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 _____	06/14/2018

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 06/11/18 and concluded on 06/14/18.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		7/12/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/29/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the medical record accurately reflected each resident's code level for 3 of 14 sampled residents (Resident #1, #41, and #157. Failure to ensure the residents' medical records accurately reflected their wishes limited emergency personnel from knowing the residents' desires in the event of a medical emergency. Findings include: - Review of Resident #1's medical record occurred on June 12-14, 2018. A "Do Not Resuscitate Request Form," dated 05/21/18 and signed by Resident #1 stated, "I do not want to be resuscitated." Review of the current physician's orders identified Resident #1's code status as "full." - Review of Resident #41's medical record occurred on June 12-14, 2018. A "Do Not Resuscitate Request Form," dated 02/06/18 and signed by Resident #41 stated, "I do not want to be resuscitated." The physician's order sheet failed to identify the resident's code status. - Review of Resident #157's medical record	F 578	1) For the following alleged violations of code level on resident #1, 41, and 157 code status was checked and changed to their wishes on 6-14-18. 2)The facility recognizes that all residents have the potential to be affected. All other code statuses were reviewed and corrected as needed. 3) The software company was notified of the DNR issues with our old system and new system. They informed us that the new system would not cross over to the old system and we would manually have to put the code status in each system. The code status is on the top of the resident's face page and that is what the staff look at for the code status. This page is also what is sent when the resident is being transferred out of the facility as well. The nurses were educated in the importance of the code status at the nurses meeting on 6-14-18. Also the code status will be put in as a physician order and will no longer be on the bottom of the physician orders page as of 6-27-18. 4) QA's will be started on 6-29-18 to verify that the code status on our software system and the physician orders match	

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F 578	Continued From page 2 occurred on June 12-14, 2018. A "Do Not resuscitate Request Form," dated 05/22/18 and signed by Resident #157 stated, "I do not want to be resuscitated." Review of the current physician's orders identified Resident #157 as a "full code." An initial care plan dated 05/22/18 stated "Code Status: I prefer to be a DNR [Do Not Resuscitate]" During an interview on the morning of 06/13/18 an administrative nurse (#1) stated the facility's computer system will automatically put in the code level if the resident had a previous stay at the facility. The nurse (#1) stated Resident #1 had a previous stay so the computer automatically identified the resident as a full code because that was the status on the previous admission.	F 578	the resident's wishes. The QA will be done by the DON / Designee on 5% of the code statuses weekly for 4 weeks, monthly for 3 months, or until all present residents code status's have been assessed. The QA Coordinator will be updated as the QA's that are completed.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or	F 644		7/12/18

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F 644	Continued From page 3 a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, review of facility policy, and staff interview, the facility failed to complete a status change assessment for 1 of 1 sampled resident (Resident #40) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in delivery of care and services inconsistent with the resident's needs. Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend [contracted service provider for screening process] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of the facility titled "Resident Assessment - Coordination with PASARR Program" occurred	F 644	1) A Level 1 and LOC PASRR screening was completed on resident #40 on 6-15-18. The level 1 was approved on 6-18-18. 2) The facility recognizes that all residents with a newly diagnosed mental illness have the potential to be affected. 3) All residents EMR will be reviewed by the LSW and DON/designee for a psychiatric diagnosis if a resident has had a significant change in status related to MI, ID, and RC that was not identified at the Level 1 screen process and the condition later emerged or was discovered. The LSW/designee will initiate a new PASRR screening through Ascend to identify that the screening has changed. 4) After completion of EMR review 10% of all current resident charts will be reviewed monthly by the DON for 6 months, every other month of 6 months and randomly there after to assure solutions are sustained. In the event that a significant change is found a new PASRR screening will be initiated upon discovery. QA will review with the social worker and DON all results each month for 6 months. Results will be discussed at the monthly QA and medical staff meeting.	

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F 644	Continued From page 4 on 06/14/18. The policy, revised 03/23/18, stated, ". . . Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review." Review of Resident #40's medical record occurred on June 12-14, 2018. The record identified, on 03/30/16, staff completed a Level I screening for Resident #40. The record showed a new diagnosis, dated 12/22/16, of "psychosis not due to a substance or known physical condition." The record lacked evidence staff performed a Level II assessment following this new diagnosis. During an interview on 06/12/18 at 5:49 p.m., a social worker (#3) stated she would look for information regarding the Level II PASARR. On 06/13/18 at 8:41 a.m., the social worker (#3) confirmed staff did not perform a Level II PASARR when Resident #40 received the new diagnosis.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		7/12/18

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F 656	Continued From page 5 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to develop a comprehensive care plan for 2 of 14 sampled residents (Resident #24 and #207). Failure to develop a care plan may negatively impact the resident's quality of life. Findings include:	F 656	1. Care plan(s) of the resident identifier(s) RI#(s) 24 and 207 were reviewed and updated as indicated. a)On 6-18-18 resident #24□s care plan was revised by the MDS Coordinator. Behavior: Wandering care plan was added. b)Resident #207□s care plan was	

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F 656	Continued From page 6 Review of the facility policy titled "Comprehensive Care Plans" occurred on 06/13/18. This policy, dated, 04/24/18, stated, ". . . implement a comprehensive person-centered care plan . . . to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." - Observation on all days of survey showed Resident #24 wandered throughout the facility. Review of Resident #24's medical record occurred all days of survey. An admission Minimum Data Set (MDS), dated 04/09/18, identified wandering and independence for walking and locomotion. An elopement risk assessment, dated 04/09/2018, identified "medium risk" for elopement. Review of progress notes for 04/19/18 to 06/09/18 identified wandering six times. The care plan failed to address the problem of wandering or elopement. - Review of Resident #207's medical record occurred on all days of survey. Current physician's order stated, continuous oxygen therapy via nasal cannula or mask at 2 to 6 liters per minute. Resident #207's care plan stated, . . . administer oxygen therapy as ordered . . . 3 lt/min [liters per minute] via nasal cannula . . ." Resident #207's care plan failed to address the residents use of oxygen and the need to monitor saturations to determine how much oxygen to administer.	F 656	revised on 6-13-2018 by the LSW. Behavior: Yelling and resisting cares care plan was added. On 6-27-2018 Behavior: wandering was added by the MDS Coordinator. Respiratory care plan was revised on 6-18-2018 by the MDS Coordinator to read □Monitor oxygen saturation levels as needed. 2. The facility has determined that all residents have the potential to be affected. 3. All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility□s policy and procedure for developing Comprehensive Care Plans and will attend a Webinar regarding F-Tag Review Series □ Comprehensive Care Plans on 6 -27-2018. Nursing staff was re-educated on the RAI definition of wandering and watched a 30 minute educational video on care planning from our software company, American Health Tech at the nurses meeting on 6-14-2018. 4. Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator. All care plans will be updated as indicated. QA will be done by the DON/designee on 5% of the care plans weekly for 4 weeks, monthly for 3 months, then every other month for 6 months until compliance is maintained and randomly there after. Audit records will be reviewed by Quality Assurance after each QA is completed.	

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F 656	Continued From page 7 Review of Resident #207's progress notes from 05/25/2018 to 06/13/2018 indicated 11 incidents of wandering, verbal, or socially inappropriate behaviors. Resident #207's care plan failed to address the problem of wandering, verbal and socially inappropriate behaviors.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide the necessary care and services for 2 of 2 sampled residents (Resident #4 and #207) receiving oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 1397, stated, "OXYGEN	F 695	1) Oxygen order for resident #4 was checked on 6-15-18 and changed as follows: "May use oxygen at 3 liters via nasal cannula during the day as needed and apply oxygen at 3 liters via nasal cannula at bedtime." oxygen orders for resident #207 were checked on 6-15-18 and changed as follows: "continuous oxygen therapy via nasal cannula at 3 liters per minute. 2) The facility recognizes that all residents have the potential to be affected. All other oxygen orders have been reviewed for the need for changes. 3) In the nurses meeting on 6-14-18 we	7/12/18

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F 695	Continued From page 8 THERAPY . . . Like many medication, oxygen is not completely harmless to the client. Clients receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ." - Review of Resident #4's medical record occurred on all days of survey. The care plan stated, ". . . Monitor oxygen saturation levels . . . Assess respiratory status as needed . . . Oxygen at 3 liters per minute per nasal cannula as needed every day . . . Oxygen at 3 liters per minute via nasal cannula at night . . ." The physician's orders, dated 03/03/17, included: * "Oxygen at 3L/MIN/NC [3 liters per minute via nasal cannula]" * "Oxygen at 3L/MIN/NC as needed every-day" In addition, the resident's May 2018 eMAR (electronic medication administration record) identified oxygen at 3L per NC at 8:00 p.m. The eMAR showed Resident #4 refused oxygen at 8:00 p.m. 15 of 31 times in May. The facility failed to clarify the resident's physicians to determine the administration of oxygen. - Review of Resident #207's medical record occurred on all days of survey. The physician's order stated, "continuous oxygen therapy via nasal cannula or mask at 2 to 6 liters per minute." Resident #207's care plan stated, ". . . administer oxygen therapy as ordered . . . 3 lt/min [liters per minute] via nasal cannula . . ."	F 695	reviewed and discussed: a) oxygen policy and procedure changes. b) oxygen orders c) documentations of PRN and continuous oxygen d) reviewed the changes on the standing orders for oxygen 4) QA's will be started on 6-29-18. The DON / Designee will review 50% of the oxygen orders every week for 4 weeks, monthly for 3 months, or until substantial compliance is obtained . The QA coordinator will review the QA's after each completion. The finding will also be discussed at the medical staff meetings until compliance is obtained.	

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F 695	Continued From page 9 Review of Resident #207's vital records showed staff checked Resident #207's O2 saturations six times since admission in May. During an interview on 06/13/18 at 1:34 p.m., an administrative nurse (#1) stated he would expect staff to check O2 saturation every shift for an oxygen range to determine how much oxygen to administer. The facility failed to regularly check the resident's oxygen saturations prior to applying the oxygen to determine the amount of oxygen to administer.	F 695		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and group interview, the facility failed to serve foods at palatable temperatures for 2 of 2 meal observed (Dinner 06/11/18 and Breakfast 06/12/18). Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include:	F 804	1) Temperatures will be monitored on food trays and milk to assure food palatability. Milk will be supplied in plastic containers and held in an ice bath during breakfast meal. Milk is held in refrigerator until use for all other meals. 2) The facility has determined that all residents have the potential to be affected by food temperatures. 3) The Temp of room trays will be tested.	7/12/18

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F 804	Continued From page 10 During an interview on the afternoon of 06/11/18, Resident A stated he eats meals in his room and the food often is cold when it arrives. A dinner test tray was received on 06/11/18 after the last room tray was delivered F approximately 6 p.m. The test tray consisted of pancakes and sausage. The 4 surveyors confirmed the test tray did not maintain a palatable food temperature. During the breakfast meal on 06/12/18, the food and beverages were tested. The temperature of the milk, sitting in a shallow pan with ice, temperature was 55 degrees F. The milk showed be stored at 40 degrees F or below. The staff immediately discarded the milk. During the group interview on 06/12/18 at 2:30 p.m., Resident B stated the food is not always hot when served. Failure to serve foods at palatable temperatures may negatively impact residents' meal consumption.	F 804	Results will be obtained in the Dietary office. T-sticks will be purchased to have in serving kitchens so the foods that are heated there can be easily temped. Education will be provided to staff on proper food temperatures to be completed by 7-12-18. Milk will be supplied in plastic containers, instead of wax coated containers, which will be emerged in ice during breakfast. 4) The Dietary Manager will prepare and conduct temperature audits of room trays which will be randomly tested, recorded and obtained in the Dietary office. Audits will be done 5x/week for the first week and then 1x/week for 1 month and 1x/month for 6 months until substantial compliance has been met. Audit results will be reviewed monthly at the QA meeting.	