| 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 _____ | 05/26/2016 |

| 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<br><br>For the standard Medicare/Medicaid recertification survey, started on 05/23/16 and completed on 05/26/16, the sample included 3 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey. | F 000 | | |
| F 176 SS=D | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to complete an assessment for 1 of 1 sampled resident (Resident #8) identified as able to self administer medication (SAM). Failure to determine if SAM is a safe practice has the potential to result in a medication error and/or harm to a resident.<br><br>Findings include:<br><br>Review of the facility policy titled "Self Administration of Medication Policy" occurred on 05/26/16. This policy, dated 10/14/15, stated, "Purpose/Objective: 1. To assist the resident to take their prescribed medications in a safe manner. . . . Policy/Procedure: 1. Physician orders will indicate which medications will be self-administered. . . . 3. Resident is instructed in | F 176 | 1) Resident #8 nurse spoke to the resident on 5-27-16 about her medications and not being able to leave her nebulizers at her bedside as she wishes as she does not self administer these medications. She also states she does not want to self administer nebulizers at this time. At that time she was also notified of the risks of leaving the nebulizers with her and she voiced her understanding. Self-administration of medication policy and procedure was reviewed at the nurses meeting on 6-2-16. The DON also spoke with resident #8 on 6-2-16 about the self-administration of medication policy.<br>2) All residents that receive medications have the potential to be affected.<br>3) A review and completion of the | 6/25/16 |

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

Electronically Signed | 06/17/2016

| 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 _____ | 05/26/2016 |

| 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 176 | Continued From page 1<br>use of medication, dose, method and times to be taken, and most probable side effects. . . . Self-administration may begin when the resident can show understanding of the medication. . . . 8. A yearly Self Administration Assessment will be done with the annual MDS [minimum data set] for residents' doing self-administration to assess if they are safe to continue."<br><br>Observation during medication pass on 05/24/16 at 9:00 a.m. showed a nurse (#6) prepared Resident #8's nebulizer medications including pulmicort, Ipratropium bromide, and albuterol. The nurse (#6) left the nebulizer medications with Resident #8 and stated she is able to self-administer.<br><br>Resident #8's SAM assessment, dated 01/04/16, identified the resident was safe to self-administer the Xopenex inhaler. The record failed to include evidence Resident #8 was safe to self-administer the nebulizer medications: pulmicort, Ipratropium bromide, and albuterol.<br><br>During an interview on 05/25/16 at 8:21 a.m. an administrative staff member (#1) confirmed Resident #8 did not have a SAM assessment completed for her nebulizer medications. | F 176 | self-administration assessment will be completed with the quarterly and annual MDS by the MDS RN.<br>4) The DON will review all self-administration of Medications assessments by 6-25-16. The DON/designee will watch 15 med passes weekly for 3 weeks then monthly for 3 months, then bi-monthly for 6 months and then randomly thereafter. QA will be done on the self-administration assessments monthly for 3 months, then bi-monthly for 6 months and then randomly thereafter. | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; | F 225 | | 6/25/16 |

| 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 _____ | 05/26/2016 |

| 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 225 | Continued From page 2<br>and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility policy, and staff interview, the facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse, and misappropriation of | F 225 | 1) The policy on missing items was reviewed at the staff, nursing, and CNA meeting on 6-2-16. The SW has recommunicated with both families of | |

| 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 _____ | 05/26/2016 |

| 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 225 | Continued From page 3<br>resident property were reported immediately to the administrator and investigated for 2 of 2 sampled residents (Resident #4 and #11) and 2 supplemental residents (Resident #15 and #16). Failure to identify, report, and investigate allegations of abuse or neglect and misappropriation of resident property placed all residents at risk for mistreatment, abuse, and loss of property.<br><br>FINDINGS INCLUDE:<br><br>Review of the facility policy titled "Abuse and Neclect [sic] Policy and Procedure" occurred on 05/26/16. This policy, dated 04/24/12, stated, "INVESTIGATION: 1. Maple Manor will investigate all alleged violations involving mistreatment, neglect, abuse, and misappropriation of resident property (including injuries of unknown source). These are to be reported to the Licensed Social Worker or Director of Nursing (or charge nurse in their absence) as soon as possible and then the Administrator (and other officials as necessary). . . . REPORTING . . . The Administrator and/or appointed person is responsible to report the incident to the State Survey and Certification agency within 24 hours. Send documentation of the investigation within five working days if facility deems incident to be neglect or abuse. . . ."<br><br>Review of Resident #4's medical record occurred on all days of survey. A missing item form, dated 10/06/15, identified a Certified Nursing Assistant (CNA) reported a missing ring to a charge nurse. The form stated, "Investigation and Findings: Room searched by housekeeping & CNA did not find in her room. Laundry notified & did not find. | F 225 | resident #4 & 11 about the rings in question. Neither family feels this has not been an issue. Both families request the facility not replace them.<br>2) All residents have the potential to be affected.<br>3) The missing items internal reporting form will be revised to include reportable, non-reportable. Department heads reviewed missing, searching and reporting requirements on 6-17-16.<br>4) DON/SW will review missing items reports and investigations daily for 5 days times 2 weeks, then weekly for 3 weeks, and biweekly for 6 months. QA will review reports of missing items every week for 2 months until such time consistent substantial compliance is met.<br><br>1) Resident #15 & 16 investigation papers were found in the former DON office after survey was completed. The investigation paperwork was faxed to the State Health Department on 6-20-16.<br>2) The facility recognizes that all residents have the potential to be affected.<br>3) An in-service was held for CNA, nurses, and all staff on 6-2-16 to include missing items, abuse and neglect, accidents/hazards/supervision/devices and reporting on allegations.<br>4) DON/designee will review all incident reports daily for 5 days times 2 weeks, then weekly for 3 weeks, and biweekly for 6 months. QA will review reports every week for 2 months until such time consistent substantial compliance is met. | |

| 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 _____ | 05/26/2016 |

| 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 225 | Continued From page 4<br>Spa room searched not found. Dining room checked not in dining area. SW [social worker] checked drawers in resident's room. Resident has been more restless & has been wringing her hands constantly. Family notified not concerned about missing ring. Family will look when they visit."<br><br>Review of Resident #11's medical record occurred on May 25-26, 2016. A progress note, dated 10/14/15 at 2:33 p.m., stated, "CNA reports that residents ring is missing is silver in color with gold leaf, two staff searched room no ring found. Housekeeping services notified to watch for item. Staff that were present at facility were interviewed and stated that they were unsure if ring was present yesterday, message left for one staff member who worked yesterday to call facility. Social Services notified."<br><br>Review of the facility's allegations of abuse or neglect occurred on the morning of 05/26/16 with an administrative staff member (#1). Facility staff failed to report Resident #4 and #11's allegation of misappropriation of resident property to the State Survey and Certification Agency.<br><br>Facility staff reported to the State Survey and Certification Agency possible neglect for Resident #16 on 12/15/15 and for Resident #15 on 12/28/15. No final investigation report was sent to the State Survey and Certification Agency. When requested, the facility failed to provide an investigation regarding possible neglect for Resident #15 and #16. | F 225 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS | F 281 | | 6/16/16 |

| 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 _____ | 05/26/2016 |

| 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 281 | Continued From page 5<br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and review of facility policy, the facility failed to complete neurological assessments according to policy for 1 of 12 sampled resident (Resident #4) who experienced a fall. Failure to perform neurological assessments may result in a delay in recognizing neurological changes following a head injury.<br><br>Findings include:<br><br>Review of the facility policy titled "Neurological Assessment Policy" occurred on 05/26/16. This policy, dated 04/08/16, stated, ". . . Policy/Procedure: Procedure for Neurological Assessment 1) Determine the need to perform neurological checks. Any trauma to the head warrants initiation. 2) Obtain neurological observations form. 3) The neurological assessment form is completed: a. Initially b. Every 15 minutes x 4 c. Every 30 minutes x 2 d. Every hour x 4 e. Every 2 hours x 3 f. Then every 4 hours g. Then every 8 hours h. Final is 3 days from initial assessment. . . ."<br><br>Review of Resident #4's medical record occurred on all days of survey. A progress note, dated 10/06/15 at 10:56 p.m., stated, "2215 [10:15 p.m.] - Resident was found on floor in room next to bed by nursing assistant. Resident was alert et [and] helped into wheelchair. No complaints of pain. Bump/swelling to left side of head discovered during assessment. Ice pack applied | F 281 | 1) In review of Resident #4 medical record in the 6 months since the fall there has been no adverse effects noted. Resident has seen the doctor on 11-19-15, 1-26-16, 3-15-16, 5-10-16, and the psychiatrist on 5-27-16.<br>2) The facility recognizes that all residents have the potential to be affected.<br>3) On 6-2-16 the DON reviewed the neuro-check policy and procedure with all nurses.<br>4) All fall incident reports will be reviewed at the Monday morning meeting for appropriate documentation, notification, and response for neuro-checks that are required. QA will review minutes of the Monday morning meeting weekly for 1 month, monthly for 6 months, and randomly thereafter to assure appropriate actions were taken. | |

| 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 _____ | 05/26/2016 |

| 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 281 | Continued From page 6<br>et swelling has decreased. Vitals stable. Neuro [neurological] assessments within normal limits for resident. Daughter was called et notified. Dr. Faxed. Nursing to continue to monitor."<br><br>The record lacked evidence nursing staff completed neurological checks as per facility policy. | F 281 | | |
| F 309 SS=E | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and review of professional reference, the facility failed to provide the necessary care and services for 1 of 2 sampled residents (Resident #5) receiving insulin. Failure to notify the physician of the resident's refusal and/or staff holding ordered doses of insulin may result in poorly controlled diabetes and does not allow the resident to maintain the highest practicable level of physical well-being.<br><br>Findings include:<br><br>Taber's Cyclopedic Medical Dictionary, 20th Edition, F.A. Davis, Philadelphia, Pennsylvania, page 580, stated, ". . . DM [diabetes mellitus] | F 309 | 1) Resident #5 was seen by her doctor on 5-31-16. He discussed her refusal of insulin and the complications that can occur. Resident voiced her understanding.<br>2) The facility has determined that all residents receiving insulin have the potential to be affected.<br>3) In-service education was conducted by the DON with nursing staff. The policy for hyper and hypoglycemia was reviewed and updated to add a parameter for hypoglycemia on 6-2-16. The nursing staff were educated that if they are holding the insulin due to hypoglycemia the Doctor should be notified. If the | 6/25/16 |

| 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 _____ | 05/26/2016 |

| 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 309 | Continued From page 7<br>may damage blood vessels, nerves, kidney, the retina . . ." Page 891 stated, "glucose . . . In healthy people, normal blood glucose levels are maintained at about 70 to 110 mg/dl [milligrams per deciliter]. Lower blood glucose levels (hypoglycemia) may cause confusion, anxiety, or other neurological complications. Higher blood glucose levels (hyperglycemia) . . . is characteristic of diabetes mellitus . . . Insulin enables cells to take in glucose for use in energy production. . . ."<br><br>Resident #5's medical record, reviewed on all days of survey, identified diagnoses including diabetes mellitus, congestive heart failure, and chronic kidney disease. Physician's orders included the following:<br>* 11/05/15: Levemir (a long-acting insulin) 40 units every a.m. - scheduled for 6:00 a.m.<br>* 02/19/16: Levemir 35 units every p.m. - scheduled for 8:00 p.m.<br>* Accucheck (bedside glucose monitoring) twice a day - scheduled for 6:00 a.m. and 8:00 p.m.<br>The above physician's orders lacked parameters for physician notification of high or low blood glucose levels.<br><br>Resident #5's care plan, dated 11/10/14, identified a problem: "Resident has labile (unstable) blood sugars related to Type II diabetes mellitus." Approaches to the problem included: ". . . Observe resident for signs of hypo/hyperglycemia . . ." The care plan failed to identify approaches for hypo or hyperglycemia or parameters for physician notification.<br><br>The most recent physician's progress note, dated 03/24/16, stated, ". . . DMII [Diabetes Mellitus | F 309 | resident is refusing the insulin it should be documented.<br>4) The DON or designee will conduct a random audit of 50% of residents on insulin weekly for 4 weeks, then monthly for 6 months, and randomly thereafter. Audit results will be reviewed at the monthly medical staff meetings. DON/designee will present reports to QA on a monthly basis for review of completion. | |

| 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 _____ | 05/26/2016 |

| 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 309 | Continued From page 8 | F 309 | | |

Type II], requiring Insulin. This has not been very well controlled. Recently mealtime insulin was discontinued as it was difficult to dose given her irregular eating habits. She is now getting Levemir 45 units SQ [subcutaneously] QPM [every evening] and 40 units SQ QAM [every morning]. We will check blood glucose BID [twice a day]. . . ." The record showed, on 02/19/16 the physician decreased Resident #5's p.m. insulin to 35 units, not 45 units as identified in the physician's note.

Review of Medication Administration Records for April and May 2016 identified the following:
* Staff administered the 6:00 a.m. dose of Levemir on April 2, 8, 10, 13, and 15. On all other mornings in April staff either held the insulin or the resident refused it.
* Resident #5 had a blood glucose of 77 mg/dl on April 3rd and 22nd. On all other mornings in April the resident's glucose ranged from 115 mg/dl to 343 mg/dl.
* Staff held or the resident refused the 8:00 p.m. dose of Levemir on 18 days in April.
* The resident's evening glucose ranged from 116 mg/dl to 423 mg/dl for the month.
* Staff held or the resident refused the 6:00 a.m. dose of Levemir 18 of the first 25 days in May.
* On May 1st Resident #5 had a blood glucose of 80 mg/dl at 6:00 a.m. On all other days from May 1st - 25th the resident's morning glucose ranged from 107 mg/dl to 302 mg/dl.
* Staff held or the resident refused the 8:00 p.m. dose of Levemir 14 of the first 25 days in May.
* The resident's evening glucose ranged from 241 mg/dl to 489 mg/dl for the month.

The record lacked evidence staff notified the

| 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 _____ | 05/26/2016 |

| 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 309 | Continued From page 9<br>physician that Resident #5 received her twice daily insulin doses less than 50% of the time, due either to refusal or staff holding the dose. This failure contributed to Resident #5 reaching blood glucose levels over 250 mg/dl at 6:00 a.m. on 11 days in April and 8 of the first 25 days of May; and over 300 mg/dl at 8:00 p.m. on 20 days in April and 18 of the first 25 days of May. These elevated blood glucose levels may result in Resident #5 experiencing complications related to her diabetes mellitus. | F 309 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to ensure a resident who entered the facility without an indwelling catheter was not catheterized without a clinical indication for 1 of 1 sampled resident (Resident #5) with an indwelling catheter. Failure to ensure the medical necessity of the catheter placed Resident #5 at risk of complications from the catheter, including urinary tract infections. | F 315 | 1) Resident #5 was seen by her primary physician on 5-31-16. He reviewed her need for an indwelling catheter.<br>2) The facility recognizes that any resident requiring a catheter may have the potential to be affected.<br>3) On 6-2-16 the DON reviewed the catheter policy and procedures at the nurse□s mtg. Regulations for catheterization were also reviewed. DON | 6/22/16 |

| 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 _____ | 05/26/2016 |

| 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 315 | Continued From page 10<br>Findings include:<br><br>Resident #5's medical record, reviewed on all days of survey, identified diagnoses including congestive heart failure (CHF), diabetes mellitus with neuropathy, stage 4 chronic kidney disease, and anxiety disorder. A quarterly Minimum Data Set (MDS), dated 01/09/15 indicated the resident had no indwelling catheter at that time. An MDS, dated 02/02/15, and the current MDS, dated 04/25/16, identified the resident with an indwelling catheter. Record review lacked evidence of a medical diagnosis indicating the necessity of the indwelling catheter.<br><br>Observation on 05/24/16 at 7:56 a.m. showed Resident #5 sitting at the edge of her bed eating breakfast with a catheter in place and draining clear yellow urine. At 8:25 a.m. a Certified Nursing Assistant (CNA) (#5) assisted Resident #5 from her wheel chair to the toilet. Observation showed the resident moved very slowly, sat down on the chair once to rest, and took several minutes to complete the transfer.<br><br>During an interview on 05/25/16 at 3:20 p.m. two administrative nurses (#1 and #4) stated the physician ordered the catheter because of the resident's CHF and the energy it takes for her to use the bathroom. When asked for physician documentation regarding the necessity of the catheter, the facility provided no additional information. | F 315 | will check to assure there is a diagnosis for the catheter.<br>4) All documentation and diagnosis for catheters in place will be monitored and reviewed weekly times 3 weeks, then at the Medical Staff Mtg every month for 3 months, then bi-monthly for 6 months. QA will review weekly documentation of catheters for 3 weeks, then medical staff minutes monthly for 3 months, then bimonthly for 6 months and randomly there after to assure that the Doctor's reason for catheter use is present for any resident with an indwelling catheter. | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards | F 323 | | 6/23/16 |

| 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 _____ | 05/26/2016 |

| 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 323 | Continued From page 11<br>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>ELOPEMENT<br><br>1. Based on record review and staff interview, the facility failed to ensure the safety of 1 of 1 sampled resident (Resident #7) who wandered and exited the facility. Failure to ensure and maintain resident safety by providing adequate supervision, implementing effective interventions, and monitoring and re-evaluating the interventions resulted in Resident #7 eloping from the facility, falling, and sustaining injuries.<br><br>Findings include:<br><br>- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia and anxiety disorder. The Minimum Data Set dated 10/06/15, identified supervision with transfers, walking in the room and corridor and locomotion on and off the unit. The current care plan stated, " . . . Problem : Exhibits exit-seeking behavior as evidenced by trying to get out the door when visitors are coming in/out. She watches out the window [and] when she sees a red vehicle she thinks it is her son. . . Approaches: *Try to reduce her anxiety; diversional visits, talk in calm quiet voice. *Provide diversional activities; 1:1 visits, activities snack, offer liquids, . . .*Check every 30 minute | F 323 | 1) All exit doors were switched to perimeter mode on 12-7-15. 15 min checks were initiated immediately upon return for resident #7. Family was talked to about the need for a bracelet on 12-7-15 and 12-9-15. Resident□ #7 son visited with the SW and DON and agreed to a Psychiatry appointment. Resident seen the psychiatrist on 12-14-15 and 1-20-16, hospital admission to psychiatric unit on 3-24-16 and returned 5-2-16. The resident has not been exit seeking since.<br>2) The facility recognizes that all residents have to potential to be affected.<br>3) All exit doors will remain in perimeter mode if facility recognizes an exit seeking resident. An elopement assessment will be completed on all residents upon admission and during the MDS□s and when wandering. The missing person policy and procedure was reviewed at the CNA, Nurses, and staff meetings on 6-2-16<br>4) The DON and/or designee along with QA will monitor new admission records for the completion of elopement assessments and annual MDS assessments weekly for 4 weeks, monthly for 3 months, bi-monthly for 6 months, | |

| 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 _____ | 05/26/2016 |

| 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 323 | Continued From page 12<br>around the clock to see where resident is at. *Check alarm system on the door daily and PRN [as needed]- notify proper staff if not working . . . D/C [discontinue] 5-2-16 30 min [minute] checks done to know where resident is during the day from 6:00 a.m. to 8:00 p.m., then hourly the remaining hours . . ."<br><br>Progress notes stated the following:<br>* 12/7/15 1:30 p.m. Nursing - "Resident talked about wanting to find her car and go to her house. This nurse told her she could not go to her house by herself and she did agree to go for walk with nurse outside. She stated when outside it was cold and she wanted to come back in. She states I will stay here (Great Room) and watch you. About 5 minutes later she was heading out side she states to go home and two staff went with her outside. She states her house is on [address] and she could walk to it. She was encouraged to come in and have a cookie and coffee and after much talking she decided to come in and had ice cream. Her nurse was notified that she was outside and wanted to walk home."<br>* 12/7/15 4:44 p.m. Activities - "[Resident] was feeling restless, so I walked up and down the halls visiting with about a variety of different topics."<br>* 12/7/15 5:14 p.m. Social Services - "Nurse reports to writer resident returned to facility with her daught [daughter]-in-law. Resident had left facility unattended, walked to pharmacy [and] got into family members car. Daughter-in-law reports she just happened to be in town [and] when she got back into her car resident was in the back seat. Resident had gone into pharmacy to purchase lotion. Pharmacy personnel had also | F 323 | and randomly thereafter.<br><br>1) Resident #6 was educated on the importance of staff using a gait belt on all transfers and ambulation. He was notified of risk factors of a gait belt not being used and he voiced his understanding. An in-service was held on 6-2-16. The proper use of a gait belt was discussed and demonstrated by the DON.<br>2) The facility has determined that all residents have the potential to be affected.<br>3) 25 transfers by certified staff will be observed for the use of gait belt by 6-17-16.<br>4) 10 transfers completed by certified staff will be observed per week for 4 weeks, monthly for 3 months, and randomly thereafter. QA along with DON will review all completed gait belt observation usage forms to assure substantial compliance monthly for 3 months.<br><br>1) SW spoke to #4 and her family about the use of the lift chair on 5-27-16. Resident #4 and Family wish her to continue to use the electric lift chair. Family feels the benefits out weigh the risk factors of using the electric lift chair. DON asked resident #4 to demonstrate her understanding and usage of electric lift chair on 6-17-16. Resident verbalized understanding through white board communication and was able to properly use chairs.<br>2) All residents that use electric lift | |

| 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 _____ | 05/26/2016 |

| 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 323 | Continued From page 13<br>contacted facility staff of resident being in the store. Daughter-in-law said she did not have a problem bringing resident back to facility. Nurse took resident to look at her knee and elbow as resident reports scraping on her way to pharmacy. Nurse, DON [Director of Nursing] and SW [Social Worker] talked with daughter-in-law about resident wearing a watchmate band [device to alert staff when resident exits building]. She said she wanted to talk with spouse. Staff will be doing frequent checks on resident's whereabouts."<br>* 12/7/15 6:19 p.m. Nursing - ". . . This afternoon Resident was on her way outside via the front door and RN [Registered Nurse} was notified and went with her. He walked around with her for awhile until she was chilled. She was in the dining room eating ice cream as witness ed [sic] by activities staff. One half hour later a phone call from Pharmacy uptown to notify nursing home that resident had just left. She was brought back to the facility by her daughter-in-law. Resident was anxious and agitated when she returned. She has 2 skin tears and a bruise. Please see skin assessment."<br><br>A handwritten note from the licensed social worker (LSW) stated the following:<br>* "Re: [Regarding Resident Name] 12/7/2015 - [Resident] left facility unattended [and] daughter-in-law returned her to facility. At admission a band was discussed for resident to wear but family had refused to have one put on [Resident], concerned the band would be more upsetting to resident. Today SW discussed band, frequent checks [and] psychiatrist visit with daughter-in-law - she wanted to talk with other family members. | F 323 | chairs have the potential to be affected.<br>3) Electric lift chair assessments will be completed on all residents with lift chairs by 6-22-16. Electric lift chair assessments will be completed on all new admissions. In house residents will be reviewed with annual MDS or if there has been a significant change in resident status.<br>4) QA coordinator and DON will review all assessments completed on residents to assure completion. Records reviewed by 6-23-16. Until such time consistent substantial compliance has been achieved.<br><br>1) All products referenced were properly secured on 5-24-16. Proper storage and safety of chemicals was reviewed at the staff meeting on 6-2-16<br>2) The facility has determined that all residents have the potential to be affected.<br>3) A facility survey has been conducted to identify other potential areas of vulnerability of placing residents at risk of injury due to storage practices. A hazardous chemical storage refresher training was conducted for department heads on 6-17-16. Hazardous chemical storage survey guide has been developed. Plans and procedures affecting chemical storage are under review.<br>4) Hazardous chemical storage surveys have been added to the QA audit calendar weekly for 3 week, monthly for 3 months, bi-monthly for 6 months and periodically thereafter. | |

| 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 _____ | 05/26/2016 |

| 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 323 | Continued From page 14<br>12/9/15 SW contacted [Psychiatrist] office to see if appointment could be made for new patient as soon as possible . . . DON [and] SW met with resident's son [name] - he did agree to [Resident] being seen by psychiatrist . . . Staff have talked to son [name] about possible transfer for [Resident] to go to facility with locked unit. [Son name] did not want to transferred [sic] to a different facility [and] wants her to remain in Maple Manor but does not want her overly sedated. Frequent checks will continue. . . ."<br><br>An incident report dated 12/7/15 3:00 p.m. identified the following<br>* Location of incident - Main Street.<br>* Resident's condition before incident - confused<br>* What happened - "Resident does not have a wanderguard (per family) she had gotten outside, stopped by (RN name) - she then was found uptown in daughter-law's vehicle. She was brought back to facility"<br>* Physician notified? Yes - (Dr. Name) at 3:15 p.m.<br>Was first aid administered? Yes - By whom? at nurses station by RN at 3:30 p.m.<br>* Type of injury - skin tear<br><br>A handwritten Missing Resident Report stated the following:<br>* 12/7/15 4:30 p.m. "Received telephone call from local pharmacy at 3:15 p.m. [Resident] was in the store to buy lotion. No one with her as she left the store. Pharmacy notified staff they (family) would bring [Resident] back to facility. [Resident] returned at 3:30 p.m. Family member stated she found [Resident] in the back seat of [description of vehicle] parked in front of the Pharmacy. Dr. Brown [code for missing person] not initiated by | F 323 | | |

| 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 _____ | 05/26/2016 |

| 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 323 | Continued From page 15 | F 323 | | |

the time we knew [Resident] was out of the facility she was on her way back. Video camera was reviewed [Resident] exited Household #1 south door at 2:38 p.m. [Resident] followed CNA [Certified Nursing Assistant] down corridor. CNA went into another resident room. [Resident] went out south door. No alarm Door did not lock. No bracelet in place. Resident noted to be wearing her black coat, scarf, gloves and had her purse. When leaving building [Resident] went around south end of MMCC [Maple Manor Care Center] double car garage. Video surveillance could not determine which direction [Resident] went from around the garage. The temperature today was 50 [degrees] no wind [and] sunny. Offered wander band to family member returning [Resident]- family member wanted to talk to [son] first. 15 minute around the clock checks initiated upon return; starting on the evening shift."

Wound Assessment Report identified the following:
*12/7/15 Skin tear on right forearm (rear) - length 4.0 centimeters (cm) width .30 cm - Resident moaning and grimacing - edges not well approximated, all torn skin flaps present - no treatment required
* 12/7/15 Skin tear right knee - length .60 cm - width .60 cm - edges well approximated - no treatment required
* Bruise left knee - length 8.0 cm - width 9.0 cm - dark purple bruise - no treatment required

Review of Resident #7's 15 minute check form identified the following on 12/7/15:
* 3:00 p.m. Resident in room until 5:00 p.m. when she went for supper.
The Missing Person's Report identified Resident

| 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 _____ | 05/26/2016 |

| 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 323 | Continued From page 16<br>#7 left the building at 2:38 p.m. and returned at 3:30 p.m. which conflicts with the 15 minute check documentation.<br><br>A fax to Resident #7's physician, dated 12/0715 at 3:31 p.m. stated, "Resident's Anxiety- she gets Ativan 0.5 mg [milligrams] four times a day she does not have a wanderguard (doorlock/monitor) on per family at this time. She was found up town-in daughter-in-law car- she is very anxious [and] can we get a PRN [as needed] one time order?<br>Response by Physician - Wanderguard"<br><br>During an interview on 05/25/16 at 5:20 p.m. an LSW (#15) reported Resident #7 informed staff she had followed the railroad tracks and had fallen off the train. The LSW further stated the facility failed to do an elopement assessment on Resident #7, although staff discussed Resident #7's elopement at safety meetings. Staff failed to provide documentation of safety meetings.<br><br>During an interview on 05/26/15 at 11:00 a.m. an administrative staff member (#16) stated Resident #7 exited the south door, walked behind the garage and would have went behind the grain bins, onto the frontage road to follow the train track and cross two streets to arrive on the main street (where the pharmacy is located).<br><br>Facility staff failed to ensure adequate supervision of Resident #7 after exit seeking incidents which resulted in an elopement on 12/07/15 to an area several blocks away from the facility without staff knowledge. Resident #7 sustained two skin tears and a large bruise during this elopement. Following the incident, the | F 323 | | |

| 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 _____ | 05/26/2016 |

| 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 323 | Continued From page 17<br>facility implemented door alarms which activate whenever the door is opened.<br><br>TRANSFERS<br><br>2. Based on observation and record review, the facility failed to appropriately utilize an assistive device for 1 of 9 sampled residents (Resident #6) who required assistance with transfers. Failure to utilize a gait belt with transfers may result in Resident #6 experiencing falls and/or injuries.<br><br>Findings include:<br><br>- Resident #6's medical record, reviewed on all days of survey, identified diagnoses including cerebral infarct and myasthenia gravis (a disease causing muscle weakness). An admission MDS, dated 03/22/16, identified Resident #6 required extensive assistance of two or more persons for transfers and walking in the room. Resident #6's care plan, dated 03/15/16, identified a problem: "Resident requires staff assistance for all ADL's [Activities of Daily Living] related to right cerebral infarction as evidenced by left hemiplegia." Approaches to the problem included: ". . . ambulates with walker, gait belt and staff assist . . ."<br><br>Observation on 05/24/16 at 9:25 a.m. showed a Certified Nursing Assistant (CNA) (#2) assisted Resident #6 to walk from the bathroom to his recliner. Observation showed the resident held onto his walker and the CNA (#2) held the resident by his right arm. The CNA (#2) failed to use a gait belt while ambulating Resident #6. | F 323 | | |

| 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 _____ | 05/26/2016 |

| 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 323 | Continued From page 18<br>LIFT CHAIR SAFETY<br><br>3. Based on observation, record review, and staff interview, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 1 sampled resident (Resident #4) with an electric lift chair. Failure to assess the safety of an electric lift chair placed this resident at risk for sustaining a fall and/or injury.<br><br>Findings include:<br><br>Review of Resident #4's medical record occurred on all days of survey. The annual Minimum Data Set, dated 04/28/16, identified short and long term memory problems and extensive assistance of two or more people for transfers.<br><br>The progress notes revealed the following:<br>* 12/31/15 at 2:50 p.m.: ". . . She was seated at the edge of her recliner, rocking back and forth. . . ."<br>* 02/18/16 at 12:44 p.m.: ". . . Staff observed resident playing with control for her reclining chair. She had put her chair in the highest position and refused to let chair control go. Staff attempted to transfer her into wheelchair and she began bouncing on the edge of her recliner holding onto the chair control. She was pushing at staff and trying to hit and bite. She refused to let go of recliner control. Four staff assisted her to sit on the floor for her own safety . . ."<br>* 02/18/16 at 1:14 p.m.: ". . . She continues to have the recliner chair controller wrapped around right hand and will not let it go. Chair has been unplugged so that she cannot put it into highest position and fall out of it." | F 323 | | |

| 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 _____ | 05/26/2016 |

| 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 323 | Continued From page 19<br>* 04/20/16 at 3:47 p.m.: ". . . she was . . . sitting on the foot part of recliner and required the assist of two to get up. . . ."<br><br>During an interview on 05/25/16 at 11:19 a.m., a certified nursing assistant (CNA) (#10) stated sometimes Resident #4 sits on the edge of her lift chair footrest.<br><br>During an interview on 05/25/16 at 1:25 p.m., an administrative nurse (#4) confirmed the record lacked evidence Resident #4's electric lift chair safety was assessed.<br><br>HAZARDOUS CHEMICALS:<br><br>4. Based on observation, review of facility policy and Material Safety Data Sheets (MSDS), and staff interview, the facility failed to ensure an environment free of accident hazards on 4 of 4 resident care units (Unit 100, 200, 300, and 400). This failure placed cognitively impaired residents residing on the units at risk of an injury.<br><br>Findings include:<br><br>Review of the facility policy titled "Chemical Safety" occurred on 05/26/16. The policy, dated, 11/09/15, stated, "Purpose/Objective: To reinforce government regulations regarding the safe use and storage of chemicals. Dietary staff will use, store and label chemicals per manufacturer's guidelines. . . ."<br><br>A tour of the dietary department occurred on 05/24/16 at 2:00 p.m. with a dietary manager (#3). Observation identified the following:<br>In the 200/400 unit open kitchen area in an | F 323 | | |

| 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 _____ | 05/26/2016 |

| 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 323 | Continued From page 20<br>unlocked cabinet under the sink:<br>* Cascade dishwasher detergent: label stated, "harmful if swallowed"<br>* Oasis 146: MSDS stated, "Causes eye and skin burns, harmful if swallowed, may cause respiratory tract irritation, Do not ingest. . . "<br>In the 100/300 unit open kitchen area in an unlocked cabinet under the sink:<br>* Our Family Rinse Agent: label stated, "May cause eye/skin irritation."<br><br>When asked during the tour, the dietary manager (#3) stated staff should store chemicals in locked cabinets.<br><br>Observations on 05/24/16 from 3:55 p.m. to 5:06 p.m. showed the 100 unit, 200 unit, 300 unit, and 400 unit unlocked spa rooms contained a cupboard with the key left inserted in the lock. The cupboards contained Cen-Kleen IV one step disinfectant.<br><br>The environmental tour of the facility occurred on 05/25/16 at 4:05 p.m. with two staff members (#8 and #9). Observation showed all four unlocked spa rooms contained cupboards with the key left inserted in the lock.<br><br>The Cen-Kleen IV MSDS stated, "Causes serious eye irritation. Causes skin irritation. . . ."<br><br>During the environmental tour on 05/25/16 at 4:05 p.m. a staff member (#8) stated he expected staff to lock the cabinet and remove the key from the lock. | F 323 | | |
| F 325 SS=D | 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE | F 325 | | 6/22/16 |

| 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 _____ | 05/26/2016 |

| 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 325 | Continued From page 21<br>Based on a resident's comprehensive assessment, the facility must ensure that a resident -<br>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and<br>(2) Receives a therapeutic diet when there is a nutritional problem.<br><br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 05/21/15.<br><br>Based on observation, record review, facility policy review and staff interview, the facility failed to provide appropriate interventions to prevent weight loss and maintain nutritional status for 1 of 5 residents (Resident #1) receiving nutritional supplements. Failure to provide interventions as ordered to prevent weight loss may result in continued weight loss, and inadequate nutritional intake.<br><br>Findings include:<br><br>Review of the facility policy titled "Weight Loss Policy" occurred on 05/26/16. This policy, dated May 2016, stated, ". . .4. If significant weight loss is noted it will be assessed and care planned at the time of detection. . . 7. The Registered Dietician will be consulted to assist with interventions . . . 9. If no weight improvement is noted within 14 days, supplements will be given | F 325 | 1) DM immediately spoke to the dietary personnel responsible for filling supplements for resident #1. The supplement list in each pantry was reviewed the same day. Resident received proper supplement on 5-25-16.<br>2) All residents who receive supplement have the potential to be affected<br>3) An in-service was held with all dietary staff. A review of our present supplement list was reviewed on 6-8-16. Glass sizes were also reviewed. All residents requiring supplements have been observed by the DM and ADON to assure proper amounts of supplements are given at the proper time. 6-8-16<br>The resident supplement log in each pantry has been updated with bold, larger font to assure easier reading for staff. Dietary staff responsible for filling must sign supplement log to assure proper amount is dispensed.<br>4) DM/designee will monitor the | |

| 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 _____ | 05/26/2016 |

| 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 325 | Continued From page 22<br>under order of physician. . ."<br><br>Review of Resident #1's medical record occurred on all days of survey. Diagnoses included GERD (gastroesphageal reflux disease) and vitamin deficiency. Physician's orders included six ounces of supplement twice a day. The current care plan stated, ". . . Problem: Alteration in nutrition . . . 4oz [sic] supplement BID [two times a day]. . . "<br><br>Dietary progress notes stated the following:<br>* 02/17/16 12:11 p.m. "Resident current weight is 121 pounds. Her quarterly weight was 133 pounds and 6mths [months] ago 133 pounds. Making her a 9% loss. She is on a soft diet with ground meats. 4oz supplement BID . . . . Writer asked resident if she would like her supplement increase to maintain her weight, she said "sure". Will start 6oz supplement 2/18/16. . . ."<br>* 05/23/16 3:40 p.m. "Residents current weight is 118 pounds. . . .She receives 6oz supplement BID . . ."<br><br>Observation on 05/24/16 at 10:00 a.m. showed Resident #1 drinking a 4 oz supplement. The resident consumed 100 % of the supplement.<br><br>Observation on 05/25/16 at 10:25 a.m. showed Resident #1 drinking a 4 oz supplement. The resident consumed 100 % of the supplement.<br><br>During an interview on 5/26/16 at 7:50 a.m. a dietary manager (#3) located the tray set up for the morning supplements. The tray of supplements contained a four ounce supplement for Resident #1. The dietary manager (#3) confirmed staff failed to provide Resident #1 a six | F 325 | supplement log daily for 5 days, weekly for 1 month, monthly for 6 months. QA will meet with DM on a bimonthly basis for 3 months until substantial compliance is achieved. | |

| 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 _____ | 05/26/2016 |

| 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 325 | Continued From page 23<br>ounce supplement as ordered.<br><br>Staff failed to provide Resident #1 the supplement as ordered and update the resident's care plan. | F 325 | | |
| F 431 SS=B | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>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.<br><br>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.<br><br>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.<br><br>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 | F 431 | | 6/22/16 |

| 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 _____ | 05/26/2016 |

| 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 24<br>can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to properly store medications in 1 of 1 medication refrigerator. Failure to store medications correctly may decrease the efficacy of the medications.<br><br>Findings include:<br><br>Review of the facility policy titled "Drug Fridge-Temperature Checking Procedure" occurred on 05/26/16. This policy, dated August/2015, stated, " . . . 4. Refrigerator temperature should be maintained between 35and [sic] 40 degrees Fahrenheit. . . 6. If the temperature has been outside of these parameters for more than 24 hours, a list of the drugs currently in the fridge should be made and sent to pharmacy for recommendation. . . ."<br><br>A tour of the medication room occurred on 05/25/16 at 3:45 p.m. with a staff nurse (#7). The medication refrigerator contained four vials of insulin and two vials of influenza vaccine. The box of the insulin vial and the influenza vaccine stated to store between 36 and 40 degrees Fahrenheit (F). Review of the medication room refrigerator temperature logs for March 2016 - May 24, 2016 identified seven days of recorded temperature at 34 degrees F and 28 days recorded at 35 degrees F.<br><br>During an interview on 05/25/16 at 5:00 p.m. an | F 431 | 1) The thermostat on the refrigerator was adjusted until the temp was maintained between 38 degrees and 43 degrees. Spoke with the pharmacist to assure medication stored at 34 degrees to 35 degrees at times instead of 36 degrees was still safe to administer. 5-27-16<br>2) The facility recognizes that all residents have the potential to be affected.<br>3) The temperature bulb was noted to be loose from the freezer compartment on the fridge ice box. This will be recorded daily with refrigerator temp checks.<br>4) DON/designee will check the temp and temperature bulb log weekly for 4 weeks, then monthly for 3 months. QA coordinator will review logs until substantial compliance is achieved then randomly thereafter. | |

| 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 _____ | 05/26/2016 |

| 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 25<br>administrative nurse (#1) stated he expected the medication refrigerator be at 35-40 degrees F.<br><br>The facility failed to store vials of insulin and influenza vaccine at the manufacturer's recommended temperatures of 36-46 degrees F. | F 431 | | |