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 _____	06/13/2019

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 The Standard Medicare/Medicaid recertification survey started on 06/11/19 and concluded on 06/13/19.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and review of facility	F 609	1. The facility understands that failure to	7/18/19

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

Electronically Signed | 07/07/2019

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F 609	Continued From page 1 policy, the facility failed to identify and report to the State Survey Agency a potential incident of neglect for 1 of 1 sampled resident (Resident #21) who experienced a fall/fracture during a transfer. Failure to report the incident to the State Survey Agency after the identified fracture places all residents at risk of neglect and/or injury. Findings include: Review of the facility policy titled "Abuse and Neclect [sic]" occurred on 06/13/19. This policy, dated February 2017, stated, ". . . Neglect: Means failure to provide goods and services necessary to avoid physical harm . . . Reporting: . . . if there is reasonable cause to believe or suspect that an injury has been inflicted upon a resident by a nurse aide or other individual . . . then the Director of Nurses is responsible to report the incident to the Administrator an/or appointed person. The Administrator . . . is responsible to report the incident to the State Survey and Certification agency within 24 hours . . ." Review of Resident #21's medical record occurred on all days of survey. The progress notes stated the following: * 06/01/19 at 7:27 a.m.: "Writer called to resident room at 630 am. Resident was found sitting on floor beside bed with WC [wheelchair] behind resident. Writer asked what happened and resident chuckled and said 'I fell onto the floor.' . . . CNA [certified nursing assistant] explained to writer that the sliding board was three quarters on the WC per resident request. CNA states that she told resident it would not work. Resident replied 'This is how I do it all the time.' CNA	F 609	report a questionable incident could possibly cause harm to a resident.. 2. The facility recognizes that all residents may be affected by the alleged deficient practices if not reported. 3. Actions put into place include the following: An in-service education will be conducted on July 9th, 2019 by the Director of Nursing for the nurses and with other staff on 7/17/19 addressing circumstances that require reporting including the appropriate time frame and persons to be notified per facility policy. 4. The DON or designee will conduct audits on all incidents resulting in injuries weekly x 4, then monthly x 4 and then randomly thereafter. The information will be given to the QA coordinator by the DON or designee and discussed at the monthly QA meeting until such time that consistent substantial compliance has been met.	

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F 609	Continued From page 2 assisted with transfers and resident was on the edge of the WC and slid off cushion . . ." * 06/03/19 at 6:51 a.m.: "Writer called to resident's room at 6 AM by CNA. CNA stated resident has a large bruise to right lower leg and when resident lifted up his leg his ankle 'gave out' Resident had a fall on Friday [sic] [fall occurred Saturday] morning while transferring from his bed to wheelchair. Resident told writer that he twisted his right leg and landed on his buttocks. Writer assessed right lower leg and it is very unstable to which a possible fracture could be present . . ." * 06/03/19 at 4:30 p.m.: ". . . Resident has a fracture to the tbial [sic] and fibia [sic] . . ." The facility completed an investigation into Resident #21's fall and subsequent fracture but failed to report the fall/fracture and their findings to the State Survey Agency. Refer to F689	F 609		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, resident interview, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents	F 689	1. Resident #21 was the only resident affected by this alleged deficient practice. Resident #21 transfer method was changed by the attending nurse to a	7/18/19

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F 689	Continued From page 3 for 1 of 1 sampled resident (Resident #21) who utilized a slide board for transfers. Failure to reassess Resident #21's ability to utilize a slide board and failure to ensure staff are consistent on the use of a slide board resulted in an avoidable fall and fracture. Findings include: Review of the facility policy titled "Slide Board Policy," dated November 2018, stated, "Policy/Procedure: 1. A sliding board is a piece of equipment that can be used if a person is not able to use their legs to complete a transfer between surfaces or if a standing transfer is not safe to perform or if the person refused the use of a full lift. The board is used to make a solid 'bridge' between the two surfaces that a person can slide across to transfer between them, with or without assistance. 2. A screening from occupational or physical therapy is advisable. Be aware the resident may not always be cooperative with the most safe method of transferring so deciding between quality of life, his wishes and safety of all involved must be determined. 3. The slide board transfer involves either transferring a paraplegic resident from the wheelchair to a bed, or from a bed to a wheelchair utilizing a board, and often with the use of a gait belt. You may still need assist of two. . . . 5. Your resident should have the physical upper body strength to help get onto the board as you transfer them from the chair to the bed, or back. 6. Encourage proper transfer technics [sic] with repeated instructions."	F 689	Hoyer lift with the assist of 2 at all times. 2. Maple Manor recognizes that all residents who require assistance with transfers have the potential for falls/injuries. . 3. The policy regarding transfer methods was reviewed and will be revised by July 15, 2019. The re-education on the reviewed policy will be completed on July 9th, at a mandatory educational in-service. Pending any additional revisions the policy will be considered complete and in place by July 15, 2019. Fall assessments are done quarterly. In addition, we will add a transfer method assessment to be completed at the same time and with any significant change. 4. The care plan nurse will complete an assessment on any changes of transfer on residents, ensure evaluations have been completed, and observation of staff to ensure safe transfers weekly X8, monthly x3, quarterly x3 & randomly thereafter until substantial compliance has been demonstrated.	

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F 689	Continued From page 4 An interview with Resident #21 occurred on 06/12/19 at 12:18 p.m. The resident indicated he fell from bed during a transfer a couple of weeks ago because the certified nursing assistant (CNA) didn't know how to use the slide board. He stated once the slide board is in place, the CNAs have to "pull him by the waistband of his pants" over the "bump" (back wheel) of the wheelchair, but on the day of the fall, the CNA pushed him instead. When the CNA pushed, the wheelchair moved, he fell to the floor, and his foot caught under the nightstand. Review of Resident #21's medical record occurred on June 12-13, 2019 and identified a fall on 06/01/19 and a closed fracture of the right tibia and fibula on 06/03/19. The care plan (prior to 06/03/19) stated, "Transfers: Requires staff assistance with sliding board . . . Transfers: One person extensive assistance PER RESIDENT REQUEST . . . Resident demands a step by step way of transferring him with sliding board. Resident has been educated about proper transfer process but refuses to allow staff to perform skill correctly." The current care plan (after the fall/fracture) stated, "Transfer: Hoyer Lift [full body mechanical lift] with Assist x 2 [with 2 staff]." Review of Resident #21's Minimum Data Sets (MDSs) dated 10/22/18, 01/26/19, and 04/19/19, all identified extensive assistance of two more staff members required for transfers. Resident #21's progress notes identified the following: * 06/01/19 at 7:27 a.m.: "Writer called to resident	F 689		

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F 689	Continued From page 5 room at 630 am [6:30 a.m.]. Resident was found sitting on floor beside bed with WC [wheelchair] behind resident. Writer asked what happened and resident chuckled and said 'I fell onto the floor.' . . . CNA explained to writer that the sliding board was three quarters on the WC per resident request. CNA states that she told resident it would not work. Resident replied 'This is how I do it all the time.' CNA assisted with transfers and resident was on the edge of the WC and slid off cushion . . ." * 06/03/19 at 6:51 a.m.: "Writer called to resident's room at 6 AM by CNA. CNA stated resident has a large bruise to right lower leg and when resident lifted up his leg his ankle 'gave out' Resident had a fall on Friday [sic] [fall occurred Saturday] morning while transferring from his bed to wheelchair. Resident told writer that he twisted his right leg and landed on his buttocks. Writer assessed right lower leg and it is very unstable to which a possible fracture could be present . . ." * 06/03/19 at 4:30 p.m.: ". . . Resident has a fracture to the tbial [sic] and fibia [sic] . . ." An occupational therapy (OT) evaluation, dated 03/26/18, stated, ". . . Clinical Impression: Patient lying in bed and refusing to get up for OT. OT explained that OT needed to assess transfers and it would only take a short time. Patient states that his transfers are going fine and doesn't need to be changed and he refused to get up. OT continued to encourage patient but he continued to refuse. OT spoke with CNAs in regards to his transfer and a slide board has been appropriate use of transfer method. Patient does not want the transfer method changed. At this time, slideboard will continue to be used due to patient not cooperative with OT at this time. . . ."	F 689		

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F 689	Continued From page 6 The facility failed to make additional attempts to evaluate Resident #21's use of the slide board and failed to educate the resident of the possible risks of injury if the slide board is not used properly. The facility failed to document the resident's refusals, if any, of any other forms of transfer. The next OT evaluation occurred on 06/06/19, five days after the fall/fracture. The evaluation stated, ". . . total assist to use sliding board to w/c [wheelchair]. encouraged patient to complete as l'ly [independently] as possible. w/c to EOB [edge of bed] completed very unsafely [with patient completing 1/2 of transfer & falling onto bed total A [assist] of 2 to advance body into bed. Patient upset with staff stating they did it wrong. Recommend cont. [continued] use of hoyer for safety of patient & staff." During an interview on the afternoon of 06/12/19, an administrative staff member (#5) stated Resident #21 chooses how many CNAs he will allow to transfer him with the slide board and he prefers just one. During an interview on 06/13/19 at 8:55 a.m., a CNA (#3) indicated Resident #21 is difficult to transfer with the slide board because he is not involved at all. "Staff need to do everything . . . pulling and pushing him onto the board and then over the wheel." The CNA stated it's hard to transfer him alone but she knows some staff do. During an interview on 06/13/19 at 10:44 a.m., an OT staff member (#4) stated she completed a screening for Resident #21's use of the slide	F 689		

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F 689	Continued From page 7 board on 06/06/19. Two CNAs totally assisted the resident with the transfers, both from bed to the wheelchair and back to bed. Resident #21 kept repeating staff were doing it wrong but, in her opinion, the CNAs completed the transfers correctly. The facility failed to reassess Resident #21 ability to utilize a slide board after he refused the assessment in March of 2018 and failed to assess the staff's safety and the safety of the resident while utilizing the slide board. These failures resulted in Resident #21's avoidable fall and fracture.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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	F 761		7/10/19

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F 761	Continued From page 8 other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of log sheets, and staff interview, the facility failed to store medication properly for 1 of 1 medication refrigerators. Failure to store medications in a safe environment may result in reduced effectiveness of medications. Findings include: Review of the facility policy titled "Drug Fridge-Temperature checking" occurred on 06/13/19. This policy, revised on 06/02/16, stated, " . . . The fridge temp [temperature] will be checked daily . . . this procedure is performed as a means of ensuring that drugs are kept at the correct temperature to assure proper effectiveness . . . refrigerator temperature should be maintained between 38 and 43 degrees F [Fahrenheit] . . . 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 the pharmacy for recommendation . . . follow pharmacy recommendations . . . contact the Director of Nursing or Administrator for further guidance . . . report malfunctioning refrigerator to maintenance to relocate drugs to an alternate refrigerator . . ." A review of the facility policy titled "Storage and Safe Environment of Drugs" occurred on 06/13/19. This policy, revised 07/16/15, stated " . . . if the fridge temp is out of range from drug	F 761	1. There were no residents found to be affected by the alleged deficient practice of variable temperature of the medication room refrigerator with the Pharmacist. When this was discussed immediately when found. 2. The identification of other residents having the potential to be affected includes all residents that have any refrigerated medications. 3. Actions put into place include the following: A. The night nurse will check the temperature of the medication refrigerator and the placement of the thermometer every night and record it on the chart on the front of refrigerator. She will date, time and legibly sign her name to the chart. The chart is on the front of the refrigerator. B. The temperature of the medication refrigerator was immediately adjusted and checked until it was in the proper range. C. Pharmacy was notified by the Director of Nursing of the medications currently in the refrigerator and the temperature in the refrigerator. Pharmacist stated that as the solutions (insulin and Ativan) were clear, there was no problem. D. Policy and procedures have been reviewed and revised to indicate allowable temperatures between 36	

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F 761	Continued From page 9 manufacturer recommendations, contact the pharmacy for further instructions." Review of the manufacturer's recommendations for Lantus insulin pens stated to store the unopened pens between 36 and 46 degrees F. The manufacturer's recommendations for Lorazepam vials stated to store the medication between 36 and 46 degrees F and to protect from freezing. A tour of the medication room occurred on 06/13/19 at 9:53 a.m. with a staff nurse (#2). The medication refrigerator contained six boxes of Insulin pens and 2 vials of Lorazepam. The thermometer displayed a reading of 31 degrees F. Review of the facility "Medication Room Fridge Temperature Log" occurred on 06/13/19. Temperature readings, identified the following: *February 01-May 31, 2019: 79 readings out of the expected range. *June 01-13, 2019: 10 readings out of the expected range. During an interview on 06/13/19 at 10:07 a.m., an administrative staff (#1) stated nursing staff should report temperatures lower than 38 degrees F and higher than 43 degrees F to maintenance and administration. This staff member stated facility staff have not reported any concerns with the medication refrigerator temperatures.	F 761	degrees F. and 46 degrees F. E. Refrigerator temperatures out of range for greater than 24 hours will be reported to the Director of Nursing or Designee and also maintenance if needed. Alternate storage is available if needed. F. This task will be included on the Nurse Orientation Listing Form. G. An in-service education will be conducted on July 9th, 2019 by the Director of Nursing for the staff nurses regarding the changes in policy and procedures regarding storage of refrigerated substances. The temperature recording chart is being revised to be more explicit and eye-catching. The charted results will be reviewed daily by the day shift nurse. 4. A quality improvement plan will be put into place to monitor the changes noted above to ensure temperatures are recorded, are within range, & reported promptly if not in range to the DON or designee. The QA will be completed by the DON or Designee weekly x 4 weeks monthly x 4 months randomly thereafter. Audit results will be reviewed at the QA/QAPI meetings.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		7/10/19

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F 812	Continued From page 10 The facility must - §483.60(i)(1) - Procure food from sources approved or 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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of sanitation log and facility policy, and staff interview, the facility failed to prepare and serve food in a sanitary manner in 2 of 3 kitchen/kitchenettes (main kitchen, north kitchenette). Failure to ensure the concentration of quatenary (Quat) solution is within manufacturer's guidelines may result in an incorrect solution concentration and inadequate sanitization of the kitchen/kitchenettes. Findings include: Review of the facility policy "Testing of Oasis 146 Multi-Quat Sanitizer" occurred on 06/13/19. This policy, revised May 2019 stated, "Purpose: To insure the proper range of sanitizer to protect our residents . . . Procedure . . . withdraw and tear off	F 812	1. No residents were found to be affected by the alleged findings. 2. The facility has determined that all residents have the potential to be affected by not properly testing the Oasis 146 Multi-Quat Sanitizer. 3. The current policy will be updated. Staff has been individually educated on properly testing the sanitizer as of 6/28/19. A staff meeting will take place on July 10, 2019 to reinforce the education that was given individually. New test strips were ordered immediately. Expiration date will be logged daily. 4. Dishwasher will continue to record the ppm daily, as well as the expiration date of the strips. Dishwasher will notify	

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F 812	Continued From page 11 approximately 2 inches of paper from dispenser . . . dip for 10 seconds. Do not shake . . . compare colors immediately with colors on the test strip package to determine ppm [parts per million] . . . testing solution should be between 150-400 ppm . . . testing is done daily in the morning . . . staff initial and record ppm range on the sheet provided . . . " A review of the facility policy "Cleaning of North and South Dining Rooms" occurred on 06/13/19. This policy, revised April 2019, stated, ". . . Procedure: Before meal service: Tables and counters are to be cleaned using these steps before setting tables and counters for meals . . . a bucket will be filled with sanitizer and a dish cloth will be placed in the bucket . . . wash tables with sanitizer, making sure you rinse cloth between each table . . . set tables appropriately to resident's needs . . . After meal service: . . . wash tables and counters first with warm soapy water; second with warm rinse water, then use Oasis 146 Multi-Quat sanitizer . . ." An initial kitchen tour occurred on 06/11/19 at 12:02 p.m. with a dietary staff supervisor (#6). Review of the June 2019 sanitization log showed staff failed to record the sanitization concentration for the Oasis 146 Multi-Quat sanitizer on 8 days. The Hydrion QT 40 test strips used to test the sanitizer showed an expiration date of March 1, 2019. During an interview on 06/11/19 at 12:19 p.m., a dietary staff supervisor (#6) stated the main kitchen Ecolab Oasis 146 Multi-Quat sanitizer dispenser has been broken since June 6, 2019. The dietary supervisor stated staff should fill the	F 812	Dietary Manager and Maintenance if ppm is not within the designated 150-400ppm as listed in our policy. Dietary Manager will do a QA of the sanitation log once a week for 1 month, then 1 x per month for 5 months and randomly thereafter to ensure that proper charting is being done and PPMs are within the proper range. Audit results will be reviewed monthly at the QAPI meeting.	

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 _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 12 sanitizer buckets from the north kitchenette. The facility failed to document the sanitization record logs for the north and south kitchenette areas. Observation on 06/12/19 at 5:34 p.m. in the north kitchenette showed a dietary staff (#8) wiped the tables and kitchen prep counters with a rag from the sanitizing bucket. The dietary staff (#8) identified the solution in the bucket as the solution obtained from the main kitchen dispenser. Upon request, the staff member (#8) tested the solution using the outdated Hydrion QT 40 strips. The solution measured 100 ppm, not between 150-400 ppm. During an interview on 06/12/19 at 5:45 p.m., a dietary staff supervisor (#6) stated she failed to notify dietary staff of the malfunctioning sanitizer dispenser in the main kitchen. Facility staff failed to correctly measure/mix the Quat solution to the correct concentration, record on sanitation logs, and report malfunctioning equipment resulted in inadequate concentration.	F 812		