDS, dated 09/26/11, indicated the resident had an indwelling catheter and on a urinary toileting plan. Record review on 03/07/12 showed Resident #2 had a catheter when the admission MDS was completed. During an interview in the morning of 03/07/12, a nursing staff member (#1) confirmed the resident had a catheter during that assessment period, and coding "yes" to a toileting plan or trial was an error.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 8 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to develop the residents' comprehensive plan of care to address specific problems identified for 4 of 12 sampled residents (Resident #4, #5, #9, and #11). Failure to develop, review and revise the residents' care plans limits the staff's ability to assist the resident to attain or maintain their highest practicable physical, mental, and psychosocial well-being, and ensure continuity of resident care. Findings include:	F 279	1) Care Plans for resident #4, 5, 9, 11 were reorganized using our new EMR system. 2) All residents will have their care plans reorganized using our new EMR system. 3) Refer to #2 4) Education on our new EMR system will continue on a monthly basis through January 2013 to aid in the review and revision of residents care plan, therefore assisting in the continuity of care. The care plan team and C.N.A.'s will review care plans quarterly and a signature will be obtained by each person that reviewed the care plan on a care plan review signature sheet. The QA coordinator will perform a QA quarterly on the signature sheet to ensure reviews are completed for the first four quarters then yearly thereafter. 5)	3-28-12

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F 279	Continued From page 9 Review of the facility "Policy and Procedure for Care Plans" occurred on 03/08/12. The policy, dated 01/30/12, stated ". . .The care plan will be based on assessment of the resident and specific wants and needs of the resident. . . . reflects social, emotional and physical needs of the resident. . . .assists with facilitating comprehensive quality care. . . . focuses on resident specific outcomes that are realistic for the resident and measurable." - Review of Resident #4's medical record occurred on all days of survey. The resident's diagnoses included dementia, Alzheimer's, and depression. The current quarterly Minimum Data Set (MDS), dated 12/27/11, identified Resident #4 had physical behavioral symptoms directed toward others, occurring 1-3 days; verbal behavioral symptoms directed toward others, occurring 4-6 days; and other behavioral symptoms not directed toward others, occurring 1-3 days. Review of Resident #4's Behavior Roster, dated January 13 - March 5, 2012, identified the resident had 54 behaviors which included, physical, verbal, and wandering. The care plan lacked a problem, specific goals, or interventions for Resident #4's behaviors. - Review of Resident #5's medical record occurred on all days of survey. The resident's diagnoses included depression, and anxiety. The current significant change MDS, dated 12/15/11, identified Resident #5 had other	F 279		

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F 279	Continued From page 10 behavior symptoms not directed at others, occurring daily. Review of Resident #5's Behavior Roster, dated January 13 - March 5, 2012, identified the resident had 37 behaviors which included, verbal, hoarding, and wandering. The care plan lacked a problem, specific goals, or interventions for Resident #5's behaviors. - Review of Resident #9's medical record occurred on March 07-08, 2012. The resident's diagnoses included reactive confusion, mental disorder, depression, and dementia. The current quarterly MDS, dated 01/23/12, identified Resident #9 had other behavioral symptoms not directed at others, occurring 1-3 days of the past seven days. Review of Resident #9's Behavior Roster, dated January 12 - March 5, 2012, identified the resident had 69 behaviors which included physical, and verbal behaviors. The care plan lacked a problem, specific goals, or interventions for Resident #9's behaviors. - Review of Resident #11's medical record occurred on March 07-08, 2012. The resident's diagnoses included mental disorder, Alzheimer's, anxiety, depression, paranoid, and hallucinations. The current quarterly MDS, dated 01/16/2012, identified Resident #11 had physical behaviors directed toward others occurring 4-6 days; and verbal behavioral symptoms directed toward	F 279		

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F 279	Continued From page 11 others, occurring 1-3 days. Review of Resident #11's Behavior Roster, dated January 13 - March 5, 2012, identified the resident had 84 behaviors which included, physical, and verbal behaviors. The care plan lacked a problem, specific goals, or interventions for Resident #11's behaviors.	F 279		