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 _____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 April 1, 2013 and completed on April 4, 2013, the sample included 3 residents for compete review, 9 residents for focused review, and 2 closed records for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. 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.	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Connie DeBoer	Administrator	04-19-13

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 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0) and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' status for 1 of 1 sampled resident (Resident #3) coded incorrectly for behaviors. Failure to accurately complete the MDS does not allow each resident's assessment to guide the creation of an effective care plan. Findings include: The Long-Term Care Facility RAI User's Manual, page E-1, stated, "Delusion: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary." Page E-2 stated, "Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses included paranoid delusions, dementia, depression, and anxiety. The current MDS, dated 03/13/13, identified Resident #3 exhibited delusions during the seven day assessment period. Review of the medical record failed to identify any delusional behaviors exhibited by Resident #3 during the MDS assessment period. During an interview on 04/03/13 at 5:00 p.m., the	F 278	1) A modification MDS on Res #3 was completed and transmitted 2) All MDS's marked with E0100A or E0100B will be reviewed by April 30th to assure supporting documentation is present. 3) Social Worker will meet with MDS Coordinator prior to the submission of any MDS where either E0100A or E0100B are indicated to review documentation for compliance as stated in the RAI Manual page E-2 4) An Audit form for Sec E100 has been developed to assure supporting documentation is present if E0100A and E0100B are checked. This will be completed during the above (#3) review by the Social Worker and MDS Coordinator. QA will review audits completed of Sec E100 monthly for 4 Months then quarterly for completion and accuracy. Results will be retained in QA office. 5)	04-15-13 04-30-13 04-30-13 04-30-13

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F 278	Continued From page 2 staff member (#2) stated Resident #3 "chants." The staff member failed to locate documentation of any delusional behaviors observed during the seven day assessment period.	F 278	1) The two oxygen cylinders that were found in an unsecured manner were immediately secured. 2) All oxygen storage areas have been observed daily since 4-4-13 and all cylinders have been found to be secured. 3) Nurses will document on an oxygen log at the nurses' station when returning a cylinder to the storage area, that it has been secured in the proper rack. This log will be kept at the nurses' station. 4) QA will be performed on the oxygen storage area to ensure all cylinders are secured, as well as the oxygen log to ensure oxygen storage compliance. QA will be done two times a week for one month, weekly for eight weeks and then monthly by the DON and those QA's will be stored in the QA office. 5)	4-5-13
F 454 SS=D	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference and staff interview, the facility failed to store oxygen according to current Life Safety Code requirements in 1 of 4 oxygen storage rooms (300 wing). Failure to store the oxygen tank in a secure manner has the potential for the tank to fall and become a projectile missile potentially causing injury to residents, visitors, and staff. Findings include: Life Safety Code requirements state, "Nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes comply with NFPA 99, 13-5.1, 7-1.2, NFPA 70." Standard for the Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders, and Tanks, NFPA 55, 7.1.4.4 states "Securing Compressed Gas Containers Cylinders, and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to	F 454		

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F 454	Continued From page 3 prevent them from falling or being knocked over by corralling (collect/gather) them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.1 and 7.1.4.2.7." Observation of oxygen storage occurred on 04/04/13 at 9:00 a.m. with an administrative nurse (#1). Observation showed two free-standing oxygen tanks on the floor in the oxygen storage room on the 300 resident wing. The oxygen tanks lacked any method of corralling or securing them. The oxygen storage room contained a rack holding oxygen tanks with one storage space available. During an interview at the time of the observation, the staff nurse (#1) confirmed staff are to store oxygen cylinders in the rack provided.	F 454		