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 _____	04/06/2011

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 04/04/11 and completed on 04/06/11 the sample included 4 residents for complete 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 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to provide treatment and services to restore or maintain normal bladder functioning for 1 of 2 sampled residents (Resident #6) who experienced a decline in urinary continence. Failure to assess Resident #6's voiding habits and patterns and implement appropriate and timely interventions resulted in a decline in urinary continence. Incontinence may also result in urinary tract infections, skin breakdown, and a loss of dignity. Findings include:	F 315	1) Resident #6 was start on Maple Manors UTI protocol on 4/5/11 to rule out a UTI. She was examined by Dr. Grandison on 4/7/11 as he made nursing home rounds. She was started on oxybutinin 10 mg bid and her lasix was increased to 40 mg bid for 1 week on 4/7/11. She had a physical therapy evaluation on 4/11/11 which it was ordered for her to work with PT 3 times per week over 60 days. On 4/12/11 a UA and CBC were done. Her UA was positive for a UTI and her WBC were 13.8. 4/13/11 resident was seen by the psychiatrist Dr. Tom Peterson and her Resperdal was discontinued and her family refused any psych visits or meds. She received a regimen of Cipro for one week. She had an F/U UA on 4/21/11 which came back negative. A toileting schedule was initiated on 4/18/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Connee Nelson	Administrator	04-25-11

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 315	Continued From page 1 Review of the facility policy titled "Bowel and Bladder Management Program" occurred on 04/06/11. This undated policy stated, ". . . Purpose: To ensure that each resident receives appropriate management of bowel and bladder needs based on assessment, evaluation, intervention (when necessary) and re-evaluation. . . . Policy For Bladder Retraining . . . A. On admission, a Bowel and Bladder assessment will be performed. The assessment will be re-evaluated quarterly and in the event of a hospital return or significant change . . . B. Based on the Bowel and Bladder assessment, a decision will be made to initiate the retraining sequence, initiate scheduled toileting, or brief the resident with incontinence cares to be performed by staff on a scheduled basis, or obtain medical consultation. . . ." Review of Resident #6's medical record occurred on all days of survey. Diagnoses included diabetes mellitus, senile dementia with delusional features, depression, congestive heart failure, and edema. Current medications included Lasix (a diuretic) 30 mg (milligrams) daily. Resident #6's Minimum Data Sets (MDSs) identified a progressive decline in urinary continence as follows: * 08/04/10: continent of bladder * 11/01/10: occasionally incontinent of bladder * 02/01/11: frequently incontinent of bladder The resident's current MDS, dated 02/01/11, identified a Brief Interview for Mental Status (BIMS) score of 5 (indicating severe mental impairment), fluctuating delirium, hallucinations, delusions, verbal behaviors directed toward others and rejection of care occurring 1 to 3 days	F 315	2) After reviewing our old bowel and bladder assessment, a new bowel and bladder assessment had been developed that is more resident focused. All residents will have a new quarterly assessment completed. The quarterly assessment will be evaluated at the quarterly care conference. 3) A new policy was implemented on 4/22/11 that will affect all residents. A new quarterly assessment has been developed. 4) Quarterly bowel and bladder assessments will be reviewed on Monday mornings at our current skin issue / weight control meeting. The Monday morning meetings will now be skin issue, weight control, and bowel and bladder changes. The 4.25 11 5) DON will be responsible to get completed audits to the Quality Assurance Coordinator. 4/23/11 5) 4/23/11

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F 315	Continued From page 2 during the seven day assessment period, and limited assistance from one person required for toilet use. The MDS did not identify the use of a toileting plan. Resident #6's care plan, dated 02/08/11, stated the following, ". . . Problem . . . Res. [resident] is inc. [incontinent] of B et B [bowel and bladder] . . . Toilets self and refuses to call or even most times let staff help her . . . Approaches . . . Res. toilets [independently] but encouraged to call for help . . . change [brief] prn [as needed] or as resident allows . . . Res. is encouraged to call for assist. . . ." The care plan lacked individualized approaches or any further interventions related to Resident #6's incontinence. Observations and interviews throughout the survey revealed Resident #6 required staff assistance for toileting and transfers. Resident #6's care plan related to behaviors stated, ". . . Problem . . . Resident accuses others of taking her belongings . . . Resident thinks someone is taking a dump or urinating in her toilet when it is her . . . Approaches . . . Assist in locating the misplaced item . . . Emotional support and redirection as needed . . . Psych. [psychiatry] appointment as ordered. . . ." The care plan lacked individualized approaches or any further interventions related to Resident #6's behaviors and resistance to cares. Resident #6's "Bowel and Bladder Initial Assessment," dated 10/23/08, identified the resident as continent of bowel and bladder. The assessment also identified Resident #6 as independent with transfers using a walker, and able to communicate the need to void. In the narrative notes accompanying the bowel and	F 315		

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F 315	Continued From page 3	F 315		

bladder assessment, staff identified Resident #6 declined from continent to incontinent but failed to re-evaluate Resident #6's bladder function and voiding patterns. Record review identified no further assessments completed since 10/23/08.

Review of Resident #6's nurses' notes from August 2010 through April 5, 2011 revealed the following:
* 09/06/10: "2 p.m. NOC [night] CNA [certified nursing assistant] reports Res. incontinent of urine x 2 [twice] during the night. Soiled clothing et [and] bedding noted."
* 09/10/10: "6 p.m. CNA reports res. bed was wet this a.m. et res. was upset when CNA was changing it. Stated 'someone else did that.' CNA also reports res. smells of urine but refused any assist [with] cares or dressing. . . ."
* 12/08/10: "7:10 p.m. CNA reports res. hung wet clothes up in BR [bathroom] then put them away in her drawer later. 7:15 p.m. CNA put wet clothes in laundry."
* 01/07/11: "2 p.m. CNA reports Res. had taken off wet pants that were soaked [with] urine et hung them in her BR. When CNA went to take them out for laundry to wash res. stated, 'I don't know who keeps coming in here et leaving their wet clothes all over.'"
* 01/09/11: "2:00 p.m. - told CNA this a.m. that someone wet all over her floor . . . she had the wet pants on the shower rail."
* 01/23/11: "[8:00 a.m.] NOC staff report that wet clothing removed from res. rm [room] x 2 - res. denies being inc."
* 01/29/11: "3:45 p.m. Res. incontinent urine [sic] a lot today - 3 pairs of pants [changed] this a.m. by CNA. Res. incontinent of urine on BR floor et told CNA that someone else came in there et did it. . . ."

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F 315	Continued From page 4 * 01/31/11: "11:00 p.m. - UA [urinalysis] negative." * 02/04/11: "1 p.m. . . . CNA reports res. was IC [incontinent] of urine on floor et stated, "I don't know who did that but when I find them I'm going to ring [sic] their neck." * 02/05/11: "2 p.m. CNA reports Res. had urine on her floor around the toilet and soiled clothing. Res. denies that it was her doing. She said someone else came in her room and did it." * 02/08/11: "[10:00 p.m.] CNA reports that res. upset this evening that someone has been coming into her room @ noc et urinating on the floor. . . ." * 02/17/11: "[6:00 a.m.] CNA reports that wet linens removed from BR x 2 et res. apologized saying she just 'had to go.'" * 02/23/11: "6:30 p.m. CNA reports res. inc. urine [sic] this shift numerous times. 6:35 p.m. Res. given cares for incontinence." * 03/01/11: "2 p.m. CNA reports several wet clothes taken from railing in res. BR. Res. states 'I don't know who put those there.' Reorientation [not] effective." * 03/04/11: "10 a.m. . . . Res. was IC of urine in bed this a.m. et hung wet items in the BR to dry. . . ." * 03/06/11: "[12:00 p.m.] Res. was inc. of urine in DR [dining room] - escorted to her room et assisted to clean up." * 03/08/11: "2 p.m. CNA reports res. was IC of urine on BR floor today et told CNA 'look what some [expletive] did to my floor.' Res. had wet pants hanging on rod in BR. . . ." * 03/13/11: "2 p.m. CNA reports Res. clothing soiled r/t [related to] inc. x 2. CNA assisted." * 03/14/11: "2:00 p.m. CNA reported bed wet when Resident got up." * 03/17/11: "2 p.m. CNA reports res. had wet pants in her room after dinner, clothing taken to	F 315		

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F 315	Continued From page 5 laundry. Res. denied incontinence although pants smelled of urine." * 03/18/11: "1 p.m. . . . CNA reported res. was IC of urine x 1 [once] this a.m. et hung wet pants in BR. Clothes removed et res. assisted [with] changing. . . ." * 03/22/11: "2 p.m. CNA reports res. IC of urine in DR today et had puddle under chair, needed much encouragement to go to room to change. Did allow CNA to assist her. . . ." * 03/24/11: "[9:00 p.m.] CNA reports assistance x 1 with brief." * 03/26/11: "[3:00 p.m.] CNA reports res. has been assisted [with] toileting et [changing] pads - pants wet x 1 - assist provided." * 03/27/11: "[3:00 p.m.] CNA reports res. was assisted with a.m. cares et toileting. Res. very wet x 1 this a.m. assistance given." * 03/28/11: "11 p.m. CNA reports res. upset. Res. believes someone else has come in et urinated all over her bed. Res. unable to be redirected et cont. [continues] to verbalize someone else did that." * 03/30/11: "6 p.m. CNA reports res. was IC of BM on BR floor, told CNA 'I'd like to find the son-of-a-[expletive] who took a [expletive] on my floor.' Reorientation [not] successful." * 04/05/11: "2 p.m. CNA reports res. IC of urine on floor, res. assisted to room et helped [with] cleaning et changing. Res reports she 'couldn't make it.' . . . Plan to initiate UTI protocol . . ." Although staff documented numerous incidents related to Resident #6's confusion and belief that someone else used her toilet or voided on the floor, staff documented only six occurrences of Resident #6 refusing cares (during toileting assistance or incontinence cares) throughout the eight months of nurses' notes reviewed.	F 315		

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F 315	Continued From page 6 Observation on the afternoon of 04/04/11 showed Resident #6 in her wheelchair in her room and a small puddle of liquid on the floor near her wheelchair. An unidentified staff member stated, "She might be wet. Or maybe she spilled something." Observation showed no beverage or drinking glass near the resident. During an interview on 04/05/11 at 9:36 a.m., a CNA (#8) stated, "She [Resident #6] was wet this morning when she got up. Wet, wet, wet. I had to change everything." The CNA also stated Resident #6 will call if she wants something, or staff will ask her periodically if she needs anything. Observation on 04/05/11 at 11:18 a.m. showed Resident #6 in her wheelchair in her room and a large puddle of urine under the resident's wheelchair and across her floor. Two CNAs (#8 and #9) assisted Resident #6 to the toilet using a sit-to-stand mechanical lift. The CNAs changed the resident's brief and pants. One CNA (#9) stated, "She's always wet like this. She can't help it. It's pretty much like this all the time." During the observation, Resident #6 stated, "I'm just a big baby, aren't I?" During an interview on 04/05/11 at 4:52 p.m., a CNA (#10) stated that around 3:00 p.m., she asked Resident #6 if she needed to use the bathroom. The resident stated "yes," and the CNA (#10) and another CNA assisted the resident with toileting. The CNA (#10) changed Resident #6's pants and brief (which were wet with urine). The CNA (#10) stated Resident #6 is not on a set toileting schedule, she just "lets us know when she has to go."	F 315		

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F 315	Continued From page 7 During an interview on 04/06/11 at 7:43 a.m., a CNA (#11) stated Resident #6 was incontinent of urine that morning. She stated Resident #6 is "typically always wet." The CNA stated she uses a sit-to-stand mechanical lift if the resident "is really wet and I need to clean her up more extensively." She also stated that sometimes Resident #6 can transfer with 2 people and sometimes she needs a lift, "it just depends on the day." She stated Resident #6 has transferred that way "for awhile now." After Resident #6 experienced a decline in urinary continence, facility staff failed to assess and implement interventions to attempt to restore as much bladder function as possible for this resident.	F 315		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility menus, and staff interview, the facility failed to follow menus and meet the nutritional needs of residents when staff served incorrect portion sizes as identified on the prepared menus for 2 of 4 tray line observations (dinner and supper 04/05/11) in the North resident dining room. Failure to use the correct utensil size had the	F 363	1) An in-service will be held on scoop sizes and importance of using sizes as indicated on the menu on April 28th. New scoop charts were obtained from Dakota Foods with scoop number, color and capacity in ounces, cups and approximate servings per quart. On 4/6/11 new scoops were purchased to match the chart on the wall.	

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F 363	Continued From page 8 potential to increase or decrease the food intake and nutritional status of all residents served in the dining room. Finding include: A poster in the facility kitchen identified the following scoop sizes with the approximate equivalency: #8 = 4 ounces (oz.); #10 = 3 1/4 oz.; #12 = 2 2/3 oz.; and #16 = 2 oz. - On 04/05/11 at 11:30 a.m. observation in the North dining room identified a dietary staff member (#4) served following meal items inconsistent with the planned menu: * Carrots: served scoop #10 (3 1/4 oz.) - menu identified 4 oz. * Ground ham: served scoop #16 (2 oz.) - menu identified 3 oz. * Pureed potato: scoop #10 (3 1/4 oz.) - menu identified 4 oz. * Pureed carrots: scoop # 12 (2 2/3 oz.) - menu identified 3 1/4 oz. * Pureed ham: scoop #12 (2 2/3 oz.) - menu identified 3 1/4 oz. - On 04/05/11 at 5:40 p.m. observation in the North dining room identified a dietary staff member (#4) served following meal items inconsistent with the planned menu: * Tomato soup: served 4 oz.- menu identified 6 oz. * Blended soup: served 4 oz - menu identified 6 oz. * Blended sandwich: served #8 scoop (4 oz.) - menu identified 6 oz. During an interview on the morning of 04/06/11, a dietary staff member (#3) confirmed facility staff	F 363	2) Scoop number and amount in ounces and cups will be written on the back of the scoops with a permanent marker for quick and easy identification. Menu binders will also have portion control menu planners placed in the front of each week so staff will have quick and easy access when setting up foods to bring over to the pantries. 3) QA Coordinator and Dietary manager will QA scoop sizes once a day for a week, once a week for a month, monthly for a quarter and periodically after that. QA reports will be kept in QA files. 4) QA Coordinator and Dietary manager will QA scoop sizes once a day for a week, once a week for a month, monthly for a quarter and periodically after that. QA reports will be kept in QA files. 5)	4/29/11

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F 363	Continued From page 9 used the wrong scoop sizes during the dinner and supper meal service observed on 04/05/11.	F 363		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	1) All Maple Manor Care Center nurses have been re-educated on the importance of labeling multi-dose vials. A new policy for multi-dose vial labeling was reviewed with nurses as part of the re-education. This will be added to the mandatory yearly nursing in-services. 2) Re-education and knowledge reviewing and understanding labeling policy will be signed by each nurse and maintained in their personnel file. 3) Multi-dose vials will be added to our quarterly QA checks and will be part of our ongoing issues to watch. QA will be complete by the DON + reported to Quality Assurance 4) Multi-dose vials will be checked for opening dates weekly for two months then quarterly. This QA will be added to our quarterly reviews as a reoccurring QA. 5)	Per T.C. 4/28/11 DON off 4/20/11 ~~6/6/11~~

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F 431	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, staff interview, and review of professional literature, the facility failed to date 4 of 17 multi use vials when opened, (three insulin and one tuberculin vial) in accordance with currently accepted professional standards and facility policy. Failure to identify the open date for the vials allows use beyond the manufacturers's recommended discard time frames. This practice may affect the potency and sterility of the insulin and tuberculin purified protein derivative. Findings include: Diabetic Care, Volume 26, Number 9, September, 2003, pages 2666-2667, "How Long Should Insulin Be Used Once a Vial Is Started?" states, ". . . Although an expiration date is stamped on each vial of insulin, a loss of potency may occur after the bottle has been in use for >1 [more than 1] month . . . Insulin products are sterile until the first dose is withdrawn by syringe...After first use, the contents of the vial . . . are technically no longer sterile . . . Sterile products should be used in as short a time as possible to minimize concerns about microbiological contamination once the container has been punctured. The CPMP [Committee for Proprietary Medicinal Products] has proposed a maximum-use period of 28 days for sterile products . . . including insulin products . . . changes in insulin action can lead to significant changes in blood glucose control." Review of the facility policy titled "Medication Administration-General Guidelines" occurred on 04/06/11. This policy, not dated, stated ". . . 21. All medications in vials refer to manufactures	F 431		

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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 431	Continued From page 11 insert for shelf life. . . ." Review of the facility policy titled "Insulin Injection Administration Procedures" occurred on 04/06/11. This policy, not dated, stated, ". . . 5. . . . (Key points: check medication expiration date. All new vials need to be dated on the vial when opened.) . . ." - During an observation of medication pass on 04/04/11 at 5:30 p.m. with a staff nurse (#7), the nurse obtained an opened vial of insulin for the resident. The nurse (#7) could not identify a date opened by staff on the vial. Two staff nurses (#1 and #5) assisted with a tour of the medication room on 04/05/11 at 1:25 p.m. A container in the medication refrigerator contained 15 open vials of insulin. Observation showed staff failed to label three vials with the date opened. The medication refrigerator contained an open vial of tuberculin purified protein derivative which facility staff failed to date when opened, in accordance with facility policy. Without a date opened identified, staff may administer this medication beyond the recommended shelf life indicated by the manufacturer. During an interview, on 04/06/11 at 9:40 a.m., an administrative nurse (#6) shared the manufacturer's insert, which stated, "A vial . . . which has been entered and in use for 30 days should be discarded . . ."	F 431		