STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345448	A. BUILDING _____ B. WING _____	C 08/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HEALTH AND REHABILITATION CENTER	308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406

(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 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		9/6/17

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

Electronically Signed | 09/03/2017

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff, pharmacist and attending physician interviews the facility failed to notify the attending physician that Marinol had not been administered for 7 days to Resident #3. This was evident in 1 of 4 residents in the sample reviewed for physician notification. Findings included: Resident #3 was admitted to the facility on 8/2/17 with cumulative diagnoses which included diabetes mellitus. Review of the admission physician orders dated 8/2/17 included Marinol 10 milligrams (mg) by mouth twice a day. Marinol is a drug used to nausea, vomiting and a poor appetite. Review of the Medication Administration Record (MAR) revealed Marinol 10 milligrams (mg) by mouth twice a day had blank spaces and circled initials indicating the drug had not been administered from 8/2/17 through 8/9/17. Medical record review revealed no evidence that the attending physician was notified that Marinol had not been dispensed from the pharmacy since admission nor problems with the resident having nausea, vomiting or poor appetite. Interview on 8/9/17 at 11:42 AM with Nurse #8	F 157	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F- 157 Resident #3 received Marinol into the facility after midnight on 8/10/2017 and began receiving prescribed dose 8/10/2017 @ 9am.	

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F 157	Continued From page 2 who stated she spoke with the attending physician a script required for the pharmacy but cannot remember the date or time. Interview on 8/10/17 at 8:10 AM with Nurse #3 indicated she had not notified the attending physician about Marinol not available from the pharmacy until a written prescription was sent to the pharmacy. Interview on 8/10/17 at 8:30 AM with Nurse #9 revealed the pharmacy required a written script from the physician for controlled substances. Usually, the pharmacy will fax the facility and the doctor requesting the script. The facility faxed request for the written script was placed in the doctor's book. Nurse #9 was unsure which nurse placed the fax in the doctor's book and that she had not notified the attending physician about a required script and Resident #3 had not been administered Marinol since admission. Continued interview with Nurse #9 revealed Marinol was delivered to the facility on 8/10/17. Interview on 8/10/17 at 1:40 PM via the phone with the pharmacist from the dispensing pharmacy revealed controlled substances required a written script and the pharmacy faxed this need to the attending physician. The pharmacist indicated that a follow-up fax would be sent within 48 hours or the pharmacy would assume the resident no longer needed the medication. Continued interview revealed the pharmacy expectation was for the attending physician to response. Interview on 8/10/17 at 5:00PM with the attending physician revealed no one ever called him or faxed him regarding the need for a written script.	F 157	An audit was performed by the Interim Director of Nursing (IDON) to ensure that medications were dispensed from pharmacy or medication refusal secondary to adverse reactions and the attending physician was notified on 8/11/2017. On August 22, 2017 a meeting was conducted at Maple Grove Health and Rehabilitation, participants present were Neil Medical Director of Clinical Services , Neil Medical pharmacy consultant Maple Grove administrator, IDON and medical record supervisor. The process of required script from physician before dispensing to facility was reviewed. Licensed nurses in serviced on obtaining medications from the pharmacy on 8/11/2017. License nurses in serviced on notification of attending physician that a script was required from pharmacy and needed before pharmacy will dispense on 8/11/2017 by the IDON. All new hired licensed nurses will be in serviced in orientation by the Staff Facilitator (SDC). The facility will monitor new admission prescriptions and medications to ensure delivery and availability daily X 5days weekly. Any medications that cannot be retrieved from back □ up pharmacy will be reported to the IDON/administrator for intervention. All new admitted resident medications will be checked daily X5 days weekly by the IDON, Director of Nursing,	

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F 157	Continued From page 3 During the interview the attending physician indicated Marinol was a scheduled 3 controlled substance and the pharmacist could have called me just like they did yesterday (referring to 8/9/17). Interview on 8/11/17 at 1:50 PM with the interim Director of Nurses revealed she expected the facility to communicate and notify the attending physician when the Marinol was not available to be administered.	F 157	Assistant Director of Nursing, and / or SDC/Quality Improvement (QI) nurse to ensure the attending physician has been notified for any scripts required from pharmacy. A Quality Improvement committee was formed on 8/28/2017 consisting of the IDON, ADON, SDC/QI nurse, rehabilitation director, Minimum Data Set nurses, activity director, dietary manager, assistant dietary manager, supply clerk, environmental supervisor, social worker and medical records supervisor. The QI committee will meet weekly X 8 weeks, then bi-monthly for 2 months, then monthly for 2 months. All discrepancies will be reported to the Administrator immediately for review of the process. The Administrator will report quarterly to the executive quality improvement committee quarterly X2. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. Recommendations to continue, alter or modify will be discussed at that time.	
F 278 SS=D	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	F 278		9/6/17

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F 278	Continued From page 4 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 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 staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the use of a pain medication for 1 of 3 sample residents reviewed who were receiving pain medications (Resident #7). The findings included:	F 278	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of	

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F 278	Continued From page 5 Resident #7 was admitted to the facility on 3/28/17. The resident ' s cumulative diagnoses included diabetes. Resident #7 re-entered the facility after a hospital stay from 6/13/17-6/17/17. The resident ' s 6/17/17 re-admission medications included 5 milligrams (mg) oxycodone (an opioid medication) to be given by mouth every 4 hours as needed for moderate pain and 5 mg oxycodone to be given as two tablets (10 mg) by mouth every 4 hours for severe pain. Oxycodone is a controlled substance medication. A review of Resident #7 ' s June 2017 Medication Administration Record (MAR) for 6/17/17 to 6/30/17 indicated no doses of oxycodone were given to the resident. However, a review of the resident ' s Controlled Substance Receipt/Count Sheet (a declining inventory of a controlled substance medication) for the 5 mg oxycodone tablets revealed one dose (one tablet) of oxycodone was pulled from the medication cart for administration to the resident on 6/28/17 at 8:30 PM. A review of Resident #7 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 7/1/17 was completed. Section J of the MDS indicated the resident was not on a scheduled pain medication regimen and did not receive any pain medications on an as needed (PRN) basis during the 7-day look back period. An interview was conducted on 8/10/17 at 10:23 AM with the facility ' s MDS nurses (MDS Nurse #1 and MDS Nurse #2). Upon inquiry, MDS Nurse #1 calculated the dates used for the 7-day look back period for the 7/1/17 quarterly MDS	F 278	compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F-278 Resident # 7 had an modification sent to the National Repository on 9/1/2017to indicate resident # 7 did receive pain medication during the look back period. Receipt of acceptance from the National Repository obtained 9/1/2017. An in serviced was conducted on 8/14/2017 by the RAI Reimbursement Auditor on accurate coding of Section J, to observe the Medication Administration Record (MAR) as well as the Controlled Substance receipt/ Count Sheet. An in serviced was conducted by the Interim Director of Nurses on 8/11/2017 to licensed nurses and medication aides on the documentation of as needed (prn) medication on the Medication Administration Record (MAR). A mandatory training for Minimum Data Set nurses will be conducted 8/21-8/22,	

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F 278	Continued From page 6 assessment. The 7-day look back period was reported to be 6/25/17 - 7/1/17. An interview was conducted on 8/11/17 at 8:51 AM with MDS Nurse #2. MDS Nurse #2 reported she had completed Resident #7 ' s MDS dated 7/1/17. The nurse stated she was not aware at that time the resident had received a dose of the pain medication (oxycodone) during the 7-day look back period. MDS Nurse #2 stated she used the information on the resident ' s MAR to complete the MDS. The nurse reported if she had been aware of the pain medication having been given to Resident #7 during look back period, she would have coded the MDS accordingly. An interview was conducted on 8/11/17 at 11:40 AM with the facility ' s Administrator. During the interview, the Administrator reported her expectation was for the MDS assessments to be coded accurately with all of the information provided.	F 278	2017 by Corporate Clinical Quality/ Reimbursement Director . MDS nurses and administrator scheduled for an in service on 9/26/2017 Coding Accuracy with Special Presentation on Baseline Care Planning by Judy Wilhide Brandt, RN, QCP, RAC-MT, DNS-CT An auditing tool was initiated for the Minimum Data Set nurses to monitor administration of as needed (prn) medications to ensure accurate coding on Section J. The auditing tool to be utilized with all assessments beginning 9/1/2017. Interim Director of Nursing, Staff Facilitator, and Director of Nursing to monitor daily X5 days weekly to ensure as needed medications signed out on the Medication Administration Record. Licensed nurses and Medication aides auditing every shift daily X 7days to ensure all medications signed on Medication Administration Record starting on 8/21/2017. A QI committee was formed on 8/28/2017 consisting of the Interim Director of Nursing, Assistant Director of Nursing, Rehabilitation Director, Minimum Data Set nurses and Medical Records Supervisor. The Quality Improvement Committee will meet weekly X 8 weeks, then bi-monthly for 2 months, then monthly for 2 months. All discrepancies will be reported to the Administrator immediately for review of the process.	

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F 278	Continued From page 7	F 278	The Administrator will report quarterly to the executive quality improvement committee quarterly X2. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. Recommendations to continue, alter or modify will be discussed at that time.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 279		9/6/17

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F 279	Continued From page 8 (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, staff interview and record review the facility failed to develop a comprehensive care plan with measureable goals and interventions to address Resident #9 bilateral hand contractures. This was evident in 1 of 1 resident reviewed for contractures.	F 279	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable	

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F 279	Continued From page 9 Findings included.: Resident #9 was admitted to the facility on 11/12/14 with cumulative diagnoses which included cerebral palsy. Review of the 5/19/17 quarterly Minimum Data Set (MDS)assessment revealed Resident #9 was severely cognitively impaired with functional limitation of range of motion in her upper extremity on both sides (contracture of both hands). Review of the occupational therapy (OT) notes revealed from 6/14/17 through 7/10/17 Resident # 9 received therapy for orthotic (splint) management. The OT notes indicated on 7/10/17 education was provided to the nursing staff regarding the bilateral application of the palm protector splints and the wear schedule. Review of the care-plan updated 7/10/17 did not reflect the limited range of motion or bilateral hand contractures. Review of the care card posted inside of Resident's #9 closet did not reflect the status of the limited range of motion. Record review of the sign posted in the room with instructions regarding the use of the palmer protector revealed to apply both palmer protectors to both hands daily for 6 to 8 hours. Interview on 8/11/17 at 9 AM with the MDS coordinator revealed acare plan should have been developed to address the hand contractures.	F 279	rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F-279 Resident #9 with functional limitation of range of motion in her upper extremity on both sides (contracture of both hands) had palm guards placed as ordered on 8/11/2017 by the C.N.A..The care plan was update on 8/24/2017 by a Minimum Data Set nurse and care guide was updated on 8/11/2017 by the Interim Director of Nursing both to reflect the use of the bilateral palm guards . An audit was conducted on 9/1/2017 to assess residents that exhibit limited range of motion have received treatment to prevent further decrease in range of motion to ensure on care guide and care plan by the Interim Director of Nursing and Staff Facilitator . A 100% in service was initiated to all	

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F 279	Continued From page 10	F 279	nursing staff to place orthotics on residents, care guides, and care plan once recommended by therapy services completed on 9/3/2017 by the Interim Director of Nursing and Staff Facilitator. All new hires will receive same in service in orientation by the Staff Facilitator. An in-service was initiated on 8/28/2017 by the Administrator with Rehabilitation Manager, Interim Director of Nursing, and Minimum Data Set nurses that all education provided to staff by the therapy department will be reviewed by the Director of Nursing, Assistant Director of Nursing, Staff Facilitator and Minimum Data Set nurses. A signature will be present to ensure continuity of care to residents with functional limitations have received treatment to prevent further decrease in range of motion. All new hires in stated positions will be in serviced in orientation by Staff Facilitator. A mandatory training for MDS nurses to be conducted 8/21-8/22, 2017 by Corporate Clinical Quality / Reimbursement Director MDS nurses and administrator scheduled for an in service on 9/26/, 2017 Coding Accuracy With Special Presentation on Baseline Care Planning The Staff Facilitator will conduct weekly audits for all residents with orders for the use of orthotics to ensure care on care guide and care plan. The audits will be weekly X8 the every other week X2, then monthly X2.	

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F 279	Continued From page 11	F 279	A QI committee was formed on 9/1/2017 consisting of the Interim Director of Nursing, Assistant Director of Nursing, Staff Facilitator Rehabilitation Director, Minimum Data Set nurses and Medical Records Supervisor. The QI committee will meet weekly X 8 weeks, then bi-monthly for 2 months, then monthly for 2 months. All discrepancies will be reported to the Administrator immediately for review of the process. The Administrator will report quarterly to the executive quality improvement committee quarterly X2. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. Recommendations to continue, alter or modify will be discussed at that time.	
F 287 SS=D	483.20(f)(1)-(4) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (f) Automated Data Processing Requirement (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there	F 287		9/6/17

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F 287	Continued From page 12 is no admission assessment. (2) Transmitting Data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data Format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete two Minimum Data Set	F 287	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of	

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F 287	Continued From page 13 (MDS) discharge assessments and two MDS entry/re-entry tracking records within the required time frame for 1 of 1 sampled resident reviewed who had multiple discharges to the hospital with re-entries back to the facility (Resident #7). The findings included: Resident #7 was admitted to the facility on 3/28/17. A review of the facility ' s census documentation indicated Resident #7 was discharged to the hospital on 7/1/17 and re-entered the facility on 7/3/17. The resident was again discharged to the hospital on 7/19/17 and re-entered the facility on 7/23/17. A review of Resident #7 ' s Minimum Data Set (MDS) records revealed the discharge assessment for 7/1/17 and the entry/re-entry tracking record for 7/3/17 had not been completed. Further review of the MDS records revealed the discharge assessment for 7/19/17 and the entry/re-entry tracking record for 7/23/17 had not been completed. An interview was conducted on 8/10/17 at 10:23 AM with the facility ' s MDS nurses (MDS Nurse #1 and MDS Nurse #2). During the interview, inquiry was made in regards to the missing discharge assessments and entry/re-entry tracking records. Upon review of the facility ' s census report, MDS Nurse #2 stated, "We missed a couple of discharges and re-entries." The MDS nurses stated the missed discharge assessments (from 7/1/17 and 7/19/17) and entry/re-entry tracking records (from 7/3/17 and 7/23/17) should have been completed and	F 287	Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F-287 Resident # 7 had a discharge (7/1/2017) assessment transmitted to the National Repository and accepted on 9/1/2017. Resident # 7 had a reentry (7/3/2017) transmitted and accepted at the National Repository on 8/29/2017. Resident # 7 had a discharge (7/19/2017) transmitted and accepted at the National Repository 9/1/2017. Resident #7 had reentry (7/23/2017) transmitted and accepted at the National Repository 8/29/2017.	

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F 287	Continued From page 14 needed to be submitted. An interview was conducted on 8/10/17 at 11:00 AM with the facility ' s Administrator. During the interview, the Administrator reported she was made aware the facility missed submitting 4 MDS records, including two discharges and two re-entries in July 2017. The Administrator stated she did not have a Quality Assurance (QA) process in place for "missed" MDS records and she understood four missing records could not be overlooked.	F 287	An in serviced was conducted on 8/14/2017 by the RAI Reimbursement Auditor on completion of entry/ reentry resident within 14 days and completion of discharged resident within 7 days of discharge to the Minimum Data Set nurses. . A mandatory training for MDS nurses to be conducted 8/21-8/22, 2017 by Corporate RAI Reimbursement Director. MDS nurses and administrator scheduled for an in service on 9/26/, 2017 Coding Accuracy with Special Presentation on Baseline Care Planning An audit of missed entry/ reentry assessments and discharges was completed on 9/1/2017 by the Medical Records Supervisor. An audit of or entries / reentries and discharges will be conducted weekly by the Medical Records Supervisor X 8 weeks the bi monthly X 2 months then monthly X2. A remote audit will be conducted by the RAI Reimbursement Auditor sporadically to ensure that entries/ reentries and discharge assessments are done timely. A QI committee was formed on 8/28/2017 consisting of the Interim Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Rehabilitation Director, Minimum Data Set nurses and Medical Records Supervisor. The QI committee will meet weekly X 8 weeks, then bi-monthly for 2 months, then monthly for 2 months. All discrepancies	

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F 287	Continued From page 15	F 287	will be reported to the Administrator immediately for review of the process. The Administrator will report quarterly to the executive quality improvement committee quarterly X2. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. Recommendations to continue, alter or modify will be discussed at that time.	
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews the facility failed to cleansed the genitals. The facility failed to wash the clumps of damp powder under the skin folds. The facility failed to comb Resident #9's hair. This was evident in 1 of 3 residents dependent on staff for personal hygiene and bathing. (Resident #9) Findings included: Resident #9 was admitted to the facility on 11/12/14 with cumulative diagnoses which included cerebral palsy. Review of the 5/19/17 quarterly Minimum Data Set assessment revealed Resident #9 was severely cognitively impaired, always incontinent of bladder and bowel and totally dependent on staff for personal hygiene and bathing.	F 312	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple	9/2/17

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F 312	Continued From page 16 Review of the care-plan updated 7/10/17 revealed a focus of incontinence due to cognitive impairment. One of the interventions included pericare after each incontinent episode. A second focus was required assistance for personal hygiene with interventions that included providing total care and to comb hair. Review of the care card posted inside of Resident's #9 closet revealed under section "hygiene/grooming" stated to "provide total care , comb hair, wash/dry face/hands and perineum. 1. Observation on 8/10/17 at 10:30 AM incontinence care was provided by Nursing Assistant (NA) #1 and assisted by NA #2 was conducted. NA #1 removed the soiled brief due to an episode of incontinence of urine. Using premoistened disposable wipes, NA #1 wiped the right side and left sides of Resident's #9 groin. Resident#9 legs were not opened to thoroughly cleanse the perineal area. NA #1 and NA #2 repositioned the resident on her right side and NA #1 used a premoistened wipe to cleanse the resident's rectum in a back to front motion. A clean brief was being placed on the resident by NA #1 and NA #2 when an inquiry was made regarding the condition of the skin under the residents abdominal folds. Observation of the skin under the folds of the resident's abdomen revealed the skim was damp and clumps of a white substance similar to powder was noted. NA #1 and NA #2 continued to fasten the clean brief. NA #1 stated that she placed the powder under the resident's abdominal fold. Interview on 8/10/17 at 10:50 AM with NA #1 who stated that this was her usual routine for providing incontinence care. NA #1 stated she was not sure why she did not clean under the folds of the resident's abdomen. "I use the care guide in the closet to let me know what care the resident	F 312	Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F-312 Resident # 9 who is dependent for ADL's immediately received perineal care inclusive of powder residue at the abdominal fold by another C.N.A. in the presence of the IDON. Resident# 9 hair was combed by another C.N.A. also at that time. C.N.A. # 1 was removed from care area and in serviced on ADL care for the dependent resident. C.N.A. # 1 was observed by Interim Director of Nursing on skills checklist before returning to resident care area on 8/11/2017. On 8/10/2017 an in-service was initiated by the Interim Director of Nursing on ADL care for the dependent resident inclusive of perineal care and combing hair 100 % completed by 9/2/2017. A management round was conducted on 8/10/2017 by department heads to ensure all residents dependent for ADL's hair was combed. . On 8/10/2017 the Interim Director of Nursing initiated skill check list on all C.N.A.'s pertaining to perineal care of the dependent resident completed on 9/2/2017.	

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F 312	Continued From page 17 needed. " Interview on 8/11/17 at 10 AM with the interim Director of Nurses stated her expectation was the resident's leg be opened to cleanse the perineal area, cleansed the rectum from front to back and remove the clumps of powder. 2. Observation on 8/10/17 at 10:10 AM revealed Resident's #9 hair was uncombed with hair loosening from the plaits and partially matted in the back portion of the head. Observation on 8/10/17 at 10:30 AM revealed Resident's #9 hair was uncombed with hair loosening from the plaits and partially matted in the back portion of the head. Observation on 8/10/17 at 11:10 AM revealed Resident's #9 hair continued to be uncombed with hair loosening from the plaits and partially matted in the back portion of the head. Observation on 8/10/17 at 3 pm revealed Resident #9's hair remained uncombed with hair loosening from the plaits and partially matted in the back portion of the head. Observation on 8/10/17 at 5:20 PM revealed there was no change in the appearance of Resident #9's hair. Interview on 8/11/17 at 9:53 AM with NA #1 revealed the resident hair was combed on her shower days by the evening shift but was not sure what day. NA #1 stated that she had not combed Resident #9 hair on 8/10/17. Interview on 8/11/17 at 10 AM with the interim Director of Nurses stated her expectation was residents to have hair combed or brushed whenever necessary.	F 312	All new hires will be in serviced in orientation by the Staff Facilitator. 10% of residents dependent for ADL care will be monitored daily X7 days for 8 weeks, 3 X weekly for 4 weeks, 2 X week for 4 weeks , weekly X 4 weeks then every other week X 4 weeks. . A QI committee was formed on 9/1/2017 consisting of the Interim Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Rehabilitation Director, and Minimum Data Set nurses, Activity Director, Dietary Manager, Assistant Dietary Manager, Supply Clerk, Environmental Supervisor, Social Worker and Medical Records Supervisor. The QI committee will meet weekly X 8 weeks, then bi-monthly for 2 months, then monthly for 2 months. All discrepancies will be reported to the Administrator immediately for review of the process. The Administrator will report quarterly to the executive quality improvement committee quarterly X2. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. Recommendations to continue, alter or modify will be discussed at that time.	

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F 318	Continued From page 18	F 318		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to apply palm protectors daily to Resident #9's contracted hands. This was evident in 1 of 1 residents reviewed for contractures. Findings included. Resident #9 was admitted to the facility on 11/12/14 with cumulative diagnoses which included cerebral palsy. Review of the 5/19/17 quarterly Minimum Data Set assessment revealed Resident #9 was severely cognitively impaired with functional limitation of range of motion in her upper extremity on both sides (contracture of both hands). Review of the occupational therapy (OT) notes revealed from 6/14/17 through 7/10/17 Resident # 9 received therapy for orthotic (splint)	F 318	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other	9/1/17

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F 318	Continued From page 19 management. The OT notes indicated on 7/10/17 education was provided to the nursing staff regarding the bilateral application of the palm protector splints and the wear schedule. Review of the care-plan updated 7/10/17 did not reflect the status of the limited range of motion. Review of the care card posted inside of Resident's #9 closet did not reflect the status of the limited range of motion. Record review of the sign posted in the room with instructions regarding the use of the palm protector revealed to apply both palmer protectors to both hands daily for 6 to 8 hours. Observation on 8/10/17 at 10:10 AM revealed no palm protectors were applied to both hands. Observation on 8/10/17 at 10:30 AM revealed no palm protectors were applied to both hands. Observation on 8/10/17 at 11:10 AM revealed no palm protectors were applied to both hands. Observation on 8/10/17 at 3:00 PM revealed no palm protectors were applied to both hands. Observation on 8/10/17 at 5:20 PM revealed no palm protectors were applied to both hands. Interview on 8/11/17 at 9:30 AM with Rehab Director revealed Resident #9 was able to tolerate wearing the palm protectors without pain or reddened skin. Interview on 8/11/17 at 9:53 AM with NA #1 revealed she did not remember to apply the palm protectors to both hands but was aware they should have been applied. Interview on 8/11/17 at 10 AM with the interim	F 318	administrative or legal proceeding. F-318 Resident #9 with functional limitation of range of motion in her upper extremity on both sides (contracture of both hands) had palm guards placed as ordered on 8/11/2017.The care plan was update on 8/24/2017and care guide was updated on 8/11/2017 both to reflect the use of the bilateral palm guards . An audit was initiated on 8/27/2017 by the administrator and completed on 9/1/2017 by the Interim Director of Nursing and Staff Facilitator to assess residents that exhibit limited range of motion have received treatment to prevent further decrease in range of motion. A 100% in service was initiated to all nursing staff to place orthotics on residents, care guides, and care plan once recommended by therapy services completed 9/3/2017. All new hires will receive same in service in orientation by the Staff Facilitator. An in-service was initiated on 8/28/2017 by the administrator with rehabilitation manager, interim director of nursing, and Minimum data Set nurses that all education provided to staff by the therapy department will be reviewed by the Director of Nursing, Assistant Director of Nursing, Staff Facilitator, and Minimum Data Set nurses. A signature will be present to ensure continuity of care to residents with functional limitations have received treatment to prevent further	

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F 318	Continued From page 20 Director of Nurses stated her expectation was palm protectors should be applied in the morning when the resident was transferred out of bed.	F 318	decrease in range of motion. All new hires in stated positions will be in serviced in orientation by the Staff Facilitators. The Staff facilitator will audit all residents with orthotics in place to ensure continuity of care for residents with functional limitations have received treatment to prevent further decrease in range of motion. Monitoring will occur weekly X 8 weeks then every other week X 2 then monthly X 2. A QI committee was formed on 8/28/2017 consisting of the Interim Director of Nursing, Assistant Director of Nursing, Rehabilitation Director, Minimum Data Set nurses and Medical Records Supervisor. The QI committee will meet weekly X 8 weeks, then bi-monthly for 2 months, then monthly for 2 months. All discrepancies will be reported to the Administrator immediately for review of the process. The Administrator will report quarterly to the executive quality improvement committee quarterly X2. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. Recommendations to continue, alter or modify will be discussed at that time.	
F 329 SS=D	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	F 329		9/6/17

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F 329	Continued From page 21 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; (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 staff interviews and record review, the facility failed to monitor a resident ' s blood	F 329	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of	

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F 329	Continued From page 22 glucose (sugar) levels to determine the insulin dose required and ensure the blood glucose levels were managed in accordance with the physician orders for 3 of 3 sampled residents receiving insulin therapy (Resident #7, Resident #4 and Resident #3). The findings included: 1. Resident #7 was admitted to the facility on 3/28/17. The resident ' s cumulative diagnoses included diabetes. A review of Resident #7 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 7/1/17 indicated the resident had intact cognitive skills for daily decision making. The resident required extensive assistance from staff for all of his Activities of Daily Living (ADLs), with the exception of requiring limited assistance for transfers and locomotion on/off the unit, and being independent with eating. Section N of the MDS indicated the resident received an insulin injection on 7 out of 7 days during the look back period. Resident #7 was discharged to the hospital on 7/19/17 and he re-entered the facility on 7/23/17. The resident ' s 7/23/17 re-admission orders at the facility included: 5 units of Lantus insulin (a long-acting insulin) to be injected subcutaneously (SQ) every night at bedtime, 2 units of Humalog insulin (a rapid-acting insulin) to be injected SQ with meals at 9:00 AM, 1:00 PM, and 6:00 PM; blood glucose (BG) checks to be done four times daily at 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM; and, Humalog insulin to be provided as sliding scale insulin (SSI) with meals (no SSI coverage provided at bedtime). SSI coverage	F 329	Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F- 329 Resident # 7 blood glucose documentation on the Medication Administration Record that was not recorded on 7/25/2017-7/31/2017.On 8/11/2017 the attending physician was notified by the Interim Director of Nursing of the 5 missing blood glucose documentation and no new orders were received. Also resident # 7 Medication Administration Record exhibited missing documentation of blood glucose results from 8/1/2017- 8/6/2017. The attending physician was again notified on 8/11/2017 by the Interim Director of Nursing of 3 missed documented blood glucose results and no new orders were received.	

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F 329	Continued From page 23 indicated that the dose of insulin administered was dependent on the resident's blood glucose result at the designated time. The SSI ordered utilized the following parameters: If BG is 201-250, give 2 units of Humalog insulin; If BG is 251-300, give 4 units of Humalog insulin; If BG is 301-350, give 6 units of Humalog insulin; If BG is 351-400, give 8 units of Humalog insulin; If BG is 401-450, give 10 units of Humalog insulin; If BG is 451 or greater, give 12 units of Humalog insulin; If the BG is still greater than 450, call the Medical Doctor (MD). A review of Resident #7 ' s July 2017 Medication Administration Record (MAR) from 7/23/17 to 7/31/17 revealed the resident ' s blood sugar results and/or SSI coverage were not documented as having been completed on the following dates/times: --On 7/25/17 at 6:30 AM: BG result and SSI coverage were not recorded; --On 7/25/17 at 11:30 AM: BG result and SSI coverage were not recorded; --On 7/26/17 at 11:30 AM: BG result and SSI coverage were not recorded; --On 7/31/17 at 6:30 AM: BG result and SSI coverage were not recorded; --On 7/31/17 at 4:30 AM: BG result was 414; there was no documentation of SSI coverage. A review of Resident #7 ' s August 2017 Medication Administration Record (MAR) from 8/1/17 to 8/8/17 revealed the resident ' s blood	F 329	Resident # 4 blood glucose results from 7/21/2017 □ 7/24/2017 without documentation on the Medication Administration Record. ON 8/11/2017 the Interim Director of Nursing notified the attending physician of the 2 missing blood glucose documentation and no new orders were obtained. Resident #3 blood glucose with missing documentation on the Medication Administration Record for 8/3/2017@ 8:30 am was reported to the attending physician on 8/11/2017 by the Interim Director of Nursing, and no new orders were obtained. An in-service was conducted for 100% of licensed nurses and medication aides on signing the Medication Administration Record (MAR) and documenting blood glucose recordings and insulin coverage. The in service was conducted by the Interim Director of Nursing and completed on 9/2/2017. An audit tool was initiated by the Interim Director of Nursing that the Medication Administration Record (MAR) has to be checked at the end of each shift with a signature indicating the Medication Administration Record has been checked by the licensed nurse and / or medication aide. The signature indicates that there are no holes and all blood glucose recordings and insulin has been documented. The tool was in serviced by	

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F 329	Continued From page 24 sugar results and/or SSI coverage were not documented as having been completed on the following dates/times: --On 8/1/17 at 11:30 AM: BG result and SSI coverage were not recorded; --On 8/4/17 at 11:30 AM: BG result and SSI coverage were not recorded; --On 8/6/17 at 11:30 AM: BG result and SSI coverage were not recorded. An interview was conducted on 8/10/17 at 1:33 PM with the facility ' s consultant pharmacist. During the interview, the pharmacist was asked if she had noticed there were multiple instances where the facility was not monitoring blood glucose levels or indicating what doses of SSI were used to manage blood glucose levels. The pharmacist stated she had made reports to the facility whenever she was "seeing holes" in the MARs and shared these as being "potential med errors." An interview was conducted on 8/11/17 at 8:00 AM with the facility ' s Administrator. During the interview, the Administrator reported she had reviewed Resident #7 ' s blood glucose/insulin records and stated she had difficulty with the "holes" identified in the resident ' s medical record. The Administrator reported the blood glucose checks should have been completed and recorded, with insulin administered as ordered. An unsuccessful attempt was made on 8/11/17 at 10:05 AM to conduct a telephone interview with Nurse #3. Nurse #3 was assigned to care for Resident #7 on 7/25/17 at 6:30 AM. A telephone interview was conducted on 8/11/17 at 10:08 AM with Nurse #4. Nurse #4 was	F 329	the Interim Director of nursing with 100% completion on 9/2/2017. A mandatory in service for all licensed nurses will be conducted on diabetes, blood glucose and insulin coverage on 9/17/2017 and 9/18/2017. Medication administration audits performed by pharmacy consultant , Interim Director of Nursing, and Staff Facilitator to licensed nurses and medication aides. Audit of Medication Administration Record reviews every shift by licensed nurses and medication aides. Licensed nurses and Medication aides audit tools reviewed by the Interim Director of Nursing, and Staff facilitator weekly X 8 weeks, then bi- monthly for 2 months, then monthly for 2 months. A QI committee was formed on 9/1/2017 consisting of the Interim Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Rehabilitation Director, Minimum Data Set nurses and Medical Records Supervisor. The QI committee will meet weekly X 8 weeks, then bi-monthly for 2 months, then monthly for 2 months. All discrepancies will be reported to the Administrator immediately for review of the process.	

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F 329	Continued From page 25	F 329		

assigned to care for Resident #7 at 11:30 AM (1st shift) on 7/25/17, 7/26/17, 8/1/17, and 8/4/17. During the interview, inquiry was made in regards to the checking of Resident #7 ' s blood glucose and SSI coverage. Nurse #4 reported the medication aides (med aides) usually did the BG checks. However, she stated if the resident was running a low blood glucose or there was another issue, she would do the BG check herself. The nurse reported if a med aide checked a resident ' s BG, the nurse was responsible to document the BG results in both the MAR and the computer. The nurse was unable to recall specifics in regards to the missing blood glucose results and/or SSI coverage.

A follow-up interview was conducted with the Administrator on 8/11/17 at 11:40 AM. During the interview, the Administrator stated her expectation was for the residents ' blood glucose and sliding scale insulin coverage to correlate with the physician ' s orders.

2. Resident #4 was admitted to the facility on 7/21/17 from a recent hospitalization with cumulative diagnoses which included diabetes. Record review revealed no 14 day admission Minimum Data Set assessment or care plan had been completed.

Review of the admission physician orders dated 7/21/17 included:
Blood glucose (BS) checks three times a day with meals with a sliding scale (SSI) coverage with Novolog insulin (fast-acting insulin) for blood sugar results as noted below:
" 70 milligrams per deciliter (mg/dl) -150 1 Unit

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(U)
" 151 mg/dl -200 mg/dl 2U
" 201 mg/dl -250 mg/dl 3U
" 251 mg/dl -300 mg/dl 5U
" 301 mg/dl -350 mg/dl 7U
" 351 mg/dl -400 mg/dl 9U
" >400 mg/dl call MD.

Review of the Medication Administration Record revealed:

" On 7/21/17 at 4:30 PM the BG result and SSI coverage were not recorded. Record review indicated no previous BG results. Record review reviewed the BG at 6:30 AM on 7/24/17 was 83 mg/dl.

" On 7/24/17 at 11:30 AM the BG result and SSI coverage were not recorded.

Interview on 8/9/17 at 11:42 AM with Nurse #8 who stated she did not perform BG check on 8/3/17 at 8:30 am because Resident #4 was out of the building smoking.

Interview on 8/10/17 at 8:50 AM with Nurse #5 revealed the blood glucose level on 7/21/17 at 4:30 PM was not done. No reason provided.

An interview was conducted on 8/10/17 at 1:33 PM with the facility's consultant pharmacist. During the interview, the pharmacist was asked if she had noticed there were multiple instances where the facility was not monitoring blood glucose levels or indicating what doses of SSI were used to manage blood glucose levels. The pharmacist stated she had made reports to the facility whenever she was "seeing holes" in the MARs and shared these as being "potential med errors."

An interview was conducted on 8/11/17 at 8:00 AM with the facility's Administrator. The Administrator stated her expectation was for the blood glucose checks to be completed and recorded with insulin administered as ordered.

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3. Resident #3 was admitted to the facility on 8/2/17 from a recent hospitalization with cumulative diagnoses which included diabetes. Record review revealed no 14 day admission Minimum Data Set assessment or care plan had been completed.
Review of the admission physician orders dated 8/2/17 included:
Blood glucose (BS) checks three times a day with meals with a sliding scale (SSI) coverage with Novolog insulin (fast-acting insulin) for blood sugar results as noted below:
" 121 milligrams per deciliter (mg/dl) -150 mg/dl 1U
" 151 mg/dl -200 mg/dl 2U
" 201 mg/dl -250 mg/dl 3U
" 251 mg/dl -300 mg/dl 5U
" 301 mg/dl -350 mg/dl 7 U
" 351 mg/dl -400 mg/dl 9 U
" >400 mg/dl call the physician.
Review of the Medication Administration Record revealed on 8/3/17 at 8:30 AM the BG result and SSI coverage were not recorded.

Interview on 8/9/17 at 11:42 AM with Nurse #8 who stated she did not perform the blood glucose check on 8/3/17 at 8:30 am because the resident was out of the building smoking. Further review revealed the 12 noon BS was 144 mg/dl
An interview was conducted on 8/10/17 at 1:33 PM with the facility's consultant pharmacist. During the interview, the pharmacist was asked if she had noticed there were multiple instances where the facility was not monitoring blood glucose levels or indicating what doses of SSI were used to manage blood glucose levels. The pharmacist stated she had made reports to the facility whenever she was "seeing holes" in the

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F 329	Continued From page 28 MARs and shared these as being "potential med errors." An interview was conducted on 8/11/17 at 8:00 AM with the facility's Administrator. The Administrator stated her expectation was for the blood glucose checks to be completed and recorded with insulin administered as ordered.	F 329		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and record reviews, the facility failed to administer sliding scale insulin (SSI) in the dose ordered by the physician for 1 of 3 sampled residents who received insulin therapy (Resident #7). The findings included: Resident #7 was admitted to the facility on 3/28/17. The resident ' s cumulative diagnoses included diabetes. A review of Resident #7 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 7/1/17 indicated the resident had intact cognitive skills for daily decision making. The resident required extensive assistance from staff for all of his Activities of Daily Living (ADLs), with the exception of requiring limited assistance for transfers and locomotion on/off the unit, and	F 333	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through	9/6/17

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F 333	Continued From page 29 being independent with eating. Section N of the MDS indicated the resident received an insulin injection on 7 out of 7 days during the look back period. Resident #7 was discharged to the hospital on 7/19/17 and he re-entered the facility on 7/23/17. The resident ' s 7/23/17 re-admission orders at the facility included: 5 units of Lantus insulin (a long-acting insulin) to be injected subcutaneously (SQ) every night at bedtime, 2 units of Humalog insulin (a rapid-acting insulin) to be injected SQ with meals at 9:00 AM, 1:00 PM, and 6:00 PM; blood glucose (BG) checks to be done four times daily at 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM; and, Humalog insulin to be provided as sliding scale insulin (SSI) with meals (no SSI coverage provided at bedtime). SSI coverage indicated that the dose of insulin administered was dependent on the resident's blood glucose result at the designated time. The SSI ordered utilized the following parameters: If BG is 201-250, give 2 units of Humalog insulin; If BG is 251-300, give 4 units of Humalog insulin; If BG is 301-350, give 6 units of Humalog insulin; If BG is 351-400, give 8 units of Humalog insulin; If BG is 401-450, give 10 units of Humalog insulin; If BG is 451 or greater, give 12 units of Humalog insulin; If the BG is still greater than 450, call the Medical Doctor (MD). A review of Resident #7 ' s July 2017 Medication Administration Record (MAR) from 7/23/17 to	F 333	Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F- 333 Resident # 7 Medication Administration Record review with 4 discrepancies in the dosing of sliding scale insulin and missing documentation of repeated blood glucose on 2 of the 4 occurrences was reported to the physician on 8/11/2017 by the Interim Director of Nursing and no new ordered were received. A 100 % in service was initiated by the Interim Director of Nursing on 8/11/2017 and completed on 9/2/2017 on the Five Rights of Medication Administration for licensed nurses and medication aides. A mandatory in service for all licensed nurses will be conducted by on diabetes, blood glucose and insulin coverage on 9/17/2017 and 9/18/2017. An in-service was conducted for 100% of licensed nurses and medication aides on signing the Medication Administration Record (MAR) and documenting insulin coverage. The in service was conducted by the Interim Director of Nursing and completed on 9/2/2017. Medication administration audits performed by pharmacy consultant , Interim Director of Nursing, and Staff Facilitator to licensed nurses to ensure accurate dosing of insulin sliding scale coverage 8/25/2017.	

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F 333	Continued From page 30 7/31/17 revealed the dose of SSI coverage was not consistent with the physician orders on the following dates/time: --On 7/26/17 at 6:30 AM: BG result was 356; SSI coverage was documented as 6 units of Humalog insulin. The SSI regimen indicated 8 units of insulin were ordered. --On 7/27/17 at 4:30 PM: BG result was 475; SSI coverage was documented as 2 units of Humalog insulin. The SSI regimen indicated 12 units of insulin were ordered and the BG needed to be rechecked in 2 hours. There was no documentation of the BG recheck in the resident ' s medical record. --On 7/29/17 at 6:30 AM: BG result was 452; SSI coverage was documented as 10 units of Humalog insulin. The SSI regimen indicated 12 units of insulin were ordered and the BG needed to be rechecked in 2 hours. There was no documentation of the BG recheck in the resident ' s medical record. A review of Resident #7 ' s August 2017 Medication Administration Record (MAR) from 7/23/17 to 7/31/17 revealed the dose of SSI coverage was not consistent with the physician orders on the following date/time: --On 8/3/17 at 4:30 PM: BG result was 414; SSI coverage was documented as 6 units of Humalog insulin. The SSI regimen indicated 10 units were ordered. A telephone interview was conducted on 8/11/17 at 10:00 AM with Nurse #2. Nurse #2 was assigned to care for Resident #7 on 7/27/17 at 4:30 PM and on 8/3/17 at 4:30 PM. Upon review of the BG checks and SSI coverage from these two dates, the nurse reported the medication aides or nursing assistants typically checked the	F 333	A QI committee was formed on 9/1/2017 consisting of the Interim Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Rehabilitation Director, Minimum Data Set nurses and Medical Records Supervisor. The QI committee will meet weekly X 8 weeks, then bi-monthly for 2 months, then monthly for 2 months. All discrepancies will be reported to the Administrator immediately for review of the process.	

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F 333	Continued From page 31 residents ' BG levels and the nurse gave the insulin. Nurse #2 could not recall specifics of the dates discussed or the accuracy of the insulin dose recorded. An unsuccessful attempt was made on 8/11/17 at 10:05 AM to conduct a telephone interview with Nurse #3. Nurse #3 was assigned to care for Resident #7 on 7/26/17 and 7/29/17 at 6:30 AM (3rd shift). An interview was conducted on 8/11/17 at 11:40 AM with the facility ' s Administrator. During the interview, the Administrator stated her expectation was for the resident to receive the insulin doses as ordered by the physician. A telephone interview was conducted on 8/11/17 at 12:20 PM with Resident #7 ' s physician at the facility. During the interview, the discrepancies between the resident ' s BG results and SSI dose administered was discussed. Initially, the physician indicated some of the discrepancies in dosing may be attributed to nursing discretion. However, when all of discrepancies were reviewed, the physician was asked if he would consider such discrepancies of insulin dosing to be a significant concern for a resident with fluctuating BG levels. When asked, the physician stated, "Oh absolutely."	F 333		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that	F 514		9/6/17

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F 514	Continued From page 32 are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to follow established procedures for the consistent and accurate documentation of the administration of controlled substance medications on the Medication Administration Record (MAR) and Controlled Substance Receipt/Count Sheet for 1 of 1 sampled resident reviewed who received a controlled substance medication (Resident #7). The facility failed to	F 514	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of	

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(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 514	Continued From page 33 document medications administered to Resident #4 for 1 of 4 residents in the sample reviewed for well being. The findings included: 1. Resident #7 was admitted to the facility on 3/28/17. The resident was discharged to the hospital on 6/13/17 and re-entered the facility on 6/17/17. The resident ' s 6/17/17 re-admission medications included 5 milligrams (mg) oxycodone (an opioid medication) to be given by mouth every 4 hours as needed for moderate pain; and, 5 mg oxycodone to be given as two tablets (10 mg) by mouth every 4 hours for severe pain. Oxycodone is a controlled substance medication. A review of Resident #7 ' s Controlled Substance Receipt/Count Sheet (a declining inventory record of an individual controlled substance medication stored on the medication cart for a resident) for the 5 mg oxycodone tablets was completed for 6/17/17 - 6/30/17. The Controlled Substance Receipt/Count Sheet revealed one tablet of oxycodone was pulled from the medication cart for administration to the resident on 6/28/17 at 8:30 PM by Medication Aide (Med Aide) #1. However, Resident #7 ' s June 2017 Medication Administration Record (MAR) for 6/17/17 to 6/30/17 indicated no doses of oxycodone were administered to the resident. Further review of Resident #7 ' s Controlled Substance Receipt/Count Sheet revealed 13 doses of oxycodone (10 doses of 1 tablet and 3 doses of 2 tablets) were documented as removed from the medication cart for administration to the resident during the month of July 2017. The	F 514	compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F- 514 Resident # 7 had no doses recorded of oxycodone from 6/17/2017 □ 6/30/2017 on the Medication Administration Record. Resident # 7 Medication Administration Record also indicated that the oxycodone was not recorded on July 30-31, 2017. Facility Medical Director notified by the Interim Director of Nursing on 8/11/2017 and no new orders obtained Resident # 4 Medication Administration Record was not signed for 3 medications(Neurontin 300 mg Keflex 500 mg and Metformin 500 mg) , although only one medication(Neurontin) was not given. The attending physician was notified by the Interim Director of Nursing on 8/11/2017and no new orders were obtained. Resident # 3 Medication Administration Record revealed 8/3/2017-8/5/2017 Cymbalta, Neurontin, Lisinopril and Multivitamin with Minerals did not have initials indicating administration of the	

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dates/times when oxycodone was pulled from the med cart included 7/30/17 at 3:00 AM (2 tablets) and 7/31/17 at 2:30 AM (2 tablets).

A review of Resident #7 ' s July 2017 MAR indicated oxycodone was administered to the resident only 11 times (10 doses of 1 tablet and 1 dose of 2 tablets) during the month. The July 2017 MAR did not document oxycodone was given to Resident #7 on either 7/30/17 or 7/31/17.

Attempts were made to interview Med Aide #1 by telephone on 8/11/17 at 10:12 AM and on 8/11/17 at 12:08 PM. There was no answer and no voice mail message could be left to request a return telephone call. Med Aide #1 was identified by her signature on the Controlled Substance Receipt/Count Sheet as having withdrawn 1 tablet of oxycodone labeled for Resident #7 ' s use on 6/28/17 without documenting its administration to the resident on his MAR.

A telephone interview was conducted on 8/11/17 at 10:20 AM with Nurse #1. Nurse #1 was identified by her initials on the Controlled Substance Receipt/Count Sheet as having pulled 2 tablets of oxycodone from the med cart for Resident #7 on 7/30/17 and 7/31/17 without documenting its administration to the resident on his MAR. During the interview, the nurse discussed the usual process involved in administering and documenting pain medications administered as needed (PRN) for this resident. The nurse reported when the resident indicated he was in pain, she would assess him and check to see if it was time to give a pain medication. If the pain medication and timing were determined to be appropriate, Nurse #1 reported she would administer the medication. Upon inquiry, the medication. Nurse admits to delivery, attending physician notified by the Interim Director of Nursing 8/11/2017 with no new orders obtained.

An in-service was conducted for 100% of licensed nurses and medication aides on signing the Medication Administration Record (MAR) when medication administered. The in service was conducted by the Interim Director of Nursing and completed on 9/2/2017.
An audit tool was initiated by the Interim Director of Nursing that the Medication Administration Record (MAR) has to be checked at the end of each shift with a signature indicating the Medication Administration Record has been checked by the licensed nurse and / or medication aide. The signature indicates that there are no holes and all administration of medication has been documented. The tool was in serviced by the Interim Director of nursing with 100% completion on 9/2/2017.

Medication administration audits performed by pharmacy consultant , Interim Director of Nursing, and Staff Facilitator to licensed nurses and medication aides.
Audit of Medication Administration Record reviews every shift by licensed nurses and medication aides.
Licensed nurses and Medication aides audit tools reviewed by the Interim Director of Nursing, and Staff facilitator weekly X 8 weeks, then bi- monthly for 2 months, then monthly for 2 months.

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F 514	Continued From page 35	F 514	A QI committee was formed on 9/1/2017 consisting of the Interim Director of Nursing, Assistant Director of Nursing, Staff Facilitator, Director of Nursing, and Assistant Director of Nursing, Rehabilitation Director, Minimum Data Set nurses and Medical Records Supervisor. The QI committee will meet weekly X 8 weeks, then bi-monthly for 2 months, then monthly for 2 months. All discrepancies will be reported to the Administrator immediately for review of the process. The Administrator will report quarterly to the executive quality improvement committee quarterly X2. The Executive Committee consist of: medical director, administrator, DON, pharmacy consultant, dietary manager, activities director and medical record director. Recommendations to continue, alter or modify will be discussed at that time.	

nurse stated she typically documented the med administration on the front of the MAR, the back of the MAR, and in the narcotic book (containing the Controlled Substance Receipt/Count Sheet) after the medication was given. When asked, Nurse #1 stated she couldn ' t recall the specifics of what happened to prevent her from documenting the medication administration on the resident ' s MAR.

An interview was completed on 8/11/17 at 11:40 AM with the facility ' s Administrator. During the interview, the Administrator stated her expectation was for nursing staff to sign the MAR when a controlled substance was given to a resident. She also indicated the documentation on a resident ' s Controlled Substance Receipt/Count Sheet and the resident ' s MAR should be consistent and coincide with one another.

2. Resident #4 was admitted to the facility on 7/21/17 from a recent hospitalization with cumulative diagnoses which included diabetes.
Review of the admission physician orders dated 7/21/17 included:

" Neurontin 300 milligrams (mg) by mouth (po) three times a day. Neurontin is a drug used to treat nerve pain.-

" Keflex 500 mg three times a day. Scheduled to be administered 9 AM, 1 PM and 9 PM. Keflex is an antibiotic.

" Metformin 500 mg po in the am with meals and 1000 mg at bedtime. Metformin is an oral hypoglycemia pill.

Review of the Medication Administration Record (MAR) revealed Keflex 500 mg at 9 PM and Metformin 1000 mg at bedtime on 7/21/17 were not documented as administered to Resident #4.
Interview on 8/10/17 at 8:50 AM with Nurse #5

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revealed she administered Keflex 500 mg at 9 PM and Metformin 1000 mg at bedtime on the day of admission (on 7/21/17) but did not document. Record review with Nurse #5 revealed an emergency drug kit replacement form showing Nurse #5 retrieved Keflex 500 mg and Metformin 1000 mg out of the medication backup kit in the facility.

An interview was completed on 8/11/17 at 11:40 AM with the facility ' s Administrator. During the interview, the Administrator stated her expectation was for nursing staff to sign the MAR when medications are administered.

3. Resident #3 was admitted to the facility on 8/2/17 with cumulative diagnoses which included diabetes mellitus.
Review of the admission physician orders dated 8/2/17 included:
" Cymbalta 60 milligrams (mg) by mouth (po) once a day (QD). Cymbalta is used to treat depression.
" Neurontin 300 mg qd po. Neurontin is used to treat nerve pain.
" Lisinopril 20 mg po qd po. Lisinopril is used to treat high blood pressure and heart failure.
" Multivitamin with Minerals 1 qd po
Review of the Medication Administration Record (MAR) revealed Cymbalta, Neurontin, Multivitamin with Minerals and Lisinopril scheduled for 8/3/17, 8/4/17 and 8/5/17 at 9 am were not documented as administered.
Interview on 8/9/17 at 11:42 AM with Nurse #8 who stated she administered Cymbalta, Multivitamin with Minerals , Lisinopril and Neurontin but did not document the medications were administered.

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F 514	Continued From page 37 An interview was completed on 8/11/17 at 11:40 AM with the facility ' s Administrator. During the interview, the Administrator stated her expectation was for nursing staff to sign the MAR when medications are administered.	F 514		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the	F 520		9/6/17

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F 520	Continued From page 38 records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place in April 2017. This was for one recited deficiency, which was originally cited during the facility ' s recertification survey completed on 5/5/16, and recited during both the last recertification survey on 4/7/17 and the current complaint survey. The deficiency was in the area of assessment accuracy (F278). One additional deficiency originally cited during the last recertification survey completed on 4/7/17 was recited on the current complaint survey. This deficiency was in the area of care planning (F279). The continued failure of the facility during three federal surveys of record show a pattern of the facility ' s inability to sustain an effective QAA Program. The findings included: This tag is cross referred to: a) F278: Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the use of a pain medication for 1 of 3 sample residents	F 520	Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding. F- 520 F -520	

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F 520	Continued From page 39 reviewed who were receiving pain medications (Resident #7). During the annual recertification survey of 5/5/16, the facility was cited F278 for failure to accurately code the MDS assessment to reflect the active diagnoses for 1 of 4 sample residents reviewed. The facility was recited F278 during the recertification survey of 4/7/17 for failure to accurately code the MDS on the oral status for 1 of 3 residents and the PASRR Level II status for 1 of 1 resident. b) F279: Based on observation, staff interview and record review the facility failed to develop a comprehensive care plan with measureable goals and interventions to address Resident #9 bilateral hand contractures. This was evident in 1 of 1 resident reviewed for contractures. During the recertification survey of 4/7/17, the facility was cited for F279 for failure to develop a care plan which addressed a therapeutic activity program for 1 of 5 residents reviewed. The facility ' s Administrator was interviewed on 8/11/17 at 2:30 PM regarding the recited deficiencies and corrective action taken for MDS accuracy and care plans. During the interview, the Administrator stated she expressed concerns about the accuracy of MDS assessments at a 7/20/17 QAA Executive Meeting. She stated audits completed on the MDS assessments continued to find a few issues, so additional educational opportunities were provided for the MDS nurses. The Administrator also reported the facility had a corporate nurse come in to complete an audit on the MDS assessments. This audit	F 520	Corrective action has been taken for the identified concerns related to F -278 Assessment Accuracy/Coordination/Certified and F 279 Comprehensive Care Plans as reflected in the plan of correction. On 8/30/2017 the Medical Director was notified by the Administrator of the Assessment Accuracy and Comprehensive Care Plan concerns without additional recommendation besides reeducation of the Minimum Data Set nurses, licensed nurses to sign for as needed medication on the Medication Administration record and audits to research for continued issues . The Quality Improvement Committee consist of the Interim Director of Nursing, Staff Facilitator, Minimum Data Set nurses, and Medical Record Supervisor. The Quality Improvement Committee will continue to meet at a minimum of monthly with the Executive QI committee meeting quarterly. The Executive QI Committee, including the Medical Director, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. Any areas of concern that needs to be corrected or changed will be done at this time. The administrator will be	

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F 520	Continued From page 40 identified some missed entries and discharges. The Administrator stated, "The plan now is we have to retrain them (MDS nurses) from the bottom up to correct this." During the interview, the Administrator also discussed the recited deficiency for care plans. She indicated care plans were initially cited for activities and the deficiency identified during the current complaint survey involved another care area. However, the Administrator indicated the MDS nurses were instructed to update residents ' care plans with every assessment and, "This just wasn ' t done."	F 520	responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting.	