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 _____	04/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CARE CENTER	1116 9TH AVE LANGDON, ND 58249

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on April 17, 2017 and completed on April 20, 2017, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for	F 156		5/20/17

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

Electronically Signed | 05/15/2017

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F 156	Continued From page 1 Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)	F 156		

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F 156	Continued From page 2 [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office,	F 156		

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F 156	Continued From page 3 adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with	F 156		

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F 156	Continued From page 4 the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 156		

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F 156	Continued From page 5 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A notices/files, the facility failed to provide adequate written notices for 4 of 4 residents (Resident #6, #10, #16, and #17) reviewed for termination of Medicare coverage. Failure of the facility to provide notices that contained the correct contact information for the intermediary review limits the residents' ability to exercise their rights related to	F 156	1) The Address was corrected on 4-21-17. No residents have been affected. There has not been any appeals requested during the past year. 2) The facility recognizes that all residents have the potential to be affected.	

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F 156	Continued From page 6 Medicare Part A. Findings include: Review of Medicare billing records occurred on 04/18/17. The facility provided Resident #6, #10, #16, and #17 with a demand bill form. These forms lacked the correct contact information for the intermediary review.	F 156	3) The administrator, MDS Coordinator, DON and Medicare biller will be attending a Medicare training on 5-19-17. The Medicare biller will be checking the noridian site monthly to verify address info has or has not changed. 4) Validation of checking the noridian address will be monitored by QA monthly for 4 months and then quarterly until such time consistent substantial compliance has been met.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 2 of 13 sampled residents (Resident #4 and #6) reviewed. Failure to determine the need for and complete a SCSA in response to a resident's decline or	F 274	1) A significant change MDS was completed on resident 4 and 6 on 5-3-17 and transmitted on 5-8-17. 2) The facility recognizes that all residents have the potential to be affected. All other MDS's have been reviewed for the need to do a significant change.	5/20/17

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F 274	Continued From page 7 improvement limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate interventions. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.14), dated October 2016, page 2-22 stated, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, ". . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example], two areas of ADL [activities of daily living] decline or improvement). . . . Decline in two or more of the following: . . . Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence . . . Improvement in two or more of the following: Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment . . ." - Review of Resident #4's medical record occurred on all days of survey. Resident #4's admission MDS (Minimum Data Set), dated 10/31/16, identified the resident required extensive assistance of one person for bed mobility, transfers, and walking in the room. A quarterly MDS, dated 1/24/17, identified the	F 274	3) The MDS team reviewed and was reeducated on SCSA on 4-21-17. They will also watch sec M3.4 the AIS (Assessment and Intelligence System) through Relias Learning for MDS clarification by 5-20-17. The MDS team has begun utilizing the RUG's analysis worksheet through AHT where we can compare quarterly and annual MDS's. The RUG's analysis will be discussed at the quarterly resident care plans. Nursing staff will be required to report any new changes in their residents at the Monday morning resident assessment meeting. 4) All significant changes and reasoning for them will be forwarded to the QA Coordinator started on 5-17-17 per email who will review them with the DON for appropriate and timely changes. These changes will be reviewed at the monthly medical staff meeting for 5 months, and bi-monthly for 6 months and then randomly there after. The RUGs analysis worksheet for comparing previous quarterly MDS's and Annual MDS will be checked Monday mornings by the DON/MDS coordinator after the Monday morning meeting along with Nurse updates on any new changes in residents this will assist in determining if a significant change MDS should be completed. The RUG analysis worksheet will also be checked for the upcoming MDS's to see if a significant change is needed. This will start on 5-22-17.	

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F 274	Continued From page 8 resident required supervision for bed mobility, transfers, and walking in the room. Facility staff should have completed a significant change MDS to reflect Resident #4's improvement in three ADL's. - Review of Resident #6's medical record occurred on all days of survey. The admission MDS, dated 11/28/16, identified limited assistance of one person required for walk in corridor, locomotion on unit, locomotion off unit, and personal hygiene. A quarterly MDS, dated 03/03/17, identified extensive assistance of one person required for walk in corridor, locomotion on unit, locomotion off unit, and personal hygiene. Facility staff should have completed a significant change MDS to reflect Resident #6's decline in four ADL's.	F 274		
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the	F 278		5/20/17

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F 278	Continued From page 9 accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 3.0), the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 8 of 13 sampled residents (Resident #1, #2, #3, #4, #6, #7, #12, and #13) and 2 closed records (Resident #14 and #15). Failure to accurately complete Section H (Bowel Patterns), Section M (Unstagable Pressure Ulcers Related to Suspected Deep Tissue Injury and Skin/Ulcer Treatment - Turning and Repositioning Program), and Section N (Medications), does not allow each assessment to reflect the resident's current status/needs and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents.	F 278	1) For the following alleged violations modifications were made to the MDS's for Resident 1,2,3,4,6,7,12,13 and discharged resident 14,15 and were transmitted on 5-8-17. 2) The facility recognizes all residents may be affected. All MDS's on Sec H0600, M0300G, M1200C, N0400D have been reviewed. Any other modifications for reviewed MDS's have been made and transmitted on 5-8-17. 3) The MDS team must watch sections H, M, N of the CMS 3.0 training available on YouTube by 5-20-17. We have changed our Med reference to a state	

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F 278	Continued From page 10 Findings include: BOWEL PATTERNS The Long-Term Care Facility RAI User's Manual (Version 1.14), October 2016, pages H-12 and H-13 stated, "H0600: Bowel Patterns . . . "Definition: CONSTIPATION: If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements). . . . * Code 0, no: if the resident shows no signs of constipation during the 7-day look-back period. * Code 1, yes: if the resident shows signs of constipation during the 7-day look-back period. . . ." - Review of Resident #1's medical record occurred on all days of survey. The annual Minimum Data Set (MDS), dated 09/20/16, identified constipation. Review of the resident's bowel records identified four bowel movements during the 7-day assessment period. - Review of Resident #2's medical record occurred on all days of survey. The annual MDS, dated 01/22/17, identified constipation. Review of the resident's bowel records identified four bowel movements during the 7-day assessment period. - Review of Resident #6's medical record occurred on all days of survey. The admission MDS, dated 11/28/16, identified constipation. Review of the resident's bowel records identified ten bowel movements during the 7-day assessment period.	F 278	recommended drug classification guide. MDS 3.0 drug class index instead of the 2016 Lippincott drug guide. 4) QA was started on 5-12-17 by the DON or designee which will include secion H0600, M0300G, M1200C, and N0400D will be done on all comp MDS's and quarterly MDS's and H0600 will be done on all comp MDS's weekly for 4 weeks, monthly for 3 months, bimonthly for 6 months and randomly there after until substantial compliance is obtained. Starting 5-22-17 sections M0300G, M1200C, H0600, N0400D of the MDS's that were completed in the previous week will be reviewed at the Monday morning meeting and assessed for accuracy at that time. This will be done prior to submission to allow corrections if needed. The QA coordinator will be updated on QA findings weekly for 4 weeks, monthly for 3 months, bimonthly for 6 months and randomly there after.	

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F 278	Continued From page 11 - Review of Resident #7's medical record occurred on all days of survey. The annual MDS, dated 11/03/16, identified constipation. Review of the resident's bowel records identified six bowel movements during the 7-day assessment period. - Review of Resident #13's medical record occurred on April 19-20, 2017. The annual MDS, dated 10/21/16, identified constipation. Review of the resident's bowel records identified five bowel movements during the 7-day assessment period. TURNING AND REPOSITIONING PROGRAM The Long-Term Care Facility RAI User's Manual (Version 1.14), October 2016, page M-38 stated, "M1200 Skin and Ulcer Treatments . . . M1200C Turning/Repositioning Program * The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [example] reposition on side, pillows between knees) and frequency (e.g. every 2 hours). . . ." - Review of Resident #1's medical record occurred on all days of survey. An annual MDS, dated 09/20/16, and a quarterly MDS, dated 03/21/17, identified a turning and repositioning program. The current care plan stated, "Problem/Need: Impaired mobility R/T [related to] weakness and complaints of right leg and hip pain. Approaches . . . Reposition every 2 hours during the day and when awake at night. . . ." The medical record lacked an individualized turning/repositioning	F 278		

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F 278	Continued From page 12 program. - Review of Resident #2's medical record occurred on all days of survey. An annual MDS, dated 01/22/17, identified extensive assistance for bed mobility and transfers, at risk for pressure ulcers but no current pressure ulcers, and on a turning and repositioning program. Resident #2's current care plan stated, "Problem: Alteration in mobility related to weakness and confusion . . . Approaches: . . . Resident is on a turning and reposition schedule every 1 - 1 1/2 hours . . ." Resident #2's medical record failed to identify an individualized turning/repositioning program. - Review of Resident #3's medical record occurred on all days of survey. An annual MDS, dated 03/14/17, identified extensive assist for bed mobility, transfers, walking in room, no current pressure ulcer, and on a turning and repositioning program. Resident #3's current care plan stated, "Problem: Alteration in skin integrity r/t [related to] hx [history] of irritation to bottom and easily torn and fragile skin. . . . Approaches: Monitor daily. . . Problem: Impaired mobility due to CVA [cerebral vascular accident] with left sided weakness . . . Approaches: . . . Reposition every 1 - 1 1/2 hours. . . ." Resident #4's medical record failed to identify an individualized turning/repositioning program. - Review of Resident #4's medical record occurred on all days of survey. A quarterly MDS assessment, dated 01/24/17, identified	F 278		

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supervision for bed mobility, transfers, walking in room/corridor, history of pressure ulcer, and on a turning and repositioning program.

Resident #4's current care plan stated, "Problem: Alteration in skin integrity related to fragile skin and Hx of ulcer to coccyx: Turn and reposition every 1 - 1 1/2 hours as she allows . . . Problem: Alteration in mobility related to Osteoarthritis of the knee . . . Independent in room . . . Encourage resident to reposition every 1 - 1 1/2 hours. Assist of 1 as needed . . ." Resident #4's medical record failed to identify an individualized turning/repositioning program.

- Review of Resident #13's medical record occurred on April 19-20, 2017. An annual MDS dated 10/21/16, and a quarterly MDS, dated 01/20/17, identified a turning and repositioning program.

The current care plan stated, "Problem/Need: Imparied mobility R/T chronic neck and shoulder pain and DX [diagnosis] of Kyphosis, Osteoarthritis, Osteoporosis . . . Approaches . . . Encourage reposition every 1-1 1/2 hours and prn [as needed] . . ." The medical record lacked an individualized turning/repositioning program.

- Review of Resident #14's medical record occurred on April 19-20, 2017. The quarterly MDS, dated 01/27/17, identified extensive assistance for bed mobility, total assistance for transfers, at risk for pressure ulcers, and on a turning and repositioning program.

Resident #14's care plan stated, "Problem: Alteration in skin integrity . . . Encourage resident

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to reposition self every 1 -1 1/2 hours or as resident allows; provide assistance PRN [as needed] per 2 staff . . ." Resident #14's medical record failed to identify an individualized turning/repositioning program.

- Review of Resident #15's medical record occurred on April 19-20, 2017. The admission MDS, dated 01/09/17 identified extensive assist for bed mobility, transfers, Stage 2 and Stage 3 pressure ulcers on the coccyx, and on a turning and repositioning program.

Resident #15's care plan stated, "Problem: Skin integrity . . . Approaches: . . . Turn and reposition per one staff every 1 - 1 1/2 hours. . . ." Resident #15's medical record failed to identify an individualized turning/repositioning program.

MEDICATIONS

The Long-Term Care Facility RAI User's Manual (Version 1.14), October 2016, pages N-4 and N-5, stated, "N0410: Medications Received . . . Coding Instructions *N0410A-G: Code medications according to the pharmacological classification, not how they are being used. . . ."

Review of Resident #12's medical record occurred on April 19-20, 2017. Medications included Lexapro and Wellbutrin (both classified as antidepressants), prescribed for depression; Trazodone (classified as an antidepressant) prescribed for insomnia; and Lorazepam (classified as an anxiolytic) prescribed for anxiety disorder.

The quarterly MDS, dated 01/13/17, identified

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F 278	Continued From page 15 Resident #12 received a hypnotic medication seven days during the assessment period. Although Resident #12 received Trazodone for insomnia and Lorazepam (which may be administered for sedation), neither of these medications are classified as a hypnotic. SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual (Version 1.14), October 2016, page M-19, stated, "M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury . . . Definition: Suspected Deep Tissue Injury - Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. . . ." Review of Resident #2's medical record occurred on all days of survey. A wound assessment, dated 01/03/17, identified a 4 by 2 centimeter (cm) dark purple bruise to her right heel. The bruise resolved in April. The current care plan stated, "Problem: Resident has bruise to right heel . . . Approaches: . . . Heel boot on right foot at all times . . ." The annual MDS, dated 01/22/17, identified Resident #2 required extensive to total assistance of two or more staff members for all activities of daily living (ADLs) and at risk for pressure ulcers. The MDS failed to identify the deep tissue injury to the resident's right heel.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered	F 280		5/20/17

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F 280	Continued From page 16 plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans	F 280		

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F 280	Continued From page 17 (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to review and revise	F 280	1) a) The care plan was revised on Resident #1 on 4-21-17 by the care plan	

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F 280	Continued From page 18 the comprehensive care plan to reflect the current status for 3 of 13 sampled residents (Resident #1, #2, and #9). Failure to revise the care plan limited the ability of staff to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plans" occurred on 04/20/17. This policy, dated 06/24/16, stated, "Purpose/Objective: The care plan is a plan of care that is tailored to the individual resident so they receive accurate customized treatments and interventions and consistent care. The care plan is a continuous process. . . . Procedure: . . . The care plan is an ongoing task and is updated/changed as needed. . . ." - Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, "Problem/Need: Alteration in elimination related to incontinence of B&B [bowel and bladder] . . . Approaches . . . Ask about toileting and take as he allows per one staff for bowels when he wakes up in am, 10am, 6pm, before bed and prn [as needed] . . ." A "Bladder and Bowel Assessment" dated 03/25/17 identified "Resident is not on a toileting program for bowels." During an interview on 04/18/17 at 10:45 a.m., a certified nursing assistant (CNA) (#10) stated staff do not toilet Resident #1 at certain times. Resident #1 tells staff when he needs to have a bowel movement.	F 280	coordinator. it was changed to read "take to bathroom for B.M. as resident requests." resident has a catheter for neurogenic bladder so does not require toileting for urination. b) The care plan for toileting was changed to read check and change with repositioning when needed for resident #2. Toileting times were discontinued from the care plan as well. Resident #2's care plan was reevaluated. it now reads "assist of 2 and gait belt and pivot transfer. Hoyer lift with 2 staff to transfer resident to tub. c) Resident #9's care plan was revised to transfer with the assist of 2 gait belt and walker. May use standing lift PRN if nurse approves. 2) The facility recognizes that any resident has the potential to be affected. The nurses will attend Monday morning meetings with department heads to address any changes that may have occurred with residents. 3) A daily care guide will be printed from the current care plan and placed on the inside of each residents closet door. The care guides will also be given to each CNA at the start of their shift. this information will be the same as the care plan which will provide the CNA's with the most up to date information on each resident they are caring for. When more than 1 form of transfer is acceptable the PRN method must be approved by the nurse prior to its use unless the resident is in danger and the CNA has no choice.	

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F 280	Continued From page 19 - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. The annual Minimum Data Set (MDS), dated 01/22/17, identified frequently incontinent of urine and always incontinent of bowel, and extensive assistance of two staff members for bed mobility, transfers, and toilet use. Resident #2's care plan stated, "Problem: Alteration in mobility . . . Approaches: *Randomly resident is able to be transferred with stand pivot transfer with assist of 2 CNA [certified nursing assistant] with gaitbelt. . . . *Assist of 2 staff and gait belt with pivot transfers *May use hoyer lift when sleepy and not able to hold onto handles . . ." Another problem stated, "Alteration in elimination related to urinary and bowel incontinence . . . Approaches: . . . *Assist resident to the bathroom with assist of 2 staff . . . *Toilet 7am, 9:30am, 12:30pm, 3pm, 5pm, 6:30pm, 9pm, 2am and PRN [as needed] *Check and change resident PRN, if she is not alert enough to be toileted . . ." Observations included the following: * 04/18/17 at 9:09 a.m. - Two CNAs (#7 and #8) applied a gaitbelt around Resident #2's waist and pivot transferred her from a wheelchair to bed. The CNA (#7) checked the resident's brief and found it dry. * 04/18/17 at 10:30 a.m. - Two CNAs (#7 and #8) checked and changed Resident #2's wet brief, applied a gaitbelt around her waist, and pivot transferred her from the bed to a wheelchair. * 04/18/17 at 4:25 p.m. - Two CNAs (#7 and #9) checked and changed Resident #2's wet brief,	F 280	New software has been purchased that will allow more choices for care planning and communication with nursing staff. 4) A validation check list has been developed and was initiated on 5-12-17. this list includes but is not limited to toileting and transfers. QA was started on 5-19-17.QA will be done by the DON/Designee on 5% of the care plans weekly for 4 weeks, monthly for 3 months, and bimonthly for 6 months until substantial compliance is obtained and randomly there after. The QA coordinator will be updated on QA findings weekly for 4 weeks, monthly for 3 months, bimonthly for 6 months and randomly there after.	

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applied a gaitbelt around her waist, and pivot transferred her from the bed to a wheelchair.

During an interview on 04/18/17 at 3:30 p.m., a CNA (#7) stated staff never toilet Resident #2 anymore and she is always a "check and change." The CNA stated the resident used to be a stand lift transfer but she could no longer hold onto the handlebars so staff pivot transfer her now. The CNA also stated the only time staff use a hoyer lift for Resident #2 is on bath days.

The facility failed to revise Resident #2's care plan to reflect her current status as pivot transfers at all times except on bath days and a check and change rather than toileted.

- Review of Resident #9's medical record occurred on all days of survey. Diagnoses included anxiety and glaucoma.

Resident #9's annual MDS, dated 03/29/17, identified extensive assistance for bed mobility, transfers, and toilet use. The current care plan stated, "Problem: Impaired mobility related to weakness, history of falls . . . Approaches . . . Transfer with assist of 2, gait belt, and walker . . . Standing lift with assist for transfers during the day PRN with assist of 1 . . ."

Observation on 04/18/17 at 9:22 a.m. showed two CNAs (#7 and #8) applied a gait belt around Resident #9's waist, assisted her to stand and hold onto her walker, and transferred her onto the toilet.

Resident #9's care plan failed to identify under what circumstances Resident #9 should transfer

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F 280	Continued From page 21 with a standing lift and who makes that determination.	F 280		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		5/20/17

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F 329	Continued From page 22 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and review of facility policy, the facility failed to ensure a medication regimen free from unnecessary medications for 6 of 13 sampled residents (Resident #3, #6, #7, #8, #10, and #12) receiving hypnotic medications or other medications used to promote sleep. Failure to attempt a gradual dose reduction (GDR) unless contraindicated, in an effort to reduce or discontinue medication use, may result in residents receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings include: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, this facility has not sustained correction of this issue. This requirement was found to be out of compliance in 2015. Review of the facility's "Psychotropic Drug Policy" occurred on 04/20/17. This policy, dated 11/15/16, stated, "Purpose/Objective: . . . It is the policy at Maple Manor to provide Health Care Services that allow the resident to attain his/her highest practical, mental, physical, and psychological well being without the use of psychotropic medications. . . . Examples of evidence that would support using a drug outside the guidelines but in the best interest of the resident are: 1. A physician or psychiatrist note	F 329	1) Pharmacy recommendations for resident #3,6,7,8,10,12 were discussed with their attending physician at the 5-9-17 Medical Staff meeting for gradual dose reduction (GDR). No changes to residents meds were made at that time. The attending physician was educated on and given the regulation for GDR and a copy of F-tag 329 from the 2567. 2) The facility recognizes that all residents may be affected. Resident #8's Ambien 5mg was changed from Q HS to PRN on 4-27-17. #12's Trazadone was discontinued on 4-25-17. There was no change to residents #3 and #10. Resident #6's Xanax was discontinued on 3-10-17. Resident #7's Ambien was reduced to 2.5mg Q HS on 4-21-16. Resident #3 and 10 dictations dated 5-9-17 are as follows. Resident # 3 has been on trazadone 50mg since his CVA. He was admitted to the facility on 3/15/16 from Texas. His wife is very adamant about not changing this medication due to his aggressive behavior when he does not sleep. We have discussed effects of long term use with spouse and resident. They do not want to try a reduction. They both feel given his present physical state it is not worth chancing his present mental or physical wellbeing, therefore it is my	

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F 329	Continued From page 23 indicating dosage, duration, indication and monitoring are clinically appropriate. Physician must consider risk/benefit to resident. . . . 3. Its use results in maintenance or improvement in residents' functional status. Policy/Procedure: . . . 2. Efforts to reduce or discontinue of psychopharmacological medications will be ongoing, as appropriate, for the clinical situation. . . ." The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the tapering of a medication dose/Gradual Dose Reduction which states the purpose of tapering a medication is to find an optimal dose or to determine whether continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized or the underlying causes of the original target symptoms have resolved. Often, however, the only way to know whether a medication is needed indefinitely and whether the dose remains appropriate is to try reducing the dose and to monitor the resident closely for improvement, stabilization, or decline. For psychopharmacological medications (other than antipsychotics and sedatives/hypnotics), the facility should attempt to taper a resident's medication at lease two separate quarters (with at least one month between the attempts) and then annually, unless clinically contraindicated. For sedatives/hypnotics, the facility should attempt a GDR quarterly unless clinically contraindicated. - Review of Resident #3's medical record occurred on all days of survey.	F 329	professional feeling the benefit outweighs the risk and his trazadone will remain as ordered. Resident #10 has been on Ambien for many years. We discussed adverse reactions from long term use of the medication with resident and family. They are aware of the long term effects and do not want to try a reduction. Resident states she will never be able to sleep or function without it. I can see no change in resident□s functional status or her mental and physical wellbeing, therefore I believe the benefit out ways the risk and we will keep her on current dose of Ambien. 3) A recommendation form for gradual dose reduction (GDR) will be added to the consultant pharmacist resident review that will address all psychotropic meds, any new additions, continuations, or increases of these medications. this will be discussed with and signed by the physician at the monthly medical staff meeting or anytime in between that requires a psychotropic medication review or GDR. 4) QA was started on 5-9-17 as discussed and reviewed at the medical staff meeting. DON/Designee will review all pharmacy GDR recommendations monthly with the residents physician at the monthly medical staff meetings or on resident rounds whichever comes first. The attending Physician will be responsible to review and document on the consultant pharmaceutical resident	

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F 329	Continued From page 24 Medical diagnoses included Alzheimer's disease, vascular dementia, depression, and insomnia. Current medications include Trazodone (antidepressant medication used for insomnia) 50 milligrams (mg) daily, initially ordered on 03/15/16. Resident #3's current care plan stated, "Problem: Alteration in sleep pattern r/t [related to] dx [diagnosis] of insomnia as evidenced by waking up frequently at night or having difficulty falling asleep. . . . Approaches: Resident is prescribed Trazodone, Notify MD [medical doctor] PRN [as needed], Provide a quiet environment for resident, Offer to take resident to the bathroom when he wakes up at night." Review of the "Consultant Pharmacist Drug Regimen Reviews" related to Resident #3's trazodone use identified the following: 07/27/16 - "Could we try a GDR on Trazodone?" Physician response: "No" 10/25/16 - "Could we try a GDR on Trazodone?" Physician response: "Decreased Risperdal on 10/19/16 to 0.25 mg QD [every day]. No decrease in Trazodone at this time." 02/21/17 - "Could we try GDR on Trazodone?" Physician response: "No" Resident #3 has been on Trazodone for over one year with no attempt of gradual dose reduction and no documentation of clinical rationale of why a reduction would be contraindicated. - Review of Resident #6's medical record occurred on all days of survey and identified an admission date of 11/21/16. Diagnoses included anxiety. Previous physician orders included	F 329	review form. The pharmacist will review psychotropic and record recommendations on the top part of this form. The attending physician will review and make recommendations at the bottom of this form. Included on this form is the physicians rationale for a GDR or not and the present prescribed dose. QA coordinator will review every month for 5 months and then bimonthly for 6 months until substantial compliance is met.	

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F 329	Continued From page 25 Xanax (an antianxiety medication) (discontinued on 03/10/17). Review of the "Consultant Pharmacist Drug Regimen Reviews" related to Resident #6's Xanax identified the following: *12/28/16 - "Could we try a GDR on Xanax?" Physician response: "Wouldn't be tolerated." The medical record lacked documentation of clinical rationale of why a reduction would be contraindicated. - Review of Resident #7's medical record occurred on all days of survey. Medical diagnoses include anxiety disorder, depression, and insomnia. Current medications include Ambien (hypnotic medication) 2.5 mg every night for insomnia. Resident has been on the current dose of Ambien 2.5 mg since 04/21/16, when the dose was decreased from 5 mg. Resident #7's current care plan states, "Problem: Alteration in sleep pattern related to insomnia . . . Approaches: Provide a quiet environment, Notify Dr. PRN, Resident has her own mattress, Allow resident to voice concerns/feelings in a non-judgmental manner, Resident is prescribed Ambien, Info: Resident wakes often to void. Info: Daughter would like resident to remain on sleep aid. States she is not concerned with her being on it long term." Review of the "Consultant Pharmacist Drug Regimen Review" for Resident #7's identified the following: 07/27/16 - "Could we try Ambien PRN?" Physician response: "Continue Ambien . . .q	F 329		

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F 329	Continued From page 26 [every] hs [evening]." 11/29/16 - "Could we try Ambien PRN?" Physician response: "[name of resident's daughter] does not want decrease. Wants to keep as is." 02/22/17 - "Could we try Ambien PRN?" Physician response: "No change - doesn't tolerate reduction." Although Resident #7 tolerated a reduction in Ambien from 5 mg to 2.5 mg one year ago, there has been no attempt of a gradual dose reduction within the last year. The medical record lacked evidence of the physician documenting discussion with the resident and/or family of risks versus benefits of long term use of hypnotics or a clinical rationale for why a reduction would be contraindicated. - Review of Resident #8's medical record occurred on all days of survey. Medications included zolpidem (Ambien) 5 mg at bedtime for insomnia, initiated 11/10/14, and lorazepam (antianxiety) 0.5 mg twice a day. Resident #8's quarterly Minimum Data Set (MDS), dated 02/28/17, identified trouble falling or staying asleep or sleeping too much and feeling tired or having little energy for half or more that half of the days during the 14-day assessment period. The current care plan stated, "Alteration in sleep pattern . . . Approaches: . . . Resident is prescribed zolpidem . . ." Review of the "Consultant Pharmacist Resident Reviews" related to Resident #8's zolpidem identified the following: * 06/29/16 - "Could we try zolpidem PRN?" The	F 329		

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F 329	Continued From page 27 provider responded, "No changes." * 10/25/16 - "Could we try Ambien PRN?" The provider responded "No - not tolerated in the past." * 01/25/17 - "Could we try Ativan and/or zolpidem PRN?" The provider responded, "No." Review Resident #8's provider progress notes identified the following: * 03/24/16 - ". . . Insomnia. Continue Ambien 5 mg QHS [at bedtime]. She indicated today that she wanted to keep the medication scheduled . . ." * 07/20/16 - ". . . Insomnia. Continue zolpidem 5 mg at bedtime. We have discussed taking her off this in the past. She refuses to attempt to discontinue and she is very pleased at this time with her sleep . . ." * 11/09/16 - "Insomnia. Continue zolpidem at bedtime . . ." Resident #8's medical record showed an undated note written by the director of nursing to the resident's provider. The note stated, ". . . we have tried reduction of meds [medications] - lorazepam and Ambien four times July 2014, Oct [October] 2014, April 2015, and June 2015. She does not tolerate this. In June 2015 the reduction lasted four days." The facility failed to consider/attempt a GDR quarterly or indicate why it is clinically contraindicated as required. - Review of Resident #10's medical record occurred on April 19-20, 2017 and identified an admission date of 11/21/16. Diagnoses included insomnia. Physician orders included Ambien 5	F 329		

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F 329	Continued From page 28 mg at night as needed for sleep (since admission). Review of the consultant pharmacist's drug regimen review recommendations and the physician's response identified the following: *03/29/17 - "Could we try D/C zolpidem (Ambien)" Physician response: "No" The medical record lacked documentation of why a reduction would be contraindicated. - Review of Resident #12's medical record occurred on April 19-20, 2017 and identified an admission date of 06/24/16. Physician's orders included trazodone 50 mg at bedtime for insomnia (since admission). The quarterly MDS, dated 01/13/17, identified Resident #12 felt tired or had little energy 2-6 days during the 14-day assessment period. Review of the "Consultant Pharmacist Resident Reviews" related to Resident #12's trazodone identified the following: * 07/27/16 - "Can we decrease trazodone to 25 mg nightly?" The provider responded, "Continue trazadone per Dr. [name]." * 12/28/16 - "Could we try GDR on trazodone?" The provider responded, "present dose required for sleep." The facility failed to consider/attempt a GDR in at least two separate quarters or indicate why it is clinically contraindicated.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or	F 371		5/20/17

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F 371	Continued From page 29 considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy/procedure, and staff interview, the facility failed to store food under sanitary conditions during 2 of 2 observations in the kitchen. Failure to store raw meat in a manner to prevent cross-contamination of other foods can affect all residents who consume the food and has the potential to result in a foodborne illness. Findings include: Review of the facility policy titled "Storage and	F 371	1) Information on 483.60(I)(1)-(3) was reviewed with this employee. Meat shelves have been labeled for proper storage. A dietary meeting was held on 4-25-17. one of the topics was proper meat storage, cooked and uncooked. The facility policy on storage and cooking foods was also reviewed. 2) The facility recognizes that all residents have the potential to be affected.	

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F 371	Continued From page 30 Cooking of Food" occurred on April 20, 2017. This undated policy stated, "Purpose/Objective: Food will be stored, cooked and handled in a manner that minimizes the risk of contamination and cross contamination. . . . Food Storage: . . . 6. In the refrigerator, the temperature will be kept between 35 and 40 degrees. Raw foods will be stored on shelves under cooked foods. . . . Raw Meat Storage and Handling: 1. Separate raw meat from food that will be eaten uncooked. Keep meat wrapped in plastic or in a sealed container on a low shelf in the refrigerator, in designated areas for Poultry, Beef and Pork, to stop bacteria-infected juices from dripping on other foods. . . ." The initial kitchen tour occurred on 04/17/17 at 2:20 p.m. Observation showed raw chicken thawing in a shallow pan on the top shelf of the walk-in cooler, above other shelves with various food products, including shell eggs and vegetables. An administrative dietary staff member (#5) immediately removed the chicken from the top shelf, and confirmed staff should place the chicken on the bottom shelf. The main kitchen tour occurred on 04/20/17 at 9:00 a.m. Observation in the walk-in cooler showed three packages of raw ground beef in a shallow pan on a shelf above packaged pre-cooked beef roasts. An administrative dietary staff member (#5) confirmed staff should store the raw ground beef below the pre-cooked beef roasts.	F 371	3) To prevent the risk of cross contamination, shelving in the cooler has been designated for areas of Pork, Poultry, and beef. Cooked and thawing meat will not be stored in the same section of the cooler. 4) QA will start on 5-19-17 by the Dietary Supervisor / designee to assure meat is stored in the proper location weekly for 4 weeks, monthly for 3 months, bimonthly for 6 months until substantial compliance is obtained and randomly there after. The QA Coordinator will be updated by the Dietary Supervisor on QA findings following each report on the above schedule.	